Task Force *for a* Healthier North Carolina

Key Findings and Final Recommendations on Access to Health Insurance Coverage for North Carolina's Children

JULY 2007

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NORTH CAROLINA Health Wellness TRUST FUND

THE UNIVERSITY of NORTH CAROLINA at CHAPEL HILL

Task Force *for a* Healthier North Carolina

The Task Force *for a* Healthier North Carolina sponsored a public forum to explore strategies to improve the health insurance coverage of North Carolina's children. The meeting was held on March 26, 2007 in Winston-Salem. The focus of invited presentations was on outreach and enrollment activities, the emerging role of Community Care of North Carolina in the State Children's Health Insurance Program (SCHIP) program, and proposals to expand health coverage to children in families with incomes between 200% and 300% of the Federal Poverty Level (FPL).

The Task Force respectfully submits the following recommendations on strategies to improve access to health insurance coverage for North Carolina's children.

Co-Chairs

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The Task Force invited formal presentations from the following individuals:

- **Ania Boer**, Health Check/NC Health Choice Outreach Campaign Coordinator, North Carolina Healthy Start Foundation
- **Christopher Dumas**, Associate Professor of Economics, UNC/Wilmington
- **Jane Foy**, Professor, Department of Pediatrics, Wake Forest University
- **Patricia Garrett**, Director, PMG Associates, LLC
- **Jim Graham**, Executive Director, Northwest Community Care Network
- **Mona Moon**, Senior Advisor, Department of Health and Human Services (DHHS)
- **Carolyn Sexton**, Health Check/NC Health Choice Outreach Consultant, Division of Public Health
- **Jeffrey Simms**, Deputy Director, Community Care of North Carolina (CCNC)
- **Tom Vitaglione**, Fellow, Action for Children North Carolina
- **Steven Wegner**, President and Medical Director, AccessCare

BACKGROUND

In 1997, as part of the Balanced Budget Act (BBA), Congress authorized nearly $40 billion in federal funds over a 10-year period to fund the State Children's Health Insurance Program (SCHIP). This program allows states to provide comprehensive health care coverage for children in working families with incomes between 100% and 200% of the Federal Poverty Level (FPL).

In North Carolina, children are currently offered health insurance coverage through an SCHIP program known as "Health Choice for Children" (children age 6-18 in families with incomes 100% to 200% FPL), and through a Medicaid program known as "Health Check" (children age 5 and under in all families up to 200% FPL; children 6-18 up to 100% FPL).[1]

In North Carolina, children are currently offered access to health insurance coverage through an SCHIP program known as "Health Choice for Children and Health Check (Medicaid). NC Health Choice covers children ages 6-18 whose families fall between 100 and 200% of the federal poverty line. Medicaid's Health Check covers all children in North Carolina ages 0-5 (200% FPL) and children ages 6-18 whose family incomes fall below 100% FPL.[2]

Together these programs provide health insurance to nearly 800,000 North Carolina children who would otherwise be without access to affordable health coverage.[3] It is estimated, however, 177,000 children are eligible but not enrolled in either of these public programs.[4]

Background information on the legislative history of Health Choice and a summary of issues for consideration at the federal and state levels, including the federal reauthorization of funds for SCHIP, can be found in The Lewin Group's report to the Task Force, "SCHIP in North Carolina: Evolution and Reauthorization, Challenges and Opportunities" available at http://www.healthwellnc.com/LewinSCHIP07report.pdf.

FINDINGS AND RECOMMENDATIONS

Finding 1: SCHIP Outreach Efforts

Since the inception of Health Choice, North Carolina has been proactive in reaching out to parents and enrolling children in the program. In fact, outreach efforts were so successful in the early years that North Carolina became the first state forced to freeze enrollment in 2001 due to insufficient funding.[5] Additional funding from the General Assembly was allocated, which allowed enrollment to resume, and steps have been taken to prevent future freezes in enrollment.

Despite ongoing outreach efforts, a large number of eligible children remain uninsured. More than 260,000 children in North Carolina do not have health insurance.[6] Approximately 177,000 of these children are eligible for either Health Choice or Health Check.[7] Estimates suggest that half are eligible for Health Check (family income below 100% FPL), and half are eligible for

Health Choice (family income between 100% and 200% FPL). Approximately 76% of these children live in families where at least one parent is working full-time, and 35% live with a parent who works for a large firm (over 100 employees)—large firms are more likely to offer health insurance to their employees than smaller firms.[8] Additionally, the percentage of North Carolina children who are uninsured has increased from 10.1% in 2000 to 11.9% in 2005.[9] The North Carolina Division of Public Health (DPH) acts as the lead state agency for outreach and has partnered with the NC Healthy Start Foundation to develop and distribute free, bilingual outreach materials and maintain a user-friendly Web site with up-to-date information about Health Choice and Health Check. In addition to printed and Web-based materials, outreach strategies also include targeted TV and radio announcements as well as the NC Family Resource telephone hotline, which answers questions and provides information about Health Choice/Health Check. The Division of Public Health also works with a variety of entities including the Division of Social Services (DSS), the Division of Medical Assistance (DMA), the NC Pediatric Society, and health care providers to reach children.

The North Carolina Healthy Start Foundation is a nationally recognized private, nonprofit organization dedicated to reducing infant death and illness and to improving the health of women and young children in North Carolina. They designed and maintain a first-rate Health Check/Health Choice website which is available at http://www.nchealthystart.org/outreach/index.html.

Covering Kids and Families, a national program of the Robert Wood Johnson Foundation (RWJF), also helps build additional capacity for outreach and enrollment into SCHIP and Health Check in all 50 states. As the lead state organization for *Covering Kids*, the North Carolina Pediatric Society Foundation works with four county coalitions in Buncombe, Moore, New Hanover, and Wake. Each local coalition has a distinct agenda and a work plan tailored to local needs. At the state level, 50 individuals representing 41 organizations, provide guidance to major state initiatives. Their website is available at http://www.ncpeds.org/Covering%20Kids/Covering%20Kids%20Main.htm.

Some of the efforts implemented in North Carolina include tailored outreach materials for specific professional and community agencies (e.g., religious leaders, child care providers, teachers and principals, human resource managers), an emergency room enrollment initiative, and a single application for SCHIP, Health Check, and Food Stamp programs.[10] Some key players and outreach methods for those involved in the state's efforts are described below.

North Carolina Division of Social Services (DSS)

DSS eligibility caseworkers determine Health Check and Health Choice eligibility and help ensure that children select a primary care provider. Caseworkers are responsible for making eligibility determinations in a timely fashion (usually 45 days), which means processing paperwork and verifying the supporting documentation. The addition of new application requirements creates further work necessary to correctly process the materials, often without any additional resources or staff.

