MA-3255 NC HEALTH CHOICE
REVISED 07/01/10 – CHANGE NO. 07-10

I. INTRODUCTION AND OVERVIEW

Title XXI of the Social Security Act created a program to provide health coverage for uninsured low-income children from birth through age 18. In North Carolina this program is known as NC Health Choice for Children (NCHC), and is only for children ages 6 through 18. Although administered by the Division of Medical Assistance, NCHC is not a Medicaid entitlement program.

In 1996, Medicaid began to use the existing Carolina Access (CA) infrastructure to build an enhanced managed care plan, Community Care of North Carolina (CCNC) formerly known as Access II & III. CCNC developed networks of CA providers in order to deliver community directed care. Each network developed an administrative entity to plan and administer disease targeted case management services. Each network brings together key participants in the community who provide services to Medicaid and North Carolina Health Choice (NCHC) recipients. These participants include primary care providers, social service agencies, health departments, and others, depending on community resources. CCNC and CA are now combined into one program, Community Care of North Carolina, CCNC/CA.

In 2005, the General Assembly passed legislation requiring NCHC children to be linked to a CCNC/CA provider. It is preferred that each child be linked to a provider participating in CCNC.

The maximum income limit to receive NC Health Choice coverage is 200% of the federal poverty level. Countable income must be greater than the maximum MIC income level but not greater than 200% of the federal poverty level. See Figure 1.

To be eligible for NC Health Choice a child cannot be eligible for full Medicaid benefits or have comprehensive private health insurance. The IMC must always evaluate eligibility for full Medicaid coverage prior to exploring eligibility for NC Health Choice.

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 requires that effective January 1, 2010, citizenship and identity be verified for each US citizen recipient of NCHC. See MA-3331, Citizenship/Identity Data Match for instructions for using the SSA Citizenship Match process to verify citizenship and identity.

With the exception of federally recognized Indian tribes and Alaskan natives, families with countable income greater than 150%, but less than 200% of the federal poverty level, must pay an annual enrollment fee of $50.00 per child, not to exceed $100 per family. The enrollment fee is retained by the county department of social services to offset administrative expenses. In addition, these families must participate in cost-sharing (a copayment) for medical services received. The total annual cost-sharing, including enrollment fees (when applicable), cannot exceed 5% of the family's annual income. SEHP will determine the maximum amount of cost-sharing per family based upon the amount of countable income transmitted from EIS.

(I.)

Families whose countable income is less than 150% of the federal poverty level do not pay an enrollment fee. With the exception of federally recognized Indian tribes and Alaskan natives, these families must participate in cost-sharing (a copayment) for prescription drugs and non-emergency visits to hospital Emergency Rooms.

II. POLICY FUNDAMENTALS AND ELIGIBILITY REQUIREMENTS

The applicant must always meet the following criteria as listed in MA-3230, Eligibility of Individuals Under Age 21, II:

- Ages 6 through 18.
- A resident of North Carolina as defined in MA-3335, State Residence.
- A US citizen, alien in the US who is exempt from the 5 year bar or qualified alien after five years from date of entry as defined in MA-3332, US Citizenship Requirements or MA-3330 Alien Requirements.
- Not incarcerated.
- Provide his Social Security Number or apply for one.
- Be uninsured as defined in IV.B.

A. NC Health Choice Requirements

1. Citizenship/Identity

   In order to receive NCHC, a child must be a citizen of the United States or meet alienage requirements. Refer to MA-3332, US Citizenship Requirements or MA-3330 Alien Requirements. Documentation must be obtained, and appropriate C/I code entered on the 8125.

2. Ineligible for Medicaid/Uninsured

   The child must be ineligible for full Medicaid benefits under any category and not covered by comprehensive health insurance (See procedures in IV.B.). Remember, a person can apply even if covered by health insurance. In order to be eligible the insurance must be stopped. However, if an absent parent is court ordered to provide health insurance, this insurance can not be dropped.

   a. Evaluate initially for MIC, MAF-N or MAF-C. If any recipients are eligible, authorize in the appropriate aid program/category.

   b. Eligibility Under M-AF Medically Needy

      When a child is potentially eligible for MAF-M and NC Health Choice, authorize him for MAF-M if medical expenses to meet the deductible have been incurred as of the date of application.

   c. Community Alternatives Program (CAP) Evaluation

      An individual who requests or receives CAP services may be approved for Medicaid or continue to receive Medicaid, even if a monthly deductible must be met. Do not authorize CAP eligibles for NC Health Choice.

(II.A.2.)

d. Failure to Comply with Procedural Requirements.

Do not evaluate for NC Health Choice when the a/r would be eligible for Medicaid except for failure to comply with procedural requirements such as providing information. The a/r must be financially ineligible for Medicaid to qualify for NC Health Choice.

Failure of a self-employed individual to provide operational expenses does not constitute failure to comply with procedural requirements. Always request the operational expenses. If operational expenses are not provided by the 45th day and income causes ineligibility for Medicaid, evaluate for NCHC. Refer to MA-3300, Income.

3. Income Limit

The income limit to be eligible for NC Health Choice is 100% - 200% of the federal poverty level. The countable income must exceed the maximum MIC (or MPW) income level for age/needs unit and not exceed 200% of the poverty level.

Refer to Figure 1 for income levels**.**

4. Resources

There is no resource test in determining eligibility for NC Health Choice.

5. Long Term Care Facilities

Children who require long term care of more than 12 months in a nursing home, ICF-MR, psychiatric hospital/institution, Psychiatric Residential Treatment Facility (PRTF), or other long term care medical facility (including long-term acute care in a hospital) must be evaluated for eligibility for Medicaid.

6. Emergency Services for Non-Qualified Aliens

NC Health Choice does not provide emergency services for non-qualified aliens or qualified aliens during the 5 year bar. Evaluate the applicant for emergency services under Medicaid.

7. Identification Card

NC Health Choice recipients receive an individual identification card from the claims processing system.

a. Each child in the household who is eligible for NC Health Choice will receive his own identification card.

b. Refer inquiries or requests for replacement cards to the claims processing contractor. The toll-free number is 1-800-422-4658.

(II.A.)

8. Transportation Services

NC Health Choice recipients are ineligible for Medicaid funded transportation services.

9. Enrollment Fee / Cost Sharing

a. Enrollment Fee

If countable family income exceeds 150% of the federal poverty level for the appropriate maintenance level, the family must pay a $50.00 enrollment fee for each child to be covered by NC Health Choice, not to exceed $100.00 per family. The enrollment fee is collected by the county and retained to offset administrative costs for NC Health Choice. Enrollment fees do not apply to federally recognized Indian tribes and Alaskan natives.

b. Cost Sharing

(1) A family with income at or below 150%

A family whose combined countable income is at or below 150% of the federal poverty level must participate in cost sharing. Cost sharing can not exceed 5% of the family's annual income. Copayment amounts are:

(a) $2.00 for each outpatient generic prescription drug and for each outpatient brand-name prescription drug for which there is no generic substitution available.

(b) $5.00 for each outpatient brand-name prescription drug for which there is a generic substitution available

(c) $10.00 for non-emergency visits to the emergency room. If the child is admitted to the hospital or if there is a true emergency then there may not be an emergency room copay.

(2) A family with income above 150%

A family whose combined countable income exceeds 150% of the federal poverty must also participate in cost sharing. Cost sharing can not exceed 5% of the family's annual income. Copayment amounts are:

(a) $5.00 per visit to a provider or outpatient hospital clinic, except for well-child visits, or for age appropriate immunizations or routine preventive dental checkups.

(II.A.9.b.(2))

(b) $2.00 for each outpatient generic prescription drug and for each outpatient brand-name prescription drug for which there is no generic substitution available.

(c) $10.00 for each outpatient brand-name prescription drug for which there is a generic substitution available.

(d) $25.00 for non-emergency visits to the emergency room. If the child is admitted to the hospital or if there is a true emergency then there may not be an emergency room copay.

c. Exemption for Federally Recognized Indian Tribes/Alaskan Natives

Members of federally recognized Indian tribes and Alaskan Natives are exempt from enrollment fees and co payments. The two tribes in North Carolina are the Catawba and the Cherokee.

