

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

---

**Agency Contact Person – Program**

[Amanda Tromblee](#)  
(919) 219-2803  
[Amanda.Tromblee@dhhs.nc.gov](mailto:Amanda.Tromblee@dhhs.nc.gov)

**Agency Contact Person – Financial**

Wayne Mohr  
(919) 855-4145  
[Wayne.Mohr@dhhs.nc.gov](mailto:Wayne.Mohr@dhhs.nc.gov)

**Address Confirmation Letters To:**

SFY 2023 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 DHHS 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 2021-2022). 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 2020-2023)"

---

The auditor should not consider the Supplement to be "safe harbor" for identifying audit procedures to apply in a particular 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.

Auditors may request documentation of monitoring visits by the State Agencies.

This compliance supplement must be used in conjunction with the OMB 2023 Compliance Supplement which will be issued in the summer. 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**

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 provided 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. In 2023, the Health Choice program will be moving to Medicaid, due to a Medicaid Expansion for children. This will raise the income limits for children up to age 18 to 211% above Federal Poverty Level. The State’s County Departments of Social Services (DSS) offices process applications for the Medicaid program.

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 was 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 could 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 2015-241 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.

A provision included in the North Carolina state budget, approved in July 2022 will transition NC Health Choice to MCHIP, and will no longer be an offered program, beginning April 1, 2023.

### **Who is eligible under the Medicaid Expansion for Children?**

Pursuant to the Balanced Budget Act of 1997, or BBA 97, P.L. 105-33 and NC SL 2022-74, House Bill 103, the North Carolina Health Choice program is moving under Medicaid. The eligibility criteria for children under this program are:

- 1.Children must:
  - a. Be between the ages of 6 through 18
  - b. 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
  - c. Be a resident of this State and eligible under federal law

### **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 Health Benefits to collect the “full premium cost” from Extended Coverage option enrollees. As the table below shows, the Health Choice beneficiaries transferring to Medicaid as of April 1, 2023, will not have any enrollment fees, or co-payments.

| <b>Beneficiary Income and Race/Ethnicity Status</b>   | <b>Cost-Sharing Responsibility</b>  |
|---|---|
| Family income is 211% or less of the poverty income level and is a member of a federally recognized Native American Tribe or Alaska Native. | <ul style="list-style-type: none"><li>• No enrollment fees</li><li>• No prescription co-payments</li><li>• No co-payments for office visits</li></ul> |

### **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 that was previously provided to children eligible under the Program was 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.”

However, as of April 1, 2023, all North Carolina Health Choice beneficiaries will be transitioning to North Carolina Medicaid, and will be able to receive services covered under the North Carolina Medicaid State Plan.

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 at [https://files.nc.gov/ncdma/NC Health Choice State Plan 2017 04.pdf](https://files.nc.gov/ncdma/NC_Health_Choice_State_Plan_2017_04.pdf). The summary of benefits as approved by the federal Centers for Medicare and Medicaid Services is in **Section 6** of the Medicaid State Plan, which is available at <https://medicaid.ncdhhs.gov/media/11300/download?attachment>.

**Enrollment Form:**

The Division of Health Benefits uses a streamlined application form for Medicaid applicants. English and Spanish versions of the form and consumer information are available for printing from the Division of Health Benefits website at [DHB-5200-ia Application for Health Coverage & Help Paying Costs](#). 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) collected an annual enrollment fee when family income was anywhere from 159% to 211% of FPL. The annual fee was \$50 per child, with a \$100 maximum per family for two or more children. The amounts previously collected were established in N.C. Gen. Stat. § 108A-70.21(c) and were 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 was retained by the DSS to help offset the administrative costs associated with eligibility determination.

After the April 1, 2023 transition of Health Choice beneficiaries to Medicaid, Medicaid guidelines for cost sharing and enrollment fees would apply to all children up to age 19 whose family income is anywhere from 159% to 211% of FPL.

**Enrollment Process:**

An applicant may apply in person in the DSS in the county where they reside, they may mail the application in to the DSS, or they may apply online or by phone, email or fax. 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 will evaluate an applicant's Medicaid (Title XIX) eligibility based on the new income guidelines.