Health Check Coordinators

North Carolina has Health Check Coordinators (HCC) who assists with outreach to eligible families and increase awareness of both Health Choice and Health Check. HCC's also educate clients about the benefits of the Community Care of North Carolina (CCNC) network, which links children to a primary care provider (PCP).[11] Coordinators are responsible for assisting eligible children in accessing comprehensive and preventive health care services, and they act as a key liaison between children and physicians, professional organizations, and agencies providing primary and preventive care services.[12]

Currently, HCC's are located in 91 North Carolina counties.[13] The position is primarily funded by DMA but can also be funded through DPH as well as through Smart Start Partnerships or grants. The number of HCC positions for which a county is eligible is based on the number of Health Check-eligible children living in the county.[14] The NC Health Directors Association has endorsed a plan to expand coordinators statewide. This would place HCC's in all counties by relocating existing positions.[15]

School Systems

Working with school systems has emerged as a logical way to reach out to families and children. When the Health Choice program began, outreach materials were sent home to every school-age child. This method was expensive and could not be maintained, but North Carolina continues to work with school professionals, such as school nurses, social workers, and counselors, to convey information about the program. North Carolina's School-Based and School-Linked Health Centers (NCSB/SLHC), health care centers located in or near schools that provide both health care and health education also help recruit uninsured children into Health Choice and Health Check.[16]

Currently, there are more than 53 school-based or school-linked health centers operating in 22 North Carolina counties. The centers are funded through a combination of sources including state, county, or city funding; community health centers; private grants; reimbursements for services from health insurance providers; and out-of-pocket payments from patients.

Another strategy for reaching out to schoolchildren is through the National School Lunch Program (NSLP). This is a federally assisted meal program that provides free or low-cost lunches to more than 29 million children throughout the nation each school day.[17] The income eligibility for NSLP and Health Choice/Health Check is similar, so children eligible for school lunches are likely to be eligible for Health Choice or Health Check as well.[18] Some research has suggested using data verification and certification from programs such as NSLP to target outreach efforts and/or enroll children from NSLP into SCHIP.[19, 20, 21]

Early Intervention

As part of the Individuals with Disabilities Education Act (IEDA), North Carolina created a system of early intervention services directed at children with special needs, birth through age five, and their families.[22] The two parts of this system include a program for infants and toddlers and the preschool program for children between ages 3 and 5. The Infant-Toddler Program and

the Preschool Program each include agencies providing a variety of services and support to children with disabilities. All of these services are managed through Children's Developmental Services Agencies (CDSA's), which serve all 100 NC counties. Children with special health care needs may qualify for additional coverage through Health Choice, which includes some of these early intervention services.[23] The CDSA's are a logical mechanism for making information available about Health Choice and Health Check for eligible children.

Although North Carolina utilizes these strategies to reach families, there is still a lack of knowledge and understanding about the program among those who are eligible but not enrolled. Unfortunately, there are also some lasting effects from the enrollment freeze in 2001. Enrollment was slow to recover once the program reopened. According to numerous individuals who play a role in outreach efforts, applicants continue to ask if the enrollment is still closed and express concern that the program will close again in the future. Currently, Health Choice does limit enrollment growth to 3% per 6-month period in order to continue to control the costs.[24] Health Check, on the other hand, is an entitlement program and therefore does not have a cap on enrollment.

Recommendation 1: Strengthen Outreach Efforts to Parents of Eligible Children

Much of the policy research literature on SCHIP outreach and enrollment indicates that there is no "magic bullet" when it comes to methods for reaching out to the parents of eligible children. North Carolina has already implemented a variety of successful outreach strategies and works with a wide range of partners in order to find and enroll as many children as possible. The Task Force offers the following recommendations to strengthen outreach efforts:

1.1 Health Check Coordinators and DSS eligibility caseworkers play a key role in outreach and enrollment. **The Task Force strongly supports the goal that all NC counties have at least one Health Check Coordinator**.

1.2 **The Task Force concludes that school-based enrollment remains a critical and effective mechanism to reach eligible children. School health clinics must play an enhanced role in strengthening outreach efforts.** Policy makers should continue to encourage adequate state funding for these centers.

1.3 **The Task Force recommends enhanced efforts to target outreach to children enrolled in programs with similar eligibility criteria, such as the school lunch program, and to target outreach through programs already serving children, such as the Early Intervention Programs and NC Smart Start.** Although broad-based outreach methods are essential for reaching out to many children and families, targeted outreach methods can direct efforts to children where they live and attend school. Working through existing structures or programs remains an important way to reach children who are eligible for Health Choice or Health Check.

1.4 **The Task Force recommends the creation of multi-county or regional Health Choice/Health Check coordinating committees that would bring together the variety**

of actors and organizations working to ensure that children have access to affordable health insurance. The committees would agree to meet on a regular basis and to create a method for disseminating information in order to update one another on pertinent issues. Possible members would include representatives from DPH, DMA, DSS, Health Check Coordinators, eligibility caseworkers, CCNC networks, local health care providers, local advocacy organizations, and others. The self-identified person willing to lead outreach efforts in each county is identified at http://www.nchealthystart.org/outreach/county/list.html.

Finding 2: The Enrollment and Annual Renewal Processes

States have flexibility in their enrollment practices, and many have chosen to eliminate some of the more burdensome enrollment procedures, including face-to-face interviews at initial enrollment and/or at time of renewal, short renewal periods, waiting periods, asset tests, and supplemental documentation requirements.

In North Carolina, efforts have been made to create a user-friendly application and renewal process for Health Choice and Health Check. For example, the joint application can be returned by mail or in person to the county Division of Social Services (DSS). North Carolina does not require a face-to-face interview or an asset test, there is no waiting period to become eligible, and once enrolled, children remain eligible for coverage for 12 months despite any changes to family income, known as "continuous eligibility."[25, 26]

The single application is screened by a DSS caseworker for eligibility for Health Check; if ineligible for that program, it is screened for eligibility for Health Choice.[27] Eligibility determination is made within 45 days and, if the application is approved, coverage begins during the month the application was submitted.[28] If a child qualifies for either program, all of the necessary materials are sent to the household by mail.[29]

The renewal application for Health Check or Health Choice is nearly identical to the initial enrollment application, but some of the key demographic information, including the child's name, is preprinted on the renewal form. Reminders about the renewal process are sent to families 2 months before the annual coverage ends. First, a post card is sent indicating that it is time to renew coverage. The renewal form is sent 10 days later with a reminder to return the form to DSS. Another notice is sent if the form is not returned by the twenty-fifth day of the eleventh month (that is, the month before coverage is set to end). If the form is not returned within 10 days, a final notice is sent to the family indicating the eligibility status for the child.[30] There is an additional grace period before termination of coverage if materials are submitted within 10 days of the final deadline.

Extensive policy research highlights the importance of securing and maintaining consistent health care coverage for children and the need for improved retention efforts in programs such as Health Choice and Health Check.[31, 32] Although some children become ineligible due to increases in family income, the renewal process itself can be a significant cause of "drop-off."[33]

Unfortunately, procedural barriers still exist that limit renewals. Examples of additional retention strategies that have been implemented in other states include using fully preprinted renewal forms, enrollment through emergency rooms, allowing families to self-report information rather than having to provide additional documentation**,** verifying information using data from other programs, and using electronic application and renewal systems.

Using Preprinted Forms

Several states use preprinted renewal applications that include all the application information that was submitted the previous year. Families only have to update any information that may have changed. In some states, if no information has changed, the forms do not need to be returned at all; this is sometimes referred to as "passive renewal." Florida has been using both of these methods to improve retention, with much success. The drops in enrollment at the time of renewal were only about 5%, compared to as high as 50% in some other states that do not use these retention strategies.[34] In Florida, families are required to return the preprinted form only if any information has changed. No response is presumed to indicate that all the information is still correct, and the child remains in the program.[35] This could be an especially effective option if coupled with a mechanism for verifying information through other government databases (see below for more information about this possibility). It is important to note that using preprinted forms may require adjustments in the technology systems used to generate and process applications.