(1) Members of the Cherokee Tribe have identification cards which verify membership.

(2) Members of the Catawba Tribe do not have an identification card.

(3) Accept the applicant's statement of tribe membership unless questionable. Contact the tribe for verification if necessary.

(4) Do not collect an enrollment fee for these applicants.

(5) The classification code in EIS for tribe members who receive NC Health Choice and whose income exceeds 150% of the poverty level is "S." The classification for those whose income is at or below 150% of the poverty level is "A."

(6) The classification code may be changed from "K" to "S" or "J" to "A" during the enrollment period or at re-enrollment. The change will always be effective the ongoing (EIS Processing) month.

Example: The dss determines on May 25th that a family authorized as "K" classification meets the criteria for "S" or "A" classification. If the classification is entered on or before "pull night" the change in classification will be effective June 1. If the change is entered after "pull night" the change is effective July 1.

Refer to Figure 1 for income levels.

10. Referrals for Fraud/Overpayments

(II.A.10)

Families who provide incorrect income or fail to report insurance information and are authorized erroneously may be required to repay the monthly premium that has been paid for each recipient in the case. Periods of ineligibility are established based upon the same guidelines as for overpayment cases in Medicaid. The guidelines can be found in MA-3535, Recipient Fraud and Abuse Guidelines.

The recipient is required to report to the county changes which may affect eligibility such as acquisition of health insurance or moving out of state. Please note that changes in household income do not affect eligibility for NC Health Choice for Children.

The process for determining the repayment amount differs from that for determining Medicaid. The Division pays a monthly fee to the claims processing contractor for every recipient who receives NCHC. The overpayment is based on the monthly fee amount for months in which the recipient was ineligible for NCHC. The county is responsible for recouping only the monthly fee, not the actual claims that were paid. The monthly fee encompasses all services received during a month.

In establishing the recipient overpayment amount for potential fraud or recipient responsible NC Health Choice ineligible cases, there is no separate evaluation for Medicaid eligibility. The monthly payment rates remain constant, with annual changes in July, if necessary. The overpayment amount is based on the rate in effect for the specific months of ineligibility and the classification.

Refer NCHC cases in which it appears that an overpayment may have occurred to the agency's program integrity staff for investigation.

B. Income Verification

1. Ask the applicant/recipient to provide pay stubs, copies of checks, business records for self-employment or other written proof of income as requested on the application form DMA-5063 or DMA-5063 (Spanish) or re-enrollment form.

2. Use the same base period as defined in MA-3300, Income, for MIC applications.

3. Refer to MA-3300, Income, for exceptions to verification of income.

C. Processing Requirements

1. Processing Standard

   The application processing standard is 45 days.

2. Enrollment Period

   The enrollment period (authorization) is always 12 months for an ongoing case.

(II.C.2.a.)

a. Enrollment period begins the first day of the month of application if the family is eligible in that month, or the first day of the month following application in which child(ren) meet NC Health Choice eligibility requirements and have not received Medicaid (the NCHC effective date and the certification from date must be the same).

b. If the child(ren) received Medicaid in the month of application, the NCHC period begins the first day of the following month in which he did not receive Medicaid.

c. If the child(ren) received NCHC in the month of application, the new NCHC period begins the first day of the month following the month of termination.

(II.)

D. Case Composition

All NC Health Choice eligibles in the household must be reported as one case and have the same case identification number in EIS even if budgeted in separate assistance units. See IV.A. below. This does not apply to individuals eligible for Optional Extended Coverage ("L" classification). See VI.I.3.

E. Automated Inquiry and Match Procedures

NC Health Choice is subject to the same inquiry and matches as applications and redeterminations of eligibility for Medicaid for Infants and Children (MIC).

F. Child Support Referrals

Referrals to Child Support Enforcement are not required. Do not complete an automated referral in EIS for applications designated as NC Health Choice. The applicant may only be required to cooperate with Child Support Enforcement if there is an existing court order or separation agreement requiring the absent parent to provide health insurance (See IV.B.2.). Otherwise, inform the caretaker that services are available for a fee if he or she is interested in pursuing support and of the location of the IV-D office and phone number if interested.

G. Appeals

Appeal rights for NC Health Choice are the same as for Medicaid. Follow procedures in Section MA-3430, Notice and Hearings Process, for hearings and appeals.

H. Enrollment Into Community Care of North Carolina/Carolina Access

Enroll NCHC children (except MIC-L) into Community Care of North Carolina/Carolina Access (CCNC/CA). CCNC/CA provides the recipient with a medical home and Primary Care Provider (PCP) who manages care for continuity and ensures services are provided that are medically necessary. It is preferred that the recipient be enrolled with a PCP who is participating in a CCNC network which provides more managed care services to the recipient. Auto enroll NCHC recipients who fail to select a PCP within a reasonable time period of 10 calendar days. Refer to MA-3435, Community Care of North Carolina/ Carolina Access for instructions on enrollment procedures.

III. APPLICATION PROCEDURES

The application is considered to be an application for medical coverage. Evaluate eligibility for full Medicaid benefits and if ineligible, consider coverage under NC Health Choice.

A. Availability of Application

1. An application may be made at the Department of Social Services, or

2. An individual may pick up an application or request an application by telephone or mail. The application may then be completed and mailed in.

3. Applications are also available at Health Departments and other local entities as determined by the local coalition formed by the DSS and Health Department directors

B. Who May Apply

1. A parent/caretaker or a representative acting on behalf of the parent/caretaker may apply for NC Health Choice coverage for children in the home.

2. An absent parent may apply as representative for children that are no longer in their custody. However, the child's eligibility is solely based upon the financially responsible person with whom the child lives.

3. A child under 19 who lives independently of parental care may apply for coverage for himself (including married and under age 19).

C. The Application Form

An application has been created to use as a joint application for Medicaid/NC Health Choice. Supplements are provided to evaluate for MAF eligibility. This application and supplements replace the previous Family and Children's Medicaid Application and consist of the following:

1. DMA-5063 (DMA-5063, Spanish)- Medicaid/NC Health Choice Application - A detachable application form which may be completed by the IMC, the applicant, or entities trained by the DSS for this purpose. Included with the form is a cover letter explaining Medicaid and NCHC, instructions for self-completion, a notice of Rights and Responsibilities and available services. The form also serves as consent for release of information.

2. DMA-5064 - MIC/NC Health Choice Budget Worksheet, Supplement 1. This form is to be used by the IMC only in determining eligibility for assistance.

3. DMA-5065 - MAF Application/Budgeting Worksheet, Supplement 2. This form is to be used for caretakers/parents; children age 19 and 20, and children ineligible for MIC and NC Health Choice.

(III.C.)

4. Use the following forms to supplement the DMA-5063. DMA continues to stock and supply these forms.

   a. DMA-5043 – Verification Form for Self-Employment Income and Expenses.

   b. DMA-5063BB – Verification of Change in Situation.

D. Obtaining an Application Form from the DSS

1. Anyone who appears in the agency requesting medical or financial assistance must be logged. This includes individuals who request a mail-in application form from the receptionist. Individuals picking up a mail-in application form without speaking with the receptionist do not have to be logged.

   a. Explain to the individual his right to apply for assistance and have him sign, as appropriate, the DMA-5094 or DMA-5094S, Notice of Your Right to Apply for Benefits.

   b. Either the reception staff or the caseworker can provide this explanation and the DMA-5094/DMA-5094S. However, because the form provides instructions regarding the application process, it is strongly suggested that the reception staff complete this task.

   c. Give the individual the original DMA-5094/DMA-5094S and file a copy with the log.

2. Give the individual the DSS-8227/DSS-8227S, Immigrant Access Notice. Either the reception staff or the caseworker can provide this information. However, because the form provides information regarding the application process, it is strongly suggested that the reception staff complete this task. Document on the bottom of the DMA-5094, Notice of Your Right to Apply for Benefits that the DSS-8227/DSS-8227S form was given to the individual.

E. Applications Taken at the DSS

1. Intake procedures are not changed for in-house applications. Treat all applications as if the applicant is applying for Medicaid.