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 can choose to remain enrolled in Medicaid during a review of a decision to terminate or suspend enrollment in the program. If the decision is upheld, they may be responsible for reimbursing Medicaid for services provided during that time.

**Continuous Enrollment:**

Medicaid 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 Medicaid 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 Medicaid minimum income requirement also does not affect eligibility during the continuous enrollment period. 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.

**III. COMPLIANCE REQUIREMENTS**

Below on the matrix are the types of compliance requirements are applicable to the federal program, noted as "Y," as determined by the federal granting agency if the federal program is listed in Part 2 of the OMB 2023 Compliance Supplement. A State agency may have added a Type. If the program is not listed in Part 2, the State Agency has determined the applicable Types. If a Type, applicable by OMB, does not apply at the local level or if the State has modified the federal requirements at the local level, this should be explained in the supplement under the Type. A Type that is not applicable at the local level is noted by "N."

If a particular Type is noted as "Y," the auditor must determine if the Type has a direct and material effect on the federal program for the auditee. For each Type of compliance requirement, the auditor must use the OMB 2023 Compliance Supplement, Part 3 (which includes generic details about each compliance requirement other than Special Tests and Provisions) and Part 4 (which includes any program-specific requirements) to perform the audit.

| CC            | A                               | B                                | C               | E           | F                                   | G                                     | H                     | I                        | J              | L         | M                       | N                            |
|---------------|---------------------------------|----------------------------------|-----------------|-------------|-------------------------------------|---------------------------------------|-----------------------|--------------------------|----------------|-----------|-------------------------|------------------------------|
| Cross cutting | Activities Allowed or Unallowed | Allowable Costs/ Cost Principles | Cash Management | Eligibility | Equipment/ Real Property Management | Matching, Level of Effort, Earmarking | Period of Performance | Procurement Suspension & | Program Income | Reporting | Subrecipient Monitoring | Special Tests and Provisions |
| Y             | N                               | Y                                | N               | Y           | N                                   | Y                                     | Y                     | N                        | N              | Y         | N                       | Y                            |

**Crosscutting** – Since Health Choice administrative reimbursement is paid through 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 <https://policies.ncdhhs.gov/departamental/policies-manuals/section-ii-budget-and-finance/manuals/dss-fiscal-manual>). Local auditors should refer to the Division of Social Services Crosscutting Supplement.

#### **A. Activities Allowed or Unallowed**

Previously, local DSS offices identified potentially eligible families and facilitated 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.

However, after the transition of North Carolina Health Choice beneficiaries to Medicaid on April 1, 2023, no enrollment fees will be collected, as there are no enrollment fees for children in Medicaid.

#### **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 Health Benefits online library at: [Medicaid State Plan Public Notices | NC Medicaid \(ncdhhs.gov\)](#). The Medicaid State Plan Amendment is available at: [Medicaid State Plan Public Notices | NC Medicaid \(ncdhhs.gov\)](#).

#### **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/nc treasurer/documents/files/SLGFD/LGC/LocalGovFiscalMngmt/AnnualAud/2021ComplianceSupp/93.778-1a.docx>.

(At [NC Department of State Treasurer](#) under State and Local Government Finance Division, select "LGC", select "Local Fiscal Management", select "Annual Audit", select "Compliance Resources", select "Compliance Supplements", and select "2021 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 (CHIP) is entitled to Federal funding at the enhanced Federal Medical Assistance Percentage (eFMAP). The rate changes each fiscal year and varies by state, the CHIP eFMAP is usually calculated by taking 30% of the non-Federal match from the state's regular Medicaid FMAP, and adding that percent to the Medicaid FMAP.

The State's portion of the Federal-State match for the Medicaid/CHIP programs are approved as part of the General Assembly's Legislative Session budget appropriations each year. Pursuant to 42 C.F.R. 457.622(d) (2) (iv), CHIP program administration costs cannot exceed 10 percent.

#### **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**

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 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](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.

#### **N. Special Tests and Provisions**

The testing of utilization of care and services is conducted by another entity. No local auditor testing is required.