93.767 **CHILDREN'S HEALTH INSURANCE PROGRAM**

State Project/Program: **HEALTH CHOICE**

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Federal Authorization: Balanced Budget Act of 1997, Title XXI, Subtitle J, Section 4901, Public Law 105-33; Public Law 105-100. Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 Public Law 106-113, Section 702; Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000, Title VIII, Section 801, 802, and 803, Public Law 106-554. Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3; Patient Protection and Affordable Care Act Title II, Subtitle B, Section 2101.

State Authorization: North Carolina General Statute 108A-70.18 through 70.29.

N. C. Department of Health and Human Services
Division of Health Benefits

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N. C. DHHS Confirmation Reports:

SFY 2020 audit confirmation reports for payments made to Counties, Local Management Entities (LMEs), Managed Care Organizations (MCOs), Boards of Education, Councils of Government, District Health Departments and DHSR Grant Subrecipients will be available by mid-October at the following web address: https://www.ncdhhs.gov/about/administrative-offices/office-controller/audit-confirmation-reports At this site, click on the link entitled "Audit Confirmation Reports (State Fiscal Year 2019-2020). Additionally, audit confirmation reports for Nongovernmental entities receiving financial assistance from DHHS are found at the same website except select "Non-Governmental Audit Confirmation Reports (State Fiscal Years 2018-2020)

The auditor should not consider the Supplement to be "safe harbor" for identifying audit procedures to apply in an engagement, but the auditor should be prepared to justify departures from the suggested procedures. The auditor can consider the Supplement a "safe harbor" for identification of compliance requirements to be tested if the auditor performs reasonable procedures to ensure that the requirements in the Supplement are current. The grantor agency may elect to review audit working papers to determine that audit tests are adequate.

This compliance supplement should be used in conjunction with the OMB 2019 Compliance Supplement which was issued in August 2019. This includes "Part 3 - Compliance Requirements," for the types that apply, "Part 6 - Internal Control," and "Part 4 - Agency Program" requirements if the Agency issued guidance for a specific program. The OMB Compliance Supplement is Section A of the State Compliance Supplement.

I. PROGRAM OBJECTIVES

Children's Health Insurance Program

The purpose of North Carolina's Title XXI Children's Health Insurance Program, Health Choice, is to ensure that every child in the State has access to an ongoing system of health care. Health Choice provides comprehensive health care coverage for children living in families with incomes that exceed the threshold to qualify for North Carolina's Title XIX Medical Assistance (Medicaid) Program but who cannot afford private or employer-sponsored health insurance. The State's County Departments of Social Services (DSS) offices process applications for the Medicaid and Health Choice programs.

Another key objective of the program is to link each beneficiary to a primary care provider medical home in one of 14 Community Care of North Carolina (CCNC) networks. The link to a primary care provider encourages well-child and other preventive visits, and the primary care provider must give referrals for specialist visits. Pursuant to N. C. GEN. STAT. § 108A-70.21(b), the Division of Health Benefits (DHB) pays a per member, per month fee to CCNC for primary care case management and reimburses providers on a fee-for-service basis.

II. PROGRAM PROCEDURES

Who is eligible for N. C. Health Choice?

Pursuant to N.C. GEN. STAT. § 108A-70.21(a), the eligibility criteria for the program are:

1. Children must:
   a. Be between the ages of 6 through 18;
   b. Be ineligible for Medicaid, Medicare, or other federal government-sponsored health insurance;
   c. Be uninsured;
   d. Be in a family whose family income is above one hundred thirty-three percent (133%) through two hundred percent (211%) of the federal poverty level;
   e. Be a resident of this State and eligible under federal law; and
   f. Have paid the Program enrollment fee, if required.

N. C. GEN. STAT. § 108A-70.18(8) defines "uninsured" as "not covered under any private or employer-sponsored comprehensive health insurance plan on the date of enrollment."

Health Choice is not an entitlement program like Medicaid. Therefore, the N. C. Department of Health and Human Services may enroll eligible applicants based on the availability of State funds to meet the Federal-State match for the Title XXI program.