2. If the applicant specifies that he or she only wants to apply for coverage through NC Health Choice explain that the application must be evaluated for Medicaid.

3. The applicant may withdraw the application if he does not wish to have coverage for children who are eligible for Medicaid.

(III.E.3.)

a. Log Procedures

Follow procedures in MA-3200, Initial Contact, to log requests for assistance.

b. Inquiries

Complete the DMA-5095 (DMA-5095S), Medicaid/Work First Notice of Inquiry only if no application is taken for any program.

c. Follow procedures in MA-3205, Conducting A Face-to-Face Intake Interview.

d. Other Services

Explain services available to the applicant. Advise the applicant that if approved for NC Health Choice the claims processing contractor will provide information about covered services and how to obtain them.

F. Processing the Application

All applications are processed as Medicaid until income verification establishes ineligibility for Medicaid, and eligibility or ineligibility for NC Health Choice.

1. Enter the application in EIS as MIC. Do not complete the NC Health Choice indicator unless income has been verified and establishes ineligibility for Medicaid.

2. If the applicant chooses to be interviewed by an IMC, follow procedures in E.

3. Follow all requirements in MA-3210, Verification Requirements for Applications, and MA-3215, Processing the Application, for requesting information, pending periods, etc.

   NOTE: NC Health Choice is excluded from monitoring and the report card. However, applications in which individuals are approved for Medicaid remain subject to monitoring and the report card requirements. Refer to MA-3217, Evaluating County/DDS Performance.

4. NC Health Choice Applications and the Eligibility Information System (EIS)

   a. Source Field Indicator

Mail In DSS Health Dept.
DATE RECEIVED __/__/_____

The application contains a source field (see example above) for specifying whether an application was completed by the county dss, provided by or assisted by the health department or was a mail-in application. State law requires that source of application be tracked. This information must be entered in the "How App Received" field on the 8124 screen prior to disposition of the application.

(III.f.4.)

b. The source of the application is important for tracking purposes and may differ from the way the application is treated for processing. For tracking purposes:

(1) Mail-in

A "mail-in" is any application (other than one obtained from the health department) which is mailed or brought to the dss by the applicant without being interviewed by an IMC. Enter code "M" in EIS.

(2) DSS

A dss application is any application in which a face to face interview is conducted in any location by an IMC. The DSS should supply the DMA-5063 (DMA-5063, Spanish) to its staff at any outstation locations where interviews are conducted. Enter code "D" in EIS.

(3) Health Department

A health department application is an application which is distributed and stamped by the health department, and is mailed or brought in to the dss without a face to face interview being conducted by an IMC. Enter code "H" in EIS.

G. MAF Eligibility

Evaluate for MAF when the applicant requests coverage for an individual who does not meet MIC/NC Health Choice eligibility requirements.

1. The DMA-5065 (MAF Supplement) may be completed by telephone contact with the applicant. A signature is not required. Document that the information was received by telephone.

2. If the applicant cannot be contacted by phone, send the DMA-5097 (DMA-5097, Spanish) requesting that the applicant contact the agency to complete the MAF application.

3. Follow procedures in MA-3210, Verification Requirements for Applications, and MA-3215, Processing the Application, for requesting information and processing the application. The dss is not required to contact the applicant about medical bills to meet an ongoing or retroactive deductible unless the mail-in application indicates a medical need.

H. Evaluate Medicaid for Retroactive Period

Evaluate for retroactive Medicaid when the applicant indicates there are medical expenses in any of the three months prior to application. Enter a separate application in EIS for the retroactive period. This application is subject to monitoring and the report card.

IV. EVALUATING NC HEALTH CHOICE ELIGIBILITY

A. Budgeting Procedures - Initial and Redetermination

1. Follow procedures as outlined in MA-3305, M-AF, M-IC, H-SF Budgeting, for evaluating Medicaid eligibility. Each child must be evaluated separately and determined ineligible for full Medicaid benefits under any category before considering coverage under NC Health Choice.

2. Unrelated children who do not have a parent in the home must be included in the NC Health Choice assistance unit (this is different than MIC).

3. Divide assistance units for budgeting purposes, as in MIC, when one child's income or a stepparent's income causes a child(ren) to be ineligible. See 5.

4. If a family includes MAF/MIC and NC Health Choice eligibles, include the MAF/MIC children in the NC Health Choice needs unit. This is necessary to ensure that the appropriate family income level is applied. Refer to MA-3305, M-AF, M-IC, H-SF, Budgeting, for instructions for establishing the needs unit

5. Countable Income Reported to the Claims Processing Contractor.

   Total net countable family income must be entered in EIS. This income is then reported to the claims processing contractor for purposes of cost sharing and is used to determine if an enrollment fee is due. The claims processing contractor uses this information to assure that cost sharing does not exceed 5% of family income.

   a. Budgeting principles allow children to be determined eligible in separate assistance units. It is conceivable that countable family income could exceed 200% of poverty, yet the children may be eligible for NC Health Choice when budgeted in separate assistance units.

   b. For purposes of transmitting records for all children in the household who are eligible for NC Health Choice to the claims processing contractor, they must be reported together as one case in EIS even if budgeted separately.

   c. When total combined family income exceeds the income level for the needs unit (200% of the poverty level), enter the income level in the countable income field. EIS will not accept a greater amount in the countable income field.

Example: Combined family income consists of countable earned income of $2,700.00 and countable child support of $250 per child for a family of three (1 parent, 2 children - ages 6 and 9) for a total of $3,200.00 monthly. $3,200.00 exceeds the maximum income limit of $3,052.00. However, budgeting separately allows each child to be eligible as only the parent's income and child support for one child is counted - total countable income equals $2,950.

Family income must be reported to the claims processing system. EIS does not accept $3,200.00 for a family of 3 with children in this age group. Enter $3,052.00 (Max. NCHC income level for 3) as the amount of total countable income.

d. Enter countable family income, not to exceed the income level, in the following situations in which children are budgeted separately.

(1) One child's budget has countable income below 150% of poverty and another child's countable income is above 150% of poverty.

(2) Children budgeted separately have income below 150% of poverty but combined family income exceeds 150% of the federal poverty level.

(3) In cases d.(1) and (2) the enrollment fee is $100.

e. Combine the children into one case in EIS and report the total family income. The family is always responsible for enrollment fees and cost sharing if total family income exceeds 150% of the poverty level. If the family refuses to pay the fee, deny the application for all children. Refer to enrollment fee procedures in IV.D. A casehead may not have more than one NC Health Choice case unless the second case has an "L" classification (Optional Extended Coverage).

B. Uninsured

1. Uninsured - To be eligible and authorized for NC Health Choice, the child must be uninsured. This means that he cannot be covered by comprehensive medical insurance.

Comprehensive medical insurance is coverage which provides basic medical care and hospitalization, whether group, private plan, HMO, or other managed care plan. It also includes Medicare, TRICARE (Insurance for Military, formerly known as Champus), insurance for government employees, state health benefit risk pools and other public health plans. **It does not include policies which pay for specific illnesses or pay a daily amount while a person is hospitalized.**

(IV.B.1.)

a. Accept the applicant's statement regarding children covered by insurance and whether insurance has been discontinued. If insurance is to be discontinued and child meets all other eligibility requirements, begin NCHC the 1st day of the following month. See 3.

b. Contact the Medicaid Eligibility Unit of the Division of Medical Assistance at (919) 855- 4000 if it is questionable as to whether a policy is comprehensive.

c. Court Order for Medical Support

An absent parent may be under court order to provide medical coverage or medical support through direct payment. Follow policy in B.2 below.

(1) Consider the child insured if the absent parent is providing coverage through a medical insurance policy. If the plan is located outside of the child's county of residence, refers to e, below.

(2) Consider the child uninsured if the absent parent is not providing coverage under a medical insurance policy even if he or she has been ordered to make direct payment for medical care.

d. School Accident Policies

School accident policies are not comprehensive insurance and do not prevent a child from being eligible for NC Health Choice. Enter the policy in EIS on a DMA-2041. The system will accept insurance information in this situation.

e. Health Plans Located Outside of County of Residence

(1) A child covered by a full service Health Maintenance Organization (HMO) which does not have a network of medical providers in the county in which the child lives is considered uninsured for purposes of determining eligibility for NC Health Choice for Children.

