

TEMPLATE FOR CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: North Carolina
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR 457.40(b))

(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following Child Health Plan for the Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following State officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: Mandy Cohen

Position/Title: Secretary, NC DHHS

Name: Dave Richard

Position/Title: Deputy Secretary for
Division of Medical Assistance

Name: Beth Daniel

Position/Title: CHIP Coordinator

*Disclosure. 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 #34). The time required to complete this information collection is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 105-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children’s Health Insurance Program (CHIP). In February 2009, the Children’s Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act of 2010 further modified the program.

This template outlines the information that must be included in the state plans and the state plan amendments (SPAs). It reflects the regulatory requirements at 42 CFR Part 457 as well as the previously approved SPA templates that accompanied guidance issued to States through State Health Official (SHO) letters. Where applicable, we indicate the SHO number and the date it was issued for your reference. The CHIP SPA template includes the following changes:

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
 - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
 - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
 - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
 - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
 - Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
 - Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
 - Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.

The Centers for Medicare & Medicaid Services (CMS) is developing regulations to implement the CHIPRA requirements. When final regulations are published in the Federal Register, this template will be modified to reflect those rules and States will be required to submit SPAs illustrating compliance with the new regulations. States are not required to resubmit their State plans based on the updated template. However, States must use the updated template when submitting a State Plan Amendment.

Federal Requirements for Submission and Review of a Proposed SPA. (42 CFR Part 457 Subpart A)
In order to be eligible for payment under this statute, each State must submit a Title XXI plan for approval by the Secretary that details how the State intends to use the funds and fulfill other requirements under the law and regulations at 42 CFR Part 457. A SPA is approved in 90 days unless the Secretary notifies the State in writing that the plan is disapproved or that specified additional information is needed. Unlike Medicaid SPAs, there is only one 90 day review period, or clock for CHIP SPAs, that may be stopped by a request for additional information and restarted after a complete response is received. More information on the SPA review process is found at 42 CFR 457 Subpart A.

When submitting a State plan amendment, states should redline the changes that are being made to the

existing State plan and provide a “clean” copy including changes that are being made to the existing state plan.

The template includes the following sections:

1. **General Description and Purpose of the Children’s Health Insurance Plans and the Requirements-** This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination-** This section should provide general information related to the special characteristics of each state’s program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls-** This section requires a description that must include both proposed methods of delivery and proposed utilization control systems. This section should fully describe the delivery system of the Title XXI program including the proposed contracting standards, the proposed delivery systems and the plans for enrolling providers. (Section 2103); (42 CFR 457.410(A))
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)
5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42 CFR 457.90)
6. **Coverage Requirements for Children’s Health Insurance-** Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations

or exclusions. (Section 2103); (42 CFR 457.410(A))

7. **Quality and Appropriateness of Care-** This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR 457.495)
8. **Cost Sharing and Payment-** This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration-** The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations-** Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)
11. **Program Integrity-** In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections-** This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

Program Options. As mentioned above, the law allows States to expand coverage for children through a separate child health insurance program, through a Medicaid expansion program, or through a combination of these programs. These options are described further below:

- **Option to Create a Separate Program-** States may elect to establish a separate child health program that are in compliance with title XXI and applicable rules. These states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children and also must screen children during the application process to determine if they are

eligible for Medicaid and, if they are, enroll these children promptly in Medicaid.

- **Option to Expand Medicaid-** States may elect to expand coverage through Medicaid. This option for states would be available for children who do not qualify for Medicaid under State rules in effect as of March 31, 1997. Under this option, current Medicaid rules would apply.

Medicaid Expansion- CHIP SPA Requirements

In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:

- 1 (General Description)
- 2 (General Background)

They will also be required to complete the appropriate program sections, including:

- 4 (Eligibility Standards and Methodology)
- 5 (Outreach)
- 9 (Strategic Objectives and Performance Goals and Plan Administration including the budget)
- 10 (Annual Reports and Evaluations).

Medicaid Expansion- Medicaid SPA Requirements

States expanding through Medicaid-only will also be required to submit a Medicaid State Plan Amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the description of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:

- 3 (Methods of Delivery and Utilization Controls)
- 4 (Eligibility Standards and Methodology)
- 6 (Coverage Requirements for Children's Health Insurance)
- 7 (Quality and Appropriateness of Care)
- 8 (Cost Sharing and Payment)
- 11 (Program Integrity)
- 12 (Applicant and Enrollee Protections)

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under "Option to Expand Medicaid" would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in "Option to Create a Separate Program" would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

Proposed State plan amendments should be submitted electronically and one signed hard copy to the Centers for Medicare & Medicaid Services at the following address:

Name of Project Officer

Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244
Attn: Children and Adults Health Programs Group
Center for Medicaid and CHIP Services
Mail Stop - S2-01-16

Section 1. General Description and Purpose of the Children’s Health Insurance Plans and the Requirements

1.1. The state will use funds provided under Title XXI primarily for (Check appropriate box) (Section 2101)(a)(1)); (42 CFR 457.70):

Guidance: Check below if child health assistance shall be provided primarily through the development of a separate program that meets the requirements of Section 2101, which details coverage requirements and the other applicable requirements of Title XXI.

1.1.1. Obtaining coverage that meets the requirements for a separate child health program (Sections 2101(a)(1) and 2103); OR

Guidance: Check below if child health assistance shall be provided primarily through providing expanded eligibility under the State’s Medicaid program (Title XIX). Note that if this is selected the State must also submit a corresponding Medicaid SPA to CMS for review and approval.

1.1.2. Providing expanded benefits under the State’s Medicaid plan (Title XIX) (Section 2101(a)(2)); OR

Guidance: Check below if child health assistance shall be provided through a combination of both 1.1.1. and 1.1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the State’s Medicaid program). Note that if this is selected the state must also submit a corresponding Medicaid state plan amendment to CMS for review and approval.

1.1.3. X A combination of both of the above. (Section 2101(a)(2))

North Carolina’s Title XXI Plan, the North Carolina Health Choice for Children (NCHC) Program, is a combination plan consisting of:

- a. Medicaid Expansion Groups with the following converted MAGI-equivalent income thresholds:
 - i. Children ages 0 (newborn) through 12 months with family income from 194% up to and including 210% of Federal Poverty Level;
 - ii. Children ages 13 months through 5 years with family income from 141% up to and including 210% of the Federal Poverty Level; and
 - iii. Children ages 6 through 18 years with family income from 107% up to and including 133% of the Federal Poverty Level.

The State enrolls children ages 0 through and including 18 residing in families with annual incomes as specified in Section 1.1.3 in the Title XXI Medicaid Expansion child health program. These children receive the same benefits as children enrolled under the Medicaid Title XIX program. As in the Medicaid program, these children may have other health insurance coverage. However, Medicaid is always the payer of last resort.

b. Separate Child Health Program:

Uninsured children from ages 6 through 18 years (up to the last day of the month in which the beneficiary turns 19):

- With converted MAGI-equivalent family income thresholds from above 133% up to and including 211% of the Federal Poverty Level;
- Who do not qualify for Medicaid, Medicare, or other federal government sponsored health insurance;
- Who are residents of North Carolina and eligible under Federal law; and
- Who have paid the Program enrollment fee.

1.1-DS The State will provide dental-only supplemental coverage. Only States operating a separate CHIP program are eligible for this option. States choosing this option must also complete sections 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template. (Section 2110(b)(5))

1.2. X Check to provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

1.3. X Check to provide an assurance that the State complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42 CFR 457.130)

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

1.4. Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan

Effective Date: October 1, 1998

Implementation Date: October 1, 1998

Superseding Pages of MAGI CHIP State Plan Material
State: North Carolina

SPA #15-0001

Purpose of SPA: The primary purpose of SPA #15-001 is to implement program eligibility changes to reflect Affordable Care Act and State legislative requirements. The North Carolina Legislature has not amended any legislation affecting program benefits or cost sharing since 2011. This SPA also documents the repeal of North Carolina's CHIP buy-in program effective October 1, 2015.

Proposed effective date: October 1, 2015

Proposed implementation date: October 1, 2015

SPA#17-0001

Purpose of SPA: This State Plan Amendment is to comply with updated template as well as to demonstrate compliance with Mental Health parity. The North Carolina Health Choice (NCHC) Program, is the only North Carolina (NC) benefit plan to which the final rule applies. The North Carolina Division of Medical Assistance (DMA) has completed an analysis of the NCHC benefit package and has determined that NC is compliant with the final rule.

In addition to the changes above, the NCHC is authorized by this State Plan to reimburse at the Medicaid established rate for the provided services. Unless otherwise authorized within this section of the State Plan, Title XXI services are prospectively reimbursed and not subject to cost settlement.

Proposed effective date: October 1, 2017

Proposed implementation date: October 1, 2017

1.4- TC Tribal Consultation (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

The North Carolina Department of Health and Human Services, Division of Medical Assistance, follows the same Tribal consultation process for the CHIP Program as it does for the State Medicaid Program. North Carolina received CMS approval on SPA 10-038 on March 17, 2011 to establish the Tribal consultation process which consists of a representative of the Eastern Band of Cherokee Indians sitting on the Medical Care Advisory Committee. The Advisory Committee meets at least quarterly to review activities of the Division of Medical Assistance and provide recommendations and advice on current and future policy initiatives and pending changes to the Medicaid and CHIP programs. During the development of this SPA and prior to submission to CMS:

- The State sought the Tribe's advice and input on matters related to the changes to Medicaid and CHIP programs through the MCAC quarterly meeting.
- The State Medicaid Agency also notified the Tribe in writing of these pending CHIP SPA changes via e-mail on April 6, 2015 providing details of the changes.
- The tribe notified the Agency on April 6, 2015 that they were in agreement with the changes.
- Please see attached in the SPA submission packet the CMS standard tribal questions/responses, the notification to the tribes, and the tribal notification back to the State.

TN No: 10-038 Approval Date: 03/17/2011 Effective Date: 01/01/2011

Section 2. General Background and Description of Approach to Children's Health Insurance Coverage and Coordination

Guidance: The demographic information requested in 2.1. can be used for State planning and will be used strictly for informational purposes. THESE NUMBERS WILL NOT BE USED AS A BASIS FOR THE ALLOTMENT.

Factors that the State may consider in the provision of this information are age breakouts, income brackets, definitions of insurability, and geographic location, as well as race and ethnicity. The State should describe its information sources and the assumptions it uses for the development of its description.

- Population
- Number of uninsured
- Race demographics
- Age Demographics
- Info per region/Geographic information

- 2.1.** Describe the extent to which, and manner in which, children in the State (including targeted low-income children and other groups of children specified) identified, by income level and other relevant factors, such as race, ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, distinguish between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (Section 2102(a)(1)); (42 CFR 457.80(a))

The North Carolina Health Choice for Children program serves all 100 counties across the State. The State screens and enrolls uninsured eligible children in the Medicaid expansion program and the separate Child Health Insurance Program based on family size, modified adjusted gross income (MAGI) as a percentage of the Federal Poverty Level (FPL %), and age.

According to the NC Institute of Medicine’s (NCIOM) 2013 *Child Health Report Card*, “More than 160,000 children in NC slipped into poverty during the recent recession, as the percentage of poor children increased from 19.5 percent of the child population in 2007 to 26 percent – more than one in every four children – in 2012.” However, the NCIOM reported that in a five-year period from 2007 to 2012, the percentage of uninsured children living under 200 percent of the FPL in NC *decreased* from 20.6 percent to 11.4 percent. Furthermore, the U.S. Census Bureau’s 2013 American Community Survey estimated the number of children in North Carolina under age 19 living below 200percent of the federal poverty level to be 1,164,000. Within this population, the number of children without health insurance and therefore potentially eligible for Title XIX or Title XXI healthcare programs was estimated at 105,000 or 9 percent.

In State Fiscal Year 2014, 124,097 children applied for NC Health Choice Program eligibility. The percentage of eligible children, by age, who applied for the NC Health Choice Program was 35 percent for ages 6 through 9; 39 percent for ages 10 – 14; and 26 percent for ages 15 through 18.

In State Fiscal Year 2014, there were over 67,000 (55%) White applicants; over 36,000 (30%) Black applicants; over 3,000 (2.5%) Asian applicants; over 1,000 (1.4%) American Indian/Alaska Native applicants. More than 14,000 (8.1%) applicants did not indicate their race on the application form. Section 5 of this State Plan describes the NC Health Choice Program’s specific outreach efforts for unique ethnic and racial groups.

For the first half of SFY2014, the average NC Health Choice [separate CHIP program] monthly enrollment was 155,539. After implementation of the Affordable Care Act CHIP Medicaid Expansion on January 1, 2014, the average NC Health Choice monthly enrollment through August 2014 was 80,825.

The purpose of North Carolina’s Title XXI plan is to ensure that every child in the state has access to an ongoing system of preventive health care. The program is designed to provide comprehensive health care coverage for children of working families who make too much to qualify for Title XIX and too little to afford employer-sponsored health insurance or private insurance available through the Federally Facilitated Marketplace.

Guidance: Section 2.2 allows states to request to use the funds available under the 10 percent limit on administrative expenditures in order to fund services not otherwise allowable. The health services initiatives must meet the requirements of 42 CFR 457.10.

2.2. Health Services Initiatives- Describe if the State will use the health services initiative option as allowed at 42 CFR 457.10. If so, describe what services or programs the State is proposing to cover with administrative funds, including the cost of each program, and how it is currently funded (if applicable), also update the budget accordingly. (Section

2105(a)(1)(D)(ii)); (42 CFR 457.10)

2.3-TC

Tribal Consultation Requirements- (Sections 1902(a)(73) and 2107(e)(1)(C)); (ARRA #2, CHIPRA #3, issued May 28, 2009) Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCA). Section 2107(e)(1)(C) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Include information about the frequency, inclusiveness and process for seeking such advice.

The NC DHHS Secretary has appointed a designated liaison in the Office of the Secretary to facilitate the intergovernmental relationship between the Department and the Eastern Band of the Cherokee Indians and any other Indian Health Program meeting the definition under the Act to assure compliance with the federal provisions for and to expedite communication and between these entities. To meet the requirements for timely notification of the Tribe for CHIP SPA submissions or other policy changes that arise between MCAC Quarterly meetings, the Division of Medical Assistance will notify the Tribe in writing of these pending changes. The State will use this combined approach to seek the Tribe's advice and input on matters related to the changes to the Medicaid and CHIP programs.

Section 3. Methods of Delivery and Utilization Controls

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 4.

Guidance: In Section 3.1., discussion may include, but is not limited to: contracts with managed health care plans (including fully and partially capitated plans); contracts with indemnity health insurance plans; and other arrangements for health care delivery. The State should describe any variations based upon geography, as well as the State methods for establishing and defining the delivery systems.

Should the State choose to cover unborn children under the Title XXI State plan, the State must describe how services are paid. For example, some states make a global payment for

all unborn children while other states pay for services on fee-for-services basis. The State's payment mechanism and delivery mechanism should be briefly described here.

Section 2103(f)(3) of the Act, as amended by section 403 of CHIPRA, requires separate or combination CHIP programs that operate a managed care delivery system to apply several provisions of section 1932 of the Act in the same manner as these provisions apply under title XIX of the Act. Specific provisions include: section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. If the State CHIP program operates a managed care delivery system, provide an assurance that the State CHIP managed care contract(s) complies with the relevant sections of section 1932 of the Act. States must submit the managed care contract(s) to the CMS Regional Office servicing them for review and approval.

In addition, states may use up to 10 percent of actual or estimated Federal expenditures for targeted low-income children to fund other forms of child health assistance, including contracts with providers for a limited range of direct services; other health services initiatives to improve children's health; outreach expenditures; and administrative costs (See 2105(c)(2)(A)). Describe which, if any, of these methods will be used.

Examples of the above may include, but are not limited to: direct contracting with school-based health services; direct contracting to provide enabling services; contracts with health centers receiving funds under section 330 of the Public Health Service Act; contracts with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Act; contracts with other hospitals; and contracts with public health clinics receiving Title V funding.

If applicable, address how the new arrangements under Title XXI will work with existing service delivery methods, such as regional networks for chronic illness and disability; neonatal care units, or early-intervention programs for at-risk infants, in the delivery and utilization of services. (42 CFR 457.490(a))

- 3.1. Delivery Standards** Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42 CFR 457.490(a))

- Check here if the State child health program delivers services using a managed care delivery model. The State provides an assurance that its managed care contract(s) complies with the relevant provisions of section 1932 of the Act, including section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance

Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. The State also assures that it will submit the contract(s) to the CMS Regional Office for review and approval. (Section 2103(f)(3))

Potential new and returning applicants for the NC Health Choice Program are simultaneously screened by a county Department of Social Services (DSS) for eligibility in the State Medicaid Program at the time of application or re-application. This one-stop application process expedites eligibility determination and enrollment in either program. Another parallel between the State Medicaid Program and NC Health Choice is the use of the same claims processing vendor, Computer Sciences Corporation (CSC), as of July 1, 2013. This consolidation of claims processing under one vendor provides a standardized and efficient means of managing health services claims. Finally, beneficiaries in both the State Medicaid Program and NC Health Choice are assigned to a primary care provider medical home via the Community Care of North Carolina (CCNC) network within a primary care case management delivery system. 2011 State legislation mandated standardized requirements for Medicaid and Health Choice Provider applications, screenings, and enrollment.

Methods for Assuring Delivery

Program eligibility is determined through the use of the aforementioned dual Medicaid and Health Choice application by county DSSs. The State transmits new, revised, and cancelled NC Health Choice beneficiary records nightly to the claims processor. Upon determination of an applicant's eligibility and the collection of any applicable enrollment fee, the county eligibility specialist enters the new or renewal applicant's eligibility and demographic information into the State eligibility and enrollment system. The claims processor creates an updated eligibility file with a unique member ID number and generates an annual ID card for each NC Health Choice beneficiary. The card contains the coverage effective date, primary care provider contact information, medical and pharmacy co-payment amounts, and toll-free numbers for providers requesting prior authorization, benefit limits, and claim filing information. The beneficiary must present the ID card when seeking services at a provider office, hospital inpatient or outpatient facilities, or pharmacy. The provider can then verify eligibility via web or phone verification with the claims processor. In the event of an emergency for a beneficiary requiring medication, the claims processor has the authority to update beneficiary eligibility in the claims processing system manually for pharmacy Point-of-Sale verification.

The Division of Medical Assistance (DMA) funds and maintains an account to reimburse the claims processor for claim and administrative expenses, in addition to expenses from other contracts established for NC Health Choice program services. Additional vendor contracts include actuarial services, third party recovery and subrogation services, independent auditor services to monitor claims payment accuracy rates, eyewear (glasses & contacts) services, and behavioral health services utilization review.

Choice of Financing

The NC Health Choice for Children Program is funded with federal funds in an enhanced Federal Medical Assistance Percentage ratio pursuant to the allotment to States in 42 USC § 1397dd and State appropriated funds.

Title XXI (Health Choice) services authorized by this State Plan are reimbursed at the Medicaid established rate for the provided service. Unless otherwise authorized within this section of the State Plan, Title XXI services are prospectively reimbursed and not subject to cost settlement.

The Division Managed Care Health Choice program services are all reimbursed on a Fee-for-Service basis within a primary care case management health service delivery structure (which qualifies as managed care under 42 C.F.R. 457.10). NC Health Choice beneficiaries are linked to a primary care provider in the Community Care of North Carolina (CCNC) primary care case management network. This network ensures cost-effective health care access and utilization. The NC Department of Health and Human Services pays CCNC providers the same per member, per month fees allowed under the State Medicaid Program. Providers are also being reimbursed on a Fee-for-Service basis for services rendered to NC Health Choice beneficiaries.

Health Choice beneficiaries select or are assigned to a CCNC Medical Home primary care provider (PCP). That provider's contact information appears on the beneficiary's health insurance ID card. Beneficiaries are encouraged to make an appointment to get a medical history established with their PCP; beneficiaries must see the PCP for most health care services and obtain referrals to see other providers.

Pursuant to 42 U.S.C. 1397cc(f)(3) and 42 U.S.C. 1396u-2(1)(c), enrollment in CCNC is optional for federally recognized American Indian Medicaid and NC Health Choice beneficiaries whether or not they receive services through tribal facilities.

Beneficiaries may change primary care providers by contacting the Department of Social Services. Beneficiary rights and procedures for changing providers are the same as those for the State Medicaid Program. Beneficiaries may change providers during a review process, when the currently authorized provider goes out of business, and when the beneficiary is changing providers for another service with an authorization period of six months or more. The current authorization for services will transfer to the new provider within five (5) business days of notification by the new provider to the Division of Medical Assistance Fiscal Agent and upon submission of written attestation that provision of the service meets NC Health Choice policy and the beneficiary's condition meets coverage criteria and acceptance of all associated responsibility; and *either*: a) Written permission of beneficiary or legal guardian for transfer; *or* b) a copy of a discharge from the previous provider.