Enrollment through Emergency Rooms

As part of the local RWJF Covering Kids and Families project, Buncombe County DSS piloted an enrollment initiative through hospital emergency rooms. Any parent or guardian of an uninsured child treated at the two participating hospitals is given an opportunity to enroll the child in Health Choice or Health Check at the time of hospital discharge. Outreach workers from DSS help train emergency room staff on filling out the application. The staff then helps the family complete a "bare bones" version of the standard application and a DSS caseworker follows up with the family to complete the application by phone.

The collaborative process between DSS and the hospitals was well received, and the hospitals described the project as financially beneficial to them.[36] The number of Health Choice and Health Check applications received from the emergency rooms has increased since the inception of the pilot project, and the program has now been adopted throughout the county.

Self-Reporting Income

Another significant step that some states have taken to ease the renewal process and increase retention is to eliminate the need for supplemental documentation of income. Instead, some states allow families to "self-report" or "self-declare" this information. Like complex application and renewal forms, verification requirements—such as income, citizenship, and residency—can be a significant barrier for some families and may prevent eligible children from applying at all.[37] Although documentation of income is not required under federal law, North Carolina does require income verification for Health Choice and Health Check. Individuals must provide

copies of all paycheck stubs for one month for all workers (adults and children) living in a household, proof of residency for first-time applicants, and proof of citizenship (birth certificate) for those applying for Health Check. The income documentation can be burdensome for some families, depending on the number of workers in the household, the number of jobs that each person holds, and the number of pay periods during a month.

Currently, 9 states allow applicants to self-report their income when they initially apply for and renew benefits for children in SCHIP and Medicaid programs.[38] One additional state allows self-reporting of income, but only for the SCHIP program (not for Health Check) and only at the time of renewal.[39] Self-reported income is generally verified by administrators through post-eligibility audits or by using information available through other government databases, such as the Social Security Administration or state Departments of Labor.[40] Often the social security number for the adult(s) is required for verifying income when it has been self-reported. Some states that allow self-reporting of income give applicants the choice of either submitting the social security number(s) needed for verification or submitting pay stubs and other necessary documentation.[41]

Although federal guidelines have encouraged states to simplify their enrollment and renewal practices, including self-report of income, many states have been hesitant to allow this because of concerns regarding fraud. Research on this topic indicates that error rates in states that allow self-reporting are, for the most part, no higher than in states that do not allow self-reporting.[42, 43] Income verification using other databases like those mentioned above helps create greater safeguards against fraud or abuse. Additionally, states often report some administrative cost savings and a decrease in the time needed to make an eligibility determination as a result of applicants self-reporting income.

Furthermore, the federal Medicaid regulations require states to conduct post-eligibility verification of income using an Income and Eligibility Verification System (IEVS). Some states also monitor quality using the Medicaid Eligibility Quality Control (MEQC) process.[44] These programs help verify income eligibility before or after a determination has been made. Although this is not necessarily required for separate SCHIP's, many states are already going through these or similar steps to ensure the quality of their programs.[45, 46]

The following two examples provide information about self-reporting procedures in other states:

- In Georgia, caseworkers verify income information by reviewing the Department of Labor database and two databases provided by the Social Security Administration.[47] Information received through these databases includes family wages, unemployment benefits, and social security benefits.

- In Michigan, the state conducts a post-eligibility audit of self-reported income on SCHIP applications. The state takes a random sample of applications each month and asks families to provide verification of income. The error rate for applications has been consistently at or below 3%.[48, 49]

Ex-Parte Verification and Streamlining Applications

Other states are also using existing information from other programs or databases to verify continued eligibility for SCHIP and Medicaid. For example, information from Food Stamp applications can be used to confirm Medicaid eligibility so that parents/guardians are not duplicating information and having to provide similar documentation verification for all programs.[50]

This strategy could go a step further to be used to automatically enroll or renew enrollment for children living in families with incomes that continue to meet the eligibility limit for Health Choice or Health Check. The current public benefits model suggests that individuals can receive benefits through public programs, but only with significant administrative effort.[51] Currently, many programs cannot easily collaborate to share pertinent information. Sharing information and/or using existing data to verify eligibility could simplify efforts for both administrators and applicants. However, adequate technology infrastructure is essential for this type of coordination.

Another similar strategy is streamlining applications for use with multiple programs. For instance, The Children's Partnership, a national nonpartisan organization, created "Express Lane Eligibility," which builds multiple doorways for entry into SCHIP and Medicaid by using enrollment information from the National School Lunch Program. This has been implemented in several California school districts. Children are allowed to use the school lunch application to also apply for Medicaid; temporary Medicaid coverage begins while any additional material is submitted in order to finalize eligibility.[52] There is a pending bill in the U.S. Congress to give all states the option of using Express Lane Eligibility and to fund some of the necessary technology improvements.[53]

This type of approach has been piloted in Buncombe County, NC, where representatives from DSS and the county's Food Stamp Program created a joint application and enrollment process for Food Stamps, Health Choice, and Health Check.[54] When a family renewed their Food Stamp benefits, the caseworker checked the Health Choice/Health Check status of any children and if they were not enrolled, referred the family to the new Food Stamp and Health Check team to process a joint application.[55]

Electronic Applications

Many states are also using electronic applications for programs such as SCHIP, Medicaid, Food Stamps, and Temporary Aid to Needy Families (TANF).[56] There are many advantages to using electronic applications including convenience for applicants, cost savings for administrators, and more complete information with fewer errors.[57] In addition, an evaluation of electronic application procedures indicated that going "paperless" is quicker (the time between application submission and eligibility determination is reduced compared to paper applications), there is increased consumer satisfaction, and because information is collected electronically, the process may improve an agency's ability to efficiently access data.[58] There are some disadvantages for both users and administrators. These include potentially high start-up costs for creating the system and developing the necessary interfaces with other systems as well as problems for consumers who prefer not to use an electronic application or have limited Internet access.

Collecting information electronically and sharing information among programs allows states to better track the movement of families between various programs. Research also recommends creating database systems that will automatically allow different programs to share information about enrolled families so that household changes only need to be reported once. This may cut down on the number of renewals in which families must participate, which is likely to lead to higher retention.[59]

Many health care foundations are playing an increasingly important role in improving children's health, including providing funds for technology infrastructure to improve access to health coverage.[60] Foundation funding for child health grew by more than 50% between 1999 and 2003.[61] Total philanthropic giving targeted toward children reached more than $4 billion in 2001; 25% of the foundation grants directed toward children were focused on health.[62] One example of grant-making directed at improving access to health coverage for kids is the California HealthCare Foundation, which invested $3 million over 3 years to help develop Health-e-App, [63] an online application system for California's SCHIP and Medicaid program. After a successful pilot of the system in one county, it was implemented statewide, and additional efforts to create a one-stop electronic enrollment system for multiple programs, known as One-e-App, are under way. *See Appendix A for more information about California's electronic application systems.*

Recommendation 2: Simplify the Enrollment and Renewal Processes

Simplifying the application and renewal procedures for SCHIP is likely to help increase enrollment and retention, reducing the number of children without access to health insurance coverage. The Task Force offers the following recommendations to further simplify the enrollment and renewal process:

2.1 **The Task Force recommends the adoption of a fully preprinted renewal application that includes information from the previous year.** This will allow individuals to simply update information that has changed from the previous year (e.g., address, increase/decrease in income). This will likely decrease the average time needed to complete the renewal application and simplify the process for both applicants and administrators. In order to do this; however, the technology system used to generate the applications and collect data will likely require some adjustments and improvements.