(2) Children are sometimes covered by plans located in another county or state. This often happens when an absent parent provides coverage through a plan obtained through employment. Use the following steps to determine if the child is insured:

(a) Determine if the coverage is through a full-service HMO which is licensed in North Carolina and the county of residence. Contact the HMO to determine the coverage area and if a medical provider network exists in the county in which the child lives (the HMO may be licensed but not providing services in the county).

(b) The child is uninsured if the plan does not have a provider network in the child's county of residence. Document this in the recipient's record.

f. A child may also be covered by:

(1) An indemnity plan. Many indemnity plans only pay a certain amount per day for hospital care. The child is only considered insured if the plan provides comprehensive coverage as defined above.

(2) A Preferred Provider Organization in which the insured is required to go to certain doctors for coverage to be provided. If the child can obtain medical care under the plan in the county in which he lives, he is considered insured.

2. Cooperation In Enforcing an Existing Court Order to Provide Health Insurance

Do not complete an automated child support referral in EIS for applications designated as NC Health Choice (See II.F.above). If a child has a parent living outside of the home, ask if the absent parent has been ordered by a court to provide health insurance, or if there is a separation agreement which specifies that the absent parent will provide health insurance. Always complete an ACTS inquiry to search for an existing case.

a. If the answer is NO, and there is not an existing case in ACTS, document the record. Never require an applicant to cooperate with Child Support Enforcement unless there is already an existing order or separation agreement requiring that the absent parent provide health insurance.

b. If the answer is YES:

(1) If the applicant says the absent parent is complying with an existing court order or separation agreement refer to IV.B.1.c.

(2) If the applicant says that the absent parent has failed to comply with an existing court order or separation agreement to provide health insurance:

(a) The custodial parent must agree to notify and cooperate with the child support enforcement agency in enforcing the order.

(b) Do not authorize NC Health Choice if the custodial parent fails to cooperate.

Note: Deny the NC Health Choice application on the 45th day of the processing period if an applicant fails to respond to a request about whether there is an existing court order or separation agreement requiring the absent parent to provide health insurance.

(IV.B.2.)

c. Verify cooperation as follows:

(1) Online verification into the ACTS system

The ACTS system contains information about court orders for support which are established in North Carolina by Child Support Enforcement.

It also contains information about new or modified orders which are not established by Child Support Enforcement.

(2) Verify through the ACTS system whether there is an existing order. Consider the custodial parent to be in compliance with requirements to cooperate if the order appears in the ACTS system.

(a) To verify if an order exists in the ACTS system, use the Social Security number of the applicant/recipient. If the a/r has ever been assigned an ID number and is part of the Common Name Database, (CNDB) you can access information on him by entering other identifying information such as his first and last names.

(b) Refer to EIS 1109 for instructions on how to access the Online Verification system.

(3) Information Unavailable Through ACTS

If the existing court order does not appear in the ACTS system, or if there is a separation agreement specifying that the absent parent provide health insurance, require the custodial parent to apply for services with Child Support Enforcement.

(a) Inform the custodial parent that he or she will be required to pay an application fee of $25.00. The custodial parent must provide the receipt showing payment of the application fee as proof of agreement to cooperate with the order.

(b) Deny the NC Health Choice application on the 45th day of the processing period if the custodial parent fails to provide proof of agreement to cooperate. Use denial code "A2."

(c) If the custodial parent cannot obtain an appointment within the 45 day processing period, he or she must bring a statement from the child support office indicating that an appointment has been scheduled.

1) Accept this as tentative proof of cooperation and approve the application if all other eligibility factors are met.

2) Flag the case for follow-up during the week after the scheduled appointment and notify the custodial parent to bring in the receipt within 12 calendar days.

3) If he or she fails to provide the receipt, send timely notice to propose termination of the case.

4) Use code 23 (There is no longer an eligible child in the home) to terminate the case if the receipt is not provided during the timely notice period.

3. Procedures to Follow When Insurance is Voluntarily Discontinued

Comprehensive medical insurance coverage for a child must be discontinued before NC Health Choice can be authorized. As soon as it is known that a child has comprehensive medical insurance coverage, notify the a/r that verification of terminated insurance must be provided by the application due date. When a freeze on new enrollment occurs, a family should not discontinue insurance until the case is reactivated.

a. Send a DMA-5097 (DMA-5097, Spanish) requesting verification of discontinued insurance coverage. Explain to the a/r that insurance coverage must end by the last day of the month in which the 45th day falls. In addition, explain to the a/r that if the insurance does not terminate on the last day of the month, the child may be without coverage as NC Health Choice cannot begin until the 1st of the next month.

b. Send a second DMA-5097 (DMA-5097, Spanish) if verification of discontinued insurance is not provided within 12 calendar days.

c. Verify discontinued insurance coverage by verbal or written contact with the a/r or the insurance company. If verification of discontinued insurance is provided by the 45th day, authorize NC Health Choice effective the 1st of the month after the insurance coverage ends but no later than the month following the month of the 45th day. The Certification From Date and the Medicaid Effective Date must be the same. The Claims Unit charges 100% to county funds when county has incorrectly authorized person for Medicaid and EIS shows authorization for NCHC if a provider demands Medicaid payment based on issuance of Medicaid Identification card.

d. Evaluate for MAF-M if insurance coverage ends prior to the last day of the month and the a/r indicates there are medical bills to meet a deductible.

e. If verification of discontinued insurance is not provided by the 45th day, deny the application, provided 2 requests with 12 calendar days in between have been sent.

(IV.)

C. Classification for NC Health Choice

1. Classification Code "J"

   Use this code for NC Health Choice cases that have income at or below 150% of the poverty level. While these families do not pay an enrollment fee, they are responsible for cost sharing.

2. Classification Code "K"

   Use this code for NC Health Choice cases that have income which exceeds 150% of the federal poverty level. These families pay an enrollment fee and cost sharing.

3. Classification Code "A"

   Use this code for NC Health Choice cases that are members of a federally recognized Indian tribe or Alaskan Native whose income is at or below 150% of the federal poverty level. These families have no enrollment fee or cost sharing.

4. Classification Code "S"

   Use this code for NC Health Choice cases that are members of a federally recognized Indian tribe or Alaskan Native whose income exceeds 150% of the federal poverty level. These families have no enrollment fee or cost sharing.

5. Classification Code "L"

   Use this code to designate a child(ren) whose family income at the NC Health Choice re-enrollment is greater than 200% but equal or less than 225% of the federal poverty level (including members of a federally recognized Indian tribe). The family has the option of "buying-in" to coverage by paying the premium for a period not to exceed one year. If erroneous classification code is entered, see VI.D.

D. Enrollment Fee

Families with countable income over 150% of the federal poverty level must pay an enrollment fee of $50.00 per child eligible for NC Health Choice, not to exceed $100.00 per family. This does not apply to federally recognized Indian tribes or Alaskan Natives. Refer to the chart in Figure 1 to determine if an enrollment fee is due. When a freeze on new enrollment occurs, a family does not pay the fee until the case is reactivated.

1. Determine if an Enrollment Fee is Due

   a. Calculate the amount of total countable net income for the individuals in the needs unit(s). If children have been budgeted separately use the income for the total number of people in the needs unit(s) which will be entered in EIS (not to exceed 200% of the poverty level) and reported to the claims processing system. See IV.A.

(IV.D.1.)

b. Compare this amount to the chart in Figure 1. If total countable income exceeds the 150% amount for the number in the needs unit, an enrollment fee is due.

2. Notification of Enrollment Fee

Upon determination that an applicant(s) is eligible for NC Health Choice and the family income exceeds 150% of the federal poverty level, notify the applicant in writing via the suggested Status Form Letter. (Figure 4)

a. Give the parent/caretaker at least 12 calendar days to pay the fee.

b. If 12 calendar days exceeds the 45 day processing standard, pend until you receive notice of payment, or, until the first workday after the due date for payment.