Authorization will be effective on the date that the new provider submits a copy of the written attestation. Prior to the end of the current authorization period, the new provider

must submit a request for reauthorization of the service in accordance with the clinical coverage policy requirements and these procedures. Beneficiaries may change providers at any other time. However, the discharging provider and the new provider must follow all policy requirements and these procedures.

Effective October 1, 2015, North Carolina Health Choice hospital outpatient services, excluding laboratory services, for in-state hospitals shall be reimbursed at 70 percent (70%) of their allowable outpatient costs. North Carolina Health Choice allowable outpatient costs shall be determined using the CMS 2552 cost report, 42 CFR § 413, and the CMS Provider Reimbursement Manual. If a hospital's interim NC Health Choice payments exceed the allowable outpatient cost for NC Health Choice services, the provider shall remit the difference at the time the cost report is filed. The Division shall return the federal share of the difference via the CMS 64 Report. If a hospital's allowable outpatient cost for NC Health Choice services exceeds the NC Health Choice interim payments on the filed and accepted cost report, and subject to the availability of federal funds in the NC Health Choice allotment, the Division shall pay the difference to the provider and submit claims to the CMS for reimbursement of the federal share of that payment in the federal fiscal quarter following payment to the provider. No cost settlement payment shall be paid to the provider if funds in the NC Health Choice allotment are unavailable or insufficient to cover the federal share of the cost settlement.

Effective July 1, 2016, Local Health Departments shall be reimbursed their allowable costs for covered services, which are rendered to North Carolina Health Choice recipients. North Carolina Health Choice allowable costs for covered services shall be determined using the CMS approved cost report methodology in the Medicaid (Title XIX) State Plan, 42 CFR § 413, and the CMS Provider Reimbursement Manual. If a local health department's interim NC Health Choice payments exceed the provider's certified cost for NC Health Choice services, the provider shall remit the excess federal share of the overpayment at the time the cost report is filed. The Division shall return the federal share of the difference via the CMS 64 Report. If a local health department's certified cost for NC Health Choice services exceeds the NC Health Choice interim payments on the filed and accepted cost report, and subject to the availability of funds in the NC Health Choice allotment, the Division shall pay the federal share of the difference to the provider and submit claims to the CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider. No cost settlement payment shall be paid to the provider if funds in the NC Health Choice allotment are unavailable or insufficient to cover the federal share of the cost settlement.

Guidance: In Section 3.2., note that utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package.

Examples of utilization control systems include, but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42 CFR 457.490(b))

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102)(a)(4) (42 CFR 457.490(b))

The NC Health Choice for Children program uses utilization controls which include:

- a. requirements for medical necessity determination;
- b. prior approval requirements;
- c. benefit limitations;
- d. utilization management reporting; and
- e. fraud and abuse detection.

a. requirements for medical necessity determination

All medical services performed must be medically necessary and may not be experimental in nature. Medical necessity is determined by generally accepted North Carolina community practice standards.

b. prior approval requirements

Numerous Health Choice clinical coverage policies for medical, surgical, and mental health and substance abuse services require prior approval before a service may be provided. However, utilization review and prior approval treatment limitations are no more restrictive among the mental health and substance abuse services than they are among the medical and surgical services. Some prior approval requirements are recommended by the Physician Advisory Group (PAG), a non-profit organization that was created for the purpose of advising the North Carolina Department of Health and Human Services. The PAG provides formal policy review and recommendations on new and existing medical coverage policies as part of a medical policy development process controlled by NC statutes. Prior approval serves to further ensure that services are only covered when medically necessary. Prior approval also allows the NC Health Choice Program to control service utilization and subsequently the cost of Program administration. This is particularly important since Health Choice is not an entitlement program and receives limited State-appropriated funding.

c. benefit limitations

NC Session Law 2011-145 mandated that “Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under the North Carolina Medicaid Program except for the following:

- 1) No services for long-term care;
- 2) No non-emergency medical transportation;
- 3) No EPSDT; and
- 4) Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.” NC Health Choice Program clinical coverage service restrictions and visit limits within clinical coverage policies are equivalent to the restrictions and limitations in the equivalent NC Medicaid Program clinical coverage policies. In the aggregate, the service restrictions and limitations help contain program administration costs.

d. utilization management reporting

The DMA contract with its claims processing agent is in compliance with applicable statutes. DMA and its contractors also agree to prescriptive requirements for internal utilization review, provider and beneficiary monitoring, and performance standards. The Claims Processing Contractor utilization management reporting includes: trending; comparison to prior reporting periods; and changes in utilization amounts, costs by type of service, and provider practice patterns.

e. fraud and abuse detection

The DMA Program Integrity Section works closely with NC Health Choice Utilization Review vendors regarding special investigations, provider site audits, identified third party resources, comprehensive insurance identified for Title XXI beneficiaries, and coordination of special projects.

North Carolina law contains provisions regarding beneficiaries’ fraudulent utilization of the NC Health Choice Program. One Health Choice eligibility requirement is being uninsured. N.C. GEN. STAT. § 108A-70.21(a) requires that if any health insurance other than Health Choice is provided to a child after enrollment in the Program and prior to the expiration of the twelve-month eligibility period, the custodial parent must notify the Department within 10 days of receipt of the other health insurance. Finally, N.C. GEN. STAT. § 108A-70.28 contains provisions for the criminal prosecution of participants’ guardians who undertake any fraudulent misrepresentation relating to eligibility for or utilization of the NC Health Choice Program.

Section 4. Eligibility Standards and Methodology

Guidance: The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. Included on the template is a list of potential eligibility standards. Please check off the standards that will be used by the state and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not

discriminate on the basis of diagnosis. In addition, if the standards vary within the state, describe how they will be applied and under what circumstances they will be applied.

States electing to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan or combination plan should check the appropriate box and provide the ages and income level for each eligibility group.
If the State is electing to take up the option to expand Medicaid eligibility as allowed under section 214 of CHIPRA regarding lawfully residing, complete section 4.1-LR as well as update the budget to reflect the additional costs if the state will claim title XXI match for these children until and if the time comes that the children are eligible for Medicaid.

4.0. X Medicaid Expansion

4.0.1. Ages of each eligibility group and the income standard for that group: NC uses Title XXI funding to expand Medicaid benefits to the following assistance categories based on family income in relation to the Federal Poverty Level:

1. Children 0 – 12 months of age with family income from 194% up to and including 210% of the federal poverty income level;
2. Children 13 months – 5 years of age with family income from 141% up to and including 210% of the federal poverty income level; and
3. Children 6-18 years of age with family income from 107% up to and including 133% of the federal poverty income level.

4.1. X Separate Program Check all standards that will apply to the State plan. (42 CFR 457.305(a) and 457.320(a))

4.1.0 Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option.

North Carolina has been conducting a daily, automated match with social security numbers provided on joint Medicaid and NC Health Choice eligibility applications since January of 2010. If an applicant claims to be a U.S. citizen, the DSS sends the Social Security number to the Social Security Administration (SSA) for a citizenship match. The average response time for a match through the SSA is 24 to 48 hours.

4.1.1 Geographic area served by the Plan if less than Statewide:

4.1.2 X Ages of each eligibility group, including unborn children and pregnant women (if applicable) and the income standard for that group:

4.1.2.1-PC Age: through birth (SHO #02-004, issued November 12,

2002)

Pursuant to N.C. GEN. STAT. § 108A 70.21(a)(1), all beneficiaries in the separate CHIP Program (NC Health Choice) must be 6 through and including 18 years of age.

4.1.3 X Income of each separate eligibility group (if applicable):

4.1.3.1-PC 0% of the FPL (and not eligible for Medicaid) through _____ % of the FPL (SHO #02-004, issued November 12, 2002)

N.C. Health Choice beneficiaries receive benefits in the following assistance categories based on family income in relation to the Federal Poverty Level.

- Income of above 133% up to and including 159% of the Federal Poverty Income Level; and
- Income in excess of 159% up to 211% of the Federal Poverty Income Level.

Household income must be above Medicaid income guidelines and from above 133% and up to and including 211% of the federal poverty level (FPL). Countable household monthly income is determined using the same Modified Adjusted Gross Income (MAGI) guidelines as for Title XIX. Earned income is determined by review of provided pay stubs, copies of checks, business records for self-employment, or other written proof of income as requested. New applications require proof of income for the month prior to application. Renewal eligibility determinations require proof of income for the month prior to renewal review. Self-employment income is determined using a base period of 12 months immediately prior to application. Exceptions to the 12-month period use the same guidelines as Title XIX. Unearned income is determined using the same guidelines as Title XIX. The monthly income base period is the month prior to application or renewal review. The child support base period is six (6) months.

Family size is determined by the tax household under the MAGI rules for both Medicaid and NC Health Choice. Under MAGI rules, there is a 5% income disregard if an applicant lives in a household with an income too high to qualify for Medicaid eligibility. (Per CMS guidance and instructions, North Carolina applies the 5% disregard if income exceeds the NC Health Choice limit. The 5% disregard would have already been applied to the highest income limit Medicaid program available prior to evaluating for NC Health Choice).

4.1.4 Resources of each separate eligibility group (including any standards relating to spend downs and disposition of resources):

4.1.5 X Residency (so long as residency requirement is not based on length of time in state):

Beneficiaries must be residents of North Carolina pursuant to N.C. GEN. STAT. § 108A 70.21(a)(1). State residency verification is controlled by N.C. GEN. STAT. § 108A-55.3.

4.1.6 Disability Status (so long as any standard relating to disability status does not restrict eligibility):

4.1.7 X Access to or coverage under other health coverage:

Pursuant to N.C. GEN. STAT. § 108A 70.21(a)(1), an applicant is ineligible for the NC Health Choice program if he or she is insured or is eligible for Medicaid, Medicare, or other federal government sponsored insurance.

A child must be uninsured to be eligible for NC Health Choice. Uninsured means the applicant is not covered under any private or employer-sponsored creditable health insurance plan on the date of enrollment into the program and is ineligible for Medicaid, Medicare or other federal government sponsored insurance.

4.1.8 X Duration of eligibility, not to exceed 12 months:

Pursuant to N.C. GEN. STAT. § 108A 70.21(a)(4), enrollment is continuous for one year. However, pursuant to N.C. GEN. STAT. § 108A 70.21(a)(3), if a beneficiary acquires health insurance other than (in addition to) the NC Health Choice Program after enrollment and prior to the expiration of the eligibility period of one year, then the beneficiary will be deemed to be insured and ineligible for continued coverage under the Program.

4.1.9 X Other Standards- Identify and describe other standards for or affecting eligibility, including those standards in 42 CFR 457.310 and 457.320 that are not addressed above. For instance:

- Pursuant to 42 USC 1397jj(b)(2), targeted low-income children do not include inmates in a public institution and patients in an institution for mental diseases, as defined in 42 C.F.R. 435.1010, at the time of initial application for the Program or at the time of eligibility redetermination.
- Applicants ineligible for the Medicaid Program solely because of a failure to comply with procedural requirements (e.g., proving required eligibility determination information) are not eligible for the Title XXI NC Health Choice Program.

Guidance: States may only require the SSN of the child who is applying for coverage. If SSNs are required and the State covers unborn children, indicate that the unborn children are exempt from providing a SSN. Other standards include, but are not limited to presumptive eligibility and deemed newborns.

4.1.9.1 X States should specify whether Social Security Numbers (SSN) are required.

Program eligibility is determined through the use of a dual Medicaid and NC Health Choice application by a county DSS. Applications require a Social Security number for each child applying for health insurance coverage.

Guidance: States should describe their continuous eligibility process and populations that can be continuously eligible.

4.1.9.2 X Continuous eligibility

The period of enrollment is twelve (12) continuous months from the date of initial enrollment. An increase in household income during the continuous enrollment period does not affect current enrollment. The eligibility worker only reviews household income during the annual renewal review to determine eligibility for a new 12-month enrollment period. However, if family income decreases during the continuous enrollment period, a family may request to apply for Medicaid eligibility.

Exceptions to the 12-month continuous enrollment period that will result in coverage cancellation include:

- Child obtains comprehensive health insurance
- Child moves out of state
- Child is incarcerated
- Child becomes eligible for Work First/TANF
- Child is removed from household by DSS & placed in foster care (child is then enrolled into Medicaid)
- Child turns age 19
- Child becomes eligible for SSI Medicaid
- Child becomes pregnant (child is then enrolled in Medicaid for Pregnant Women; see Section 6.2.9)
- Child dies
- Child enters Long Term Care
- Child's family submits a voluntary request for termination
- County case workers are unable to locate the child

On September 18, 2015, Session Law 2015-241, Appropriations Act of 2015 (State budget) was signed into law. As a result, Section 12H.14. (c) of the Act repealed N.C. General Statute §108A-70.21(g), which authorized the purchase of Extended Coverage or buy-in for NC Health Choice beneficiaries who had become ineligible for insurance because of a family income increase. Due to the repeal of the Extended Coverage General Statute, effective October 1, 2015, the program was terminated.

4.1-PW **Pregnant Women Option** (section 2112)- The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. Describe the population of pregnant women that the State proposes to cover in this section. Include all eligibility criteria, such as those described in the above categories (for instance, income and

resources) that will be applied to this population. Use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option.

Guidance: States have the option to cover groups of “lawfully residing” children and/or pregnant women. States may elect to cover (1) “lawfully residing” children described at section 2107(e)(1)(J) of the Act; (2) “lawfully residing” pregnant women described at section 2107(e)(1)(J) of the Act; or (3) both. A state electing to cover children and/or pregnant women who are considered lawfully residing in the U.S. must offer coverage to all such individuals who meet the definition of lawfully residing, and may not cover a subgroup or only certain groups. In addition, states may not cover these new groups only in CHIP, but must also extend the coverage option to Medicaid. States will need to update their budget to reflect the additional costs for coverage of these children. If a State has been covering these children with State only funds, it is helpful to indicate that so CMS understands the basis for the enrollment estimates and the projected cost of providing coverage. Please remember to update section 9.10 when electing this option.

4.1- LR X Lawfully Residing Option (Sections 2107(e)(1)(J) and 1903(v)(4)(A); (CHIPRA # 17, SHO # 10-006 issued July 1, 2010) Check if the State is electing the option under section 214 of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding lawfully residing to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

A child or pregnant woman shall be considered lawfully present if he or she is:

- (1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);
- (2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;
- (3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;
- (4) An alien who belongs to one of the following classes:
 - (i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);
 - (ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;
 - (iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);
 - (iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;

- (v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
 - (vi) Aliens currently in deferred action status; or
 - (vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;
- (5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;
 - (6) An alien who has been granted withholding of removal under the Convention Against Torture;
 - (7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J));
 - (8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or
 - (9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

- Elected for pregnant women.
- Elected for children under age 19

4.1.1-LR The State provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA Lawfully Residing option, it has verified, at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

4.1-DS **Supplemental Dental** (Section 2103(c)(5) - A child who is eligible to enroll in dental-only supplemental coverage, effective January 1, 2009. Eligibility is limited to only targeted low-income children who are otherwise eligible for CHIP but for the fact that they are enrolled in a group health plan or health insurance offered through an employer. The State's CHIP plan income eligibility level is at least the highest income eligibility standard under its approved State child health plan (or under a waiver) as of January 1, 2009. All who meet the eligibility standards and apply for dental-only supplemental coverage shall be provided benefits. States choosing this option must report these children separately in SEDS. Please update sections 1.1-DS, 4.2-DS, and 9.10 when electing this option.

4.2. Assurances The State assures by checking the box below that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

4.2.1. These standards do not discriminate on the basis of diagnosis.

4.2.2. Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income. This applies to pregnant women included in the State plan as well as targeted low-income children.

4.2.3. These standards do not deny eligibility based on a child having a pre-existing medical condition. This applies to pregnant women as well as targeted low-income children.

4.2-DS Supplemental Dental - Please update sections 1.1-DS, 4.1-DS, and 9.10 when electing this option. For dental-only supplemental coverage, the State assures that it has made the following findings with standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

4.2.1-DS These standards do not discriminate on the basis of diagnosis.

4.2.2-DS Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3-DS These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Methodology. Describe the methods of establishing and continuing eligibility and enrollment. The description should address the procedures for applying the eligibility standards, the organization and infrastructure responsible for making and reviewing eligibility determinations, and the process for enrollment of individuals receiving covered services, and whether the State uses the same application form for Medicaid and/or other public benefit programs. (Section 2102)(b)(2)) (42 CFR 457.350)

A. Application Availability:

Joint application forms for Medicaid and NC Health Choice for Children are available at community government offices including local health departments, county DSS offices, and unemployment offices. Special displays and application forms are also available at community locations frequented by potential applicants. These include: Human Resource departments of local employers; public school administration and school nurse areas; neighborhood churches; non-profit food distribution centers; subsidized and church-based day care; and Mother's Day Out locations. In addition, outreach workers regularly visit and maintain outstations within safety net hospital Emergency Departments, Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC), migrant health centers, and Indian health centers.

English and Spanish versions of application forms and educational materials are available for on-line completion and printing from the NC DHHS Health Choice Program Web pages.

Assistance in filling out the forms is available through county DSS and any of the specially

designated outstations.

Eligibility Determination:

NC Health Choice provides 12 months of continuous coverage for eligible children. The 12-month certification period for siblings within the same household can differ if the siblings apply for and are approved for coverage in different months.

All new and renewal applications are processed within the CMS standard of 45 calendar days from the received date of the signed application. The receipt date (Processing Day One) is the calendar day on which the county social services office receives the signed application. Mail picked up from the post office for processing on a non-State business day is determined as officially received on the next State business day. Applicants may apply via telephone with a DSS and the date of the application will be the call date. However, applicants must follow up with a signature page within the application processing time frame. Any unsigned application is not a valid application and does not preserve the potential effective date even if the child is ultimately approved for coverage.

Enrollment Fee:

Counties collect an annual enrollment fee when family income is between 159% and 211% of FPL. The annual fee is \$50 per child, with a \$100 maximum per family for two or more children. The county DSS retains each enrollment fee to help offset application processing administrative costs. Applicants who are members of a federally recognized American Indian tribe and Alaskan Natives are exempt from the enrollment fee and are identified by a unique race code and enrollment category.

Enrollment Method:

County DSS caseworkers enter new enrollments into NC FAST, a statewide eligibility information system. NC FAST also generates an automated Notice of Eligibility or denial of approval for benefits for each applicant. The notice is mailed to the applicant within one (1) business day of the decision.

Once an applicant is deemed eligible, coverage is retroactively effective as of the first day of the month in which the applicant submitted a signed application. There are, however, two exceptions to the availability of a retroactive effective date since Health Choice beneficiaries cannot have any other form of comprehensive health insurance:

1. If the child has active Medicaid in the month of a Health Choice application, NC Health Choice coverage begins the first day of the month *following* Medicaid termination.
2. If the child has active comprehensive insurance in the month of application, NC Health Choice coverage begins the first day of the month *following* other insurance termination. The State requires written proof of the other insurance termination date and cannot accept verbal confirmation from the applicant.

New Enrollments:

The experience of the typical enrollee will be as follows:

The family learns about the NC Health Choice program, completes the joint Medicaid – Health

Choice application form online on the Federally Facilitated Marketplace, via mail, or in person at the county DSS. The local DSS assesses the application and makes one of three possible determinations within 45 days:

1. The child is eligible for Medicaid

The caseworker enters application and enrollment information into NC FAST, including the Medicaid coverage effective date.

2. The child is eligible for NC Health Choice

The caseworker enters application and enrollment information into NC FAST with three possible outcomes:

No Annual Enrollment Fee Required The caseworker creates the new enrollment with the coverage effective date in NC FAST.

a. Annual Enrollment Fee Required:

The annual enrollment fee must be paid in full prior to enrollment and coverage activation for eligible children in a family with an annual income level requiring the fee. The child is enrolled in the Title XXI program *after* receipt of the appropriate enrollment fee for families between 159-211% FPL. American Indian and Alaskan Native children are exempt from this requirement regardless of family income.

The enrollment fee is \$50 for one child and \$100 for two or more children in the same family. The family has twelve (12) calendar days from the date on the county DSS Notice of Eligibility to pay the enrollment fee. During the initial 12-day period, applicants may ask for an additional twelve (12) days to pay the enrollment fee. If the fee remains unpaid as of the 13th calendar day of the extension period DSS will mail a denial / termination notice to the applicant.

c. Enrollment Freeze

The child is eligible for NC Health Choice. However, he or she cannot be enrolled because the State's NC Health Choice budget is insufficient to cover additional enrollees (Title XXI is not an entitlement program). New eligible applications are frozen and the child's name is added to the statewide "wait list." The enrollment fee (if required) is not billed or requested until an enrollment opening becomes available for the child. Section 4.3.1 contains additional information about the Enrollment Freeze policy and procedures.

