93.778 **MEDICAL ASSISTANCE PROGRAM**

State Project/Program: MEDICAL ASSISTANCE

U.S. Department of Health and Human Services Administration of Aging

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, 104-20.8 and 104-134; Balanced Budget Act of 1997, Public Law 105-33.

State Authorization: North Carolina General Statutes 108.A-54 through 70.17.

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SFY 2025 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 Division of Health Services Regulation (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 2024-2025)". 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: Oct' 2023-2025)".

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 State compliance supplement must be used in conjunction with the OMB 2025 Compliance Supplement which is scheduled to be issued in May 2025. The OMB supplement will include "Part 3 - Compliance Requirements," for the types that apply, and "Part 6 - Internal Control." If a federal Agency issued guidance for a specific program, this will be included in "Part 4 - Agency Program". The OMB Compliance Supplement is Section A of the State Compliance Supplement.

I. PROGRAM OBJECTIVES

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 children, or members of families with dependent children or qualified pregnant women.

II. PROGRAM PROCEDURES

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: https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices), which lists the requirements of titles XIX and XXI 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 N. C. 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 outline how the State of North Carolina will administer its Medicaid program and enable the State to request Federal Financial Participation (FFP) dollars from the Federal Government, provided that the established plan is followed. The federal guidelines from the State Plan are incorporated into North Carolina's General Statutes through administrative rules adopted under N.C. General Statute 150B. Currently, amendments to the State Plan are drafted by the Division of Health Benefits on behalf of the State. Once these amendments are approved by the Centers for Medicare & Medicaid Services (CMS), they are integrated into N.C. General Statute 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 Health Benefits (DHB) was created within the Department of Human Resources in 1978. In over 40 years of operation, Medicaid's programmatic complexity has paralleled the growth in both program expenditures and beneficiaries. Historically, DHB has allocated a relatively small portion of its budget to 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 to increase its 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) spans from July to June. Since the federal and State fiscal years do not align, different federal service matching rates may apply during overlapping periods of the State fiscal year. The federal match rate for administrative costs remains the same from year to year.

Medicaid operates as a vendor payment program. Eligible families and individuals are issued a Medicaid identification card annually. Program eligible beneficiaries may receive medical care from any of the over 100,000 active providers who are currently enrolled in the program. Providers then bill Medicaid for their services. The Community Care of North Carolina/Carolina

ACCESS (CCNC/CA) primary care case management program is available across the State. Participation in CCNC/CA is mandatory for a majority of Medicaid and Children's Health Insurance Program beneficiaries in North Carolina. Beneficiaries of Medicaid/Medicare are not mandated but may opt to enroll in CCNC/CA. Medicaid beneficiaries who are in long-term care facilities are not enrolled in CCNC/CA at this time.

- CAROLINA ACCESS: A primary care case management model (PCCM), which is characterized by a primary care provider who provides direct primary care services and care coordination.
- CCNC: A state-wide public-private partnership comprised of 14 regional networks that work in concert with Carolina ACCESS providers, care managers, pharmacists, hospitals, health departments, social service agencies, Local Management Entities/ Managed Care Organizations (LME/MCOs), and other organizations. The LME-MCOs manage the care of beneficiaries who receive services for mental health, developmental disabilities, or substance use disorder. These professionals collaborate to deliver a cooperative, evidenced-based, well-coordinated system of care grounded in patient-centered medical homes. The goal is to improve patient experience and health outcomes while reducing Medicaid cost.
- CCNC MANAGED CARE: Starting July 1, 2021, most Medicaid beneficiaries began receiving the same Medicaid services in a new way. Called "NC Medicaid Managed Care," beneficiaries choose a health plan and get care through a health plan's network of doctors. The Medicaid health plans are Standard Plans, Tailored Plans, NC Medicaid Direct, and Eastern Band of Cherokee Indians Tribal Option.
- MEDICAID EXPANSION FOR CHILDREN: A provision included in the North Carolina state budget, approved in July 2022, directed the Department of Health and Human Services to move NC Health Choice beneficiaries to Medicaid. The NC Health Choice program was dissolved effective April 1, 2023, creating a merge for beneficiaries ages 6–18 who were eligible for NC Health Choice to begin receiving Medicaid benefits as part of the Medicaid for Infants and Children program beginning April 1, 2023.
- MAGI ADULT MEDICAID EXPANSION: Effective December 1, 2023, NC Medicaid expanded to cover beneficiaries ages 19 through 64 who earn up to 138% of the federal poverty limit.

For all 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) and the Centers for Medicare and Medicaid Services (CMS) administer 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. The federal participation is received through the State Division of Social Services. The State Division of Social Services also conducts Medicaid beneficiary appeals when the person making the application contests eligibility denials. A disability determination unit of the State's Division of Vocational Rehabilitation Services ascertains whether 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 Beneficiaries to be covered by the North Carolina Medicaid Program. Among these are infants and children under age 21, caretaker relatives of children under age 18, pregnant women, children in foster homes or adoptive homes, persons who meet Social Security criteria as disabled or blind, persons aged 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. Eligible beneficiaries 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, 2014, the Affordable Care Act (ACA) of 2010 gives hospitals the option to determine eligibility presumptively for individuals who appear to qualify for certain Medicaid programs. A qualified hospital may elect to make presumptive eligibility determinations based on preliminary information and according to policies and procedures established by the North Carolina Division of Health Benefits (DHB).