Allow for the exclusion of days when income verification is received and the application must pend beyond 45 days in order to notify the applicant and receive the North Carolina Health Choice (NCHC) fee. The exclusion of days will begin on the day of the request for the fee and end on the day the fee is received or on the 13th calendar day, whichever occurs first. Use FEE code for this purpose. Refer to MA-3215, Processing the Application.

c. Inform the office or individual responsible for collecting the fee of the date by which the fee must be paid and by when the IMC must be informed of payment or non-payment.

3. Payment/Collection/Notification

a. Each county is responsible for establishing procedures for collection of enrollment fees.

(1) Determine which methods of payment (i.e. cash, check, money order) are acceptable. If the county chooses to accept personal checks, they cannot terminate the NCHC case if the check does not clear the bank.

(2) Partial payment is not allowed. The entire fee must be paid prior to approval of the application.

b. Determine what office and/or person(s) are responsible for collection of enrollment fees for NC Health Choice. This decision must be communicated in writing to all staff who are determining eligibility for NC Health Choice.

c. Establish procedures for communication between the IMC staff and the fee collector for:

(1) Identification of case/individuals who must pay an enrollment fee, and

(2) The amount of the fee due, and

(3) The date by which the fee must be paid, and

(IV.D.3.c.)

(4) The time frame and method for notification to the IMC that the fee has been paid, or

(5) Notification that the parent/caretaker refused to pay, or failed to pay the fee by the date due.

d. The enrollment fee may be paid with funds provided by individuals or organizations other than the applicant, including county funds. The total of enrollment fees due offset the county's reimbursement for administrative purposes.

4. Decision Following Payment or Non-Payment

a. Upon receipt of notification from the fee collector that the enrollment fee has been paid, authorize eligibility according to instructions in V. below.

b. Upon receipt of notification from the fee collector that the parent/caretaker refused to pay the fee, or failed to pay the fee, deny the application according to instructions in V. below.

c. If no communication has been received from the fee collector on the first workday following the date on which the fee was due, contact the collection agency/person to verify status. If payment has not been made, document the contact and deny the application according to instructions in V. below.

V. DISPOSITION OF APPLICATION

A family may include both Medicaid and NC Health Choice eligibles. Refer to EIS 4300 for instructions as well as codes for the disposition of applications as NC Health Choice. EIS can send an automated notice of approval, denial, or withdrawal.

A. Social Security SOLQ Procedures For All Children Eligible for NCHC

It is important that Social Security numbers (SSN) be entered correctly in EIS. Take the following steps to ensure the correct SSN is entered for NCHC recipients.

1. Verify each child's SSN by using the SOLQ process. Refer to EIS 1107. Document findings in the case record.

2. Check the SSN keyed for ID assignment. Verify that the correct SSN has been keyed and that it belongs to the child. Verify that the numbers have not been transposed.

3. Before keying an approval for NCHC, or releasing an 8125 that may have been placed on hold because of a second party review, verify again that all children have the correct SSNs entered by reviewing the 8124 online in EIS. This can be done by using the "AD" function to avoid deleting the pending 8125.

(V)

B. All Children Are Eligible for Medicaid

If all applicants are eligible for MIC or MAF, approve Medicaid eligibility in the appropriate aid program/category.

C. All Children Are Eligible for NC Health Choice

1. Approve NC Health Choice using the approval codes in EIS 4300 unless the application has pended until the 45th day.

2. If it is the 45th day of the processing period, override the notice on the 8125 screen and send a manual notice approving eligibility for NC Health Choice.

3. This will prevent the county from exceeding the application processing standards (EIS registers an automated notice sent on the 45th day as sent the next workday).

D. If some children are eligible for MIC/MAF and others for NC Health Choice (or pending disposition):

1. Approve all Medicaid eligible children on the original application. Refer to the EIS Codes Appendix.

2. Enter an application for the remaining children evaluated as NC Health Choice.

   a. Approve the application if income for NC Health Choice has been verified. Use a manual notice if the application is being approved on the 45th day (see C. above).

   b. Pend the application if additional information or payment of an enrollment fee is required. Refer to IV.D. for enrollment fee procedures.

E. Children Who Are Ineligible for Medicaid

Enter the appropriate denial code to deny the application.

F. Children Who Are Ineligible for NC Health Choice

Enter the appropriate denial code to deny the application unless the application has pended until the 45th day. If it is the 45th day of the processing period, override the notice on the 8125 screen and send a manual notice denying eligibility for NC Health Choice. This will prevent the county from exceeding the application processing standards (EIS registers an automated notice sent on the 45th day as the 46th day).

(V.)

G. Community Care of North Carolina/Carolina Access (CCNC/CA)

EIS requires (at application and review) a valid (active on the Managed Care Provider Database) CCNC/CA Primary Care Provider (PCP) number or Exempt number be keyed in the PCP/Exempt number field on the DSS-8125 for each NCHC child. See Manual Section MA-3435, Community Care of NC/Carolina Access.

H. Open/Shut Applications

NC Health Choice applications may be approved as open/shut if necessary (i.e. child dies or moves out of state prior to completion of application). Do not enter information into the PCP/ exempt number field for an NCHC open/shut approval, even if there is also an ongoing application for this case.

VI. ONGOING CASE MAINTENANCE

Always inform the applicant to report changes in situation. How the dss reacts to the reported change is outlined below. Figure 5 is a chart with instructions for changes in situation.

A. Changes in Income

Do not apply reported changes in income until the end of the 12 month enrollment period. Increases or decreases in household income do not affect eligibility or cost sharing for NC Health Choice. However, the recipient is notified as part of the application process to report changes in situation as it may not be known prior to disposition whether approval is for NC Health Choice or for one of the Medicaid categories. Document reports of a change in income in the record.

1. Most children will remain eligible under NCHC for the full 12 month certification (continuous eligibility) even if a change in income would result in Medicaid eligibility.

2. At re-enrollment, compare verified income with reports of changes. Question discrepancies unless the reason is clear, such as the number of weeks worked is higher or lower.

B. Change of Address

1. Change the address in EIS only if the entire assistance unit's address changes.

2. When a child in a multiple a.u. leaves the home to live elsewhere (e.g., goes to live with another parent) he remains eligible in the established a.u. for the entire 12 month enrollment period as long as he lives in NC.

   a. Document the move in the case record. (Question the parent/caretaker about his location if he is included on the reenrollment form at the end of the 12 months.)

   b. Do not make changes to the case in EIS. See Figure 5 at the end of section.

   c. Remind the caretaker to give the child's ID card to him or to his new caretaker.

d. At re-enrollment, send a DMA-5063/DMA-5063S or DMA-5063R/DMA-5063S to the child at his new address.

C. Changes Which Result in Termination

Note: Do not refund enrollment fees when recipients are terminated or deleted from the NC Health Choice assistance unit.

Terminate (or delete) a recipient from NC Health Choice coverage who:

1. Acquires comprehensive health insurance or Medicare.

2. Moves out of the state. If recipient moves back to the state within original 12 month enrollment period and applies for NCHC again, assign a new enrollment period. Do not use the old case ID. Worker should complete a new application with a new case ID.

3. Is deceased.

4. Requests termination of assistance.

5. Turns age 19. Evaluate for other Medicaid categories, including the Family Planning Waiver.

6. Is incarcerated.

7. Becomes eligible for Work First.

8. Is removed from the home by the department of social services for placement purposes and is eligible for HSF or IAS.

   a. When a child is placed in foster care, delete the child (or terminate NC Health Choice if only one child) and approve as HSF or IAS.

   b. If the child is returned to the home of the parents within the same 12-month enrollment period terminate HSF or IAS. Complete an administrative reapplication against the terminated NCHC case id (or add to existing a.u.) to authorize NCHC for the remainder of the enrollment period. The original date of application and original certification from date must be entered into EIS in order for the claims processing contractor to calculate the correct 12-month enrollment period. Authorize the month after Medicaid terminates. See EIS-4300.

   c. Do not collect an enrollment fee.

(VI. C.)