3. Applicant is Ineligible for both Medicaid and NC Health Choice

The child fails to meet one or more eligibility requirements for both programs and is ineligible for both Medicaid and NC Health Choice.

B. Renewal Review/ Enrollment:

NC Health Choice provides 12 months of continuous enrollment without regard to changes in income.

An *increase* in family income during the enrollment period has no impact on NC Health Choice eligibility, even if the new household income is above 211% FPL. Enrollees are not required to

notify the DSS ~~or tribal~~ caseworker regarding income changes during the continuous enrollment period. If the family notifies the caseworker of increased household income, the file will be annotated and reviewed at renewal through current income verification requirements.

A *decrease* in family income below the NC Health Choice minimum income requirement also does not affect eligibility during the continuous enrollment period. However, a parent or guardian may request an eligibility re-evaluation to determine Medicaid eligibility. Upon Medicaid approval, NCHC coverage is terminated and Medicaid enrollment created with no gap in coverage.

North Carolina DSS offices implement an *ex parte* process to facilitate re-enrollment for CHIP beneficiaries.

If an enrollment fee is due, the family has 12 calendar days from the date on the county DSS ~~or tribal~~ Notice of Enrollment Fee to pay the fee. If the fee remains unpaid as of the 13th calendar day following the notice date, the case is terminated for non-payment of the enrollment fee.

Guidance: The box below should be checked as related to children and pregnant women. Please note: A State providing dental-only supplemental coverage may not have a waiting list or limit eligibility in any way.

4.3.1. Limitation on Enrollment Describe the processes, if any, that a State will use for instituting enrollment caps, establishing waiting lists, and deciding which children will be given priority for enrollment. If this section does not apply to your state, check the box below. (Section 2102(b)(2)) (42 CFR 457.305(b))

Check here if this section does not apply to your State.

The North Carolina DHHS Secretary may choose to freeze new NC Health Choice enrollments if State-appropriated funds are depleted prior to the end of the State fiscal year. This process is referred to as a “freeze.” Current beneficiaries who remain eligible at renewal receive another 12-month continuous eligibility period; however newly eligible applicants are placed on a waiting list. The State notifies CMS prior to initiation of an enrollment freeze and associated wait list. The general public, potential beneficiaries, and enrolled children receive notification through public media (newspaper and website) of the new enrollment suspension and wait list process.

The freeze remains in place indefinitely until the NC DHHS Secretary determines that enrollment levels are within budgeted and legislated parameters. However, a freeze period can be no less than two consecutive months. The chart below identifies Enrollment Freeze Notice Requirements.

<i># Days Prior to Freeze Effective Date:</i>	<i>Contact</i>	<i>Notification Method</i>
45 calendar days	US DHHS CMS	Phone call to CMS Regional Coordinator Written notice to same
60 calendar days	Current Enrollees	Written notice to currently enrolled beneficiaries NC DHHS website alert
30 calendar days	Public – Providers	DMA NC Medicaid Provider Bulletin Recorded notice on Automated Verification Response System (AVRS) Posted notice on web-based eligibility system, NC FAST

<i># Days Prior to Freeze Effective Date:</i>	<i>Contact</i>	<i>Notification Method</i>
30 calendar days	Public – DSS Offices	“Dear County Director” notification letter Notice of enrollment freeze posted on DSS intranet.
30 calendar days	Public Outreach Groups Other State Agencies NCHC Contractors	Notification Letter to existing advocacy, outreach, and key stakeholder entities Mass internal email notice to all state agency management personnel
20 calendar days	Media	NC DHHS Press Release

Notice will be provided to the Centers for Medicaid and Medicare Services (CMS) 45 days in advance of the implementation of any enrollment freeze. Written notification will be announced to the current enrollees via letter 60 days prior to the imposition of an enrollment freeze and to the news media no later than 20 days before a new enrollment freeze is to be implemented. The purpose of the plan is two-fold:

- Limit enrollment in a manner that does not impose an extra burden on families to file multiple repeat applications; and
- Allow children to enroll as slots become available rather than waiting for a pre-established date.

The initial closure will last a minimum of two consecutive months to allow children with renewals in the first month of the freeze period adequate time to submit their renewal application, including the grace period, and to begin to build an inventory of open enrollment slots.

New Application Processing:

The NC Health Choice freeze has no impact on the Medicaid program. Medicaid is an entitlement program in which the State enrolls all qualified beneficiaries. As a Title XXI program, NC Health Choice is not an entitlement program. Enrollment is dependent upon available State funding to cover plan medical and administrative expenses for current enrollees in addition to new applicants. However, families may continue to file applications and counties will determine eligibility as usual. In addition, Medicaid is always evaluated first before applying the NC Health Choice freeze

Medicaid Eligible:

Children determined eligible for Medicaid will be approved and enrolled.

- NC Health Choice Eligible (during new enrollment freeze)

Children determined newly eligible for NC Health Choice will be denied enrollment and provided with information that the child qualifies for the program, yet cannot be enrolled due to a freeze. The child will be added to the statewide wait list for later notification by the DSS caseworker when a new enrollment slot becomes available or the freeze is lifted. The State establishes an automated wait list within NC FAST and adds the child to the end of the waiting list. Children eligible for NC Health Choice on the inactive wait list are not included in the nightly updates sent to the Claims Processing Contractor until they are enrolled in an available program slot or the new enrollment freeze is lifted.

- Ineligible for Medicaid and NC Health Choice

If the child is determined to be ineligible for either program, the application will be denied with no further action. However, the family may choose to re-apply at any time.

Renewal Enrollments:

Children currently enrolled in NC Health Choice receive a new 12-month continuous eligibility period with no break in coverage if the signed renewal application is received within the ten-day grace period. The signed application must be received by the county DSS office within ten (10) calendar days of the renewal date. An unsigned application is not a valid application and does not preserve the renewal enrollment exception permitted during the freeze. Renewal applications received by the county DSS after the ten-day grace period are handled as new applications and processed accordingly.

New Application Wait List Procedures:

- At the time of application, a registration number is created so the wait list applications can be sequenced chronologically according to the date of application stored in NC FAST.

- The State reactivates applications on a first in – first out method based on the registration number. When a child’s application is re-activated for enrollment, the child is removed from the waiting list and the number of NC Health Choice children on the application reduces available enrollment slots.
- When the NC DHHS Department of Medical Assistance (DMA) determines that there are available program openings to allow for new enrollments, it will notify the Division of Information Resources Management (DIRM) of the specific number of open slots. The notification can occur during the freeze if it is determined enough children have dropped off of NC Health Choice (due to ineligibility or becoming eligible for Medicaid). The waiting list can be reduced in increments as determined by DMA Management until the freeze is lifted. The waiting list is reduced in date order.
- The 45-calendar day application processing timeline begins the day the case is re-activated. NC FAST generates notification to the family that the application has been re-opened and asks that the family confirm their current residence address and the child’s current insurance status. The family has 12 calendar days to provide the requested information. Day One is the date of re-activation notice issuance as recorded in the NC FAST case history data.
- If the family does not return the reactivation notice within 12 calendar days from the letter production date, the county caseworker checks agency records to see whether an address change has occurred and will mail a second notice. The family has 12 calendar days from the date of the EIS re-activation notice to respond to the 2nd request for current information.
- Incomplete or unsigned information forms received by the DSS or result in a new letter to the family requesting the missing information. The family has 12 calendar days from the date of the letter to respond. A 2nd letter is sent on the 13th calendar day and gives the family another 12 calendar days to respond.
- The application is denied on the 46th calendar day after reactivation if there is no response or it remains incomplete. The county DSS takes no action on the re-activated application pending return of the completed and signed information update. Should a family not reply within 45 days, the application is denied and the number of enrollment positions allotted for the children in the family are released to the children next in line on the wait list. The family has the right to submit a new application at any time, and is subject to all new application requirements and/or restrictions in place at that time.
- If required information is completed and the child remains eligible and approved for NC Health Choice, the caseworker mails a notice within 45 days of the decision. The notice includes the amount of any enrollment fee due with the statement that full payment is required prior to the child’s enrollment and NC Health Choice coverage activation.
- NC Health Choice benefits begin the first day of the application re-activation month and will continue for 12 consecutive months from that date.

Ending the Enrollment Freeze

If the State budget shortfall and enrollment cap are resolved, all children on the wait list receive enrollment review priority. Wait list children must have the first opportunity to enroll in the program before enrollment opens to new applicants in general. The NC DHHS immediately notifies CMS in writing of the freeze end date and the number of children on the wait list. Wait listed applications will be

reviewed in chronological order based on the date that they were added to the wait list.

If an application on the wait list is re-activated within three months (90 calendar days) of the date the child was initially placed on the wait list, the family must confirm the child's current insurance status.

The State will use the verified income from when the applicant first applied to determine eligibility. If an applicant is on the wait list for longer than three months, caseworkers will re-verify insurance *and* income at the time of re-activation.

Based upon family income, some children must pay annual enrollment fees in order to re-enroll. Children who have applied and been determined eligible for NC Health Choice with an enrollment fee requirement do not pay the enrollment fee until they are off of the waiting list and ready to enroll in the program. However, if the required annual enrollment fee is not paid, the wait listed applicant will be denied re-enrollment.

Guidance: Note that for purposes of presumptive eligibility, States do not need to verify the citizenship status of the child. States electing this option should indicate so in the State plan. (42 CFR 457.355)

4.3.2. Check if the State elects to provide presumptive eligibility for children that meets the requirements of section 1920A of the Act. (Section 2107(e)(1)(L)); (42 CFR 457.355)

Guidance: Describe how the State intends to implement the Express Lane option. Include information on the identified Express Lane agency or agencies, and whether the State will be using the Express Lane eligibility option for the initial eligibility determinations, redeterminations, or both.

4.3.3-EL Express Lane Eligibility Check here if the state elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of CHIP eligibility. The state agrees to comply with the requirements of sections 2107(e)(1)(E) and 1902(e)(13) of the Act for this option. Please update sections 4.4-EL, 5.2-EL, 9.10, and 12.1 when electing this option. This authority may not apply to eligibility determinations made before February 4, 2009, or after September 30, 2013. (Section 2107(e)(1)(E))

4.3.3.1-EL Also indicate whether the Express Lane option is applied to (1) initial eligibility determination, (2) redetermination, or (3) both.

4.3.3.2-EL List the public agencies approved by the State as Express Lane agencies.

4.3.3.3-EL List the components/components of CHIP eligibility that are determined under the Express Lane. In this section, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between CHIP eligibility determinations for such children and the determination under the Express Lane option.

4.3.3.3-EL List the component/components of CHIP eligibility that are determined under the Express Lane.

4.3.3.4-EL Describe the option used to satisfy the screen and enrollment requirements before a child may be enrolled under title XXI.

Guidance: States should describe the process they use to screen and enroll children required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 457.80(c). Describe the screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by an Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated. Describe whether the State is temporarily enrolling children in CHIP, based on the income finding from an Express Lane agency, pending the completion of the screen and enroll process.

In this section, states should describe their eligibility screening process in a way that addresses the five assurances specified below. The State should consider including important definitions, the relationship with affected Federal, State and local agencies, and other applicable criteria that will describe the State's ability to make assurances. (Sections 2102(b)(3)(A) and 2110(b)(2)(B)), (42 CFR 457.310(b)(2), 42 CFR 457.350(a)(1) and 457.80(c)(3))

4.4. Eligibility screening and coordination with other health coverage programs
States must describe how they will assure that:

4.4.1. X only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance (including access to a State health benefits plan) are furnished child health assistance under the plan. (Sections 2102(b)(3)(A), 2110(b)(2)(B)) (42 CFR 457.310(b), 42 CFR 457.350(a)(1) and 42 CFR 457.80(c)(3)) Confirm that the State does not apply a waiting period for pregnant women.

Pursuant to N.C. GEN. STAT. § 108A 70.21(a)(1), an applicant is ineligible for the NC Health Choice program if he or she is insured or is eligible for Medicaid, Medicare, or other federal government sponsored insurance. A child must be uninsured to be eligible for NC Health Choice. Uninsured means the applicant is not covered under any private or employer-sponsored creditable health insurance plan on the date of enrollment into the program and is

ineligible for Medicaid, Medicare or other federal government sponsored insurance.

4.4.2. X children found through the screening process to be potentially eligible for medical assistance under the State Medicaid plan are enrolled for assistance under such plan; (Section 2102(b)(3)(B)) (42 CFR 457.350(a)(2)).

Medicaid and NC Health Choice use the same application form to ease the administrative burden on families applying for benefits. County caseworkers initially screen all applications for Medicaid eligibility. If the child is not eligible for Medicaid, the review progresses with an evaluation of NC Health Choice eligibility. The review includes a search of the NC FAST database for existing Title XIX or Title XXI enrollment or the presence of other creditable insurance. Citizenship and identity status for each applicant is validated through automated queries and responses between the SS Bendex database and the DSS county office or tribal office. DSS workers obtain income verification, and request any additional information necessary. If family income is within Title XIX limits and the child meets all other Medicaid eligibility requirements, Medicaid enrollment occurs.

4.4.3. X children found through the screening process to be ineligible for Medicaid are enrolled in CHIP. (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

During the application process described in 4.4.2 above, if family income exceeds the Medicaid income limit and is at or below 211% of FPL, the child will be enrolled in the NC Health Choice Program if all other Program eligibility requirements set forth in G.S. 108A-70.21(a) are met.

4.4.4. X the insurance provided under the State child health plan does not substitute for coverage under group health plans. (Section 2102(b)(3)(C)) (42 CFR, 457.805)

A child must be uninsured to be eligible for NC Health Choice. As defined in G.S. 108A-70.18(8), “uninsured” means the applicant is not covered under any private or employer-sponsored comprehensive health insurance plan on the date of enrollment. Comprehensive coverage is health insurance that provides basic medical care and hospitalization, whether group, private plan, HMO, or other managed care plan. It also includes Medicare, TRICARE, State health insurance risk pools and other public health plans. Comprehensive insurance does not include policies that pay for specific illnesses or pay a daily amount while a person is hospitalized.

A child is also considered uninsured if:

- The non-custodial parent with a court order for medical support is providing coverage through a medical insurance plan (e.g., a managed care plan with a limited network of providers) that is located outside of the child's state of residence.
- The non-custodial parent with a court order for medical support is not providing coverage under a medical insurance policy even if he or she has been ordered to make direct payment for medical care.
- He or she is covered by a full service Health Maintenance Organization (HMO) which does not have a network of medical providers in the child's county of residence (and therefore the child does not have “reasonable geographic access to care” pursuant to 42. C.F.R. § 457.310(b)(2)(ii).

State employees must pay 100% of the monthly health insurance premium costs for any dependents covered under the State Employees' health insurance plan. There is no "more than nominal" amount contributed by the State. Therefore, pursuant to 42 C.F.R. § 457.310(c)(1), children of State employees and teachers are eligible for coverage under Title XXI in North Carolina.

If an otherwise eligible child has active comprehensive health insurance as of the date of application, NC Health Choice enrollment will begin on the first day of the month following proof of a termination date for other coverage. Beneficiaries enrolled following voluntarily termination of private or employer-sponsored comprehensive health insurance are assigned a specific enrollment code to permit the State to determine whether the crowd out rate is negatively impacted.

4.4.4.1. (formerly 4.4.4.4) If the State provides coverage under a premium assistance program, describe: 1) the minimum period without coverage under a group health plan. This should include any allowable exceptions to the waiting period; 2) the expected minimum level of contribution employers will make; and 3) how cost-effectiveness is determined. (42 CFR 457.810(a)-(c))

4.4.5. Child health assistance is provided to targeted low-income children in the State who are American Indian and Alaska Native. (Section 2102(b)(3)(D)) (42 CFR 457.125(a))

American Indian and Alaska Native children who self-identify at the time of application are exempt from all enrollment fees and co-payments associated with the Program. Eligibility categories and cost-sharing requirements are outlined in Section 8.

American Indian and Alaska Native beneficiaries in the NC Health Choice Program are also subject to other exceptions pursuant to federal regulations. For example, these beneficiaries are eligible for the federal Vaccines for Children Program, and the Division of Medical Assistance notifies providers that they are to administer vaccines accordingly. All other beneficiaries in North Carolina's separate CHIP Program are deemed "insured" and therefore ineligible for the Vaccines for Children Program. For American Indian and Alaska Native beneficiaries, the assignment of a primary care provider medical home within the Community Care of North Carolina (CCNC) primary care case management delivery system is optional; the assignment is mandatory for all other NC Health Choice Program beneficiaries.

Guidance: When the State is using an income finding from an Express Lane agency, the State must still comply with screen and enroll requirements before enrolling children in CHIP. The State may either continue its current screen and enroll process, or elect one of two new options to fulfill these requirements.

4.4-EL The State should designate the option it will be using to carry out screen and enroll requirements:

- The State will continue to use the screen and enroll procedures required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 42 CFR 457.80(c). Describe this process.
- The State is establishing a screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by the Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated.
- The State is temporarily enrolling children in CHIP, based on the income finding from the Express Lane agency, pending the completion of the screen and enroll process.

Section 5. Outreach and Coordination

- 5.1.** (formerly 2.2) Describe the current State efforts to provide or obtain creditable health coverage for uninsured children by addressing sections 5.1.1 and 5.1.2. (Section 2102)(a)(2) (42 CFR 457.80(b))

Guidance: The information below may include whether the state elects express lane eligibility a description of the State's outreach efforts through Medicaid and state-only programs.

- 5.1.1.** (formerly 2.2.1.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in public health insurance programs (i.e., Medicaid and state-only child health insurance):

North Carolina employs a combined marketing approach for the State Title XIX and XXI Programs. Outreach approaches employ social marketing principles and consider the needs of diverse populations (e.g., preferred languages, ethnic and cultural social norms, the specific concerns for parents/guardians of children with special health care needs, and materials targeted for low literacy populations).

The Division of Public Health in the NC Department of Health and Human Services has a staff position focusing specifically on minority outreach for Health Check (Medicaid for Children) and NC Health Choice. Establishing trust within the minority communities opens new doors for outreach and education. The DPH Minority Outreach Consultant works through minority-led State and Community-Based Organizations (CBOs) to reach African American, American Indian, Latino, and other Immigrant/Refugee communities.

Education is carried out in venues such as mobile consulate visits, Latino heritage festivals, Hmong cultural celebrations, American Indian pow wows and the Commission on Indian Affairs, African

American sororities/fraternities, and other social/cultural events. Minority-owned businesses (e.g., grocery stores, beauty salons, media, and restaurants) are often willing to share child health insurance information with their customers. Another outreach opportunity has been through faith-based services and family events within the Catholic (Latino, Vietnamese, and Congolese), Baptist (Korean) and Muslim (Arabic) traditions. Through the statewide Refugee Advisory Council, these relationships enable the State to focus-test professionally translated outreach materials in seven languages. The Refugee Advisory Council also keeps DMA abreast of the most rapidly growing refugee populations (currently Burmese, Bhutanese/Nepali, Vietnamese, Iraqi, Cuban and Somalian).

The NC Division of Public Health (DPH) leads outreach and marketing efforts in collaboration with a host of State, regional and local public and private partners. DPH publishes a one-page, bi-lingual (English and Spanish) fact sheet as part of its marketing efforts. Hard copies are mailed out with other consumer information about federal poverty guidelines, and DPH maintains electronic copies of the fact sheet on its Women's and Children's Health Web page. The Division of Medical Assistance also provides links to the electronic version of the fact sheet on its website. The fact sheet highlights income eligibility guidelines, health benefits available, and how to apply for both Medicaid and NC Health Choice.

Guidance: The State may address the coordination between the public-private outreach and the public health programs that is occurring statewide. This section will provide a historic record of the steps the State is taking to identify and enroll all uninsured children from the time the State's plan was initially approved. States do not have to rewrite his section but may instead update this section as appropriate.

5.1.2. (formerly 2.2.2.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in health insurance programs that involve a public-private partnership:

As the Title XXI program has matured since its inception in 1998, NC has re-focused outreach efforts on infrastructure development by working with partners to integrate outreach for child health insurance programs into the ongoing work of their State and local organizations. State and local partners engaged in child health insurance outreach include:

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

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

Literacy staff have also been partners in assisting with outreach efforts with their GED, Adult High School, and English-as-a-Second-Language classrooms (faculty and students).

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

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

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

Businesses: Collaborators include the NC Association of Health Insurance Underwriters; the NC Hotel / Motel Association; Community College Small Business Centers; Banks; Local Chambers of Commerce, including the NC Hispanic and Black Chambers of Commerce; and Tax Preparers—particularly VITA centers across the State.

Media: The DPH consultant partners with minority media outlets whenever possible, including an annual appearance on the Univision talk show.

