

93.778

MEDICAL ASSISTANCE PROGRAM (MEDICAID; TITLE XIX)

State Project/Program: MEDICAL ASSISTANCE

U.S. Department of Health and Human Services

Federal Authorization: Social Security Act, Title XIX, as amended; Public Laws 89-97, 90-248, and 91-56, 42 U.S.C. 1396, et --- 42 CFR parts 430 through 456, 1002, 1007 seq., as amended; Public Laws 92-223, 92-603, 93-66, 93-233, 96-499, 97-35, 97-248, 98-369, 99-272, 99-509, 100-93, 100-202, 100-203, 100-360, 100-436, 100-485, 100-647, 101-166, 101-234, 101-239, 101-508, 101-517, 102-234, 102-170, 102-394, 103-66, 103-112, 103-333, 104-91, 104-191, 104-193, 104-208 and 104-134; Balanced Budget Act of 1997, Public Law 105-33.

State Authorization: General Statutes 108A-54; 108A-55

**N. C. Department of Health and Human Services
Division of Medical Assistance**

Agency Contact Person – Program**Program**

Jon York
(919) 855-4000
Jon.York@dhhs.nc.gov

Financial

Pat Jeter
(919) 855-4145
Pat.Jeter@dhhs.nc.gov

N. C. DHHS Confirmation Reports: SFY 2010 audit confirmation reports for payments made to Counties, Area Programs, Boards of Education, Councils of Government, District Health Departments, DCD State Level Contractors and HRSA Bioterrorism Grant Subrecipients will be available by around late August to early September at the following web address: <http://www.dhhs.state.nc.us/control/> At this site, page down to “Letters/reports/forms for ALL Agencies” and click on “Audit Confirmation Reports (State Fiscal Year 2009-2010)”. Additionally, audit confirmation reports for Nongovernmental entities receiving financial assistance from the DHHS are found at the same website except select “Non-Governmental Audit Confirmation Reports (State Fiscal Years 2008-2010)”.

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.

Note: In accordance with OMB Circular A-133, 525(c)(2), http://www.osbm.state.nc.us/files/pdf_files/BudgetManual.pdf when the auditor is using the risk-based approach for determining major programs, the auditor should consider that HHS has identified the Medicaid Assistance Program as a program of higher risk. While not precluding an auditor from determining that Medicaid qualifies as a low-risk program (e.g., because prior audits have shown strong internal controls and compliance with Medicaid requirements), this identification by HHS should be considered as part of the risk assessment process.

I. PROGRAM OBJECTIVES

Medical Assistance Program

The objective of the Medical Assistance Program (Medicaid or Title XIX of the Social Security Act, as amended, (42 USC 1396, et seq.)) is to provide payments for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children.

II. PROGRAM PROCEDURES

History and Administration

Congress created the Medicaid program in 1965. It was designed to be a medical safety net for two categories of low-income people receiving cash assistance:

- Parents and children and
- Elderly, blind and disabled persons.

In the late 1980's, Congress began expanding the Medicaid program to cover specified population groups that do not receive cash assistance. Some of the population groups included in the ongoing expansion is:

- Pregnant women
- Children in intact working families
- Medicare beneficiaries

Medicaid programs are governed by federal guidelines, but vary in eligibility criteria and covered services. Each State develops a *State Plan*, (NC's State Plan is located at the following address: <http://www.dhhs.state.nc.us/dma/sp.htm>) which lists the requirements of titles XI and XIX of the Social Security Act, and all applicable Federal regulations and other official issuances of the U.S. Department of Health Services. North Carolina's plan was developed by the NC Department of Human Resources (now known as the Department of Health and Human Services), and was approved by U.S. Centers for Medicare and Medicaid Services (CMS) as the official federal rules for the State of North Carolina. These rules dictate how the State of North Carolina will run the Medicaid program and allow the State to request Federal Financial Participation (FFP) dollars from

the Federal Government as long as the Plan is followed. The Federal guidelines from the State Plan are then added to North Carolina's General Statutes through administrative rules adopted under G.S. 150B. Today, Amendments to the State Plan are written by the Division of Medical Assistance on behalf of the State, and once approved by CMS are added to the General Statutes through G.S. 150B.