Previously, in addition to Health Choice, N.C. GEN. STAT. § 108A-70.21(g) authorized an Extended Coverage option. At the time of the annual renewal review for continued eligibility, children residing in families with income exceeding Health Choice eligibility requirements were possibly eligible to purchase up to 12 consecutive months of transitional health insurance immediately following the last month of Health Choice eligibility. Extended Coverage was available to children who:

- Had immediate prior enrollment in Health Choice;
- Resided in a family with income from 201 to 225 percent of the FPL; and
- Had been denied Health Choice eligibility at the time for renewal because of excess family income.

All other Health Choice eligibility requirements applied. However, Session Law 2015-24 repealed North Carolina Health Choice Extended Group Coverage (MIC-L) effective November 1, 2015. Individuals enrolled in the program when it was repealed were able to continue benefits through October 31, 2015, provided premium payment is made.

What it costs?

N. C. GEN. STAT. § 108A-70.21(c) and (d) set forth the Health Choice enrollment fee and cost sharing amounts for the program. Members of federally recognized Native American tribes and Alaska Natives are exempt from all cost sharing. N. C. GEN. STAT. § 108A-70.21(g) authorizes the Division of Medical Assistance to collect the "full premium cost" from Extended Coverage option enrollees. As the table below shows, the enrollees have co-payments for office visits, prescriptions, and emergency room visits. The monthly premium cost as of January 2015 for each enrollee is $171.12.

Beneficiary Income and Race/Ethnicity Status	Cost-Sharing Responsibility
Family income is 159% or less of the poverty income level and is a member of a federally recognized Native American Tribe or Alaska Native.	• No enrollment fee • No prescription co-payments • No co-payments for office visits

Family income of 134% - 159% of the Federal Poverty Income Level.	• No enrollment fee
	  • Generic Prescription co-pay: $1
	  • Brand Prescription when no generic available co-pay: $1
	  • Brand prescription when generic available co-pay: $3
	  • Over-the-counter co-pay: $1
	• No co-payments for office visits
	• $10 non-emergency, emergency room visits

Family income of 159% to 211% of the Federal Poverty Income Level.	• Enrollment fee: $50 per child or $100 maximum for two or more.
	  • Generic Prescription co-pay: $1
	  • Brand Prescription when no generic available co-pay: $1
	  • Brand prescription when generic available co-pay: $10
	  • Over-the-counter co-pay: $1
	• $5 co-payments for office visits
	• $25 non-emergency, emergency room visits

Family income of 159% to 211% of the poverty income level and is a member of a federally recognized Native American Tribe or Alaska Native.	• No enrollment fee • No prescription co-payments • No co-payments for office visits

Some health services are also exempt from cost sharing for all beneficiaries, pursuant to federal regulations. Those are:

- 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).

What is covered?

Health Choice is a comprehensive health insurance plan with Medicaid-equivalent benefits for program beneficiaries. There are four broad exceptions to coverage set forth in N.C. GEN. STAT. § 108A-70.21(b): “Benefits. – All health benefits changes of the Program shall meet the coverage requirements set forth in this subsection. 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 North Carolina Medicaid Program except for the following:

- No services for long-term care.
- No nonemergency medical transportation.
- No Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).
- Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”

The summary of benefits as approved by the federal Centers for Medicare and Medicaid Services is in **Section 6** of the Health Choice State Plan, which is available athttps://files.nc.gov/ncdma/NC_Health_Choice_State_Plan_2017_04.pdf .

Enrollment Form:

The Division of Health Benefits uses one joint application form for Medicaid and Health Choice applicants. English and Spanish versions of the form and consumer information are available for printing from the Division of Health Benefits Web site at http://www.ncdhhs.gov/dma/medicaid/applications.htm. Effective January 1, 2014 the application also became available online on the NC DHHS ePASS portal for the state’s public assistance programs and the NC Federally Facilitated Marketplace.

Enrollment Fee:

County Departments of Social Services (DSS) collect an annual enrollment fee when family income is anywhere from 159% to 211% of FPL. The annual fee is $50 per child, with a $100 maximum per family for two or more children. The amounts to be collected

are established in N.C. GEN. STAT. § 108A-70.21(c), and are assessed for each 12-month continuous enrollment period. Members of a federally recognized American Indian tribe and Alaska Natives are exempt from the enrollment fee and are identified by a unique race code and enrollment category. The enrollment fee is retained by the DSS to help offset the administrative costs associated with eligibility determination.