2.2 **The Task Force recommends that the emergency room enrollment initiative that has already been piloted in Buncombe County be extended to additional NC counties and if successful, adopted statewide.** This strategy reaches children and families when they are most in need of assistance and creates an additional doorway to enrollment. The arrangement in place between DSS and local hospitals in Buncombe County can be used as a model for adopting this enrollment initiative throughout the state.

2.3 Some states have begun to streamline the application process for multiple programs in order to simplify the procedures for administrators, avoid duplicating efforts, and ease the process for applicants. **North Carolina must move toward enrolling children into Health Choice or Health Check when they apply for the National School Lunch**

Program and/or the Food Stamp program. The joint application process that has already been implemented in Buncombe County, NC can be used as a model for how to incorporate this strategy throughout the state.

2.4 **The Task Force recommends that DHHS pilot an online application for Health Choice**. Research suggests that the time and start-up costs for implementing such a system vary widely depending on the precise needs and design. Initially, a pilot program could be implemented in select counties to help contain start-up costs and better monitor quality and effectiveness. Further information about the specific considerations, such as implementation costs, training for administrators, how to handle documentation requirements, and applicant signatures would need to be examined.

Finding 3: Transitioning Children (0-5) from SCHIP to Health Check and Linking Them to a CCNC Primary Care Provider

On January 1, 2006, SCHIP children between the ages of 0 and 5 years were transferred from the North Carolina Health Choice program to the Community Care of North Carolina (CCNC)/ Health Check program. The transition enabled North Carolina to avoid enrollment freezes similar to what occurred in 2001. In addition to easing the burden on the Health Choice program, it allowed children who were transferred to CCNC to benefit from its enhanced primary care case management (E-PCCM) structure and services.

The impact of the transition for children less than 6 years of age has not been thoroughly evaluated. Yet an additional 110,000 lower-income children enrolled in NC Health Choice, ages 6 to 18 years, are in the process of being linked with the CCNC networks in 2007. The Kate B. Reynolds Charitable Trust has provided short-term grant support to Dr. Daniel Gitterman and Dr. Julie Jacobson Vann at UNC-Chapel Hill to examine and review the process of the SCHIP to CCNC transition for 0- to 5-year-old children in North Carolina and make policy recommendations to enhance the health care financing and delivery systems for children of low-income families in North Carolina. This evaluation is under way; preliminary findings are presented here as part of the Task Force report.

Enrollment of Children in CCNC Health Check and Linkage with Primary Care Providers

For children who are less than 6 years of age and have been transferred from Health Choice to CCNC Health Check, the primary responsibility for formally linking them with a primary care provider resides with the county-based Department of Social Services (DSS) caseworkers. Yet the DSS caseworkers generally do not have a direct reporting relationship with the CCNC administrative offices or CCNC networks. Therefore, state-level goals are being delegated to employees who are accountable to meet the goals of their respective counties, not of the state. Because the client linkage with PCPs has not been fully successful, other mechanisms were added to increase the proportion of eligible clients who get appropriately linked with a PCP. County-based Health Check Coordinators (HCCs) have been asked to assist with this effort. This supplemental strategy is important given that HCCs are employed by more than 90 NC counties to assist families with obtaining medical benefits and other services needed by their children,

educate families about Health Check and Health Choice, help enroll eligible children, and follow Health Check-enrolled children in their counties to make sure that they are receiving well child check-ups and recommended follow-up care. The third strategy for linking eligible children with CCNC primary care providers involves primary care physician offices. These health care practices have been provided with Carolina ACCESS Enrollment Forms and instructions. Employees of CCNC participating physician practices are asked to work with patient clients to complete the brief forms and then fax them to DSS.

The overall success of these three strategies has not yet been validated with quantitative evidence; however, anecdotal reports and completed key interviews indicate that the results have not met expectations. In addition, the interview data provide initial evidence that the processes to link patients with PCPs vary from network to network and county to county, and that collaboration and communication among all involved entities can be inconsistent. Some CCNC networks and providers seem unaware of the respective roles of those responsible for the linkage process. Enrollment reports that summarize the success of linking children with PCPs are pending.

Data Management

The North Carolina Health Check and Health Choice programs, DSS case workers, Health Check Coordinators, CCNC Networks and case managers, and CCNC participating providers utilize a number of databases. These serve to document and manage Health Check and Health Choice eligibility, enrollment, linkage with PCPs, case management performed by CCNC case managers, case management performed by clinicians, disease management and registry functions, and efforts to facilitate compliance with regular Health Check screenings, immunizations, and referrals for special health care problems.

Based on findings from key interviews, evidence suggests that the existing databases are not integrated to the degree necessary for optimally managing the linkage of children with PCPs, as well as identifying patients (ages 6 to 18 years in Health Choice) in need of case management services. The Health Check eligibility database, used by DSS caseworkers to link children with PCPs during eligibility determinations and re-determinations, is reported to lack real-time tracking, at the client level, of those children who have been linked with a PCP versus those who have not. In addition, the attempted and actual contacts made by DSS caseworkers with parents or guardians to initiate the PCP link are not electronically documented to facilitate monitoring and evaluate the relative success of the various strategies. Access to the Health Check eligibility database for purposes of linking children with PCPs is reported to be restricted to the DSS caseworkers and is not available to Health Check Coordinators, CCNC networks, CCNC case managers, or providers who may assist with the linkage efforts.

A second major database limitation is related to the 6- to 18-year-old Health Choice enrollees who are to be linked with a CCNC primary care provider. Because these children are enrolled in Health Choice, their health care claims are processed by Blue Cross and Blue Shield (BCBS) of North Carolina. The claims files are sent to the North Carolina Division of Medical Assistance on a weekly and monthly basis. However, findings from interviews indicate that the claims data and related case management reports are not readily available to CCNC networks to facilitate

rapid identification of children who are likely to benefit from case management and/or disease management programs.

Recommendation 3: Improving the Linkage of Children and Primary Care Providers

A more fully integrated and collaborative approach to the process of linking children with a primary care provider is likely to improve the overall success of the program. In addition, CCNC case managers need to receive Health Choice claims data and lists of Health Choice enrollees potentially in need of case management services in a timely manner. The Task Force offers the following recommendations to enhance the transition of children aged 0 to 5 years from Health Choice to Health Check and link children with a primary care provider:

Strengthening Collaboration between CCNC, DSS and Health Check Coordinators for SCHIP Kids

3.1 **Encourage the CCNC networks, through future contractual relationships, to work collaboratively with Departments of Social Services and Health Check Coordinators in their geographic service areas to develop annual strategic plans to link children with primary care providers and promote the CCNC systems and medical home concept**. This collaborative plan should also address efforts to educate the participating providers and enrollees about the advantages of the CCNC health care delivery system and the concept of the "medical home." The CCNC network needs to be promoted not only as an approach to managing children with chronic illnesses but also as an integrated health care delivery system that facilitates access to primary and preventive care. The CCNC networks should facilitate this, in part, through orienting and training DSS caseworkers and HCCs about CCNC and the "medical home" concept.

In the interim, until contracts are amended, the CCNC networks should be encouraged to work with other involved agencies on a plan that focuses on linking patients with PCPs and promoting the CCNC and medical home concepts. The voluntary efforts of some CCNC networks to orient DSS caseworkers and HCCs in some counties have been reported to enhance the linkage of clients with PCPs.