In North Carolina, each county determines eligibility for Medicaid benefits through their local DSS offices. North Carolina's program began in 1970 under the North Carolina Department of Social Services. A separate Division of Medical Assistance (DMA) was created within the Department of Human Resources in 1978. In over 20 years of operation, Medicaid's programmatic complexity has paralleled the growth in both program expenditures and recipients. Historically, however, DMA has spent a relatively modest percentage of its budget on administration. This level of expenditure reflects Medicaid's use of efficient administrative methods and innovative cost control strategies. The federal government pays the largest share of Medicaid costs. Federal matching rates for services are established by CMS, Centers for Medicare and Medicaid Services. CMS uses the most recent three-year average per capita income for each state and the national per capita income in establishing this rate. As North Carolina's per capita income rises, the federal match for Medicaid declines, requiring the state and counties to increase their proportionate share of Medicaid costs. The established federal matching rates for services are applicable to the federal fiscal year, which extends from October 1 to September 30. The state's fiscal year (SFY) runs from July through June. Because the federal and state fiscal years do not coincide, different federal service matching rates may apply for each part of the overlapped state fiscal year. The federal match rate for administrative costs does not change from year to year.

Medicaid operates as a vendor payment program. Eligible families and individuals are issued a Medicaid identification card each month. Program eligibles may receive medical care from any of the over 50,000 providers who are currently enrolled in the program. Providers then bill Medicaid for their services. Managed care options for Medicaid recipients are now available in all 100 counties. There are 1,055,000 Medicaid recipients enrolled in the managed care plan. Options include CCNC (Community Care of North Carolina)/Carolina ACCESS. Eligibility to participate in a managed care plan is mandatory for a majority of Medicaid recipients in North Carolina. Recipients of Medicaid/Medicare are optionally enrolled in Carolina ACCESS. Medicaid recipients who are in long-term care facilities are not enrolled in any managed care plan.

- CAROLINA ACCESS: A primary care case management model (PCCM), characterized by a primary care physician gatekeeper.
- CCNC: Incorporated the former ACCESS II/III programs which build on the Carolina ACCESS program by working with local providers and networks to better manage the Medicaid population with processes that impact both the quality and cost of healthcare.

For all of these healthcare models the objectives are:

- Cost-effectiveness
- Appropriate use of healthcare services
- Improved access to primary preventive care

The U.S. Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) administers the Medicaid program in cooperation with State governments. The Federal Government, the State of North Carolina and the State's local county governments jointly finance the Medicaid program. The Department of Social Services in each of North Carolina's 100 counties has the central role in determining Medicaid eligibility for their residents. In addition, counties contributed approximately 5.5 percent of the cost of services for Medicaid patients. This contribution for services was gradually phased out with the state assuming full responsibility for the county share in State fiscal year 2009-2010. For Medicaid eligibility determination, the county pays fifty percent of the cost associated and the Federal Government pays the other fifty percent of cost. The federal participation is paid through the State Division of Social Services. The State Division of Social Services also conducts Medicaid recipient appeals when the person making the application contests eligibility denials. A disability determination unit of the state's Division of Vocational Rehabilitation ascertains whether or not a disabled individual is eligible for Medicaid. This unit also makes disability determinations for two federal programs under a contract with the Social Security Administration (Title II - Social Security and Title XVI - Supplemental Security Income.)

As stated above, the local departments of social services play an important role in determining Medicaid eligibility. Under authority of 42 CFR 431.10 and G.S. 108A, the 100 county departments of social services are responsible for determining financial eligibility for families and non-SSI recipients to be covered by the North Carolina Medicaid Program. Among these are infants and children under age 21, caretaker relatives of children under age 19, pregnant women, children in foster homes or adoptive homes, persons who meet Social Security criteria as disabled or blind, persons age 65 and above including individuals who have income and/or assets greater than Medicaid standards who qualify only for payment of Medicare cost sharing charges and/or Medicare premiums. Eligibles are classified as categorically needy, medically needy or categorically needy, no money payment. The classification helps to define reporting categories for federal reports and the federal participation rate for service payments and Medicare premiums and cost sharing charges.