If an enrollment fee is due, the family has 12 calendar days from the date on the county DSS 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. During the initial 12-day period, applicants may ask for an additional ten days to pay the enrollment fee. If the fee remains unpaid as of the 11th calendar day of the extension period, DSS will mail a denial / termination notice to the applicant.

Enrollment Process:

An applicant may apply in person in the DSS in the county where he resides, he may mail the application in to the DSS, or he may apply online. Telephone and in-person assistance with applications are available through county DSS offices**.** County caseworkers have administrative flexibility to utilize multiple methods for completing and verifying renewal application information including: mail; telephone follow-up; and face-to-face interviews.

Eligibility Determination:

Each county DSS evaluates an applicant's Medicaid (Title XIX) eligibility first. If the applicant is ineligible for Medicaid, then the family income is assessed for North Carolina Health Choice (Title XXI) eligibility within the same 45-day time standard that is used for Title XIX applications. An assets test is not applicable to the Health Choice program eligibility assessment.

Pursuant to N.C. GEN. STAT. § 108A-70.29(a), new and renewing program applicants may request a review of adverse eligibility and enrollment decisions through the process outlined in N.C. GEN. STAT. § 108A-79. Current beneficiaries remain enrolled in Health Choice during a review of a decision to terminate or suspend enrollment in the program.

Continuous Enrollment:

Health Choice provides 12 months of continuous enrollment regardless of changes in family income. Beneficiaries are not required to notify the DSS caseworker regarding income changes during the continuous enrollment period.

An *increase* in family income during the enrollment period has no impact on Health Choice eligibility, even if the new household income is above 211% FPL. If the family notifies the caseworker of increased household income, the file is noted and reviewed at renewal through current income verification requirements.

A *decrease* in family income below the 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, Health Choice coverage is terminated, and Medicaid enrollment created with no gap in coverage. Pursuant to N. C. GEN. STAT. § 108A-70.21(a) (2), a beneficiary's legal representative must report a change in the beneficiary's health insurance status within 60 days of the change. If the child has a second form of

comprehensive health insurance, he will be deemed insured and ineligible for Health Choice.

III. COMPLIANCE REQUIREMENTS

Crosscutting – Since Health Choice administrative reimbursement is paid through

The Type of Compliance Requirements can be found in Section B in the link: 2020 Agency Matrix for Federal Programs. This matrix incorporates the OMB Compliance Supplement "Part 2 - Matrix of Compliance Requirement." A State Agency may have added a compliance requirement that the OMB matrix in Part 2 has a "N" (Not Applicable).

the State Division of Social Services (DSS), procedures for evaluating fiscal reporting requirements should include a review of DSS's county reimbursement form, the DSS-1571 report, and the DSS Fiscal Manual (which contains instructions for completion of the DSS-1571 and may be located at http://info.dhhs.state.nc.us/olm/manuals/ooc/fsc/man/). Local auditors should refer to the Division of Social Services Crosscutting Supplement.

A. ACTIVITIES ALLOWED OR UNALLOWED

Local DSS offices identify potentially eligible families and facilitate the completion of applications. Each DSS collects $50 per child or $100 for two or more children for enrollment fees to offset administrative expenses incurred. The State's Division of Social Services reimburses local DSS offices the remainder of the eligibility administrative cost incurred (Eligibility costs minus enrollment fees). Local DSS offices report their administrative costs on the State's Division of Social Services' Form DSS-1571.

B. ALLOWABLE COSTS/COST PRINCIPLES

For costs to be allowable for reimbursement, they must be allowable in accordance with federal and State policy (see OMB 2 CFR, Part 200). The North Carolina Health Choice State Plan is available in the Division of Medical Assistance online library at: https://files.nc.gov/ncdma/NC_Health_Choice_State_Plan_2017_04.pdf

E. ELIGIBILITY

The auditor should test Modified Adjusted Gross Income (MAGI) case for Medicaid eligibility determinations as described below.