3.2 **Develop a mechanism that creates a reporting relationship or accountability between DSS caseworkers and CCNC**. One proposed strategy would involve partial payment of DSS caseworker salaries by CCNC to compensate counties for linking children with primary care providers. An alternative strategy would involve compensating counties on a per case basis for linking children with primary care providers. Because a per case-basis reimbursement potentially provides incentives to link children with PCPs in an expedited way, perhaps without parental buy-in, accountability should be built into the system. Refer to the recommendations listed below concerning data systems, online documentation of linkage attempts, and monitoring systems that are proposed to facilitate accountability.

3.3 **Restructure the outreach strategies of Health Check Coordinators to educate Health Check and Health Choice families about the CCNC networks at the time of enrollment or reenrollment.** The first documented "primary purpose" in the Health Check Coordinator Job Description is to "Increase community and family awareness of the benefits of Carolina ACCESS/Community Care of North Carolina and Health Check and Health Choice program." Ideally, this educational process should occur when children are enrolled in Health Check or Health Choice rather than after a problem is detected (e.g., lack of routine health visits or inappropriate use of emergency department services). The Health Check Coordinators' operational strategies should be restructured so that they meet with Health Check and Health Choice clients shortly after enrollment to discuss the medical home concept, advantages of the CCNC program, and the importance of well child checks, immunizations, and other preventive care, and to verify that the child has been linked with a PCP. If the PCP has not been selected, the HCC should facilitate the link at this meeting. This proposed approach is expected to facilitate more appropriate use of services.

3.4 **Clarify the role of the Health Check Coordinator in linking 6- to 18-year-old children who are enrolled in Health Choice with a CCNC primary care provider**. The current HCC job description lists the following as the "primary purpose of position": "Coordinate the activities of Health Check and Health Choice and serve as a link with existing child health programs, local physicians, Health Check agencies and professional organizations." The specific role of the HCC in linking 6- to 18-year-old children enrolled in Health Choice with a CCNC primary care provider is not clear. This responsibility should be delineated more clearly in the job description and policies and procedures and in the "Suggested Local Orientation Guide for New Health Check Coordinators."

Improving Collaboration by Exploring Options for New Technology to Enhance Existing Information Systems

3.5. **Explore the use of new or enhanced information systems by DSS caseworkers, Health Check Coordinators, and others involved in linking children with CCNC primary care providers to support and facilitate the linkage process, document contacts and linkage attempts, and monitor the relative success of alternative strategies**. Creating a more fully integrated information system that can be used and viewed by all involved with the linkage process is likely to improve communication and collaboration. One proposed approach is to add a PCP linkage tracking component to the State Eligibility Information System (SEIS) used by DSS caseworkers. This proposed tracking system would include a simple data entry screen to document attempted contacts with families (to link patients with PCPs), including the date, time, reason for the contact (other options to be used for other HCC activities), person initiating the contact, and result of the contact. If this component of the system were made available online to all entities involved in the linkage process, a more coordinated effort to link patients could be developed. This proposed tracking system would also include online real-time tracking reports and reminders that list enrollees who have not yet been linked with a PCP. The reports would be automatically updated whenever an enrollee is linked with a PCP. The

proposed system module and data would also be used to generate reports to monitor and evaluate progress and respective success of each strategy used to link children with PCPs.

3.6 Because the Health Check Coordinators utilize the Automated Information and Notification System (AINS) to identify and follow Health Check-eligible children to determine which in their respective counties are receiving regular Health Check screenings, immunizations, and referrals for special health care problems, **the Task Force believes that it would be critical to link the SEIS and AINS databases to optimize the efficient documentation activities of Health Check Coordinators.** The information systems used to monitor the linkage of children with CCNC primary care providers should also include the 6- to 18-year-old children who are enrolled in Health Choice.

Finding 4: Expanding Coverage for Children in Families with Incomes Between 200% and 300% of the Federal Poverty Level (FPL)

Extensive policy research on the topic of children's health documents the countless benefits of ensuring consistent access to high-quality health care. Children with health insurance coverage are more likely to receive vaccinations and other critical preventive services, as well as more timely treatment for illnesses or other special needs.[64] Increasing access to health insurance is also cost-effective for the state and local economies.[65]

A coalition of advocates led by Action for Children, a statewide, nonprofit, nonpartisan organization, worked together to create a plan – NC Kids Care – to make health insurance coverage more affordable for children in North Carolina with assistance from Mercer Government Human Services Consulting. The proposal included a limited benefits package (compared to the traditional Health Check benefits for children), sliding-scale fees for families with incomes between 200% and 300% of the FPL, and an option for families with incomes above 300% to buy in to the program at the full premium cost (approximately $160 per month). *See Appendix B for more information on this proposal.*

Governor Michael Easley also put forth a proposal to expand children's health insurance that is based on previous work done by the NC Institute of Medicine's Task Force on Covering the Uninsured.[66] In his plan, the governor offers a more limited benefits package, known as "Medicaid Lite." It is not an entitlement program for those with family incomes between 200% and 300% of the FPL and it does not include the option for families with incomes above 300% of the FPL to buy in. *See Appendix C for more information on the governor's proposal.*

In their recent budget bills, both the North Carolina House and the Senate included sections on expanding health insurance coverage for children. The version included in the House budget bill is similar to the plan put forth by Action for Children and their coalition, but it does not include the buy in option for families earning more than 300% of the FPL and it gives the DHHS some flexibility in making final decisions about co-payments and other components. The Senate's version proposes to assemble a study commission to further examine the issue of expanding

coverage for children and then, based on its findings; provide funding for an expansion in the second year. *See Appendix D for more information on the House and Senate proposals.*

Several states offer coverage for families with incomes above 200% FPL, and the current debate at the federal level about the reauthorization of funds for SCHIP is prompting more states to evaluate their programs and increase eligibility. Six states (Illinois, Pennsylvania, Massachusetts, Vermont, Maine, and Washington) have enacted universal health coverage for children and several more states have proposed universal coverage or are working to expand coverage eligibility for children.

With the proposed plans for expanding coverage, North Carolina is taking an important step toward reaching more children who are in need of affordable health insurance. However, it is important to point out that the current proposals offer some differences in eligibility, services covered, and cost-sharing arrangements.

Plans to expand Health Check coverage generally require a federal waiver. Section 1115 of the Social Security Act allows states to apply for a waiver to alter the state's Health Check eligibility criteria without loosing federal funds.[67,68] Health Check waivers are often required to be budget neutral, meaning that the federal government's Health Check contribution to the state would not be more with the waiver than it was without the waiver. This is primarily true if the proposed expansion will include individuals who are not ordinarily covered under Health Check.

With the proposed expansions, budget neutrality may not be an issue because Health Check language allows inclusion for "traditional coverage groups," which does include children in families with incomes between 200% and 300% of the FPL. This is an issue that requires further investigation and may depend on the specific details of an expansion plan once (if) it is approved by the North Carolina General Assembly. If budget neutrality rules do apply, North Carolina would have to document projected cost savings in other areas of the Health Check program.

Recommendation 4: Expand Public Health Insurance Coverage for Children in Families with Incomes between 200% and 300% of the FPL

4.1 **The Task Force reaffirms our support for NC Kids' Care** included in the North Carolina General Assembly's House Budget Bill (H1473), to expand health insurance coverage for children living in families with incomes between 200% and 300% of the FPL.

4.2 **Programs for expanding children's health insurance coverage will require additional outreach and enrollment support, and the Task Force recommends adequate funding be directed toward these efforts.** Individuals and organizations currently involved in Health Choice and Health Check outreach should be consulted in order to better evaluate funding needs for any potential expansion programs as well as linkages to the CCNC.