Effective January 1, 2002, Medicaid coverage was authorized for women between the ages of 18 and 64 with a diagnosis of breast or cervical cancer. This coverage is known as Breast and Cervical Cancer Medicaid (BCCM). Recipients must be screened through the Breast and Cervical Cancer Control Program (BCCCP) operated through health departments, community health centers and other medical facilities contracted to participate as screening providers and coordinators for the program. Applications for this coverage group are taken by BCCCP and forwarded to staff at the county department of social services for eligibility determination. Effective October 1, 2005, Medicaid began covering family planning services under a waiver as a separate eligibility group. The program provides family planning related services for both men and women who are ineligible for Medicaid benefits. Effective October 1, 2007, Medicaid coverage was extended through the month of the 21st birthday for individuals who were in foster care on their 18th birthday. Effective November 1, 2008, North Carolina added Health Care for the Working Disabled (HCWD) which covers blind or disabled workers age 16 through 64 with incomes equal to or less than 150% of the federal poverty level. Effective January 1, 2010, an application for the Low Income Subsidy (LIS) placed through the Social Security Administration is considered an application for the Medicare Savings Programs (MSP), known in North Carolina as the MQB programs. Since in North Carolina, an application for MQB is considered an application for Medicaid, the county must evaluate the individual for all possible Medicaid programs. LIS assists eligible individuals with Medicare related expenses. Based on LIS data transmitted from the Social Security Administration to the state, an application for Medicaid is created in the state's Eligibility Information System (EIS) for any individual on the LIS file not currently eligible for Medicaid.

As pertains to recipients of Supplemental Security Income (SSI) benefits, the Secretary of the NC Department of Health and Human Services signed an agreement with the Administrator of the Social Security Administration under the authority of Section 1634 of the Social Security Act to accept the application and determination of eligibility for the Supplemental Security Income Program as an application and determination of eligibility for Medicaid. These determinations are transmitted to the state through the State Data Exchange (SDX). The SDX is used to create an on-line Medicaid eligibility record in the state's database. Social Security Administration staff performs case maintenance as long as the individual receives SSI and transmits any changed information on the SDX. The on-line record can be updated by the county department of social services to create an eligibility segment only for the 1-3 month period prior to the SSI-Medicaid application if the person has unpaid medical bills in those months. They may change the living arrangement code from private home to the code for an adult care home or nursing home, establish a cash payment to supplement the person's income for payment of costs in an adult care home, or to establish the portion of the person's income that must be applied to cost of care in a nursing facility. When SSA terminates SSI eligibility, the county is required to make an exparte (on the record) determination for eligibility under any other coverage group in the State Plan. This determination is required to be made within 120 days after the termination of the SSI payment.

The groups eligible for Medicaid and the conditions for eligibility are described in the Act and federal regulations as mandatory or optional. The Medicaid State 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. The provisions contained in the above authorities along with procedures for applying the laws, regulations and rules are issued to county departments of social services by DMA in the form of policy instructions in Eligibility Manuals and Administrative Letters. (Located at the following address: <http://info.dhhs.state.nc.us/olm/manuals/manuals.aspx?dc=dma>). One manual contains policy and procedure for determining eligibility for persons who are disabled, blind or age 65 and above. A separate manual contains policy and procedure for determining eligibility for families with children under age 21, pregnant women and caretakers of children under 21, women with breast cancer, and the family planning waiver. The two Eligibility Manuals and DMA Administrative Letters are the official directives, which must be used by all county departments of social services to make determinations of eligibility for Medicaid benefits. Counties may not change or disapprove administrative decisions or the eligibility policies issued by DMA.

Compliance with the state's eligibility policies and instructions is tested through a statistical case sampling by the Quality Assurance Section of DMA's Program Integrity Organization and by selected case record reviews by DMA's Medicaid Program Representatives. The MPR's provide policy training, case consultation and technical assistance to county departments of social services in addition to targeted monitoring for selected program components or modifications. The MPR's also perform special reviews of case records for appropriate eligibility determination as assigned. In addition, the applications monitoring unit evaluates county application records to assure that benefits are issued in a timely and accurate manner, and, that individuals are not discouraged from applying for benefits.

Also as part of their administrative responsibilities, county departments of social services must assess the need of approved Medicaid recipients for assistance with medically related non-emergency transportation to obtain necessary medical care and treatment. Sections MA-3550 of the Family and Children's eligibility manual and MA-2910 of the Aged, Blind and Disabled eligibility manual provides the guidelines for counties to use in assessing the availability of transportation. Recipients

must be given written notification of the decision on any request for transportation and the right to appeal a denial of assistance. When a recipient has no means for providing his own transportation, or is unable to use prior sources for transportation, the county must assist him in arranging and paying for medically-related transportation for services reimbursed by the Medicaid Program. Guidelines require that transportation be to the nearest provider of the recipient's choice, and by the least expensive means appropriate for the individual's needs. County records must document the decisions made about the need for and arrangements made for medically related transportation to support federal and state reimbursement through the Medicaid Program. County departments of social services may use local transportation resources when consistent with the above guidelines. In addition, the agency may delegate responsibilities to other local entities provided the county agency requires and receives documentation of decisions consistent with the policy in the manual sections cited above and it ensures administrative responsibilities of the county department of social services.