The focus of statewide activities is ultimately on local efforts through all of DMA's partners, including Community Care of North Carolina (CCNC). Fourteen CCNC networks coordinate DMA Health Check Coordinators (HCCs). HCCs are available to assist parents and providers. The HCCs promote initial enrollment in Title XIX and XXI services, retention in the health insurance programs, access to a quality medical home, and the importance of preventive services and appropriate service utilization. Because the NC Health Choice Program has limited State appropriations for medical and administrative costs, it is critical to educate NC Health Choice members' parents to use the health care system in the most appropriate way to keep their children healthy. The Program undertakes ongoing efforts to identify children with asthma, diabetes, behavioral-mental health, and other chronic diagnoses. The goal is to assure that children with chronic conditions are receiving all of the help they need to prevent emergency episodes. A major focus is medical management with the goal of providing health information and case management services for families with frequent visits or high cost episodes.

Guidance: The State should describe below how it's Title XXI program will closely coordinate the enrollment with Medicaid because under Title XXI, children identified as Medicaid-eligible are required to be enrolled in Medicaid. Specific information related to Medicaid screen and enroll procedures is requested in Section 4.4. (42 CFR 457.80(c))

5.2. (formerly 2.3) Describe how CHIP coordinates with other public and private health insurance programs, other sources of health benefits coverage for children, other relevant child health programs, (such as title V), that provide health care services for low-income children to increase the number of children with creditable health coverage. (Section 2102(a)(3), 2102(b)(3)(E) and 2102(c)(2)) (42 CFR 457.80(c)). This item requires a brief overview of how Title XXI efforts – particularly new enrollment outreach efforts – will be coordinated with and improve upon existing State efforts described in Section 5.2.

The Division of Medical Assistance (DMA) in the NC Department of Health and Human Services has overall responsibility for the administration of Title XIX and XXI and assists outreach partners, providers and other stakeholders involved in seeking, identifying and enrolling uninsured children by providing county-level data. DMA also provides oversight of the eligibility determination and enrollment process implemented by local Departments of Social Services. The NC Health Choice Program works with the Division of Public Health to increase general public awareness and targets special populations (low income, minority, and children with special health care needs) to assure that they know about both of the State's publicly-funded child health insurance programs.

Applicants for both Medicaid and NC Health Choice complete a joint application online via the Federally Facilitated Marketplace, in person at a county Department of Social Services or via U.S. Mail. Applicants are screened first for Title XIX eligibility, and then for Title XXI eligibility. The "assets test" is not applicable to the NC Health Choice Program; children qualify for 12 months of continuous eligibility without regard to changes in family income during the enrollment period. To assist with renewal retention, the State mails *ex parte* renewal applications during the 10th month of continuous enrollment with a cover letter that advises beneficiaries to notify case workers if anything material that would affect program eligibility (such as health insurance status in the case of NC Health Choice) has changed. Otherwise, the beneficiaries do not have to return the form and renewal is automatic for an additional 12 consecutive months.

The efficient application process provides a number of program benefits:

- It assures that children who are eligible for either Title XIX or Title XXI are enrolled in the most appropriate program based on the applicant's eligibility;
- It provides one standardized and consolidated source of enrollment data, which can be analyzed for the purpose of further refining outreach efforts; and
- It avoids duplicative eligibility and enrollment infrastructures for the Title XIX and Title XXI programs.

5.2-EL The State should include a description of its election of the Express Lane eligibility option to provide a simplified eligibility determination process and expedited enrollment of eligible children into Medicaid or CHIP.

5.3. Strategies

Guidance: Describe the procedures used by the State to accomplish outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: (Section 2102(c)(1)) (42CFR 457.90) The description should include information on how the State will inform the target of the availability of the programs, including American Indians and Alaska Natives, and assist them in enrolling in the appropriate program.

Outreach strategies may include, but are not limited to, community outreach workers, outstationed eligibility workers, translation and transportation services, assistance with enrollment forms, case management and other targeting activities to inform families of low-income children of the availability of the health insurance program under the plan or other private or public health coverage.

Outreach efforts include all uninsured low-income North Carolina children potentially eligible for Title XIX or Title XXI coverage. Tribal organizations collaborate with State and local outreach staff to assist with educating tribal members about the North Carolina Medicaid and NC Health Choice programs. Education includes how to apply, eligibility criteria, covered benefits, how to access healthcare services, and appropriate use of the Emergency Room. Representatives from the NC Commission of Indian Affairs, will craft best practice strategies to reach the State's American Indian communities and assure that all families with potentially eligible children are contacted and informed about this program and the health care benefits available to low-income children.

The North Carolina Division of Public Health runs a State-supported toll-free specialized resource line focused specifically on the needs, questions, benefits, and resources available to families of children with special needs in both the Health Check and NC Health Choice programs. The helpline provides telephone assistance for families with children with special needs and providers regarding health insurance and healthcare needs. The toll-free number is available to callers from 8 a.m. until 5 p.m. Monday through Friday at 1-800-737-3028. Additional outreach to families of children with special health care needs is done via health care providers and community-based organizations; NC Children's Developmental Services Agencies; Family Support Networks; the Exceptional Children's Assistance Center; and various diagnosis-specific groups such as the United Cerebral Palsy Association and the NC Autism Society.

A claims analysis for the 2014 State Fiscal Year revealed that out of the 20,016 NC Health Choice claims for Emergency Department visits, the top three reasons for the visits were: 1) asthma; 2) long-term use of

medication; and 3) fever. In an effort to promote the most appropriate utilization of primary care and emergency room care, the NC Health Choice Program implements targeted efforts to promote wellness and disease management strategies. Related outreach materials have been developed in both English and Spanish.

Section 6. Coverage Requirements for Children’s Health Insurance

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State’s Medicaid plan and proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

6.1. The State elects to provide the following forms of coverage to children: (Check all that apply.) (Section 2103(c)); (42 CFR 457.410(a))

Guidance: Benchmark coverage is substantially equal to the benefits coverage in a benchmark benefit package (FEHBP-equivalent coverage, State employee coverage, and/or the HMO coverage plan that has the largest insured commercial, non-Medicaid enrollment in the state). If box below is checked, either 6.1.1.1., 6.1.1.2., or 6.1.1.3. must also be checked. (Section 2103(a)(1))

6.1.1. Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

Guidance: Check box below if the benchmark benefit package to be offered by the State is the standard Blue Cross/Blue Shield preferred provider option service benefit plan, as described in and offered under Section 8903(1) of Title 5, United States Code. (Section 2103(b)(1) (42 CFR 457.420(b))

6.1.1.1. FEHBP-equivalent coverage; (Section 2103(b)(1) (42 CFR 457.420(a)) (If checked, attach copy of the plan.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is State employee coverage, meaning a coverage plan that is offered and generally available to State employees in the state. (Section 2103(b)(2))

6.1.1.2. State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is offered by a health maintenance organization (as defined in Section 2791(b)(3) of the Public Health Services Act) and has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage

plans offered by an HMO in the state. (Section 2103(b)(3) (42 CFR 457.420(c))

- 6.1.1.3. HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: States choosing Benchmark-equivalent coverage must check the box below and ensure that the coverage meets the following requirements:

- the coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:
 - dental services
 - inpatient and outpatient hospital services,
 - physicians' services,
 - surgical and medical services,
 - laboratory and x-ray services,
 - well-baby and well-child care, including age-appropriate immunizations, and
 - emergency services;
- the coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages (FEHBP-equivalent coverage, State employee coverage, or coverage offered through an HMO coverage plan that has the largest insured commercial enrollment in the state); and
- the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the additional categories in such package, if offered, as described in 42 CFR 457.430:
 - coverage of prescription drugs,
 - mental health services,
 - vision services and
 - hearing services.

If 6.1.2. is checked, a signed actuarial memorandum must be attached. The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3) and (b)(4) of 42 CFR 457.431. The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State results.

The actuarial report must be prepared by an individual who is a member of the American Academy of Actuaries. This report must be prepared in accordance with the principles and standards of the American Academy of Actuaries. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan, apply

the same principles and factors in comparing the value of different coverage (or categories of services), without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used, and take into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage. (Section 2103(a)(2))

- 6.1.2. Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431.

Guidance: A State approved under the provision below, may modify its program from time to time so long as it continues to provide coverage at least equal to the lower of the actuarial value of the coverage under the program as of August 5, 1997, or one of the benchmark programs. If “existing comprehensive state-based coverage” is modified, an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997, or one of the benchmark plans must be attached. Also, the fiscal year 1996 State expenditures for “existing comprehensive state-based coverage” must be described in the space provided for all states. (Section 2103(a)(3))

- 6.1.3. Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

Guidance: Secretary-approved coverage refers to any other health benefits coverage deemed appropriate and acceptable by the Secretary upon application by a state. (Section 2103(a)(4)) (42 CFR 457.250)

- 6.1.4. Secretary-approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

Guidance: Section 1905(r) of the Act defines EPSDT to require coverage of (1) any medically necessary screening, and diagnostic services, including vision, hearing, and dental screening and diagnostic services, consistent with a periodicity schedule based on current and reasonable medical practice standards or the health needs of an individual child to determine if a suspected condition or illness exists; and (2) all services listed in section 1905(a) of the Act that are necessary to correct or ameliorate any defects and

mental and physical illnesses or conditions discovered by the screening services, whether or not those services are covered under the Medicaid state plan. Section 1902(a)(43) of the Act requires that the State (1) provide and arrange for all necessary services, including supportive services, such as transportation, needed to receive medical care included within the scope of the EPSDT benefit and (2) inform eligible beneficiaries about the services available under the EPSDT benefit.

If the coverage provided does not meet all of the statutory requirements for EPSDT contained in sections 1902(a)(43) and 1905(r) of the Act, do not check this box.

6.1.4.1. Coverage of all benefits that are provided to children that is the same as the benefits provided under the Medicaid State plan, including Early Periodic Screening, Diagnostic, and Treatment (EPSDT).

6.1.4.2. Comprehensive coverage for children under a Medicaid Section 1115 demonstration waiver.

6.1.4.3. Coverage that the State has extended to the entire Medicaid population.

Guidance: Check below if the coverage offered includes benchmark coverage, as specified in §457.420, plus additional coverage. Under this option, the State must clearly demonstrate that the coverage it provides includes the same coverage as the benchmark package, and also describes the services that are being added to the benchmark package.

6.1.4.4. Coverage that includes benchmark coverage plus additional coverage.

6.1.4.5. Coverage that is the same as defined by existing comprehensive state-based coverage applicable only in New York, Pennsylvania or Florida. (under 42 CFR 457.440)

Guidance: Check below if the State is purchasing coverage through a group health plan, and intends to demonstrate that the group health plan is substantially equivalent to or greater than coverage under one of the benchmark plans specified in 457.420, through the use of a benefit-by-benefit comparison of the coverage. Provide a sample of the comparison format that will be used. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in 457.431 to determine actuarial equivalence.

- 6.1.4.6.** Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Provide a sample of how the comparison will be done).

Guidance: Check below if the State elects to provide a source of coverage that is not described above. Describe the coverage that will be offered, including any benefit limitations or exclusions.

6.1.4.7. X Other. (Describe)

The Division of Medical Assistance administers NC Health Choice benefits equivalent to those of the NC Medicaid Program, with four exceptions:

1. No services for long-term care;
2. No non-emergency medical transportation;
3. No EPSDT; and
4. Dental services on a restricted basis in accordance with the criteria adopted by the Department.

Session Law 2011-145 directed the Department of Health and Human Services to transition health benefit changes in the NC Health Choice Program to provide coverage equivalent to benefits provided for Medicaid beneficiaries, with the exceptions noted above.

In July 2013, the NC Health Choice Program transitioned the administration of medical and pharmacy claims to CSC, the third party administrator for the Medicaid program operated under Title XIX of the Social Security Act. NC Division of Medical Assistance administrators believe that this transition will be the most cost-effective approach to administration of the NC Health Choice program. Having the NC Health Choice program clinical coverage policies, prior approval processes, utilization review, and claims systems administration parallel the NC Medicaid Program processes will reduce the cost of running the program.

NC Health Choice Program administration will parallel Medicaid administration only to the extent allowable by Title XXI, the code of federal regulations, and State statutes. NC Health Choice beneficiaries will therefore continue to be subject to unique eligibility, cost sharing requirements, and review process rights.

Guidance: All forms of coverage that the State elects to provide to children in its plan must be checked. The State should also describe the scope, amount and duration of services covered under its plan, as well as any exclusions or limitations. States that choose to cover unborn children under the State plan should include a separate section 6.2 that specifies benefits for the unborn child population. (Section 2110(a)) (42 CFR, 457.490)

If the state elects to cover the new option of targeted low income pregnant women, but chooses to provide a different benefit package for these pregnant women under the CHIP plan, the state must include a separate section 6.2 describing the benefit package for pregnant women. (Section 2112)

6.2. The State elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42 CFR 457.490)

6.2.1. X Inpatient services (Section 2110(a)(1))

The NC Health Choice Program will not cover any long-term care services. See Section 8 for co-payment requirements associated with this benefit. Utilization review and prior authorization for services may be required.

6.2.2. X Outpatient services (Section 2110(a)(2))

See Section 8 for co-payment requirements associated with this benefit. Utilization review and prior authorization for services may be required.

6.2.3. X Physician services (Section 2110(a)(3))

6.2.4. X Surgical services (Section 2110(a)(4))

The NC Health Choice Program will cover medically necessary surgical services under inpatient and outpatient services covered in Sections 6.2.1 and 6.2.2.

6.2.5. X Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))

NC Health Choice will not include Early and Periodic Screening, Detection, and Treatment (EPSDT) services. However, pursuant to 42 CFR § 457.410(b)(1), NC Health Choice will cover annual office visits for preventive services (well-child visits) for children ages 6 through 18 and age-appropriate immunizations in accordance with the recommendations of the Advisory Committee on Immunization Practices. Pursuant to 42 CFR § 457.520, NC Health Choice Program beneficiaries receive well-child visits and age-appropriate immunizations at no cost to their families (an exception to the co-payment requirements outlined in Section 8). The following are considered well-child care services:

- Routine physical examinations as recommended and updated by the American Academy of Pediatrics (AAP) “Guidelines for Health Supervision III” and described in “Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents.”;
- Laboratory tests associated with well-child routine physical examinations;
- Immunizations and related office visits as recommended and updated by the Advisory Committee on Immunization Practices (ACIP); and

- Routine preventive and diagnostic dental services (such as oral examinations, prophylaxis and topical fluoride applications, sealants, and x-rays) as described in the most recent guidelines issued by the American Academy of Pediatric Dentistry (AAPD).

6.2.6. X Prescription drugs (Section 2110(a)(6))

The Department may establish authorizations, limitations, and reviews for specific drugs, drug classes, brands, or quantities in order to effectively manage the NC Health Choice pharmacy program. Prior authorization must be obtained from the NC Health Choice Pharmacy Benefit Management Coordinator or its authorized agent for any drug on the prior authorization list before reimbursement will be available. The NC Health Choice Preferred Drug List is identical to the Medicaid Program Preferred Drug List. There is no limit to the number of prescriptions covered. See Section 8 for co-payment requirements associated with this benefit.

6.2.7. X Over-the-counter medications (Section 2110(a)(7))

The Department may establish authorizations, limitations, and reviews for specific drugs, drug classes, brands, or quantities. Prior authorization may be required based on criteria as published in the NC Division of Medical Assistance’s NC Health Choice Clinical Coverage Policies. See Section 8 for co-payment requirements associated with this benefit.

6.2.8. X Laboratory and radiological services (Section 2110(a)(8))

Utilization review and prior authorization for services may be required.

6.2.9. X Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))

Family planning services and supplies are covered benefits. However, contraceptives that can be purchased without a prescription or do not require the services of a physician for fitting or insertion are not covered. In addition, Health Choice does not cover sterilizations; neither the Health Choice nor Medicaid Program covers sterilization reversals.

Prenatal care and childbirth are not covered benefits under the NC Health Choice Program. However, if an NC Health Choice beneficiary becomes pregnant, she will be enrolled in the NC Medicaid for Pregnant Women program if her income is less than 196% of the Federal Poverty Level (FPL). The Medicaid for Pregnant Women program provides:

- prenatal care, delivery, and care 60 days postpartum;
- Services to treat medical conditions which may complicate the pregnancy (*some services require prior approval*);
- Childbirth classes; and
- Family planning services.

6.2.10. X Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including

residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))

Utilization review and prior authorization for services may be required.

6.2.11. X Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))

Utilization review and prior authorization for services may be required.

6.2.12. X Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))

6.2.13. X Disposable medical supplies (Section 2110(a)(13))

Guidance: Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.

6.2.14. X Home and community-based health care services (Section 2110(a)(14))

Personal Care Services (PCS) are not a covered benefit in the NC Health Choice Program.

Home and community-based covered benefits for beneficiaries are:

Home Health: Skilled Nursing
 Specialized Therapies
 Home Health Aide Services
 Medical Supplies

Hospice: Physician Services
 Nursing Services
 Medical Social Services
 Counseling Services
 Hospice Aide and Homemaker Services
 Volunteer Services
 Medical Appliances and Supplies
 Drugs and Biologicals
 Therapy Services
 Short-Term Inpatient Care
 Ambulance Services
 Nursing Facility and ICF/MR Room and Board

Home
Infusion
Therapy:

Total Parenteral Nutrition (TPN)
Enteral Nutrition (EN)
Intravenous Chemotherapy
Intravenous Antibiotic Therapy

Pain Management Therapy

Guidance: Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school or other setting.

- 6.2.15. Nursing care services (Section 2110(a)(15))
- 6.2.16. X Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))
- 6.2.17. X Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)
- 6.2.18. X Vision screenings and services (Section 2110(a)(24))
Utilization review and prior authorization for services may be required.
- 6.2.19. Hearing screenings and services (Section 2110(a)(24))
- 6.2.20. Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
- 6.2.21. Outpatient substance abuse treatment services (Section 2110(a)(19))
- 6.2.22. Case management services (Section 2110(a)(20))
- 6.2.23. Care coordination services (Section 2110(a)(21))
- 6.2.24. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 6.2.25. Hospice care (Section 2110(a)(23))

Guidance: See guidance for Section 6.1.4.1 for guidance on the statutory requirements for EPSDT under sections 1905(r) and 1902(a)(43) of the Act. If the benefit being provided does not meet the EPSDT statutory requirements, do not check the box below.

6.2.26. EPSDT consistent with requirements of sections 1905(r) and 1902(a)(43) of the Act

Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

6.2.27. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))

6.2.28. Premiums for private health care insurance coverage (Section 2110(a)(25))

6.2.29. Medical transportation (Section 2110(a)(26))

Guidance: Enabling services, such as transportation, translation, and outreach services, may be offered only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

6.2.30. Enabling services (such as transportation, translation, and outreach services) (Section 2110(a)(27))

6.2.31. Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28))

6.2-DC Dental Coverage (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) The State will provide dental coverage to children through one of the following. Please update Sections 9.10 and 10.3-DC when electing this option. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

6.2.1-DC X State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT¹) codes are included in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)

2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

Health Choice will have a State-defined dental benefit plan and cover procedures from all of the above service categories.

6.2.1.1-DC Periodicity Schedule. The State has adopted the following periodicity schedule:

- State-developed Medicaid-specific
- American Academy of Pediatric Dentistry
- Other Nationally recognized periodicity schedule
- Other (description attached)

The revised Medicaid dental periodicity schedule follows a modified version of the American Academy of Pediatric Dentistry's *Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Children*. You can view the schedule at: <http://www.ncdhhs.gov/dma/dental/DentalPeriodicitySchedule11012011.pdf>. The "6 – 12" and "12 years and older" categories of covered services will apply to Health Choice beneficiaries.

No benefits are to be provided for services and materials under this subsection that do not meet the standards accepted by the American Dental Association.

Prior approval is required for the following services:

- Some oral surgery services, including developmental and congenital orthognathic surgery procedures
- Orthodontic services (limited to children with malocclusions caused by severe craniofacial anomalies such as cleft lip and/or palate)
- Some periodontal services including periodontal surgeries, scaling, and root planning
- Prosthodontics (dentures and acrylic partial dentures)

Services not covered:

- Oral evaluations for patients under 3 years of age (NC Health Choice children are ages 6 – 18)

- Upper and lower cast metal partial dentures
- Denture/partial denture reline services
- Oral surgery/preprosthetic services
 - Alveoloplasty
 - Vestibuloplasty

Removal/reduction of lateral exostoses, tori and osseous tuberosities

6.2.2-DC Benchmark coverage; (Section 2103(c)(5), 42 CFR 457.410, and 42 CFR 457.420)

6.2.2.1-DC FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT² codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.2-DC State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.3-DC HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2-DS **Supplemental Dental Coverage-** The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children (Section 2110(b)(5)(C)(ii)). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

Guidance: Under Title XXI, pre-existing condition exclusions are not allowed, with the only exception being in relation to another law in existence (HIPAA/ERISA). Indicate that the plan adheres to this requirement by checking the applicable description.