4.3 **Previous recommendations regarding easing the enrollment and renewal process as well as linking children with a PCP would also apply to any expansion programs.** Individuals and organizations involved in the enrollment, application, and renewal process as well as linkage with a PCP should be consulted to better understand the need for easing the process. Additional resources should be made available to facilitate appropriate modifications to current Health Choice and Health Check enrollment and referral efforts.

4.4 The current proposals to expand coverage to children in families with incomes between 200% and 300% of the FPL are an important step in the right direction. **The Task Force recommends that the key stakeholders continue to collaborate on a broader plan to ensure that all children and their parents in North Carolina have affordable and quality health insurance coverage available to them.** RWJF's *Consumer Voices for Coverage: Strengthening State Advocacy Networks to Expand Health Coverage* seeks to strengthen advocacy efforts to promote health care policies that will expand health insurance coverage. **The Task Force strongly recommends that advocacy groups collaborate on one-strong proposal from North Carolina.** *The program will only fund proposals from one registered applicant per state.* All applicant organizations must register online by July 13, 2007 (3 p.m. ET) in order to be eligible.

Conclusion

Access to affordable health insurance coverage for children remains a major issue nationally and statewide. Two recent issues of *Health Affairs* dedicated entirely to child health has documented the need for additional progress in ensuring access to affordable health insurance benefits for all children.[69]

In North Carolina, Health Choice and Health Check provide critical health coverage for low-income children. NC Kids' Care offers the opportunity to take another step toward the goal of making sure every child in North Carolina has access to affordable health insurance. Although North Carolina has taken important steps to enroll all eligible children and keep them enrolled in Health Choice and Health Check, additional areas for improvement remain.

With this report, the Task Force recommends that North Carolina continue outreach and enrollment efforts in order to reach the estimated 177,000 eligible children not yet enrolled in Health Choice or Health Check. The state must also strengthen retention efforts to ensure that no eligible children lose coverage at the time of renewal. Finally, it is also critical that children continue to be linked to a primary care provider and receive the benefits available through the CCNC network.

North Carolina must continue to move forward and be a leader on this issue. The current proposals to expand coverage to children in families with incomes between 200% and 300% of the FPL are an important step in the right direction toward the goal of access to affordable health insurance coverage for all children and their parents.

Appendix A
Examples of Electronic Applications and Other Innovations

Healthy-e-App

Health-e-App is the first fully automated Web-based application in the United States for enrolling low-income children and pregnant women in public health insurance programs. Developed by the California HealthCare Foundation (CHCF), in partnership with Deloitte Consulting LLC, Health-e-App is a real-time ecommerce application. It was developed to demonstrate the impact information technologies could have on improving access to, and the business processes of, government-sponsored health programs.

Health-e-App was developed with the cooperation of the California Health and Human Services Agency, which approved its pilot testing in San Diego County. Subsequently, CHCF licensed Health-e-App to the state of California at no cost. Health-e-App is being implemented throughout California to enroll eligible applicants in Healthy Families and Medi-Cal. It has also been licensed for use in Arizona and Indiana.

Health-e-App offers a faster, more secure, and consumer-friendly way to apply for public health insurance. It provides better quality application data and a more streamlined enrollment process, and it shows promise of increasing program enrollment because it is quick and easy to use.

Source: http://www.chcf.org/topics/medi-cal/index.cfm?itemID=19675

One-e-App

California originally developed Health-e-App, which is now available throughout the state, and is piloting One-e-App, which is available in 7 counties (Alameda, Fresno, Los Angeles, San Joaquin, San Mateo, Santa Clara, Santa Cruz).

One-e-App is a Web-based system for connecting families with a range of publicly funded health and social service programs. This one-stop approach improves the efficiency and user-friendliness of the application process for families seeking health coverage.

One-e-App helps to improve the quality and completeness of applications. As the data are entered, the system performs routine error checks and provides immediate notification when a required field is incomplete or data are incorrectly entered.

Other services are provided in real time, including an instant toggle between English and Spanish versions of the application, real-time selection of a provider and a health plan, and real-time submission of applications for final eligibility determination. The result is a system that is more efficient, cost-effective, and consumer-friendly.

Source: http://www.oneeapp.org/works/

One-e-App offers benefits to a wide range of constituencies, including consumers, county agencies, Healthy Kids programs and sponsors, health plans, and health care providers. These benefits are described below.

Benefits for Consumers

- Provides a one-stop application process for a range of publicly-funded health and social services programs.
- Offers immediate answers about preliminary eligibility and real time electronic submission of applications.
- Gives the ability to select appropriate health plans and doctors in real time when applying for several programs.
- Prints application documents and notification letters in the client's preferred language.
- Simplifies annual renewals for many programs. Eliminates or reduces the need to re-submit verification documents for renewals or future applications; the documentation is already in the system.

Benefits for County Government Agencies

- Helps Counties better serve their clients by providing a one-stop process for preliminary eligibility determination and electronic application submission across multiple programs.
- Interfaces with Statewide Automated Welfare Systems (SAWS) without requiring changes to those systems.
- Eliminates the need for manual data re-entry.
- Improves the quality of applications and decreases the number of incomplete applications through a consumer-friendly, interview style format and built-in error checking features.
- Provides outreach management and retention tools.
- Allows counties to track and support enrollment activities across programs and in the community.
- Protects data security and applicant confidentiality.
- Funds used to implement, maintain and administer One-e-App can be used to leverage federal matching dollars, thereby increasing the value to counties even further.

Benefits for Healthy Kids Programs and Sponsors

- Provides an easy-to-use application and eligibility determination tool for Healthy Kids Programs. As several counties have demonstrated, paper applications are not necessary, and the need for duplicate data entry is eliminated.
- Insures that funding for state and federal health coverage programs is maximized before children and adults are enrolled in programs funded with scarce local dollars.
- Allows Healthy Kids enrollment entities to help families apply for a broad range of programs beyond Healthy Kids, thereby increasing the value of their service to consumers and the community.

Benefits for Health Plans

- Provides an automated, consumer-friendly tool for health plans to conduct the entire Healthy Kids enrollment process, including eligibility determination, enrollment, provider selection, and premium collection.

- Performs preliminary eligibility determination and electronic application submission for parents in Medi-Cal at the same time that their children are being screened and applying for Medi-Cal, Healthy Families or Healthy Kids, thus improving enrollment rates and plan revenues.
- Ensures that complete and consistent information is supplied for every application, saving staff time that would otherwise be required to follow-up.
- Reduces delays associated with mailing and processing paper Medi-Cal and Healthy Families applications.
- Streamlines re-enrollment by notifying plans of Healthy Kids annual renewal dates. Reduces expensive "churn" that undermines continuity of care.

Benefits for Health Care Providers (Hospitals, Clinics, Physicians)

- Increases the number of insured patients, thereby increasing provider revenues.
- Preserves care grants and charity funds for those patients who truly aren't eligible for other coverage.
- Helps providers better serve their patients by assisting them with enrollment in a broad range of health coverage programs.
- Case management tools permit efficient tracking of applications.

Source: http://www.oneeapp.org/works/index.cfm?subclass=CL399&nlvl=1

Express Lane Eligibility

Nearly 7 million children in America are uninsured yet eligible for the federal-state programs Health Check and the State Children's Health Insurance Program (SCHIP). At the same time, over 4 million low-income, uninsured children already participate in public programs with similar income eligibility rules: the National School Lunch Program (NSLP), the Supplemental Nutrition Program for Women, Infants, and Children (WIC), food stamps, and child care programs. To enroll in these programs, families complete an application and submit necessary documentation, providing much of the same information that is required for Health Check and SCHIP enrollment.