The State Medicaid agency or its designee is required to determine client eligibility in accordance with eligibility requirements defined in the approved State plan (42 CFR Section 431.10). In North Carolina, the local Department of Social Service offices is the designee for eligibility determination. Local DSS offices use two manuals as guidelines for eligibility determination for Medicaid, the Aged, Blind and Disabled manual and the Family and Children Medicaid manual. Also, any "time limited" changes in eligibility determination rules are communicated to local DSS offices by Administrative Letters from the Division of Health Benefits. Section II of the State Medicaid Plan describes mandatory and

optional groups covered by North Carolina and the mandatory and optional conditions for eligibility.

In addition, G. S. 108A, the Appropriations Act and administrative rules adopted under
G. S. 150B authorize coverage for specific groups of families and individuals and establish rules for determining eligibility. This section of the State Plan is a resource for the Medicaid eligibility manuals used by the county DSS offices. The eligibility manuals provide detailed instructions to county social services workers for taking and processing applications, the time standard for making a determination, information required for specific groups of individuals/families to make a determination of eligibility or ineligibility, what information must be provided to applicants for or beneficiaries of program benefits, required written and verbal notifications about the status of the application or continuation of benefits, periodic review of eligibility, and what forms must be used in the application and determination process. The instructions explain how information can be obtained and verified, whose income and assets must be counted in the determination and what sources of information to use in evaluating ownership interests and the market value of assets. County workers use the statewide North Carolina Families Accessing Services through Technology (NC FAST) to register and track an application and upon a determination of eligibility or ineligibility, the decision is entered into NC FAST where historical information is maintained for inquiry, maintenance and interfaces. County workers also use the statewide NC FAST to register and track an application and upon data entered the NC FAST, the business rules are run for determination of eligibility or ineligibility. The decision in NC FAST is where historical information is maintained for inquiry, maintenance and interfaces. The county worker maintains accuracy of the on-line eligibility record by entering changes to the demographic information, amount of income or benefits, eligibility period, case members and codes that are used to generate messages and notices to the recipient. Please note that some county departments of social services are entering into contracts with private companies who provide "virtual staffing" in which individuals employed by the company who are located off site complete the eligibility determination process. Applications processed by these individuals must meet the same standards as those processed by employees of the DSS. The Operational Support Team provides technical support and training to local DSS offices on eligibility requirements.

The Division has created an Eligibility Review Document, to be used for the audit process. The document can be copied and used for each case reviewed. The document provides guidance in verifying the eligibility review items. The Eligibility Review Document and the supplemental Attachment are available at the NC Department of State Treasurer (DST) under the Medicaid State compliance supplement link. Below is the link, scroll down to 93.778-1a.

https://files.nc.gov/nctreasurer/documents/files/SLGFD/LGC/LocalGovFiscalMngmt/AnnualAud/2019ComplianceSupp/SectionB/93.778-1a.pdf

(At www.nctreasurer.com, under Division, select “Local Fiscal Management”, select “Single Audit”, select “Compliance Supplement and Single Audit Links” and select “2019 Compliance Supplement.” Select “Section B.”)

Auditors requesting information used to determine questioned cost should use the "CPA Data Request Document." This is also included under the Medicaid State Compliance Supplement.

Suggested Audit Procedures and Audit Objectives: Below are suggested audit procedures and audit objectives prepared by OSA.

- Obtain an understanding of internal control, assess risk, and test internal controls over the major programs as required by *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Grants, Audits of States, Local Governments, and Non-Profit Organizations* as found in 2 CFR 200.514.

- For the eligibility compliance requirement: Determine whether required eligibility determinations/redeterminations were performed (including obtaining any required documentation/verifications), that individual program participants were determined to be eligible, and that only eligible individuals participated in the program by selecting and performing tests on a sample from the population of all individuals receiving benefits during the entire fiscal year.

- For the eligibility compliance requirement: Note that if an individual is found to be presumptively eligible for a program based on eligibility for a different program determined at the county, the eligibility intake process and compliance with federal regulations must be determined based on the requirements of the originating program. For example, if a recipient is presumptively eligible for the Medicaid program based on eligibility for the TANF program, then the recipient should be audited for the requirements of the TANF program.