In the event that the State provides benefits through a group health plan or group health coverage, or provides family coverage through a group health plan under a waiver (see Section 6.4.2.), pre-existing condition limits are allowed to the extent permitted by HIPAA/ERISA. If the State is contracting with a group health plan or provides benefits through group health coverage, describe briefly any limitations on pre-existing conditions. (Formerly 8.6.)

6.2- MHPAEA Section 2103(c)(6)(A) of the Social Security Act requires that, to the extent that it provides both medical/surgical benefits and mental health or substance use disorder benefits, a State child health plan ensures that financial requirements and treatment limitations applicable to mental health and substance use disorder benefits comply with the mental health parity requirements of section 2705(a) of the Public Health Service Act in the same manner that such requirements apply to a group health plan. If the state child health plan provides for delivery of services through a managed care arrangement, this requirement applies to both the state and managed care plans. These requirements are also applicable to any additional benefits provided voluntarily to the child health plan population by managed care entities and will be considered as part of CMS’s contract review process at 42 CFR 457.1201(l).

6.2.1- MHPAEA Before completing a parity analysis, the State must determine whether each covered benefit is a medical/surgical, mental health, or substance use disorder benefit based on a standard that is consistent with state and federal law and generally recognized independent standards of medical practice. (42 CFR 457.496(f)(1)(i))

6.2.1.1- MHPAEA Please choose the standard(s) the state uses to determine whether a covered benefit is a medical/surgical benefit, mental health benefit, or substance use disorder benefit. The most current version of the standard elected must be used. If different standards are used for different benefit types, please specify the benefit type(s) to which each standard is applied. If “Other” is selected, please provide a description of that standard.

International Classification of Disease (ICD)

Diagnostic and Statistical Manual of Mental Disorders (DSM)

State guidelines (Describe: _____)

Other (Describe: _____)

6.2.1.2- MHPAEA Does the State provide mental health and/or substance use disorder benefits?

Yes

No

Guidance: If the State does not provide any mental health or substance use disorder benefits, the mental health parity requirements do not apply ((42 CFR 457.496(f)(1)). Continue on to Section 6.3.

6.2.2- MHPAEA Section 2103(c)(6)(B) of the Social Security Act (the Act) provides that to the extent a State child health plan includes coverage of early and periodic screening, diagnostic, and treatment services (EPSDT) defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the plan shall be deemed to satisfy the parity requirements of section 2103(c)(6)(A) of the Act.

6.2.2.1- MHPAEA Does the State child health plan provide coverage of EPSDT? The State must provide for coverage of EPSDT benefits, consistent with Medicaid statutory requirements, as indicated in section 6.2.26 of the State child health plan in order to answer “yes.”

Yes

X No

Guidance: If the State child health plan *does not* provide EPSDT consistent with Medicaid statutory requirements at sections 1902(a)(43) and 1905(r) of the Act, please go to Section 6.2.3- MHPAEA to complete the required parity analysis of the State child health plan.

If the state *does* provide EPSDT benefits consistent with Medicaid requirements, please continue this section to demonstrate compliance with the statutory requirements of section 2103(c)(6)(B) of the Act and the mental health parity regulations of 42 CFR 457.496(b) related to deemed compliance. Please provide supporting documentation, such as contract language, provider manuals, and/or member handbooks describing the state’s provision of EPSDT.

6.2.2.2- MHPAEA EPSDT benefits are provided to the following: n/a

All children covered under the State child health plan.

A subset of children covered under the State child health plan.

Please describe the different populations (if applicable) covered under the State child health plan that are provided EPSDT benefits consistent with Medicaid statutory requirements.

Guidance: If only a subset of children are provided EPSDT benefits under the State child health plan, 42 CFR 457.496(b)(3) limits deemed compliance to those children only and Section 6.2.3- MHPAEA must be completed as well as the required parity analysis for the other children.

6.2.2.3- MHPAEA To be deemed compliant with the MHPAEA parity requirements, States must provide EPSDT in accordance with sections 1902(a)(43) and 1905(r) of the Act (42 CFR 457.496(b)). The State assures each of the following for children eligible for EPSDT under the separate State child health plan: N/A

- All screening services, including screenings for mental health and substance use disorder conditions, are provided at intervals that align with a periodicity schedule that meets reasonable standards of medical or dental practice as well as when medically necessary to determine the existence of suspected illness or conditions. (Section 1905(r))

- All diagnostic services described in 1905(a) of the Act are provided as needed to diagnose suspected conditions or illnesses discovered through screening services, whether or not those services are covered under the Medicaid state plan. (Section 1905(r))

- All items and services described in section 1905(a) of the Act are provided when needed to correct or ameliorate a defect or any physical or mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan. (Section 1905(r)(5))

- Treatment limitations applied to services provided under the EPSDT benefit are not limited based on a monetary cap or budgetary constraints and may be exceeded as medically necessary to correct or ameliorate a medical or physical condition or illness. (Section 1905(r)(5))

- Non-quantitative treatment limitations, such as definitions of medical necessity or criteria for medical necessity, are applied in an individualized manner that does not preclude coverage of any items or services necessary to correct or ameliorate any medical or physical condition or illness. (Section 1905(r)(5))

- EPSDT benefits are not excluded on the basis of any condition, disorder, or diagnosis. (Section 1905(r)(5))

- The provision of all requested EPSDT screening services, as well as any corrective treatments needed based on those screening services, are provided or arranged for as necessary. (Section 1902(a)(43))

- All families with children eligible for the EPSDT benefit under the separate State child health plan are provided information and informed about the full range of services available to them. (Section 1902(a)(43)(A))

Guidance: For states seeking deemed compliance for their entire State child health plan population, please continue to Section 6.3. If not all of the covered populations are offered EPSDT, the State must conduct a parity analysis of the benefit packages provided to those populations. Please continue to 6.2.3- MHPAEA.

Mental Health Parity Analysis Requirements for States Not Providing EPSDT to All Covered Populations

Guidance: The State must complete a parity analysis for each population under the State child health plan that is not provided the EPSDT benefit consistent with the requirements 42 CFR 457.496(b). If the State provides benefits or limitations that vary within the child or pregnant woman populations, states should perform a parity analysis for each of the benefit packages. For example, if different financial requirements are applied according to a beneficiary's income, a separate parity analysis is needed for the benefit package provided at each income level.

Please ensure that changes made to benefit limitations under the State child health plan as a result of the parity analysis are also made in Section 6.2.

6.2.3- MHPAEA In order to conduct the parity analysis, the State must place all medical/surgical and mental health and substance use disorder benefits covered under the State child health plan into one of four classifications: Inpatient, outpatient, emergency care, and prescription drugs. (42 CFR 457.496(d)(2)(ii); 42 CFR 457.496(d)(3)(ii)(B))

6.2.3.1 MHPAEA Please describe below the standard(s) used to place covered benefits into one of the four classifications.

The State used the following standard definitions to determine classification (services that can be provided in both inpatient and outpatient settings were classified as both):

Inpatient: Benefits that are ordered by a doctor to formally admit an enrollee to a hospital or other facility that provides treatment 24 hours per day. Room and board are included in the cost for inpatient.

Outpatient: Benefits that do not require a doctor's order for formal hospital admission. Outpatient benefits can include services delivered in a hospital setting, including outpatient surgery, lab tests, x-rays, etc.

Emergency Care: Benefits provided evaluate and/or treat a medical, mental health or substance use disorder condition that requires immediate, unscheduled medical care.

Prescription Drugs: Pharmaceuticals that legally require a medical prescription to be dispensed.

6.2.3.1.1 MHPAEA The State assures that:

X The State has classified all benefits covered under the State plan into one of the four classifications.

X The same reasonable standards are used for determining the classification for a mental health or substance use disorder benefit as are used for determining the classification of medical/surgical benefits.

6.2.3.1.2- MHPAEA Does the State use sub-classifications to distinguish between office visits and other outpatient services?

Yes

X No

6.2.3.1.2.1- MHPAEA If the State uses sub-classifications to distinguish between outpatient office visits and other outpatient services, the State assures the following:
n/a

The sub-classifications are only used to distinguish office visits from other outpatient items and services, and are not used to distinguish between similar services on other bases (ex: generalist vs. specialist visits).

Guidance: For purposes of this section, any reference to “classification(s)” includes sub-classification(s) in states using sub-classifications to distinguish between outpatient office visits from other outpatient services.

6.2.3.2 MHPAEA The State assures that:

X Mental health/ substance use disorder benefits are provided in all classifications in which medical/surgical benefits are provided under the State child health plan.

Guidance: States are not required to cover mental health or substance use disorder benefits (42 CFR 457.496(f)(2)). However if a state does provide any mental health or substance use disorder benefits, those mental health or substance use disorder benefits must be provided in all the same classifications in which medical/surgical benefits are covered under the State child health plan (42 CFR 457.496(d)(2)(ii).

Annual and Aggregate Lifetime Dollar Limits

6.2.4- MHPAEA A State that provides both medical/surgical benefits and mental health and/or substance use disorder benefits must comply with parity requirements related to annual and aggregate lifetime dollar limits for benefits covered under the State child health plan. (42 CFR 457.496(c))

6.2.4.1- MHPAEA Please indicate whether the State applies an aggregate lifetime dollar limit and/or an annual dollar limit on any mental health or substance abuse disorder benefits covered under the State child health plan.

Aggregate lifetime dollar limit is applied

Aggregate annual dollar limit is applied

X No dollar limit is applied

Guidance: A monetary coverage limit that applies to all CHIP services provided under the State child health plan is not subject to parity requirements.

If there are no aggregate lifetime or annual dollar limits on any mental health or substance use disorder benefits, please go to section 6.2.5- MHPAEA.

6.2.4.2- MHPAEA Are there any medical/surgical benefits covered under the State child health plan that have either an aggregate lifetime dollar limit or an annual dollar limit? If yes, please specify what type of limits apply.

Yes (Type(s) of limit:)

X No

Guidance: If no aggregate lifetime dollar limit is applied to medical/ surgical benefits, the State may not impose an aggregate lifetime dollar limit on any mental health or substance use disorder benefits. If no aggregate annual dollar limit is applied to medical/surgical benefits, the State may not impose an aggregate annual dollar limit on any mental health or substance use disorder benefits. (42 CFR 457.496(c)(1))

6.2.4.3 – MHPAEA. States applying an aggregate lifetime or annual dollar limit on medical/surgical benefits and mental health or substance use disorder benefits must determine whether the portion of the medical/surgical benefits to which the limit applies is less than one-third, at least one-third but less than two-thirds, or at least two-thirds of all medical/surgical benefits covered under the State plan (42 CFR 457.496(c)). The portion of medical/surgical benefits subject to the limit is based on the dollar amount expected to be paid for all medical/surgical benefits under the State plan for the State plan year or portion of the plan year after a change in benefits that affects the applicability of the aggregate lifetime or annual dollar limits. (42 CFR 457.496(c)(3))
N/A

The State assures that it has developed a reasonable methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable.

Guidance: Please include the state's methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit and the results as an attachment to the State child health plan.

6.2.4.3.1- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to a lifetime dollar limit:

- Less than 1/3
- At least 1/3 and less than 2/3
- At least 2/3

6.2.4.3.2- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to an annual dollar limit:

- Less than 1/3
- At least 1/3 and less than 2/3
- At least 2/3

Guidance: If an aggregate lifetime limit is applied to less than one-third of all medical/surgical benefits, the State may not impose an aggregate lifetime limit on *any* mental health or substance use disorder benefits. If an annual dollar limit is applied to less than one-third of all medical surgical benefits, the State may not impose an annual dollar limit on *any* mental health or substance use disorder benefits (42 CFR 457.496(c)(1)). Skip to section 6.2.5-MHPAEA.

If the State applies an aggregate lifetime or annual dollar limit to at least one-third of all medical/surgical benefits, please continue below to provide the assurances related to the determination of the portion of total costs for medical/surgical benefits that are subject to either an annual or lifetime limit.

6.2.4.3.2.1- MHPAEA If the State applies an aggregate lifetime or annual dollar limit to at least 1/3 and less than 2/3 of all medical/surgical benefits, the State assures the following (42 CFR 457.496(c)(4)(i)(B)); (42 CFR 457.496(c)(4)(ii)):

The State applies an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits.

Guidance: The state's methodology for calculating the average limit for medical/surgical benefits must be consistent with 42 CFR 457.496(c)(4)(i)(B) and 42 CFR 457.496(c)(4)(ii). Please include the state's methodology and results as an attachment to the State child health plan.

6.2.4.3.2.2- MHPAEA If at least 2/3 of all medical/surgical benefits are subject to an annual or lifetime limit, the State assures either of the following (42 CFR 457.496(c)(2)(i)); (42 CFR 457.496(c)(2)(ii)):

The aggregate lifetime or annual dollar limit is applied to both medical/surgical benefits and mental health and substance use disorder benefits in a manner that does not distinguish between medical/surgical benefits and mental health and substance use disorder benefits; or

The aggregate lifetime or annual dollar limit placed on mental health and substance use disorder benefits is no more restrictive than the aggregate lifetime or annual dollar limit on medical/surgical benefits.

Quantitative Treatment Limitations

6.2.5- MHPAEA Does the State apply quantitative treatment limitations (QTLs) on any mental health or substance use disorder benefits in any classification of benefits? If yes, specify the classification(s) of benefits in which the State applies one or more QTLs on any mental health or substance use disorder benefits.

X Yes (Specify: **Outpatient, Emergency Care**)

No

Guidance: If the state does not apply any type of QTLs on any mental health or substance use disorder benefits in any classification, the state meets parity requirements for QTLs and should continue to Section 6.2.6 - MHPAEA. If the state does apply QTLs to any mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue.

6.2.5.1- MHPAEA Does the State apply any type of QTL on any medical/surgical benefits?

Yes

No

Guidance: If the State does not apply QTLs on any medical/surgical benefits, the State may not impose quantitative treatment limitations on mental health or substance use disorder benefits, please go to Section 6.2.6- MHPAEA related to non-quantitative treatment limitations.

6.2.5.2- MHPAEA Within each classification of benefits in which the State applies a type of QTL on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the classification which are subject to the limitation. More specifically, the State must determine the ratio of (a) the dollar amount of all payments expected to be paid under the State plan for medical and surgical benefits within a classification which are subject to the type of quantitative treatment limitation for the plan year (or portion of the plan year after a mid-year change affecting the applicability of a type of quantitative treatment limitation to any medical/surgical benefits in the class) to (b) the dollar amount expected to be paid for all medical and surgical benefits within the classification for the plan year. For purposes of this paragraph, all payments expected to be paid under the State plan includes payments expected to be made directly by the State and payments which are expected to be made by MCEs contracting with the State. (42 CFR 457.496(d)(3)(i)(C))

The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above for each classification within which the State applies QTLs to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Guidance: Please include the state’s methodology and results as an attachment to the State child health plan. Please see Attachment A

6.2.5.3- MHPAEA For each type of QTL applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of QTL to “substantially all” (defined as at least two-thirds) of the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

Yes Outpatient services

No Emergency Services. **Note** – Mobile Crisis is a mental health / substance use disorder service with a QTL. This has been identified as non-complaint with parity. The State is taking the necessary steps to remove the QTL from Clinical Coverage Policy. The policy

has been revised and is pending stakeholder feedback, review by the State Physician Advisory Group, public comment and final revision. The

Guidance: If the State does not apply a type of QTL to substantially all medical/surgical benefits in a given classification of benefits, the State may not impose that type of QTL on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

6.2.5.3.1- MHPAEA For each type of QTL applied to mental health or substance use disorder benefits, the State must determine the predominant level of that type which is applied to medical/surgical benefits in the classification. The “predominant level” of a type of QTL in a classification is the level (or least restrictive of a combination of levels) that applies to more than one-half of the medical/surgical benefits in that classification, as described in 42 CFR 457.496(d)(3)(i)(B). The portion of medical/surgical benefits in a classification to which a given level of a QTL type is applied is based on the dollar amount of payments expected to be paid for medical/surgical benefits subject to that level as compared to all medical/surgical benefits in the classification, as described in 42 CFR 457.496(d)(3)(i)(C). For each type of quantitative treatment limitation applied to mental health or substance use disorder benefits, the State assures:

X The same reasonable methodology applied in determining the dollar amounts used to determine whether substantially all medical/surgical benefits within a classification are subject to a type of quantitative treatment limitation also is applied in determining the dollar amounts used to determine the predominant level of a type of quantitative treatment limitation applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

X The level of each type of quantitative treatment limitation applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Guidance: If there is no single level of a type of QTL that exceeds the one-half threshold, the State may combine levels within a type of QTL such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))

Non-Quantitative Treatment Limitations

6.2.6- MHPAEA The State may utilize non-quantitative treatment limitations (NQTLs) for mental health or substance use disorder benefits, but the State must ensure that those NQTLs comply with all the mental

health parity requirements. (42 CFR 457.496(d)(4)); (42 CFR 457.496(d)(5))

6.2.6.1 – MHPAEA If the State imposes any NQTLs, complete this subsection. If the State does not impose NQTLs, please go to Section 6.2.7-MHPAEA.

The State assures that the processes, strategies, evidentiary standards or other factors used in the application of any NQTL to mental health or substance use disorder benefits are no more stringent than the processes, strategies, evidentiary standards or other factors used in the application of NQTLs to medical/surgical benefits within the same classification.

Guidance: Examples of NQTLs include medical management standards to limit or exclude benefits based on medical necessity, restrictions based on geographic location, provider specialty, or other criteria to limit the scope or duration of benefits and provider network design (ex: preferred providers vs. participating providers). Additional examples of possible NQTLs are provided in 42 CFR 457.496(d)(4)(ii). States will need to provide a summary of its NQTL analysis, as well as supporting documentation as requested.

6.2.6.2 – MHPAEA The State or MCE contracting with the State must comply with parity if they provide coverage of medical or surgical benefits furnished by out-of-network providers.

6.2.6.2.1- MHPAEA Does the State or MCE contracting with the State provide coverage of medical or surgical benefits provided by out-of-network providers?

Yes

No

Guidance: The State can answer no if the State or MCE only provides out of network services in specific circumstances, such as emergency care, or when the network is unable to provide a necessary service covered under the contract.

6.2.6.2.2- MHPAEA If yes, the State must provide access to out-of-network providers for mental health or substance use disorder benefits. Please assure the following:

The State attests that when determining access to out-of-network providers within a benefit classification, the processes, strategies, evidentiary standards, or other factors used to determine access to those providers for mental health/ substance use disorder benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used to determine access for out- of-network providers for medical/surgical benefits.

Availability of Plan Information

6.2.7- MHPAEA The State must provide beneficiaries, potential enrollees, and providers with information related to medical necessity criteria and denials of payment or reimbursement for mental health or substance use disorder services (42 CFR 457.496(e)) in addition to existing notice requirements at 42 CFR 457.1180.

6.2.7.1- MHPAEA Medical necessity criteria determinations must be made available to any current or potential enrollee or contracting provider, upon request. The state attests that the following entities provide this information:

XState

Managed Care entities

Both

Other

Guidance: If other is selected, please specify the entity.

6.2.7.2- MHPAEA Reason for any denial for reimbursement or payment for mental health or substance use disorder benefits must be made available to the enrollee by the health plan or the State. The state attests that the following entities provide denial information:

XState

Managed Care entities

Both

Other

Guidance: If other is selected, please specify the entity.

6.3. The State assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42 CFR 457.480)

6.3.1. The State shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR

6.3.2. The State contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.6.2. (formerly 6.4.2) of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA. (Formerly 8.6.) (Section 2103(f)) Describe:

Guidance: States may request two additional purchase options in Title XXI: cost effective coverage through a community-based health delivery system and for the purchase of family coverage. (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

6.4. Additional Purchase Options- If the State wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the State must address the following: (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

6.4.1. **Cost Effective Coverage-** Payment may be made to a State in excess of the 10 percent limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the State to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The State may cross reference Section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42 CFR 457.1005(b))

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42 CFR 457.1005(b))

Guidance: Check below if the State is requesting to provide cost-effective coverage through a community-based health delivery system. This allows the State to waive the 10 percent limitation on expenditures not used for Medicaid or health insurance assistance if coverage provided to targeted low-income children through such expenditures meets the requirements of Section 2103; the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under Section 2103; and such coverage is provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Services Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923.