9. Is approved for SSI Medicaid.

   a. EIS automatically terminates/deletes the child and authorizes for MAD.

   b. If the child is subsequently terminated from SSI during the same 12-month enrollment period, complete an administrative reapplication against the terminated NCHC case id (or add to existing a.u.) to authorize NCHC for the remainder of the enrollment period. The original date of application and original certification from date must be entered into EIS in order for the claims processing contractor to calculate the correct 12-month enrollment period. Authorize the month after Medicaid terminates. See EIS-4300.

   c. Do not collect an enrollment fee.

10. Is eligible for CAP services or Medicaid for payment of long term care services. (Contact the Claims Analysis Section at DMA (919) 855-4045 if Medicaid eligibility needs posting for months in which the recipient was authorized for NC Health Choice).

11. Is pregnant and eligible for coverage under MPW, MIC, or MAF.

   a. Complete an eligibility determination to assure that the recipient is eligible for Medicaid. Verify pregnancy and document eligibility in the case record.

   b. Treat as an administrative application. Enter an unsigned 8124 in EIS. The date of application is the date the recipient requests coverage.

   c. Approve ongoing eligibility effective the month after NC Health Choice terminates. Do not attempt to update eligibility in EIS for months already covered by NC Health Choice.

   d. Contact the Claims Analysis Unit in DMA at (919) 855-4045 if "retroactive" coverage of pregnancy related services is needed. A Claims Analyst will take the information necessary to provide coverage.

   e. Refer further inquiries about pregnancy related services to Claims Analysis.

   f. If a pregnant woman is deleted from NCHC, goes to MPW, and then is eligible again for NCHC, use the original 12 month enrollment period if still in that 12 months. Complete an administrative reapplication against the terminated NCHC case id (or add to existing a.u.) to authorize NCHC for the remainder of the enrollment period. The original date of application and original certification from date must be entered into EIS in order for the claims processing contractor to calculate the correct 12-month enrollment period. Authorize the month after Medicaid terminates. See EIS-4300.

(VI.C.)

12. Is pregnant and presumptively eligible.

    a. Hold the presumptive eligibility determination until the pregnant woman requests Medicaid or until the last workday of the month following the month of the presumptive eligibility determination.

        (1) If the pregnant woman requests and is eligible for Medicaid proceed with items b. and c. below. This is an administrative application. A signed application is not required.

        (2) If the woman does not request Medicaid by the last workday of the month following the month presumptive eligibility is determined or is determined ineligible for Medicaid, she is eligible only for presumptive eligibility coverage. Call the Medicaid Eligibility Unit at DMA, (919) 855-4000, for instructions on entering presumptive eligibility coverage.

    b. Once eligibility is determined for MPW, send an adequate notice to terminate North Carolina Health Choice.

    c. Follow same procedures as in 11.a. through e above.

        Send an automated timely or adequate notice as appropriate. Always document the circumstances and reason for termination in the case record.

D. Classification Changes

1. Cases Authorized In Error for NCHC that should be MIC-N, MIC-1 or MAF

    a. Overlay existing "J", "K", "S", or "A" classification only for CAP, long-term care recipients, or coverage of pregnancy related services as specified in C.10., 11., and 12.

    b. Begin coverage on the first day of the month following the month in which NCHC coverage terminates. Please Note: If the error is found within two months of re-enrollment, make the change at re-enrollment.

2. Cases Authorized In Error For Incorrect NCHC Class

    If a NCHC case is approved into an incorrect classification code in error, the code can be changed during the 12 month enrollment period, effective with the ongoing month. If the change is within the two months prior to re-enrollment, make the change at re-enrollment.

    Counties will be subject to being charged the premiums paid for any months in which the recipient(s) is authorized in error.

(VI.D.2.)

a. If "J" code is erroneously used instead of "K" code, the classification code may be changed during the enrollment period or at re-enrollment. The change will always be effective the ongoing (EIS Processing) month. If the error is found within two months of re-enrollment, make the change at re-enrollment.

(1) Send a manual timely notice.

(2) The county will be responsible for any possible overpayments.

(3) The county cannot request that the family pay an enrollment fee during the current enrollment period.

b. If "K' code is erroneously used instead of "J" code, the classification code may be changed during the enrollment period or at re-enrollment. The change will always be effective the ongoing (EIS Processing) month. If the error is found within the two months prior to re-enrollment, make the change at re-enrollment.

(1) Send a manual adequate notice.

(2) The county will be responsible for refunding the enrollment fee to the client. There is no recourse for the family to be reimbursed for any prescription co-payments they may have been required to pay during the time the case was in error.

c. See II.A.9.c., Exemption for Federally Recognized Indian Tribes/Alaskan Natives, for changes concerning "S" and "A" codes.

3. Cases Authorized in Error for Medicaid that should be NCHC

The Claims Unit charges 100% to county funds when the county has incorrectly authorized an individual for Medicaid, and EIS shows authorization for NCHC if a provider demands Medicaid payment.

E. Transfer to Another County

If all individuals in the case move to another county:

1. County 1 (the original county of residence)

Transfer the case following procedures and time frames outlined in MA-3340, County Residence.

(VI.E.)

2. County 2 (the receiving county)

   a. Review the case when eligibility is redetermined at the end of the 12-month enrollment period unless the recipient reports a change in situation that affects NC Health Choice eligibility.

   b. Do not require the family to pay any additional enrollment fee when transferring to another county.

      Note: Do not make changes to the case if only a portion of the assistance unit moves to another residence, including moves to another county. County 1 should send a DMA-5063 (DMA-5063, Spanish) for the children at the new address.

F. Individuals Placed in Nursing Facility/ICF-MR or PRTF

An individual who will receive medical treatment in a long term care facility or Psychiatric Residential Treatment Facility must be evaluated for eligibility for Medicaid. If the child is eligible for Medicaid for payment of long term care:

1. Delete the child from the NC Health Choice assistance unit.

2. Enter an administrative 8124 screen in the appropriate Medicaid category.

3. Complete the 8125 screen to authorize Medicaid. This application counts in the processing standards.

G. Changes In Household Composition

"Continuous eligibility" requires that children be treated in the following manner when a change in household situation occurs which normally would affect Medicaid eligibility.

Note: Contact an EIS consultant if you have questions concerning the classification.

1. A child authorized for NC Health Choice remains in the same NC Health Choice case for the established 12-month enrollment period unless he becomes ineligible for NC Health Choice as specified in C above.

   a. If the child becomes ineligible for NC Health Choice, delete him from the assistance unit.

   b. Update the needs unit and income level.

   c. Do not update the classification code or the total countable income of the household until redetermining eligibility at the end of the enrollment period.

   d. The remaining members of the a.u. continue to receive NC Health Choice for the remainder of the enrollment period. This is true even if countable income now exceeds the maintenance allowance. The system does not edit changes in situation.

(VI.G.)

2. When a child who is not authorized for NC Health Choice or Medicaid enters a NC Health Choice household during the 12 month enrollment period (child age 6 through 18 comes to live with parent or guardian):

   a. The family must make an application for the new child.

   b. Evaluate for Medicaid eligibility. If the child is ineligible for Medicaid:

      (1) Add the child to the NC Health Choice case for the remainder of the enrollment period if the child is uninsured. Do not count his income.

      Note: Add the child to the NC Health Choice case even if the caretaker is not financially responsible for the child.

      (2) Update the number in the needs unit and the income level.

      (3) Do not update the classification code or total countable income until redetermining eligibility at the end of the enrollment period (even if the child has his own income).

      (4) Do not charge an additional enrollment fee.

3. When a child who is authorized for NC Health Choice (household #1) moves into a household which is not authorized for NC Health Choice (household #2):

   a. The child remains authorized in the original case (household # 1) until the end of the enrollment period.

   b. Do not make any changes in EIS.

   c. Remind the casehead (household # 1) to give the child's ID card to the child or head of household # 2.

   d. At the end of household # 1's enrollment period, the head of household # 2 must apply for the child.