At the State level, DMA contracts with Hewlett Packard (HP) to perform many of Medicaid's administrative functions. Currently, HP pays claims, serves as a focal point for provider questions and problems, trains new providers, operates the prior approval system for most Medicaid services and operates the North Carolina Medicaid Management Information System (MMIS).

Although DMA administers Medicaid, other agencies, DHHS divisions, and state departments work closely with the program and perform significant functions as follows:

Division of Social Services (DSS) -- NC DSS conducts Medicaid recipient appeals when the person making the application contests eligibility denials.

Division of Vocational Rehabilitation Services (DVR) - a disability determination unit within this division ascertains whether or not a disabled individual is eligible for Medicaid. This unit also makes disability determinations for two federal programs under a contract with the Social Security Administration (Title II - Social Security and Title XVI - Supplemental Security Income.)

Division of Mental Health/ Developmental Disabilities/ Substance Abuse Services (DMH/DD/SAS) - DMA works closely with the DMH/DD/SAS to finance community mental health services. Many services provided by community mental health centers are covered by Medicaid. DMA and DMH/DD/SAS also work cooperatively to offer the Community Alternatives Program for persons with Mental Retardation/Developmental Disabilities (CAP-MR/DD). This program is a valuable resource for providing community-based services as a cost-effective alternative to institutional care.

Division of Public Health (Epidemiology) - DMA and the Division of Epidemiology cooperate in a number of efforts to improve care for people with HIV and AIDS. The AIDS Care Branch in the Division operates HIV Case Management Services (HIV CMS).

Division of Aging and Adult Services (DAAS) -- DMA and DAAS staff work together on many issues important to the aged population. Jointly DMA and DAAS design a long-range plan of services for the elderly in North Carolina. In particular, DMA staff routinely participates in policy development projects on housing and in-home aide services.

Division of Facility Services (DFS) -- DFS has the responsibility for certifying and monitoring long-term care facilities in North Carolina. DFS ensures that all patients, including those covered by Medicaid, receive quality care if they reside in a long-term care facility.

Division of Public Health (Maternal and Child Health -DMCH) - DMCH, within the Department of Health and Human Services (DHHS), operates a variety of health care programs. Medicaid pays for services offered through DMCH programs and local health departments. DMCH and local health departments also play a central role in the operation of Baby Love, a care coordination program designed to help pregnant women and the Health Check Program which benefits children from birth through age 20.

Department of Public Instruction (DPI) -- The Individual with Disabilities Education Act (IDEA) is the federal law requiring education related services to pre-school and school aged children with handicapping conditions. DMA works with DPI to provide Medicaid funding for those related services that are medically indicated, for example, speech, physical, and occupational therapy.

Office of Rural Health and Resource Development -- The ORHRD and DMA in collaboration with the North Carolina Pediatric Society, Academy of Family Physicians, and the Society of Internal Medicine, have established a foundation called the Generalist Physician's Medicaid Assistance Program (GPMAP). The function of GPMAP is to recruit primary care physicians to accept Medicaid eligible children for screening and treatment.

III. COMPLIANCE REQUIREMENTS

Cross-Cutting Requirements – Please refer to the Division of Social Services cross-cutting section at DSS-0. Note that only the reporting requirements in the cross-cutting section apply to this grant.

A. Activities Allowed or Unallowed

Administrative funds to local DSS offices can be used for expenditures related to administration and training related to eligibility determination. For Medicaid eligibility determination, the county pays fifty percent of the cost associated and the Federal Government pays the other fifty percent of cost.

B. Allowable Costs/Cost Principles

For costs to be allowable for reimbursement, they must be determined to be allowable in accordance with federal and State policy (see OMB Circular A-87 and Division of Medical Assistance eligibility Manuals). Located at the following address: http://www.osbm.state.nc.us/files/pdf_files/BudgetManual.pdf

C. Cash Management

Testing for federal cash management requirements is not required at the local level.