If the cost-effective alternative waiver is requested, the State must demonstrate that payments in excess of the 10 percent limitation will be used for other child health assistance for targeted low-income children; expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and other reasonable costs incurred by the State to administer the plan. (42 CFR, 457.1005(a))

- 6.4.1.3.** The coverage must be provided through the use of a community based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42 CFR 457.1005(a))

Guidance: Check 6.4.2.if the State is requesting to purchase family coverage. Any State requesting to purchase such coverage will need to include information that establishes to the Secretary’s satisfaction that: 1) when compared to the amount of money that would have been paid to cover only the children involved with a comparable package, the purchase of family coverage is cost effective; and 2) the purchase of family coverage is not a substitution for coverage already being provided to the child. (Section 2105(c)(3)) (42 CFR 457.1010)

- 6.4.2.** **Purchase of Family Coverage-** Describe the plan to purchase family coverage. Payment may be made to a State for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42 CFR 457.1010)

- 6.4.2.1.** Purchase of family coverage is cost-effective. The State’s cost of purchasing family coverage, including administrative expenditures, that includes coverage for the targeted low-income children involved or the family involved (as applicable) under premium assistance programs must not be greater than the cost of obtaining coverage under the State plan for all eligible targeted low-income children or families involved; and (2) The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage, including administrative costs, for children or families under premium assistance programs to the cost of other CHIP coverage for these children or families, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

6.4.2.2. The State assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42 CFR 457.1010(b))

6.4.2.3. The State assures that the coverage for the family otherwise meets title XXI requirements. (42 CFR 457.1010(c))

6.4.3-PA: Additional State Options for Providing Premium Assistance (CHIPRA # 13, SHO # 10-002 issued February, 2, 2010) A State may elect to offer a premium assistance subsidy for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(B), to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage. No subsidy shall be provided to a targeted low-income child (or the child's parent) unless the child voluntarily elects to receive such a subsidy. (Section 2105(c)(10)(A)). Please remember to update section 9.10 when electing this option. Does the State provide this option to targeted low-income children?

Yes
 No

6.4.3.1-PA Qualified Employer-Sponsored Coverage and Premium Assistance Subsidy

6.4.3.1.1-PA Provide an assurance that the qualified employer-sponsored insurance meets the definition of qualified employer-sponsored coverage as defined in Section 2105(c)(10)(B), and that the premium assistance subsidy meets the definition of premium assistance subsidy as defined in 2105(c)(10)(C).

6.4.3.1.2-PA Describe whether the State is providing the premium assistance subsidy as reimbursement to an employee or for out-of-pocket expenditures or directly to the employee's employer.

6.4.3.2-PA: Supplemental Coverage for Benefits and Cost Sharing Protections Provided under the Child Health Plan.

6.4.3.2.1-PA If the State is providing premium assistance for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(E)(i), provide an assurance that the State is providing for each targeted low-income child enrolled in such coverage, supplemental coverage consisting of all items or services that are not covered or are only partially covered, under the qualified employer-sponsored coverage consistent with 2103(a) and cost sharing protections consistent with Section 2103(e).

6.4.3.2.2-PA Describe whether these benefits are being provided through the employer or by the State providing wraparound benefits.

6.4.3.2.3-PA If the State is providing premium assistance for benchmark or benchmark-equivalent coverage, the State ensures that such group health plans or health insurance coverage offered through an employer will be certified by an actuary as coverage that is equivalent to a benchmark benefit package described in Section 2103(b) or benchmark equivalent coverage that meets the requirements of Section 2103(a)(2).

6.4.3.3-PA: Application of Waiting Period Imposed Under State Plan: States are required to apply the same waiting period to premium assistance as is applied to direct coverage for children under their CHIP State plan, as specified in Section 2105(c)(10)(F).

6.4.3.3.1-PA Provide an assurance that the waiting period for children in premium assistance is the same as for those children in direct coverage (if State has a waiting period in place for children in direct CHIP coverage).

6.4.3.4-PA: Opt-Out and Outreach, Education, and Enrollment Assistance

6.4.3.4.1-PA Describe the State’s process for ensuring parents are permitted to disenroll their child from qualified employer-sponsored coverage and to enroll in CHIP effective on the first day of any month for which the child is eligible for such assistance and in a manner that ensures continuity of coverage for the child (Section 2105(c)(10)(G)).

6.4.3.4.2-PA Describe the State’s outreach, education, and enrollment efforts related to premium assistance programs, as required under Section 2102(c)(3). How does the State inform families of the availability of premium assistance, and assist them in obtaining such subsidies? What are the specific significant resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the State child health plan? (Section 2102(c))

6.4.3.5-PA Purchasing Pool- A State may establish an employer-family premium assistance purchasing pool and may provide a premium assistance subsidy for enrollment in coverage made available through this pool (Section 2105(c)(10)(I)). Does the State provide this option?

Yes
 No

6.6.3.5.1-PA Describe the plan to establish an employer-family premium assistance purchasing pool.

6.6.3.5.2-PA Provide an assurance that employers who are eligible to participate: 1) have less than 250 employees; 2) have at least one employee who is a pregnant

woman eligible for CHIP or a member of a family that has at least one child eligible under the State's CHIP plan.

6.6.3.5.3-PA Provide an assurance that the State will not claim for any administrative expenditures attributable to the establishment or operation of such a pool except to the extent such payment would otherwise be permitted under this title.

6.4.3.6-PA Notice of Availability of Premium Assistance- Describe the procedures that assure that if a State provides premium assistance subsidies under this Section, it must: 1) provide as part of the application and enrollment process, information describing the availability of premium assistance and how to elect to obtain a subsidy; and 2) establish other procedures to ensure that parents are fully informed of the choices for child health assistance or through the receipt of premium assistance subsidies (Section 2105(c)(10)(K)).

6.4.3.6.1-PA Provide an assurance that the State includes information about premium assistance on the CHIP application or enrollment form.

Section 7. Quality and Appropriateness of Care

Guidance: **Methods for Evaluating and Monitoring Quality-** Methods to assure quality include the application of performance measures, quality standards consumer information strategies, and other quality improvement strategies.

Performance measurement strategies could include using measurements for external reporting either to the State or to consumers and for internal quality improvement purposes. They could be based on existing measurement sets that have undergone rigorous evaluation for their appropriateness (e.g., HEDIS). They may include the use of standardized member satisfaction surveys (e.g., CAHPS) to assess members' experience of care along key dimensions such as access, satisfaction, and system performance.

Quality standards are often used to assure the presence of structural and process measures that promote quality and could include such approaches as: the use of external and periodic review of health plans by groups such as the National Committee for Quality Assurance; the establishment of standards related to consumer protection and quality such as those developed by the National Association of Insurance Commissioners; and the formation of an advisory group to the State or plan to facilitate consumer and community participation in the plan.

Information strategies could include: the disclosure of information to beneficiaries about their benefits under the plan and their rights and responsibilities; the provision

of comparative information to consumers on the performance of available health plans and providers; and consumer education strategies on how to access and effectively use health insurance coverage to maximize quality of care.

Quality improvement strategies should include the establishment of quantified quality improvement goals for the plan or the State and provider education. Other strategies include specific purchasing specifications, ongoing contract monitoring mechanisms, focus groups, etc.

Where States use managed care organizations to deliver CHIP care, recent legal changes require the State to use managed care quality standards and quality strategies similar to those used in Medicaid managed care.

Tools for Evaluating and Monitoring Quality- Tools and types of information available include, HEDIS (Health Employer Data Information Set) measures, CAHPS (Consumer Assessments of Health Plans Study) measures, vital statistics data, and State health registries (e.g., immunization registries).

Quality monitoring may be done by external quality review organizations, or, if the State wishes, internally by a State board or agency independent of the State CHIP Agency. Establishing grievance measures is also an important aspect of monitoring.

- Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 8.

Guidance: The State must specify the qualifications of entities that will provide coverage and the conditions of participation. States should also define the quality standard they are using, for example, NCQA Standards or other professional standards. Any description of the information strategies used should be linked to Section 9. (Section 2102(a)(7)(A)) (42 CFR 457.495)

- 7.1.** Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (Section 2102(a)(7)(A)) (42 CFR 457.495(a)) Will the State utilize any of the following tools to assure quality? (Check all that apply and describe the activities for any categories utilized.)

7.1.1. X Quality standards

The recommended services for children with special health care needs are set forth by the nine-member Commission for Children with Special Needs, established in 1998 per NC General Statute Chapter 143-682. The focus is on children with high cost and/or high incidence conditions such as:

- Asthma;

- Diabetes; and
- Emotional Behavioral Conditions.

Measures for these children may include:

- The proportion of children who have hospital stays;
- The average length of hospital stays;
- The proportion of beneficiaries requesting durable medical equipment;
- The proportion of beneficiaries receiving durable medical equipment;
- Types of mental health / behavioral health services received, by age;
- The average number of mental health / behavioral health outpatient treatments per beneficiary;
- The average number of mental health / behavioral health home health visits per beneficiary;
- Quantitative and/or qualitative summaries of information from periodic surveys of parents of children with special health care needs; and
- The average number of emergency room visits per beneficiary.

Notable gaps in service will act as trigger points for the Commission to develop recommendations to improve access to and quality of care for children with special health care needs. These recommendations are then submitted to the Secretary of DHHS and the NC General Assembly for consideration on an annual basis.

7.1.2. X Performance measurement

7.1.2 (a) X CHIPRA Quality Core Set

7.1.2 (b) Other

The NC Health Choice Program will monitor progress using several of the CHIPRA 2014 Core Performance Measures:

- Childhood Immunizations
- Immunization Status for Adolescents
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Assessment for /Children/Adolescents
- Developmental Screening in the First Three Years of Life
- Chlamydia Screening in Women
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Adolescent Well-Care Visit
- Child and Adolescent Access to Primary Care Practitioners
- Ambulatory Care – Emergency Department (ED) Visits
- Consumer Assessment for Healthcare Providers and Systems® (CAHPS) 5.0H Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items

- Human Papillomavirus (HPV) Vaccine for Female Adolescents

These data are available for tracking within claims data. DMA has IT staff and the capacity to use SAS software to conduct database queries and generate reports on the measures. DMA also receives annual measures reporting from the PCCM contractor, Community Care of North Carolina (CCNC).

NC Health Choice beneficiaries' use of preventive health services will be evaluated through the following measures:

- The immunization rate per (1000) beneficiaries*
- The well-child screening rate per (1000) beneficiaries, by age.
 - ages 6-10 (middle childhood)**
 - ages 11-18 (adolescence)**

*The immunization rate among NC Health Choice Program participants will be compared with the immunization rate at the State and national levels.

** Age categories are in line with the American Academy of Pediatrics' Recommendations for Preventive Pediatric Health Care.

The rate of use of acute care services will be evaluated via the following measures:

- Average number of ambulatory visits per month (in a State fiscal year), by age;
- Number and rate of ambulatory visits per 1000 member months, by age
- Number and rate of emergency room visits per 1000 member months
- Number and rate of hospital stays per 1000 member months, by age

Average length of hospital stay per beneficiary, by age

7.1.3. Information strategies

Application, enrollment, and claims data reporting are completed on a monthly basis. Periodic ad hoc queries to evaluate claims for specific conditions and payment scenarios are also done. The regular reporting and periodic queries allow NC Health Choice Program administrators to monitor program cost efficiency, claims processing accuracy, and service utilization patterns.

7.1.4. Quality improvement strategies

Data collection and analysis will yield insight into Health Choice Program beneficiaries' health service utilization and the subsequent health status outcomes among the target population. Furthermore, the data will provide a feedback loop for outreach and education efforts relevant to Program enrollees. As needed, program staff may develop supplemental notices to participants or modify the beneficiary Handbook content from year-to-year.

Guidance: Provide a brief description of methods to be used to assure access to covered services, including a description of how the State will assure the quality and appropriateness of the care provided. The State should consider whether there are sufficient providers of care for the newly enrolled populations and whether there is reasonable access to care. (Section 2102(a)(7)(B))

7.2. Describe the methods used, including monitoring, to assure: (Section 2102(a)(7)(B)) (42 CFR 457.495)

7.2.1. Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42 CFR 457.495(a))

NC Health Choice Program staff review paid claims data, independent studies by researchers and State immunization registry data to monitor access to well-child care and age-appropriate immunizations. Furthermore, the Health Choice Program excludes these covered benefits from the cost sharing component of Program enrollment, as required by federal regulations.

7.2.2. Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42 CFR 457.495(b))

NC Health Choice Program staff review paid claims data to monitor access to covered services, including emergency services. NC Health Choice Program beneficiaries have access to emergency services in out-of-state settings also. Only non-emergency, out-of-state services require prior approval.

At the time of enrollment in NC Health Choice, each beneficiary selects or is assigned to a primary care provider within the CCNC network. As of October 2014, there were 78,718 NC Health Choice providers across all 100 NC counties available to serve approximately 80,000 NC Health Choice beneficiaries.

7.2.3. Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42 CFR 457.495(c))

All NC Health Choice Program providers are required to enroll as Medicaid-enrolled providers with the NC Medicaid program and go through the credentialing process. DMA periodically conducts focused studies on high cost or high incidence conditions or provider practice patterns. If the investigation results indicate provider and/or member education is appropriate, DMA develops a collaborative multi-strategy to contact, educate, and monitor for expected changes.

In 2011, North Carolina legislation mandated that the NC Health Choice Program provides health benefits coverage equivalent to coverage provided for Medicaid beneficiaries, with some exceptions. One of the exceptions is no EPSDT services in the Health Choice Program. However, the Health Choice Program covers all well-child visits and immunizations, inpatient and outpatient mental health services, and the provision of durable medical equipment. Home and community based health care services are also covered. Prior approval based on the medical necessity of services is required for all specialized therapies.

7.2.4. Decisions related to the prior authorization of health services are completed in accordance with State law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42 CFR 457.495(d)) Exigent medical circumstances may require more rapid response according to the medical needs of the patient.

Pursuant to 42 CFR 457.495(d)(1), Prior authorization decisions are made in accordance with the medical needs of the patient within 5 days after receipt of a request for medical services and within 24 hours after receipt of a request for pharmacy services, unless the utilization review contractor needs additional information from the requesting provider. Compliance is verified through spot-checking, provider feedback, and reports from the Claims Processing Contractor.

Section 8. Cost-Sharing and Payment

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State’s Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42 CFR 457.505) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

8.1.1. Yes

8.1.2. No, skip to question 8.8.

8.1.1-PW Yes

8.1.2-PW No, skip to question 8.8.

Prenatal care and childbirth are not covered benefits under the NC Health Choice Program. However, if an NC Health Choice beneficiary becomes pregnant, she will be enrolled in the NC Medicaid for Pregnant Women program if her income is less than 196% of the Federal Poverty Level (FPL).

Guidance: It is important to note that for families below 150 percent of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the family cannot exceed 5 percent of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge by age and income (if applicable) and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2.1. Premiums:
NC Health Choice beneficiaries do not pay health insurance premiums.

8.2.2. Deductibles:
NC Health Choice beneficiaries do not pay deductibles.

8.2.3. Coinsurance or copayments:
The State imposes different co-payments on families in two different income categories: families

with annual income from above 133% FPL up to and including 159% FPL, and families with annual income FPL above 159% up to and including 211% FPL have co-payment requirements set forth in N.C.G.S. 108A-70.21(d) and (e). Those requirements are outlined in the table below. Providers collect co-payments for services, and then claim payments for covered benefits are reimbursed net of the applicable co-payment.

Health Choice Cost Sharing

Income Level		Cost Sharing
Family income is \leq 159% FPL and Native American Tribe or Alaskan Native		<ul style="list-style-type: none"> • No annual enrollment fee • No cost sharing
Family income is \leq 159% FPL	•	<ul style="list-style-type: none"> • No annual enrollment fee • No copayments for office visits • Generic Prescription copay: \$1 • Brand Prescription when no generic available copay: \$1 • Brand prescription when generic available copay: \$3 • Over-the-counter copay: \$1 • \$10 non-emergency emergency room visits
Income $>$ 159% and \leq 211% FPL and Native American Tribe or Alaskan Native.		<ul style="list-style-type: none"> • No annual enrollment fee • No cost sharing
Income $>$ 159% and \leq 211% FPL		<ul style="list-style-type: none"> • Annual enrollment fee: \$50 per child or \$100 maximum for two or more. • Office visit copay: \$5 • Outpatient hospital: \$5 • Generic Prescription copay: \$1 • Brand Prescription when no generic available copay: \$1 • Brand prescription when generic available copay: \$10 • Over-the-counter copay: \$1 • \$25 non-emergency emergency room visits

For all members of federally recognized Native American tribes and Alaska Natives, there is no cost-sharing imposed. A \$0 co-payment is printed on each qualified beneficiary's health insurance card. Pursuant to 42 C.F.R. § 457.505(d)(1), all beneficiaries receive well-child visits and age-appropriate immunizations at no cost to their families. NC law (N.C. GEN. STAT. § 108A-70.21(e) restricts the total annual aggregate (12 months, continuous coverage as opposed to a calendar or fiscal year)

cost-sharing for beneficiaries' subject to co-payments to 5% of the family's income.

8.2.4. Other:

For children in families living above 159% and up to 211% of the federal poverty level, there is also an annual enrollment fee of \$50 per child, with a \$100 maximum for two (2) or more children in the same family. Families are required to pay the annual enrollment fee both at the time of initial enrollment and upon each annual renewal, as appropriate based on family income level. The State activates initial enrollment and renewal eligibility periods following full payment of the enrollment fee. The county social service departments retain the enrollment fee to assist with defraying administrative expenses.

For all members of federally recognized Native American tribes and Alaska Natives, there is no enrollment fee imposed.

8.2-DS **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and dental insurance. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

8.2.1-DS Premiums:

8.2.2-DS Deductibles:

8.2.3-DS Coinsurance or copayments:

8.2.4-DS Other:

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)(1)(A)) (42 CFR 457.505(b))

Beneficiary cost sharing charges are prominently posted in the beneficiary Handbook, on membership ID cards, and on the Health Choice Program Web pages. Cost sharing requirements, including co-payments and enrollment fees, are legislated through the NC General Assembly and set forth in N.C.G.S. 108A-70.21(d) and (e). The public has the opportunity for input through healthcare advocacy groups and direct communication with their elected representatives. Media coverage in print, radio, and television keeps the general public informed regarding public policy changes, including those to federal and state Title XIX and Title XXI programs. Pending legislation is available for public review on the NC legislative website.

In the event of a cost sharing change, DMA mails letters to each beneficiary head of household at least 15 calendar days in advance of the change effective date. Each beneficiary also receives a new ID card with updated co-payment information.

Guidance: The State should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.

8.4. The State assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

- 8.4.1.** Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42 CFR 457.530)
- 8.4.2.** No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42 CFR 457.520)
- 8.4.3** No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42 CFR 457.515(f))

8.4.1- MHPAEA X There is no separate accumulation of cumulative financial requirements, as defined in 42 CFR 457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits. (42 CFR 457.496(d)(3)(iii))

8.4.2- MHPAEA N/A If applicable, any different levels of financial requirements that are applied to different tiers of prescription drugs are determined based on reasonable factors, regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits. (42 CFR 457.496(d)(3)(ii)(A))

8.4.3- MHPAEA X Cost sharing applied to benefits provided under the State child health plan will remain capped at five percent of the beneficiary's income as required by 42 CFR 457.560 (42 CFR 457.496(d)(3)(i)(D)).

8.4.4- MHPAEA Does the State apply financial requirements to any mental health or substance use disorder benefits? If yes, specify the classification(s) of benefits in which the State applies financial requirements on any mental health or substance use disorder benefits.

XYes (Specify: The State applies co-payments to services based on type of service and family income, rather than the type of condition the service is intended to treat. There is no difference between the financial requirements of mental health and substance use disorder benefits and medical/surgical benefits. Please see Attachment B for NC Health Choice financial requirements analysis.

No

Guidance: For the purposes of parity, financial requirements include deductibles, copayments, coinsurance, and out of pocket maximums; premiums are excluded from the definition. If the state does not apply financial requirements on any mental health or substance use disorder benefits, the state meets parity requirements for financial requirements. If the state does apply financial requirements to mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue below.

Please ensure that changes made to financial requirements under the State child health plan as a result of the parity analysis are also made in Section 8.2.

8.4.5- MHPAEA Does the State apply any type of financial requirements on any medical/surgical benefits?

X Yes

No

Guidance: If the State does not apply financial requirements on any medical/surgical benefits, the State may not impose financial requirements on mental health or substance use disorder benefits.

8.4.6- MHPAEA Within each classification of benefits in which the State applies a type of financial requirement on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the class which are subject to the limitation.

N/A - The State applies financial requirements (co-payments and annual enrollment fees) to services based on type of service and family income, rather than the type of condition the service is intended to treat. There is no difference between the financial requirements of mental health and substance use disorder benefits and medical/surgical benefits. Please see Attachment B for NC Health Choice financial requirements analysis. All medical and surgical benefits are subject to this limitation.

The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above (Section 6.2.5.2-MHPAEA) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Guidance: Please include the state's methodology and results of the parity analysis as an attachment to the State child health plan.