4. When a child who is authorized for NC Health Choice (household #1) moves into another NC Health Choice household (household #2):

   a. The child remains enrolled in the original case until the end of the enrollment period of household #1. Do not make changes in EIS. Remind the head of household # 1 to give the ID card to the child or head of household #2.

   b. At the end of household # 1's enrollment period:

(1) Household #2 can apply to have the child added to their NC Health Choice case for the remainder of the re-enrollment period if the child is ineligible for Medicaid without re-determining eligibility.

(2) Add the child to household # 2's existing enrollment without redetermining eligibility. Update the number in needs unit and income level. Do not make changes to the classification code or income, even if the child has countable income.

c. At the end of household # 2's enrollment period, redetermine eligibility for the children listed on the reenrollment form. Evaluate Medicaid eligibility before considering NC Health Choice.

5. If a parent who is a member of the budget unit but not authorized for NC Health Choice leaves the household on a permanent basis make no changes to the case.

H. Automated Re-enrollment in NC Health Choice

1. Families must re-enroll in NC Health Choice each year. EIS automatically sends a reenrollment notice and application to each recipient during the first week of the 11th month of the current enrollment period. Refer to automated redetermination/re-enrollment procedures in MA-3420, Re-Enrollment.

2. If the form is returned, evaluate for eligibility for Medicaid first as family composition and/or income may have changed.

a. If any children are now eligible for full Medicaid benefits, authorize under the appropriate category following instructions in EIS 2000 for processing applications for Medicaid.

b. If the child(ren) continues to be eligible for NC Health Choice, authorize for another 12 month enrollment period following instructions in EIS 4300, Part Five, for re-enrolling a North Carolina Health Choice case.

c. If an enrollment fee is due:

(1) Send the family notice of the annual enrollment fee if countable income exceeds 150% of the federal poverty level (See procedures in IV.D.above.

(2) Allow the family at least 12 calendar days to pay the enrollment fee.

(3) Follow instructions in EIS 4300 to approve or deny the re-enrollment period.

3. Failure to Return Reenrollment Form

If the recipient does not return the re-enrollment form or the review is not completed, refer to MA-3420, Re-Enrollment, for procedures on termination.

(VI.)

I. Optional Extended Coverage (200 - 225% of Federal Poverty Level)

If family income at re-enrollment is greater than 200% but equal to or less than 225% of the federal poverty level, the family has the option to pay the full monthly premium charged by the claims processing contractor and remain on NC Health Choice for a period not to exceed one year. Complete the following steps when determining eligibility:

1. Verify that income falls in the appropriate range (See the income chart –Figure 1).

2. Send a manual timely notice. Inform the family that:

   a. Coverage under NCHC will stop, and

   b. The family may purchase coverage for the children under Optional Extended Coverage, and

   c. The claims processing contractor will send additional information about continued coverage.

3. At the end of the timely notice period, transfer the case to Optional Extended Coverage in EIS for 12 months.

   a. Enter adequate change code 53 (see EIS 4300 for instructions). Do not override the notice.

   b. Change the classification to "L."

   c. Update the certification period in EIS.

   d. EIS generates an automated notice to the recipient informing the family of eligibility for optional extended coverage.

   e. The notice states that the claims processing contractor will contact the family about the option to purchase coverage and inform them of the premium amount.

   f. Children who are authorized as "L" may be in a separate case from other children in the home who are eligible as "J", "K", "S" or "A." The "L" children must remain in the original NCHC case. Open a new case for the "J", "K", "S" or "A" children.

4. The family should contact Blue Cross/Blue Shield of North Carolina (BCBSNC), toll-free at 1-800-422-4658 if they have not received an enrollment letter within a week after being notified by the agency that a family member is eligible for Optional Extended Coverage. BCBSNC can also answer any questions about Optional Extended Coverage that the family may have. Refer any calls regarding change of address, premium payment, identification card, etc. to this number.

(VI.I.)

5. The family is not "locked in" to Optional Extended Coverage during the certification period. If the family contacts the county and wishes to apply for Medicaid or NC Health Choice for Children.

   a. Have the family complete form DMA-5063 (DMA-5063, Spanish) to reapply for benefits.

   b. Evaluate for Medicaid or NC Health Choice for Children coverage.

   c. Refer to instructions in VI.I.9 below for authorizing MIC "J", "K", "S", "A" or "N" for months in which the case was in Optional Extended Coverage status. The IMC must call EIS to verify if the family has paid premiums for any of the months for which coverage is requested and follow instructions to authorize coverage.

      Note: Once the family is eligible for Optional Extended Coverage, an increase in income over the 225% of poverty limit does not make the family ineligible during the 12 month enrollment period.

6. Unless the family reapplies for Medicaid/NC Health Choice for Children, the case will remain as MIC "L" in EIS for 12 months regardless of whether the family chooses Optional Extended Coverage. At the end of the 12-month enrollment period, EIS will automatically terminate the case. Refer to MA-3420, Re-Enrollment.

7. Families are not allowed to re-enroll into Optional Extended Coverage. A family may only qualify for Optional Extended Coverage again if they later receive NC Health Choice for Children for another 12-month enrollment period, and, are again ineligible for NC Health Choice for Children at re-enrollment due to increased income.

8. A case which terminated with a "J", "K", "S" or "A" classification may be reopened into "L" classification if criteria in MA-3420, Re-enrollment, are met.

   a. Complete an administrative reapplication against the terminated case. Enter an unsigned 8124 in EIS. Enter "Y" in the ADMIN field on the DSS-8124 screen.

   b. Enter disposition code B5.

   c. Override the automated notice.

   d. Send a manual adequate notice informing the family – "Your child(ren) no longer qualifies for NC Health Choice for Children due to the income limit. You may opt to pay the full NCHC premium for coverage of the child(ren) for 12 months after loss of NCHC. You will receive additional information from Blue Cross and Blue Shield of NC. If you do not receive a letter from BCBSNC within one week, contact them at 1-800-422-4658."

(VI.I.)

9. Authorizing MIC "J", "K", "N", "S", "A" for a Case Which Is Currently MIC "L"

Recipients potentially eligible for Optional Extended Coverage - (MIC "L") are entered in EIS with a 12 month certification period. Neither DMA nor the county dss knows if the family is actually paying premiums and receiving coverage. Only the claims processing contractor can provide this information

If child(ren) are authorized as MIC "L", follow these procedures when a family applies for a Medicaid program or NCHC:

As soon as the application is taken/received and the Income Maintenance Caseworker is aware that the child(ren) is potentially eligible for Medicaid or NC Health Choice ("J", "K", "S", or "A"), he or she must contact a DMA EIS Consultant to verify if the family has paid premiums to the claims processing contractor.

a. EIS confirms premium payment status with the claims processing contractor and informs the IMC if premiums have or have not been paid. This may take a few days. **Do not wait until the 45th day to call EIS.**

b. If no premiums were paid:

(1) Enter as a reapplication against the active case.

(2) Evaluate for retroactive coverage (up to 3 months) if potentially Medicaid eligible.

(3) Evaluate for ongoing coverage (12-month certification).

(4) If eligible, terminate the Optional Extended Coverage in EIS. A termination notice is not required.

(5) Approve any retro months of Medicaid for which the child(ren) are eligible and an ongoing certification period of 12 months.

(6) Once the approval has processed in EIS, the IMC must contact DMA Claims Analysis Unit to request overlay of MIC "L" class with Medicaid or NCHC for approved months of coverage up to the "ongoing" month.

Example of Ongoing Month: From the day following pull in January through pull night in February, the ongoing month is March. From the day following pull in February through pull night in March, the ongoing month is April. The Claims Analysis Unit will overlay "L" coverage with the classified coverage as requested so that all data contained in the system and transmitted to the claims processing contractor is correct.

(VI.I.9)

c. If premiums have been paid:

(1) EIS informs IMC of months for which premiums have been paid.

(2) Do not approve coverage for months in which a premium has been paid as child is already covered by NCHC.

(3) Enter a new application, using a new case ID.

(4) Evaluate for ongoing coverage (12-month certification).

(5) If eligible, terminate the Optional Extended Coverage in EIS. A termination notice is not required.

(6) The termination in EIS does not terminate the Optional Extended Coverage in the claims processing system. EIS notifies the IMC of the termination date when the claims processing system indicates the coverage is canceled.