As pertains to beneficiaries 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 perform 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 retroactive 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 DHB in the form of policy instructions in Eligibility Manuals and Administrative Letters located at:

https://policies.ncdhhs.gov/divisional-a-m/health-benefits-nc-medicaid/

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 18, women with breast cancer, family planning program, and the MAGI adult Medicaid expansion program. The two Eligibility Manuals and DHB 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 eligibility policies issued by DHB.

Compliance with the state's eligibility policies and instructions is tested through a statistical case sampling by the Member Compliance team of DHB's Office of Compliance and Program Integrity. DHB's Member Operations Operational Support Team provides 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 applications monitoring unit evaluates county application records to assure that benefits are issued in a timely and accurate manner, and individuals are not discouraged from applying for benefits.

At the State level, DHB contracts with General Dynamics Information Technology, Inc. (GDIT) to perform many of Medicaid's administrative functions. Effective July 1, 2013, GDIT 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 NC Tracks, North Carolina's Medicaid Management Information System (MMIS).

III. COMPLIANCE REQUIREMENTS

Noted below in the following matrix are the types of compliance requirements (Types) that are applicable to the federal program. These Types are either determined by the Federal Agency or the State Agency may have added the Type. This is noted by "Y." If the State determines that the federal requirement does not apply at the local level or if the State modifies the federal requirements, this is discussed in the supplement under the type of compliance requirement. If the Federal and/or State agencies have determined that the type is not applicable, this is indicated by "N."

If the Type is applicable, the auditor must determine if the Type has a direct and material effect on the federal program for the auditee. The auditor must use the OMB 2025 Compliance Supplement, Part 3 and Part 4 (if an OMB supplement is issued) in addition to this State supplement to perform the audit.

CC	A	B	C	E	F	G	H	I	J	L	M	N
Cross Cutting Requirements	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 & Debarment	Program Income	Reporting	Subrecipient Monitoring	Special Tests and Provisions
Y	Y	Y	N	Y	N	Y	N	N	N	Y	N	Y

Crosscutting Requirements - Please refer to the Division of Social Services Crosscutting 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 the cost.

B. Allowable Costs/Cost Principles

For costs to be allowable for reimbursement, they must be determined to be allowable in accordance with OMB 2 CFR, Part 200, the North Carolina State Budget Manual located at https://www.osbm.nc.gov/budget/budget-manual, and DHB's Medicaid Eligibility manual located at https://policies.ncdhhs.gov/divisional-a-m/health-benefits-nc-medicaid/.

E. Eligibility

The auditor should test Modified Adjusted Gross Income (MAGI) and non-MAGI cases for Medicaid eligibility determinations as described below.

The State Medicaid agency or 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 are the designee for Medicaid eligibility determination. Local DSS offices use two manuals as guidelines for Medicaid eligibility determination, 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 for county social service workers on taking and processing applications. The manuals outline the time standards for making eligibility determinations, specify the information needed for individuals or families, and clarify the criteria for determining eligibility or ineligibility. The manuals also specify what information must be provided to individuals applying for program benefits as well as beneficiaries approved for program benefits. Additionally, eligibility manuals include required written and verbal notifications regarding the status of applications or the continuation of benefits. The Medicaid eligibility manuals provide guidance on the annual renewal of eligibility and the specific forms that must be used in the application and renewal process. The instructions explain how information can be obtained and verified, whose income and assets must be counted in the eligibility determination, and what sources of information to use in evaluating ownership interests and the market value of assets. County agency workers are responsible for conducting second party reviews of Medicaid eligibility determination actions, conducted by their agency, for both applications and renewals. County workers use the statewide North Carolina Families Accessing Services through Technology (NC FAST) system to register and track applications. Based on the data entered in NC FAST, system business rules are run resulting in an eligible or ineligible determination. Upon determination of eligible or ineligible, the decision is retained in NC FAST 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 beneficiary. 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. Access the link below and scroll down to 93.778-1. Accompanying documents are available by following the link provided below:

https://www.nctreasurer.com/divisions/state-and-local-government-finance/lgc/local-fiscal-management/annual-audit/compliance-supplements-and-resources/2024-compliance-supplement-section-b-federal-programs#Agency93USDepartmentofHealthandHumanServices82-3867

(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 on applications and renewals were performed (including obtaining any required documentation/verification), 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 Temporary Aid Needy Families (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: Audit the determination related to the date of service for the payment for the individuals selected for the audit.

G. Matching, Level of Effort, Earmarking

For Medicaid eligibility determination, the county pays twenty-five percent of the cost associated with eligibility determination and the Federal Government pays the other seventy-five percent. No local auditor testing is required. The Level of Effort and Earmarking is not applicable.

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 form 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.

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 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 CHIP 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://medicaid.ncdhhs.gov/documents/county/011311-chip/download. 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 CHIP) for which the enhanced payment is being claimed.

N. Special Tests and Provisions

Requirements in the DSS Crosscutting compliance supplement are not applicable at the local level. No local auditor’s testing is required.