8.4.7- MHPAEA For each type of financial requirement applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of financial requirement to at least two-thirds (“substantially all”) of all the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

Yes

No

Guidance: If the State does not apply a type of financial requirement to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose financial requirements on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

8.4.8- MHPAEA For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in 42 CFR 457.496(d)(3)(i)(B)) of that type which is applied to medical/surgical benefits in the classification. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State assures:

The same reasonable methodology applied in determining the dollar amounts used in determining whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement also is applied in determining the dollar amounts used to determine the predominant level of a type of financial requirement applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

The level of each type of financial requirement applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Guidance: If there is no single level of a type of financial requirement that exceeds the one-half threshold, the State may combine levels within a type of financial requirement such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))

8.5. Describe how the State will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family’s income for the length of the child’s eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the State for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR

457.560(b) and 457.505(e))

The NC Health Choice program annual maximum cost sharing requirements are legislatively set at the federal annual limit of 5% of the countable family income. To date, no families have incurred annual cost sharing expenses that met the annual maximum. The Division of Medical Assistance eligibility database includes the family countable net income for each NC Health Choice beneficiary. The claims processing contractor calculates the annual cost-sharing maximum by multiplying the monthly income by 12 months and multiplying the result by five percent. For example, countable household income of \$2500-month x 12 months = \$30,000 countable annual income. The annual family cost sharing maximum is \$1500 ($\$30,000 \times .05 = \$1,500$).

Cost sharing contributions, including the annual enrollment fee (if applicable) are accumulated for all enrolled children in the family towards the maximum annual limit. NC Health Choice children in the same family accumulate cost sharing expenses in a combined tracking tool aggregated under the case head/ head of household.

The claims processor generates a monthly report to monitor the total cost sharing expenses for each family and ensure that the total is below the annual maximum. In the event the cost-sharing ceiling is reached during the annual enrollment period, the beneficiary's family will be notified that co-payments are suspended for the remainder of the annual enrollment period. Each beneficiary will then receive a new ID card with \$0 co-payment amounts. Beneficiaries will be instructed to provide the notice and new ID card to providers and pharmacists as evidence that no co-payment is due. During the remainder of the 12-month continuous enrollment period, provider claims for covered services will be reimbursed without the applicable co-pay deduction from provider proceeds.

As a precaution, the claims processor generates an annual report grouping all enrollees under the same case. Total cost sharing expenses (including those from Pharmacy claims) will be listed with the cost sharing maximum to ensure that all cases have multiple review checkpoints.

- 8.6.** Describe the procedures the State will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42 CFR 457.535)

NC Health Choice and Medicaid share a joint application. The application requests self-reported, demographic data including race and ethnicity. American Indian and Alaska Native children identification is Race Code "I," a specific classification that excludes them from cost-sharing requirements. Applicants declaring US citizenship and American Indian status are asked to provide evidence (such as a Tribal Membership Card) of membership in a federally recognized Native American tribe. Verification of race exempts American Indian and Alaska native children from all program cost-sharing requirements including the enrollment fee (if applicable) and co-payments. The beneficiary's health insurance ID card also shows \$0 co-payment amounts for pharmacy and

medical services, so the exclusion from cost-sharing is clearly communicated to providers each time a qualifying beneficiary accesses medical services.

- 8.7.** Provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42 CFR 457.570 and 457.505(c))

As described in Section 8.6, American Indian and Alaska Native children are exempt from paying an annual enrollment fee. For all other eligible children in a family with an annual income level between 159-211% FPL, the annual enrollment fee must be paid in full prior to enrollment and coverage activation. The annual enrollment fee is \$50 for one child and \$100 for two or more children in the same family. The family has 12 calendar days from the date on the county Department of Social Services Notice of Eligibility to pay the enrollment fee. If the fee remains unpaid as of the 13th calendar day following the Notice date, the application will be denied for non-payment.

Regarding any applicable cost sharing payment at the time of service, the beneficiary handbook states, “If a NC Health Choice for children recipient is not able to pay the co-payment, a provider may permit the patient to be billed for the co-payment after the service is provided or refuse treatment to the patient.”

Guidance: Section 8.7.1 is based on Section 2101(a) of the Act provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

- 8.7.1.** Provide an assurance that the following disenrollment protections are being applied:

Guidance: Provide a description below of the State’s premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (Section 2103(e)(3)(C))

- 8.7.1.1.** X State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42 CFR 457.570(a))
- 8.7.1.2.** X The disenrollment process affords the enrollee an opportunity to show that the enrollee’s family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42 CFR 457.570(b))
- 8.7.1.3.** X In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child’s cost-sharing category as appropriate.

(42 CFR 457.570(b))

8.7.1.4 X The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42 CFR 457.570(c))

Active beneficiaries are disenrolled from the NC Health Choice Program during their 12-month continuous enrollment period for the following reasons:

- The beneficiary reaches the age of 19 (disenrolled on the last day of the month in which their 19th birthday occurs);
- The beneficiary requests voluntary disenrollment;
- The beneficiary no longer resides in North Carolina (moves out of state);
- The beneficiary obtains comprehensive health insurance;
- The beneficiary enters foster care (enrolled in Medicaid program);
- The beneficiary dies; or
- The beneficiary becomes eligible for SSI.

Active beneficiaries are disenrolled from NC Health Choice at the annual redetermination review for the following reasons:

- The beneficiary's family income exceeds program income limits (211% FPL);
- The beneficiary no longer resides in North Carolina (moves out of state);
- The beneficiary cannot be located (returned mail with no forwarding address);
- The beneficiary has become eligible for Medicaid;
- The beneficiary has requested voluntary disenrollment;
- The beneficiary has comprehensive health insurance in effect on the renewal date;
- The beneficiary has not paid the annual enrollment fee (if required);
- The beneficiary resides in a public institution; or
- The beneficiary has submitted an incomplete renewal application when material changes in, e.g., health insurance status must be reported.

8.8. The State assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1.X No Federal funds will be used toward State matching requirements. (Section 2105(c)(4)) (42 CFR 457.220)

8.8.2. X No cost-sharing (including premiums, deductibles, copayments, coinsurance and all other types) will be used toward State matching requirements. (Section 2105(c)(5) (42 CFR 457.224) (Previously 8.4.5)

8.8.3. X No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42 CFR 457.626(a)(1))

- 8.8.4.X Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42 CFR 457.622(b)(5))
- 8.8.5. X No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42 CFR 457.475)
- 8.8.6. X No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42 CFR 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration

Guidance: States should consider aligning its strategic objectives with those discussed in Section II of the CHIP Annual Report.

- 9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42 CFR 457.710(b))
1. To reduce the overall number of uninsured children in NC living in families with incomes below 200% of the federal poverty guidelines.
 2. To identify and decrease disparities by race and ethnicity for the number of program applications received relative to the number of uninsured children.

Guidance: Goals should be measurable, quantifiable and convey a target the State is working towards.

- 9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42 CFR 457.710(c))

Strategic Objective 1: To reduce the number of uninsured children living in families with incomes below 200% of the federal poverty guidelines.

Performance goal 1: Increase the number of eligible applicants accepted into the NC Health Choice Program by 3%.

Strategic Objective 2: 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.

Performance goal 1: 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.

Performance goal 2: Identify the number of uninsured children by county, living below 200% FPL, by race and ethnicity

Performance goal 3: Work with the subcontractor to provide supplemental outreach and education to the top 2 races with the identified disparity.

Guidance: The State should include data sources to be used to assess each performance goal. In addition, check all appropriate measures from 9.3.1 to 9.3.8 that the State will be utilizing to measure performance, even if doing so duplicates what the State has already discussed in Section 9.

It is acceptable for the State to include performance measures for population subgroups chosen by the State for special emphasis, such as racial or ethnic minorities, particular high-risk or hard to reach populations, children with special needs, etc.

HEDIS (Health Employer Data and Information Set) 2008 contains performance measures relevant to children and adolescents younger than 19. In addition, HEDIS 3.0 contains measures for the general population, for which breakouts by children's age bands (e.g., ages < 1, 1-9, 10-19) are required. Full definitions, explanations of data sources, and other important guidance on the use of HEDIS measures can be found in the HEDIS 2008 manual published by the National Committee on Quality Assurance. So that State HEDIS results are consistent and comparable with national and regional data, states should check the HEDIS 2008 manual for detailed definitions of each measure, including definitions of the numerator and denominator to be used. For states that do not plan to offer managed care plans, HEDIS measures may also be able to be adapted to organizations of care other than managed care.

- 9.3.** Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the State's performance, taking into account suggested performance indicators as specified below or other indicators the State develops: (Section 2107(a)(4)(A),(B)) (42 CFR 457.710(d))

Check the applicable suggested performance measurements listed below that the State plans to use: (Section 2107(a)(4))

9.3.1.X The increase in the percentage of Medicaid-eligible children enrolled in Medicaid. The Title XIX's Medically Indigent Children program has measured the annual increase of children enrolled by parents seeking health insurance only since the inception of the CHIP program in 1998.

9.3.2.X The reduction in the percentage of uninsured children. The reduction, as a percent, of uninsured children statewide using U.S. Census and NC Institute of Medicine data.

The reduction, as a percent, of uninsured children statewide with family income that would qualify them for Medicaid or NC Health Choice, using U.S. Census and NC Families Accessing Services through Technology (NC FAST) data.

9.3.3. X The increase in the percentage of children with a usual source of care. NC Health Choice children are required to enroll in the Community Care of North Carolina (CCNC) primary care medical home and be linked to a primary care provider. Prior to Oct 1, 2011, the process was not mandatory. DMA will measure any increase in the percentage of children with a usual source of care with NC FAST data.

9.3.4. X The extent to which outcome measures show progress on one or more of the health problems identified by the state.

North Carolina is already a leader in the implementation of new models of care with Community Care North Carolina (CCNC), in which Health Choice beneficiaries are linked to a primary care provider. Continued monitoring of CCNC patient enrollment, satisfaction, and health outcomes statistics will be one means of quantifying the extent of progress made within the NC Health Choice program. Each year, the NC Institute of Medicine also publishes a *Child Health Report Card* which tracks health insurance coverage, health services utilization, and health status indicators that are relevant to the Health Choice Program. Health Choice will put corresponding measures in place for outcomes monitoring as DMA continues to manage and administer the Program.

9.3.5. X HEDIS Measurement Set relevant to children and adolescents younger than 19. NC Health Choice will use nine (9) HEDIS style measures adopted by CMS (See 9.3.7).

9.3.6. Other child appropriate measurement set. List or describe the set used.

9.3.7. X If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

- 9.3.7.1. X** Immunizations
- 9.3.7.2. X** Well childcare
- 9.3.7.3. X** Adolescent well visits
- 9.3.7.4. X** Satisfaction with care
- 9.3.7.5. X** Mental health
- 9.3.7.6. X** Dental care
- 9.3.7.7. X** Other, list:

- HEDIS Immunization for Adolescents
- HEDIS Children and Adolescents' Access to a Primary Care Provider

9.3.8. Performance measures for special targeted populations.

9.4. X The State assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42 CFR 457.720)

Guidance: The State should include an assurance of compliance with the annual reporting requirements, including an assessment of reducing the number of low-income uninsured children. The State should also discuss any annual activities to be undertaken that relate to assessment and evaluation of the program.

9.5. X The State assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the State’s plan for these annual assessments and reports. (Section 2107(b)(2)) (42 CFR 457.750)

Upon receipt of the Annual CARTS Template from CMS, the Division of Medical Assistance sends appropriate template sections to agency IT staff and contractors and coordinates the requests for the required data.

DMA staff gather all of the information and populates the report template.

DMA submits the CHIP Annual Report for review and edits to all parties who provide data and substantive updates. Following edit incorporation and approval from the Division Director, staff submit the final report to CMS.

9.6. X The State assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review or audit. (Section 2107(b)(3)) (42 CFR 457.720)

Guidance: The State should verify that they will participate in the collection and evaluation of data as new measures are developed or existing measures are revised as deemed necessary by CMS, the states, advocates, and other interested parties.

9.7. X The State assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42 CFR 457.710(e))

9.8. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42 CFR 457.135)

9.8.1.X Section 1902(a)(4)(C) (relating to conflict of interest standards)

9.8.2. X Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)

9.8.3.X Section 1903(w) (relating to limitations on provider donations and taxes)

9.8.4.X Section 1132 (relating to periods within which claims must be filed)

Guidance: Section 9.9 can include discussion of community-based providers and consumer representatives in the design and implementation of the plan and the method for ensuring ongoing public involvement. Issues to address include a listing of public meetings or announcements made to the public concerning the development of the children's health insurance program or public forums used to discuss changes to the State plan.

9.9. Describe the process used by the State to accomplish involvement of the public in the design and implementation of the plan and the method for ensuring ongoing public involvement. (Section 2107(c)) (42 CFR 457.120(a) and (b))

NC state law mandates that the Department may not amend the State Plan unless the General Assembly or the federal government change a law that requires a State Plan Amendment (N.C. GEN. STAT. § 108A-54.1A). Although the same statute requires the 10-day posting of the State Plan Amendment to the Department's Web page prior to CMS submission, there is no public notice and comment period. However, during General Assembly general sessions, consumers and advocates have opportunities to sign up and speak at hearings, and they always have the opportunity to provide input about NC Health Choice Program implementation via mail, email, or telephone calls to Legislators and the Department.

9.9.1. Describe the process used by the State to ensure interaction with Indian Tribes and organizations in the State on the development and implementation of the procedures required in 42 CFR 457.125. States should provide notice and consultation with Tribes on proposed pregnant women expansions. (Section 2107(c)) (42 CFR 457.120(c))

Division of Medical Assistance, submitted a letter to confirm that the State will follow the same Tribal consultation process for the CHIP Program as it does for the State Medicaid Program.

North Carolina received CMS approval on March 17, 2011 to establish the Tribal consultation process which consists of a representative of the Eastern Band of Cherokee Indians sitting on the Medical Care Advisory Committee. The Advisory Committee meets at least quarterly to review activities of the Division of Medical Assistance and provide recommendations and advice on current and future policy initiatives and pending changes to the Medicaid and CHIP programs.

9.9.2. For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR 457.65(b) through (d).

Benefits may be amended via either legislation or individual clinical coverage policies which may require a State Plan Amendment. Eligibility requirements may be amended via legislation. During General Assembly legislative sessions, consumers and advocates have opportunities to sign up and speak at hearings, and always have the opportunity to provide input about the NC Health Choice Program implementation via mail, email, or telephone calls to Legislators. Once new legislation becomes effective, the Division of Medical Assistance (DMA) notifies potential applicants and current beneficiaries via

Consumer Notices on the DMA Web Page and via mailed letters to currently enrolled beneficiaries. Beneficiaries also receive Handbooks which are revised annually to reflect any eligibility or benefits changes. The process for notification regarding new or amended clinical coverage policies is described below, and the process for notification regarding a State Plan Amendment is described in Section 9.9 above. Once a State Plan Amendment is approved by CMS, it is posted on the Division's Web page

The process for any adoption of or amendment to medical policy is also mandated by State law (N.C. GEN. STAT. § 108A-54.2). The Department must consult with and seek the advice of the Physician Advisory Group and other organizations that the Secretary deems appropriate. The Secretary must also consult with officials of professional societies or associations representing providers who would be affected by the new or amended medical policy. At least 45 days prior to the adoption of a new or amended policy, the Department must publish the policy on the Department's Web site and notify all NC Health Choice providers. During a 45-day period after publishing the proposed new or amended policy, the Department must accept oral and written [public] comments. If the proposed new or amended policy is modified after the comment period, then the Department must notify all NC Health Choice providers and upon request, provide persons notice of amendments to the proposed policy, for at least 15 days prior to posting the new or amended policy. Effective 2013, NC State Law requires posting for 30 and 10 day periods, respectively, if the adoption of new or amended medical coverage policy is necessitated by an act of the General Assembly or a change in federal law.

In addition to the public notice and comment period for any proposed new or amended policies, the NC Health Choice program includes information about any Health Choice policy changes that impact beneficiaries in Medicaid Notification documentation to all Department of Social Services case heads.

9.9.3. Describe the State’s interaction, consultation, and coordination with any Indian tribes and organizations in the State regarding implementation of the Express Lane eligibility option.

North Carolina does not implement the Express Lane eligibility option

9.10. Provide a 1-year projected budget. A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42 CFR 457.140)

- Planned use of funds, including:
 - Projected amount to be spent on health services;
 - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
 - Assumptions on which the budget is based, including cost per child and expected enrollment.
 - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc.
 - All cost sharing, benefit, payment, eligibility need to be reflected in the budget.

- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
 - Total 1-year cost of adding prenatal coverage
 - Estimate of unborn children covered in year 1

CHIP Budget

STATE: NORTH CAROLINA	FFY Budget
Federal Fiscal Year	2018
State's enhanced FMAP rate	
Benefit Costs	
Insurance payments	
Managed care	54,019,865
per member/per month rate	\$37 M/C PMPM Rate
Fee for Service	393,877,390
per member/per month rate	\$147 FFS PMPM Rate
Total Benefit Costs	447,897,255
(Offsetting beneficiary cost sharing payments)	
Net Benefit Costs	447,897,255
Cost of Proposed SPA Changes – Benefit	
Administration Costs	
Personnel	3,568,563
General administration	8,441,048
Contractors/Brokers	
Claims Processing	545,845
Outreach/marketing costs	
Health Services Initiatives	
Other	
Total Administration Costs	12,555,456
10% Administrative Cap	44,789,725
Cost of Proposed SPA Changes	
Federal Share	459,845,300
State Share	607,411
Total Costs of Approved CHIP Plan	460,452,711

NOTE: Include the costs associated with the current SPA.

The Source of State Share Funds: State Appropriations

State Appropriations

Section 10. Annual Reports and Evaluations

Guidance: The National Academy for State Health Policy (NASHP), CMS and the states developed framework for the annual report that states have the option to use to complete the required evaluation report. The framework recognizes the diversity in State approaches to implementing CHIP and provides consistency across states in the structure, content, and

format of the evaluation report. Use of the framework and submission of this information will allow comparisons to be made between states and on a nationwide basis. The framework for the annual report can be obtained from NASHP's website at <http://www.nashp.org>. Per the title XXI statute at Section 2108(a), states must submit reports by January 1st to be compliant with requirements.

10.1. Annual Reports. The State assures that it will assess the operation of the State plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42 CFR 457.750)

10.1.1.X The progress made in reducing the number of uninsured low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. X The State assures it will comply with future reporting requirements as they are developed. (42 CFR 457.710(e))

10.3. X The State assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

10.3-DC X The State agrees to submit yearly the approved dental benefit package and to submit quarterly current and accurate information on enrolled dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website. Please update Sections 6.2-DC and 9.10 when electing this option.

The NC Division of Medical Assistance is currently in compliance with providing current and accurate information for the Insure Kids Now! website. A current posting of all dental benefits available to Health Choice beneficiaries is available at: <http://www.insurekidsnow.gov/state/northcarolina/>.

Section 11. Program Integrity (Section 2101(a))

Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue to Section 12.

11.1. X The State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42 CFR 457.940(b))

11.2. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42 CFR 457.935(b)) (The items below were moved from

section 9.8. Previously 9.8.6. - 9.8.9.)

- 11.2.1.X** 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2. X** Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3. X** Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4. X** Section 1128A (relating to civil monetary penalties)
- 11.2.5. X** Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6. X** Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and Enrollee Protections (Sections 2101(a))

- Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State’s Medicaid plan.

12.1. Eligibility and Enrollment Matters- Describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. Describe any special processes and procedures that are unique to the applicant’s rights when the State is using the Express Lane option when determining eligibility.

The North Carolina Health Choice Program for Children has a program-specific review process that is compliant with 42 CFR 457.1120 – 1180. Although county Departments of Social Services use one application form to assess eligibility for the State Medicaid Program and NC Health Choice, the eligibility criteria and enrollment processes for each program differs. Pursuant to N.C. GEN. STAT. § 108A-70.21(a), NC Health Choice Program applicants must:

- Be between the ages of 6 through 18
- Be ineligible for Medicaid, Medicare, or other federal government-sponsored health insurance;
- Be uninsured;
- Be in a family whose family income is above 133% of the FPL and does not exceed 200% of the FPL;
- Be a resident of the State and eligible under federal law; and
- Have paid the Program enrollment fee.

The enrollment fee is collected and retained by county Departments of Social Services; each Department establishes its own procedures for collection. Pursuant to N.C. GEN. STAT. § 108A-70.26(c), N.C. GEN. STAT. § 108A-70.29(a), and N.C. GEN. STAT. § 108A-79, applicants have an opportunity to appeal a denial of eligibility for either an initial or re-application. Each applicant or beneficiary shall be notified in writing of his right to appeal upon denial of his application for assistance and at the time of any subsequent action on his or her case. Active Program beneficiaries remain enrolled during the review of a decision to terminate or suspend enrollment.

Guidance: “Health services matters” refers to grievances relating to the provision of health care.

12.2. Health Services Matters- Describe the review process for health services matters that complies with 42 CFR 457.1120.

Pursuant to N.C. GEN. STAT. § 108A-70.29 and applicable federal regulations, NC Health Choice Program beneficiaries may seek review of any delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services, through a two-level review process.