California has also used a program called Express Lane Eligibility (ELE) to help identify children who are potentially eligible for Medi-Cal or Healthy Families by targeting children enrolled in the National School Lunch Program. ELE helps to make connections between Health Check and SCHIP and other public programs. At a minimum, ELE can be used to target outreach to the large numbers of uninsured children in public programs. A recent evaluation shows moderate success in identifying uninsured but eligible kids but does support the program as a useful tool in helping reach those in need. The evaluation also highlights the importance of efforts to streamline the application process for families.

Source: http://www.calendow.org/reference/publications/pdf/access/SC_ExpressLane_final.pdf
Dr. Michael R. Cousineau and Erika O. Wada, "Express Lane Eligibility Project: Evaluation Report," The Division of Community Health, University of Southern California, July 2006 (accessed May 31, 2007).
and
http://www.expresslaneinfo.org/AM/Template.cfm?Section=About_Express_Lane_Eligibility

Appendix B
Carolina Cares for Children Proposal
Covered Services and Cost-Sharing Summary

Category of Service	Covered Service	Co-Payment	Coinsurance	Deductible	Benefit Limit
Inpatient Non-Maternity Physical Health	Yes	$0	None	Ded applies, then 100% coverage	
Skilled Nursing Facility	Yes	$0	None	Ded applies, then 100% coverage	
Outpatient Physical Health	Yes				
Medical / Surgery	Yes	$30	None	Waived	
PT, OT, & Speech Therapy	Yes	$30/visit for first 3 visits, may be waived afterwards with OK from medical home	None	Waived	
Emergency Room	Yes	$30, Waived if admitted	None	Waived	
Primary Care Physician	Yes	$10, none if EPSDT or preventive care	None	Waived	
Specialist Physician	Yes	$30	None	Waived	
Inpatient Non-Maternity Behavioral Health	Yes	$0	None	Ded applies, then 100% coverage	
Outpatient Behavioral Health	Yes	$30/visit	None	Waived	6 visits allowed without diagnosis, 26 visits annually
Behavioral Health Other	No				
Pharmacy					
Generic	Yes	$0	None	Waived	
Brand	Yes	$20	None	Waived	
Brand Non-Formulary	Yes	$20	None	Waived	
Family Planning	Yes	$0	None	Ded applies, then 100% coverage	
Case Management	CCNC only	$0	None	Waived	
Home Health	Yes	$0	None	Ded applies, then 100% coverage	
Personal Care	Yes	$0	None	Ded applies, then 100% coverage	210 minutes per day, 60 hours per month
School Based Services	Yes	$0	None	Ded applies, then 100% coverage	
Lab & Radiology	Yes	$0	None	Ded applies, then 100% coverage	
Dental	No				
Vision/Hardware	Yes	$0	None	Ded applies, then 100% coverage	One exam annually; with prior approval, one set of lenses annually and one set of frames every 24 months
DME / Supplies	Yes	$0	None	Ded applies, then 100% coverage	
Preventive Care (EPSDT Services)	Yes	$0	None	Waived	
Ambulance	Yes	$0, $100 if determined non-emergent	None	Ded applies, then 100% coverage	
Maternity	No				

Source: Information available from Action for Children, http://www.ncchild.org/images/stories/Carolina_Cares_for_Children/Carolina_Cares_Services_and_Cost_Sharing_11_2006.pdf

Appendix C
Governor Easley's "Medicaid Light" Proposal

Title of Request: Limited Health Check Benefit Package for Uninsured Children Between 200% and 300% of Poverty

Description of Request: Expand Health Check coverage to provide a limited benefit package, "Health Check Light," to children with incomes between 200% of the federal poverty level (the current Health Check/NCHC eligibility level) and 300%. Services covered will be similar to the current Health Check program, but will require increased coinsurance, co-payments and deductibles depending on the type of service provided. Coverage for inpatient hospitalization (non-maternity/non-behavioral health) will be limited to $10,000. Skilled nursing, home health/personal care services and dental services will not be covered. A federal waiver will be required to implement this limited benefit package. The requested General Fund appropriation will cover the total non-federal cost share (i.e. counties will not cost share the Health Check Light coverage). It will be necessary to contract with a third party to collect premiums as the MMISsystem can not accommodate this component. This request does not include this cost. Effective January 1, 2008.

Purpose of Expansion Request: Provide basic health care coverage to approximately 12,100 additional low-income North Carolinians by expanding the Health Check program to establish a limited benefit package, "Health Check Light." Coverage will be extended to children with incomes between 200% of the federal poverty level (the current Health Check/NCHC eligibility level) and 300%.

Necessary changes in operation: Because the Health Check Light program will offer more limited benefits, focusing on primary and preventive care and limiting inpatient coverage, with increased cost sharing compared to the state's Health Check program, the state will need approval from the Centers for Medicare and Health Check Services (CMS) to waive applicable federal requirements.

Anticipated outcome/impact after implementation of changes: Increase the number of NC residents with health care coverage by an estimated 11,800 children. Improve access to primary and preventive health care services for low income individuals by providing them with a medical home through Community Care of North Carolina (CCNC). Improve the health status of covered children by emphasizing cost-effective primary care and managing chronic conditions in lieu of delayed expensive inpatient services.

Relation to Agency Goals: Supports the division's mission to by increasing access to high-quality, medically necessary health care for North Carolina residents.

Source: Information provided by NC DHHS, Office of State Budget and Management

Appendix D
North Carolina Kids' Care Proposal

NC KIDS' CARE *(from House Bill 1473, p.105-108)*

SECTION 10.48. (a) The Department of Health and Human Services, Division of Medical Assistance, shall develop and implement a limited benefit medical assistance program, NC Kids' Care, to expand health care coverage to children in families with incomes between two hundred percent (200%) and three hundred percent (300%) of the federal poverty guidelines, as revised April 1 of every year. The Department shall apply for any federal Health Check waivers required to implement this section. Eligibility for and benefits under this program are not entitlement and are subject to availability of funds and other changes to State and federal law.

SECTION 10.48. (b) Eligibility.—The Department may enroll eligible children based on the availability of funds. Following are the eligibility and other requirements for participation in NC Kids' Care children must:

(1) Be between the ages of birth and 19 years of age;
(2) Be ineligible for Health Check, Medicare, or other government sponsored health insurance;
(3) Have been uninsured for three months;
(4) Be in a family whose family income is above two hundred percent (200%) through three hundred percent (300%) of the federal poverty level;
(5) Be a resident of this State, meet applicable federal citizenship and immigration requirements, and be eligible under Federal law; and
(6) Have paid the monthly premiums required by NC Kids' Care.

SECTION 10.48.(c) Benefits and Limitations.—Except as otherwise provided, health benefits, including limitations, provided to children shall be as follows:

(1) Excluded benefits:
    a. Dental.
    b. Maternity.
    c. Skilled nursing facility.
    d. Personal care services.
(2) Capped benefits:
    a. Inpatient physical health benefits are limited to two hundred fifty thousand dollars ($250,000) per eligible child.
    b. Inpatient behavioral health benefits are limited to two hundred fifty thousand dollars ($250,000) per eligible child.
    c. Outpatient behavioral health benefits are limited to 26 visits annually.
    d. Primary care and special care physician visits are limited to five annually, except that:
        1. Additional specialty physician visits are allowed if approved by a primary care physician enrolled in Community Care of North Carolina; and

2. Additional wellness visits are allowed according to a predetermined schedule.

e. Prescriptions are limited to six per month, but this limit is waived if the child is participating in a Community Care of North Carolina case or disease management program.

f. Durable medical equipment and supplies are limited to five hundred dollars ($500.00) with prior approval by CCNC, except there is no limit on diabetic supplies.