E. Eligibility for Individuals

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 Division of Medical Assistance. 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 recipients 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 Eligibility Information System (EIS) to register and track an application and upon a determination of eligibility or ineligibility, the decision is data entered into the EIS 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 Division has Medicaid Program Representatives that provide technical support and training to local DSS offices on eligibility determination as well as perform special case reviews as assigned to assure that eligibility is determined properly. The Division’s Program Integrity section audits local DSS offices on eligibility determination to insure that the process is being performed correctly. Applications monitors evaluate the application process to assure that benefits are processed accurately and timely.

The county department of Social Services establishes a local case record when a person initially applies for Medicaid. The case file (paper or electronic) is maintained and updated as needed throughout the period of eligibility. Although eligibility determination is evaluated by the aforementioned entities, the auditor should review the local case file to assure that the process is being completed properly by verifying that the file contains (or in the case of electronic data, makes available) the following information:

Signed Application (DMA 5063, DMA 5000, DMA 5008 or DSS 8124)

- Verification documents – these documents are program specific:

DMA 5008 – Aged, Blind and Disabled Medicaid, or

DMA 5000 – Aged, Blind and Disabled Mail-in Application

DMA 5007 – Re-determination form for Aged, Blind and Disabled

DMA 5007 MR – Mail re-determination form

DMA 5007 V – Required form for the DMA 5007 MR

DMA 5063 – Application for Family/Children’s Medicaid

DMA 5063 S – Spanish version of the DMA 5063 (if the English version was not used)

DMA 5063 R – Mail out review form for MIC

DMA 5032 – Verifies presumptive eligibility for Medicaid Pregnant Women

- Notice of rights to transportation assistance (DMA-5046) should be maintained in the eligibility case record. However, with the use of “mail-in” applications/re-determinations, the county is required to send a copy of the form to the recipient when the application is approved, but, a signed copy may not be available if the recipient fails to return the form.
- The transportation record should contain a copy of the DMA-5024, Transportation Request Notification, which specifies the action taken on requests for transportation assistance. Please note that some counties now maintain this form in an electronic format and can provide access to the auditor as needed.

Turnaround documents/Online Reports and Data to Substantiate Eligibility:

The county receives documents from the state for each action taken in the Eligibility Information System. Data is also available in the systems described below. The auditor can substantiate that eligibility matches the information contained on the application or re-determination form by viewing the following:

- DSS-8124I - an application turnaround document that is produced when an application is registered, and then denied or withdrawn.
- Case Profile – a turnaround document that is produced when an application is approved or upon re-approval/termination of benefits for an ongoing case.
- Electronic Verification – The County may access these systems and provide the auditor with data to substantiate issuance of benefits if the turnaround documents are not available.
 - Information regarding the disposition of applications and re-determinations are found on the Notice Registers contained in the Report Distribution System (NCXPTR)
 - Eligibility information is contained in the Applications Data, Individual Data, and Case Data segments of the Eligibility Information System (EIS).

Eligibility Review Document – At the request of the Department of State Treasurer and the Office of State Auditor, the Division has created a tool to assist the auditor with review of basic elements of eligibility during the audit process. The first three pages are the actual review document which the auditor can copy and use for each case reviewed. The attachments provide guidance in verifying the eligibility review items. The review document has been issued to the independent auditors by the Department of State Treasurer and may also be found on the DMA website at the following link:

<http://www.ncdhhs.gov/dma/dcdss/2007/070307eligreviewdoc.pdf>

G. Matching, Level of Effort, Earmarking

For Medicaid eligibility determination, the county pays fifty percent of the cost associated with eligibility determination and the Federal Government pays the other fifty percent.

H. Period of Availability of Federal Funds

Monies are made available on no less than a monthly basis through the North Carolina Division of Social Services.

I. Procurement and Suspension and Debarment

Not passed down to the local level. No testing required.

J. Program Income

Sub-recipient does not earn program income. No testing is required.

L. Reporting

Since Medicaid 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. Information is found in Section D of this State Compliance supplement as DSS-0. Presently the Local DSS offices report the amount of their expenditures for eligibility determination on the DSS -1571. DSS then reimburses the counties for the federal participation percentage by drawing the funds from the State's Medicaid administration grant and electronically transferring the funds to the counties.

M. Subrecipient Monitoring

The local social services department does not subgrant monies.

N. Special Tests and Provisions

Requirements in crosscutting supplement are not applicable at the local level. No further procedures/ tests are necessary.