Beneficiaries have the right to request an internal first level review of the decision with the North Carolina Department of Health and Human Services (DHHS) followed by an external second level review with the DHHS Hearing Office. Both levels of review must be completed within 90 calendar days of the date of receipt of the internal first level review request.

To Request a Review:

Beneficiaries and/or legal guardians or authorized representatives may request an internal first level review of an adverse prior approval decision or a claims denial within 30 calendar days of the date on the adverse notice or the date the claim was adjudicated. If the beneficiary and/or legal guardian are not satisfied with the outcome of the internal first level review decision, they may request a second level review within 15 calendar days of the internal first level review decision date.

An authorized representative may submit completed request forms for an internal first level review or external second level reviews, or submit a letter of request. If a letter of request is submitted, each item of information specified below must be included with the request.

- A. Child’s name
- B. Child’s NCHC identification number
- C. Telephone number
- D. Address
- E. Date the service was provided
- F. Name(s) of the provider(s) of the service
- G. Reason for review request
- H. The letter about the benefit decision
- I. Name of the representative in Customer Service who handled the inquiry if applicable
- J. Completed NCHC Authorized Representative Form if an attorney or other representative is assisting the beneficiary or authorized representative in the review process.
- K. Authorized representative’s signature and date on the review request form or letter requesting a review
- L. Both the review request form and the authorized representative form are available at: <http://www.ncdhhs.gov/dma/healthchoice/revrequest.htm#nchcr>. Hard copy forms will be included with the adverse decision letter that is mailed to the beneficiary.

Additional or supplemental information (such as medical records, letters from a doctor, etc.) may be included with the request for review.

Internal first level review requests (completed form or letter requesting a review and a completed NCHC Authorized Representative Form, if applicable) shall be mailed or faxed to NCHC.

NCHC Review Coordinator
2501 Mail Service Center
Raleigh, NC 27699-2501
FAX: (919) 733-6608

Internal First Level Review: Beneficiaries have the right to an internal first level review by the Clinical Medical Director of the Division of Medical Assistance or clinical designee, who will review the determination and any other information submitted.

- The beneficiary must submit the request for an internal first level review within 30 days of the date of the adverse decision notice.
- The beneficiary will receive a written decision by certified mail.
- The internal decision notice will provide further information about how the beneficiary may request a second level review.

If beneficiaries disagree with the internal first level review decision, they may request an external second level review with the DHHS Hearing Office by writing a letter or filling out an External Second Level Review Request Form. External second level review requests (completed form or letter requesting a review and a completed NCHC Authorized Representative Form, if applicable), shall be mailed or faxed to the Department of Health and Human Services (DHHS) Hearing Office.

DHHS Hearing Office
2501 Mail Service Center
Raleigh, NC 27699-2501
Telephone: 919-814-0090
FAX: (919) 814-0032

External Second Level Review: If a beneficiary is not satisfied with the internal first level review decision, he or she may request an external second level review by the DHHS Hearing Office.

- The beneficiary must request this review within 15 days of the date of the first level review decision.
- The DHHS Hearing Office will conduct a hearing in Raleigh, which the beneficiary may attend in person or by telephone.
- At the hearing, the beneficiary may represent him/herself or have a representative, including an attorney at the beneficiary's expense.
- The beneficiary will receive a written decision by certified mail.

- As required in N.C.G.S. 108A-70.29(b)(3), the hearing officer must render a written decision within 90 calendar days of the date the beneficiary requested the first level review.

Expedited Review: If a Health Choice beneficiary's physician determines that the standard 90-day time frame could seriously jeopardize the child's life or health or ability to attain, maintain, or regain maximum function, the beneficiary may request that the review be completed within an expedited time frame. Under the expedited time frame, each level of review must be completed within 72 hours unless the beneficiary requests additional time (no more than 14 days may be allowed).

Review Decisions: All review decisions are based on coverage noted in the North Carolina General Statutes and in the NC Health Choice clinical coverage policies.

When a Review Will Not Be Held: A review will not be held if the sole basis of the decision is a provision in the State Plan or in a Federal or State law requiring an automatic change in eligibility, enrollment, or a change in coverage under the health benefits package that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.

Services Provided During the Review Process: Maintenance of service is not provided during the review process. When the decision is a reduction, suspension, termination, or denied request for increase of existing services, the services shall be covered in accordance with the decision under review. Services which are terminated or suspended shall not be covered, unless and until the decision is overturned on review.

Enrollment: A Health Choice beneficiary will remain enrolled in the Health Choice program during the review process as long as he or she is eligible.

12.3. Premium Assistance Programs- If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, describe how the State will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

Key for Newly Incorporated Templates

The newly incorporated templates are indicated with the following letters after the numerical section throughout the template.

- PC- Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
- PW- Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
- TC- Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
- DC- Dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- DS- Supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- PA- Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
- EL- Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
- LR- Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)

CMS Regional Offices

CMS Regional Offices	States		Associate Regional Administrator	Regional Office Address
Region 1- Boston	Connecticut Massachusetts Maine	New Hampshire Rhode Island Vermont	Richard R. McGreal richard.mcgreal@cms.hhs.gov	John F. Kennedy Federal Bldg. Room 2275 Boston, MA 02203-0003
Region 2- New York	New York Virgin Islands	New Jersey Puerto Rico	Michael Melendez michael.melendez@cms.hhs.gov	26 Federal Plaza Room 3811 New York, NY 10278-0063
Region 3- Philadelphia	Delaware District of Columbia Maryland	Pennsylvania Virginia West Virginia	Ted Gallagher ted.gallagher@cms.hhs.gov	The Public Ledger Building 150 South Independence Mall West Suite 216 Philadelphia, PA 19106
Region 4- Atlanta	Alabama Florida Georgia Kentucky	Mississippi North Carolina South Carolina Tennessee	Jackie Glaze jackie.glaze@cms.hhs.gov	Atlanta Federal Center 4 th Floor 61 Forsyth Street, S.W. Suite 4T20 Atlanta, GA 30303-8909
Region 5- Chicago	Illinois Indiana Michigan	Minnesota Ohio Wisconsin	Verlon Johnson verlon.johnson@cms.hhs.gov	233 North Michigan Avenue, Suite 600 Chicago, IL 60601
Region 6- Dallas	Arkansas Louisiana New Mexico	Oklahoma Texas	Bill Brooks bill.brooks@cms.hhs.gov	1301 Young Street, 8th Floor Dallas, TX 75202
Region 7- Kansas City	Iowa Kansas	Missouri Nebraska	James G. Scott james.scott1@cms.hhs.gov	Richard Bulling Federal Bldg. 601 East 12 Street, Room 235 Kansas City, MO 64106-2808
Region 8- Denver	Colorado Montana North Dakota	South Dakota Utah Wyoming	Richard Allen richard.allen@cms.hhs.gov	Federal Office Building, Room 522 1961 Stout Street Denver, CO 80294-3538
Region 9- San Francisco	Arizona California Hawaii Nevada	American Samoa Guam Northern Mariana Islands	Gloria Nagle gloria.nagle@cms.hhs.gov	90 Seventh Street Suite 5-300 San Francisco Federal Building San Francisco, CA 94103

Region 10- Seattle	Idaho Washington	Alaska Oregon	Carol Peverly carol.peverly@cms.hhs.gov	2001 Sixth Avenue MS RX-43 Seattle, WA 98121
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GLOSSARY

Adapted directly from Sec. 2110. DEFINITIONS.

CHILD HEALTH ASSISTANCE- For purposes of this title, the term ‘child health assistance’ means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the following (and includes, in the case described in Section 2105(a)(2)(A), payment for part or all of the cost of providing any of the following), as specified under the State plan:

1. Inpatient hospital services.
2. Outpatient hospital services.
3. Physician services.
4. Surgical services.
5. Clinic services (including health center services) and other ambulatory health care services.
6. Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.
7. Over-the-counter medications.
8. Laboratory and radiological services.
9. Prenatal care and pre-pregnancy family planning services and supplies.
10. Inpatient mental health services, other than services described in paragraph (18) but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.
11. Outpatient mental health services, other than services described in paragraph (19) but including services furnished in a State-operated mental hospital and including community-based services.
12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).
13. Disposable medical supplies.
14. Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).
15. Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.
16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.
17. Dental services.
18. Inpatient substance abuse treatment services and residential substance abuse treatment services.
19. Outpatient substance abuse treatment services.
20. Case management services.
21. Care coordination services.
22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

23. Hospice care.
24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is--
 - a. prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,
 - b. performed under the general supervision or at the direction of a physician, or
 - c. furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.
25. Premiums for private health care insurance coverage.
26. Medical transportation.
27. Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.
28. Any other health care services or items specified by the Secretary and not excluded under this section.

TARGETED LOW-INCOME CHILD DEFINED- For purposes of this title--

1. **IN GENERAL-** Subject to paragraph (2), the term ‘targeted low-income child’ means a child--
 - a. who has been determined eligible by the State for child health assistance under the State plan;
 - b. (i) who is a low-income child, or
(ii) is a child whose family income (as determined under the State child health plan) exceeds the Medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the Medicaid applicable income level; and
 - c. who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in Section 2791 of the Public Health Service Act).
2. **CHILDREN EXCLUDED-** Such term does not include--
 - a. a child who is a resident of a public institution or a patient in an institution for mental diseases; or
 - b. a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.
3. **SPECIAL RULE-** A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program's operation.
4. **MEDICAID APPLICABLE INCOME LEVEL-** The term ‘Medicaid applicable income level’ means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under Section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical

assistance under Section 1902(1)(2) for the age of such child.

5. **TARGETED LOW-INCOME PREGNANT WOMAN.**—The term ‘targeted low-income pregnant woman’ means an individual— (A) during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends; (B) whose family income exceeds 185 percent (or, if higher, the percent applied under subsection (b)(1)(A)) of the poverty line applicable to a family of the size involved, but does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and (C) who satisfies the requirements of paragraphs (1)(A), (1)(C), (2), and (3) of Section 2110(b) in the same manner as a child applying for child health assistance would have to satisfy such requirements.

ADDITIONAL DEFINITIONS- For purposes of this title:

1. **CHILD-** The term ‘child’ means an individual under 19 years of age.
2. **CREDITABLE HEALTH COVERAGE-** The term ‘creditable health coverage’ has the meaning given the term ‘creditable coverage’ under Section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver).
3. **GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC-** The terms ‘group health plan’, ‘group health insurance coverage’, and ‘health insurance coverage’ have the meanings given such terms in Section 2191 of the Public Health Service Act.
4. **LOW-INCOME CHILD -** The term ‘low-income child’ means a child whose family income is at or below 200 percent of the poverty line for a family of the size involved.
5. **POVERTY LINE DEFINED-** The term ‘poverty line’ has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.
6. **PREEXISTING CONDITION EXCLUSION-** The term ‘preexisting condition exclusion’ has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).
7. **STATE CHILD HEALTH PLAN; PLAN-** Unless the context otherwise requires, the terms ‘State child health plan’ and ‘plan’ mean a State child health plan approved under Section 2106.
8. **UNINSURED CHILD-** The term ‘uninsured child’ means a child that does not have creditable health coverage.

Attachment A

Quantitative Treatment Limitations

NCHC Clinical Coverage Policies include the following Quantitative Treatment Limitations (QTLs):

Quantitative Treatment Limitations (QTLs)	Inpatient	Outpatient	Emergency Care	Prescription Drug
MH/SUD	No QTLs	<p>Day Limits 10-day limit on Detoxification Services 60-day limit Substance Abuse Intensive Outpatient Program</p> <p>Unit Limits 32 units per 24-hour period limit on Multisystemic Therapy;</p>	24 hour per episode limit on Mobile Crisis (under revision)	QTLs for prescription drugs are determined based on Federal Drug Administration standards and are not specific to MH/SUD or M/S services.
M/S	Not analyzed*	<p>Day Limits 2 units per day for <u>up to 30 days</u> for Hyperbaric Oxygenation Therapy; 7-day limit for Home Infusion Therapy (S9379 code only);</p> <p>Unit Limits 1 unit per day for Case Conference for Sexually Abused Children; <u>2 units per day</u> for up to 30 days for Hyperbaric Oxygenation Therapy; 1 unit per day for Extracorporeal Shock Wave Lithotripsy; 1 unit per day for Transcranial Doppler Studies 1 unit per day for Sleep Studies and Polysomnography Services 1 unit per day for Endovascular</p>	No limits	QTLs for prescription drugs are determined based on Federal Drug Administration standards and are not specific to MH/SUD or M/S services.

		Repair of Aortic Aneurysm 4 units per day limit on Sexually Transmitted Disease Treatment and Tuberculosis Control and Treatment Provided in Health Departments 1 unit per day for most Allergy Immunotherapy services 1 unit per day for Echocardiography and Intravascular Ultrasound; 6 units per day pulpotomy;		
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**QTLs for M/S benefits were not analyzed for benefits or benefit classifications without corresponding QTLs for MH/SUD benefits.*

Methods Used to Collect Information and Determine Compliance

DMA completed a comprehensive review of all MH/SUD and M/S benefits. This included a comprehensive desk review of DMA Clinical Coverage Policies, a review of North Carolina General Statutes, and interviews with DMA subject matter experts in each clinical policy area. DMA only considered QTLs that apply to MH/SUD benefits. QTLs that only apply to M/S services are not relevant and were not considered during this review.

Treatment limitations with imbedded exceptions for exceeding limits based on medical necessity are considered Non-Quantitative Treatment Limitations and were not considered in this section of the analysis. For example, the language in Clinical Coverage Policy 8A for Diagnostic Assessments states that this service is limited to one assessment per year, but allows exceptions without limitation based on medical necessity.

Inpatient

DMA found that there were no QTLs applied to MH/SUD benefits under the inpatient classification. QTLs for M/S benefits were not analyzed under the inpatient classification and are not relevant to this review.

Outpatient

DMA determined that there are MH/SUD benefits that have QTLs under the outpatient classification as follows:

1. Ambulatory Detox. Clinical Coverage Policy 8A imposes a 10-day maximum QTL for Ambulatory Detoxification. Detoxification treatment needs that extend beyond 10 days require a higher level of care than can provided in an outpatient setting. Detoxification is available to NCHC enrollees who are 18 years of age only. There were no NCHC requests, authorizations or

claims for this benefit in State Fiscal Year (SFY) 2016. The QTL for MH/SUD is more restrictive than the QTL for M/S. DMA and the NC DHHS are reviewing the entire continuum of SUD services across the State and will consider if Ambulatory Detoxification is a necessary benefit in the NCHC package. DMA will also consider lifting the 10-day maximum QTL for NCHC beneficiaries. DMA will continue to monitor usage of this service for NCHC beneficiaries through the utilization management vendor, Beacon Health Options.

2. Substance Abuse Intensive Outpatient Program. Clinical Coverage Policy 8A imposes a 90-day QTL on the Substance Abuse Intensive Outpatient Program (SAIOP) service. The policy allows for a 30 day ‘pass through’ with no authorization, but limits reauthorization to a maximum of 60 days (for a total of 90 days). M/S benefits that have comparable day limits are Hyperbaric Oxygenation Therapy (30-day limit) and Home Infusion Therapy (7-day limit for S9379/termination period only). The 90-day limit imposed on SAIOP is less restrictive than the limits imposed on either M/S benefit and is compliant with parity.

3. Multisystemic Therapy. Clinical Coverage Policy 8A imposes a 32 unit per 24-hour period QTL on Multisystemic Therapy. There are ten (10) M/S outpatient benefits with comparable unit per day limitations as follows:

Service	Number of Units Per Day
Case Conference for Sexually Abused Children	1
Hyperbaric Oxygenation Therapy	2
Extracorporeal Shock Wave Lithotripsy	1
Transcranial Doppler Studies	1
Sleep Studies and Polysomnography Services	1
Endovascular Repair of Aortic Aneurysm	1
Sexually Transmitted Disease Treatment Provided in Health Departments	4
Tuberculosis Control and Treatment Provided in Health Departments	4
Allergy Immunotherapy (most codes)	1
Echocardiography and Intravascular Ultrasound	1
Pulpotomy	6
Multisystemic Therapy	30

The QTL for the MH/SUD benefit, Multisystemic Therapy, is **less restrictive** than the QTL for M/S benefits. This demonstrates compliance with the parity rules and further analysis is not required.

Emergency Care

DMA determined that there is a QTL of 24 hours per episode for Mobile Crisis, an MH/SUD benefit. There are no comparable QTLs for M/S benefits in this classification. DMA has determined that this benefit is **non-compliant**. The Clinical Coverage Policy for Mobile Crisis is currently being revised to remove this QTL.

Prescription Drug

NCHC prescription drug coverage is based on multiple criteria as follows:

- a. The prescribed drug must have Federal Drug Administration (FDA) approved indications.
- b. The prescribed drug must bear the federal legend statement.
- c. A legend drug must be manufactured by a company that has signed a National Medicaid Drug Rebate Agreement with the Centers for Medicare and Medicaid Services (CMS).
- d. The prescription must be written for whom the bill is claimed.

NCHC covers compounded products when:

- a. A mixture of two or more ingredients is physically inseparable;
- b. At least one of the components of the compounded drug is a legend drug;
- c. It is expected that the quantity of legend drug is sufficient to have a therapeutic effect; and
- d. The legend drug is manufactured by a company that has signed a national Medicaid Drug Rebate Agreement with CMS.

NCHC does not cover the following products:

- a. OTC products;
- b. Any drug manufactured by a company who has not signed a rebate agreement;
- c. Fertility drugs;
- d. Drugs used for cosmetic indications;
- e. Medical supplies and devices;
- f. Diaphragms which are a family planning service;
- g. Intravenous (IV) fluids (Dextrose 500 ml or greater) and irrigation fluids;
- h. Erectile dysfunction drugs;
- i. Weight loss and weight gain drugs;
- j. Drug samples;
- k. Drugs obtained from any patient assistance program;
- l. Drugs used for the symptomatic relief of cough and colds that contain expectorants or cough suppressants;
- m. Legend vitamins and mineral products;
- n. All Drug Efficacy Study Implementation (DESI) drugs and combinations equivalent to a DESI drug in compounded prescriptions. Drugs described by the FDA as DESI are products that the FDA has found to be less than effective or not proven to be as effective as indicated. Drug products that are identical, related or similar to DESI drugs are considered DESI.

A 72-hour emergency supply of any prescription drug may be provided if an enrollee is waiting for

acknowledgement of the prior authorization request.

All QTLs applied to benefits within this classification are applied equally to all benefits, regardless of the condition the benefit is intended to treat. This is compliant with the parity rules.

Attachment B

Financial Requirements

The NCHC program does not apply Aggregate Lifetime Limits (ALs) or Annual Dollar Limits (ADLs) to any NCHC benefits.

List MH/SUD and M/S Financial Requirements

There are no financial requirements or limitations that specifically apply to NCHC MH/SUD benefits.

Financial requirements are applied equally to MH/SUD and M/S services.

No cumulative financial requirements for MH/SUD services apply.

North Carolina General Statute 108A-70.21

http://www.ncleg.net/EnactedLegislation/Statutes/PDF/BySection/Chapter_108A/GS_108A-70.21.pdf

sets forth the financial requirements for North Carolina Health Choice (NCHC). The financial requirements listed in this Statute apply equally regardless of the type of benefit or service being provided. **There is no difference between financial requirements for MH/SUD benefits or services and financial requirements for M/S benefits or services.**

Cost sharing requirements are listed in the NCHC State Plan, Section 8, Cost-Sharing and Payment

https://ncdma.s3.amazonaws.com/s3fs-public/NC_Health_Choice_State_Plan_2017_04.pdf. There are

no additional cost sharing requirements for emergency medical services delivered outside of the network.

All DMA Clinical Coverage Policies (including MH/SUD and M/S) refer to General Statute 108A-70.21 when addressing financial requirements for NCHC.

The financial (cost-sharing) requirements in NCGS 108A-70.21 and NCHC State Plan are as follows:

Service	Financial Requirement	Family Income ≤ 159% of Federal Poverty Level	Family Income > 159% of Federal Poverty Level and < 211% of Federal Poverty Level

Nonemergency visits to the emergency room	Copayment	\$10.00	\$25.00
Outpatient prescription drugs, generic or brand-name when no generic is available	Copayment	\$1.00	\$1.00
Outpatient prescription drugs, brand-name when generic is available	Copayment	\$3.00	\$10.00
Provider visits (except well-baby, well-child, or age-appropriate immunization services)	Copayment	\$0.00	\$5.00
Well-baby, well-child, or age-appropriate immunization services	Copayment	\$0.00	\$0.00
Outpatient hospital	Copayment	\$0.00	\$5.00
Emergency room visits	Copayment	\$0.00	\$20.00
Emergency room visits when child is admitted to the hospital	Copayment	\$0.00	\$0.00
N/A	Annual Enrollment Fee	\$0.00	\$50 per child or \$100 maximum for two or more