SECTION 10.48.(d) Community Care of North Carolina.—The Department of Health and Human Services shall provide services to children enrolled in the NC Kids' Care program through Community Care of North Carolina and shall pay Community Care of North Carolina providers for these services as allowed under Health Check.

SECTION 10.48.(e) Cost Sharing.—NC Kids' Care shall require enrollees to contribute to the cost of their care through the use of deductibles, co-payments, coinsurance, and premiums as follows:

(1) A monthly premium is to be charged for each child enrolled in NC Kids' Care.

(2) The premium amount charged for each child shall vary depending on family income between two hundred percent (200%) FPL and three hundred percent (300%) FPL, except that:

a. The average premium charged for a child between two hundred percent (200%) and three hundred percent (300%) FPL shall not be more than sixty-five dollars ($65.00) PM/PM; and

b. The total premium cost shall not exceed two percent (2%) of an individual's annual income and four percent (4%) of a family's annual income.

(3) Coinsurance of not more than twenty percent (20%) may apply to the following benefits:

a. Inpatient physical health;

b. Outpatient physical health;

c. Surgery;

d. Physical therapy, occupational therapy, and speech therapy;

e. Emergency room;

f. Inpatient behavioral health;

g. Laboratory and radiology;

h. Durable medical supplies; and

i. Ambulance services.

(4) The maximum out-of-pocket coinsurance is two thousand five hundred dollars ($2,500) per child annually.

(5) Co-Payments.—NC Kids' Care may require enrollees to pay a co-payment for the following services offered. The co-payment for each service shall not exceed:

a. Twenty dollars ($20.00) for a primary care physician visit;

b. Forty dollars ($40.00) for a specialty care physician visit;

c. One hundred dollars ($100.00) for an emergency room visit, except the co-payment is waived if the enrollee is admitted to the hospital;

d. One hundred fifty dollars ($150.00) for ambulance service, except the co-payment is waived if the enrollee is admitted to the hospital;
e. Prescription drugs, as follows:
1. Five dollars ($5.00) for each generic drug prescription;
2. Thirty dollars ($30.00) for each brand-name drug prescription; and
3. Sixty dollars ($60.00) for each brand-name drug prescription, not on the list of preferred drugs.

SECTION 10.48. (f) Enrollment in NC Kids' Care shall not exceed funds appropriated for the program.

SECTION 10.48.(g) The nonfederal costs of NC Kids' Care shall be paid with State funds and enrollee premiums. Counties shall not be required to share in the nonfederal costs of NC Kids' Care.

SECTION 10.48.(h) Providers of services under NC Kids' Care shall be paid at Medicare rates except that pharmacy providers shall be paid at Health Check rates.

SECTION 10.48.(i) Until such time as the Department of Health and Human Services has an electronic data system that has the ability to collect and accept premiums and provide the other management activities inherent in administering NC Kids' Care, the Department may contract with a third party to administer this program.

SECTION 10.48.(j) This section becomes effective January 1, 2008, or upon approval of all required federal waivers and State Medical Assistance Plan amendments, whichever is later.

NC KIDS' CARE STUDY *(From Senate Finance Subcommittee Substitute for House Bill 1473 p, 107-108)*

SECTION 10.48. The Department of Health and Human Services, Division of Medical Assistance, shall determine the most cost-efficient and cost-effective method for implementing a limited benefit medical assistance program, NC Kids' Care. In developing the Program, the Department shall include the following:

(1) Eligibility for benefits under NC Kids' Care is not an entitlement, is for legal residents of North Carolina, and is subject to availability of funds and State and federal requirements.

(2) NC Kids' Care shall provide health coverage to children whose income is not less than two hundred percent (200%) and not more than two hundred twenty-five percent (225%) of the federal poverty level.

(3) Children enrolled in NC Kids' Care must be ineligible for Health Check, Medicare, or other government-sponsored health insurance.

(4) The premium for enrollment in NC Kids' Care shall be not more than twenty-five dollars ($25.00) per member per month except that the premium for a family shall not exceed seventy-five dollars ($75.00) per family per month.

(5) Providers of services to children enrolled in NC Kids' Care shall be paid at Health Check rates.

The Department of Health and Human Services shall report its findings and recommendations on the scope and benefits of NC Kids' Care to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division not later than April 1, 2008.

Source: Information available from the North Caroling General Assembly Web Site, http://www.ncleg.net/Sessions/2007/Bills/House/PDF/H1473v7.pdf

[1] In North Carolina, Health Check for children is sometimes referred to as Health Check. Health Check covers preventive services including complete medical and dental check-ups, and provides vision and hearing screenings and referrals for treatment. Nationally, Health Check's prevention services for children are provided under Early Periodic Screening, Diagnostic and Treatment (EPSDT). This is the federal law that requires Health Check to provide medically necessary health care services to Health Check-eligible children through the age of 20 even if the services are not normally covered by Health Check or normally only covered for recipients 21 years of age and older.

[2] In North Carolina, Medicaid for children is referred to as Health Check. Health Check covers preventive services including complete medical and dental check-ups, and provides vision and hearing screenings and referrals for treatment. Nationally, Health Check's prevention services for children are provided under Early Periodic Screening, Diagnostic and Treatment (EPSDT). This is the federal law that requires Health Check to provide medically necessary health care services to Health Check-eligible children through the age of 20 even if the services are not normally covered by Health Check or normally only covered for recipients 21 years of age and older.

[3] Data adapted from Annie E. Casey Foundation, *CLIKS Database: Community-Level Information on Kids*, http://www.kidscount.org/cgi-bin/cliks.cgi?action=rank_indicator&subset=NC&areatype=county (accessed June 20, 2007).

[4] Adapted from Carolina Cares for Children (chart) created by Action for Children based on original data from *Federal Register* 71, no. 15 (January 24, 2006): 3848-3849, http://www.ncchild.org/images/stories/Carolina_Cares_for_Children/Childrens_Health_Insurance_Chart.pdf (accessed June 15, 2007).

[5] Data from CPS, which are used to allocate funding for the program, underestimated the number of children who would be eligible. A special session of the General Assembly allocated additional funding for the program and enrollment began to increase again. In 2005, the General Assembly passed legislation to move children under 6 to the Health Check program, helping to prevent another enrollment freeze.

[6] Adapted from "State Health Facts" from the Kaiser Family Foundation based on original data from the Census Bureau's March 2005 and 2006 Current Population Survey (CPS: Annual Social and Economic Supplements), http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=North+Carolina&category=Health+Coverage+%26+Uninsured&subcategory=Health+Insurance+Status&topic=Children+%280%2d18%29 (accessed June 22, 2007).

[7] Adapted from Carolina Cares for Children (chart) created by Action for Children based on original data from *Federal Register* 71, no. 15 (January 24, 2006): 3848-3849, http://www.ncchild.org/images/stories/Carolina_Cares_for_Children/Childrens_Health_Insurance_Chart.pdf (accessed June 15, 2007).

[8] Information prepared by Action for Children (in 2007) for the NC Coalition to Promote Health Insurance for Children. Data are based on calculations from the NC Institute of Medicine.

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