- For the eligibility compliance requirement: If an individual is found to be presumptively eligible for a program based on eligibility determinations performed by a federal program such as Medicare or Social Security Insurance, these sample items should not be replaced. The eligibility for those federal programs should be verified and these individuals will be considered eligible for the program.

- For the eligibility compliance requirement: Also, audit the determination related to the date of service for the payment for the individuals selected for audit.

G. MATCHING, LEVEL OF EFFORT, EARMARKING

Each state administering a Title XXI children's health insurance program is entitled to Federal funding at the enhanced Federal Medical Assistance Percentage (eFMAP). The rate changes each fiscal year and varies by state. Starting with Federal Fiscal Year (FFY) 2016, states were awarded a temporary 23% point bump in eFMAP for Title XXI. The NC eFMAP for Federal Fiscal Year (FFY) 2017 was 99.82% of every dollar expended on the program and beginning with Federal Fiscal Year (FFY) 2018 (10/1/2017 - 9/30/2018) the eFMAP became 100.00%. The state continues to receive 100% eFMAP in FFY2019 (10/1/2018 thru 9/30/2019) for Title XXI. As for FFY 2020, the eFMAP for Title XXI dropped by half of the temporary bump (11.5%), eFMAP is 88.42%.

The State's portion of the Federal-State match for the program is approved as part of the General Session budget appropriations each year. The counties receive a Health Choice administrative State allocation. If a county exceeds this allocation, the federal funds can be requested, provided there are sufficient county funds to support the non-federal share. Pursuant to 42 C.F.R. 457.622(d) (2) (iv), program administration costs cannot exceed 10 percent**.** No testing required at local level.

Level of Effort and Earmarking will determine Title XXI funds are used only for North Carolina Health Choice Program.

H. PERIOD OF PERFORMANCE

Pursuant to 42 C.F.R. 457.630(a), the federal Centers for Medicare and Medicaid Services makes quarterly Title XXI grant awards to cover the federal share of expenditures for the program. The amount of the grant is determined by State estimate and expenditure information submitted on a quarterly basis. The Division of Health Benefits draws down available funding each week through the Federal Grants section of the NC Department of Health and Human Services' Controller's office. No testing required at local level.

L. REPORTING

Since North Carolina Health Choice administrative reimbursement is paid through the State Division of Social Services (DSS), procedures for evaluating fiscal reporting requirements should include review of the DSS county reimbursement form, the DSS-1571, and the DSS Fiscal Manual (which contains instructions for completion of the DSS-1571). Local auditors reviewing local DSS offices must review the DSS "Cross-Cutting Section" for more information on the DSS-1571 reporting form. Presently the Local DSS offices report the amount of their expenditures for eligibility determination on the DSS-1571. DSS then reimburses the counties for NCHC administrative costs minus enrollment fees.

Section 201(b) of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) provided for increased Federal Medical Assistance Percentages (FMAP) funding for translation or interpretation services provided under CHIP (Health Choice) and Medicaid. This legislation provided the increased funding for interpretation/translation services in connection with program enrollment, maintenance of eligibility, and accessing of covered services by children of families for whom English is not their primary language. This includes individuals who have Limited English Proficiency (LEP) as well as American Sign Language or Braille.

A Dear County Director of Social Services Letter containing instructions for counties to claim enhanced funding for translation and interpreter services provided under NC Health Choice and Medicaid has been added to the DHB website. Counties may claim enhanced funding on form DSS-1571 effective February 1, 2011. The letter may be found at the following web address:

https://files.nc.gov/ncdma/documents/County/011311_CHIP.pdf Local Divisions of Social Services may either contract with or employ individuals who provide translation or interpretation functions. The increased FMAP is available for these translation/interpretation activities. The State is required to assure that there is adequate source documentation to support payments. For example, if time studies (i.e., day sheets) are the method used to capture and allocate the cost of allowable translation activities, the time study forms must be retained to document the claimed amounts. The time studies must clearly delineate the program (Medicaid or Health Choice) for which the enhanced payment is being claimed.