(7) Approve coverage effective with the first month following the termination month in the claims processing system.

(8) Enter an ongoing certification period of 12 months effective with the first month in which premiums were not paid.

J. Medicaid Re-Enrollment and Terminated Medicaid/Work First Cases

When completing a re-enrollment or reviewing ineligible Medicaid/Work First cases for ongoing Medicaid, evaluate eligibility for NC Health Choice if the case is ineligible for Medicaid in any other aid program category. (Refer to MA-3410, Terminations and Deletions, and MA-3420, Re-Enrollment.) Terminated cases include cases ineligible due to income or other eligibility factors as well as Transitional Medicaid cases which terminate due to income, failure to return the Transitional Benefit Report or the expiration of the 12-month eligibility period. See MA-3405, Twelve Months Transitional Medicaid.

During the re-enrollment process:

1. Concurrently reverify income and determine whether the recipient(s) has private health insurance. See IV.B., when reviewing for health insurance.

2. Health Insurance

a. If the child does not have health insurance continue processing the re-enrollment following instructions VI.J.3.a. below.

(VI.J.2.)

b. If the child has health insurance, verification of the termination of the health insurance must be received by the deadline to complete the re-enrollment timely.

(1) It must be terminated by the end of the current certification period before approving NCHC. See IV.B.3. for procedures to follow.

(2) To verify that insurance will be discontinued and the effective date of the insurance termination, accept the client's or the insurance company's statement that the insurance will be discontinued and effective date of the discontinuance.

(3) If you later learn that the insurance was not terminated after you transferred the case to NCHC, send a timely notice proposing termination of the NCHC case.

(4) If the verification is not provided by the established deadline, the Medicaid case/individual must be terminated. Do not key a DSS-8124.

3. If verification of the terminated insurance is received, determine if the family is eligible with no enrollment or with an enrollment fee.

a. If the family is eligible for NCHC with no enrollment fee:

(1) Authorize NCHC for a 12- month enrollment period.

(2) The enrollment period begins with the month following termination of Medicaid or Work First.

(3) Enter an administrative DSS-8124 in EIS. Enter "Y" in the Health Choice indicator. The date of application is the date entered in EIS.

b. If the family has income over 150% of poverty, they will have an enrollment fee.

(1) Notify the family of the enrollment fee using the status form letter in Figure 4. Follow procedures in IV.D above.

(2) Allow 12 calendar days for the fee to be paid. See MA-3215, Processing the Application.

(VI.J.3.b.)

(3) If the fee is paid, key an administrative DSS-8124 with a Health Choice "Y" indicator and approve NC Health Choice. The date of application is the date entered in EIS. See EIS 2012, Completing An Application Form For New Applications, Reapplications, and Add-An-Individual Applications for M-AF, M-IC, M-PW, and M-RF.

c. If a terminated case is reopened within the first 10 calendar days of the following month the enrollment period begins the month following the termination. See MA-3215, Processing an Application.

(Refer to Figure 5 for instructions for making changes when a child is terminated or deleted from a case).

4. If the case is eligible for WFFA, a signed DSS-8124 reapplication must be entered in EIS. The date of application is the date signed. This application will be included in the report card.

5. Enroll all NCHC children (except MIC-L) into Community Care of North Carolina/Carolina Access (CCNC/CA). Refer to II.H. above and MA-3435, Community Care of North Carolina/ Carolina Access for instructions on enrollment procedures.

K. Automated Termination at Age 19

NC Health Choice recipients will be automatically deleted/terminated by EIS on "pull night" of the month in which the recipient turns age 19.

1. EIS will send a timely termination notice on the first day of the month. A special review message appears on the case management report.

2. Review each recipient for ongoing Medicaid and update EIS if eligible.

VII. NC HEALTH CHOICE FREEZE PROCEDURES

NC Health Choice for Children is not an entitlement program. If federal and state matching funds are insufficient to cover the number of eligible children, states must limit enrollment or pay for the unmatched program costs using all state funds. Follow procedures below when a North Carolina Health Choice enrollment freeze is implemented.

A. Implementation of the Freeze

DMA monitors the funding of the NC Health Choice program and notifies the Division of Information Management (DIRM) and the counties when funding is no longer adequate to support additional enrollments. A freeze is then implemented. DIRM establishes a waiting list based on actions taken by the counties. As funds become available, DMA notifies DIRM and DIRM reactivates applications using the waiting list in EIS. DMA notifies counties of the reactivated applications. Counties then process the reactivated applications to enroll children.

(VII.)

B. Applications Dated Prior to the Freeze Implementation Date are Not Affected by the Enrollment Freeze.

Process the application using current policies and procedures.

1. First, evaluate the case for Medicaid. If eligible, approve the case under the appropriate Medicaid program.

2. If ineligible for Medicaid, evaluate the case for NC Health Choice and, if eligible, approve for NC Health Choice. The case can be approved for NC Health Choice even if it is dispositioned after the enrollment freeze implementation date. If ineligible, deny the case using the appropriate denial code.

2. Advise applicants requesting to withdraw their NC Health Choice application that, due to the enrollment freeze, their child may not be able to enroll in NC Health Choice at a later date.

C. Applications Dated on or After the Freeze Implementation Effective Date are Affected by the Enrollment Freeze.

1. First, evaluate the application for Medicaid. If the case is eligible for Medicaid, approve it under the appropriate Medicaid program.

2. If ineligible for Medicaid, evaluate the case for NC Health Choice. Change the Health Choice indicator on the DSS-8124 to "Y" if not previously done to ensure the county will continue to draw the administrative funds.

   There are two possible outcomes for the NC Health Choice applications taken on or after the freeze implementation date:

   a. The first possibility is that the case is ineligible for NC Health Choice due to failure to meet eligibility requirements. In this case, deny the application using the appropriate denial code for NC Health Choice.

   b. The second possibility is that the child is determined to be eligible for NC Health Choice.

      (1) Follow the instructions in VII.E.below for adding cases to the waiting list.

      (2) Do not require that the family pay an enrollment fee or drop health insurance prior to placing the children on the waiting list. Advise the family to keep insurance, if possible, until the case is reactivated.

(VII.C.2.)

c. Advise the applicant requesting to withdraw his NC Health Choice application that:

(1) If he proceeds with the application, his child, if otherwise eligible for NCHC, would be placed on the waiting list due to the enrollment freeze. The applicant will be notified when the child's application is reactivated.

(2) By withdrawing the application, he is forfeiting the child's position on the waiting list. To protect the child's position on the waiting list, he must decide to continue with the application.

Edits in EIS will not allow the approval of NC Health Choice applications with application dates on or after the enrollment freeze.

D. Re-enrollments

1. Work First or Medicaid Re-enrollments – Case Eligible for MIC-N

a. MIC-N cases that are recertified without a change in the classification code are not affected by the enrollment freeze.

b. Other Medicaid or Work First cases that have children eligible for MIC-N at redetermination or change in situation are not affected by the enrollment freeze.

2. MIC-N Re-enrollments – Case Becomes Ineligible for MIC-N

a. Prior to the Freeze Implementation Date

(1) Evaluate MIC-N cases no longer eligible for MIC-N for NC Health Choice when the DMA-5063R is received. To enroll these cases in EIS for NCHC, actions must be taken prior to the enrollment freeze implementation date. If found eligible, enroll in NC Health Choice. These cases are not affected by the enrollment freeze and will be processed using current policy and procedures, provided the county has processed the eligibility in EIS prior to the effective date of the enrollment freeze.

(2) If the case was due for a re-enrollment prior to the freeze, but the DMA-5063R is not returned until the first 10 days of the next month and the children are only eligible for NCHC, register an NCHC application. Deny with a C4 code.

(2) If during the re-enrollment process, the county does not register an NCHC application or does not change the classification prior to the freeze and the children are only eligible for NCHC, the children will be placed on the waiting list. Register a NCHC application with a date of application after the freeze and deny with a C4.

(VII.D.2.)

b. On or After the Freeze Implementation Date

MIC-N cases ineligible for MIC-N and the DMA-5063R is returned or the review completed after the enrollment freeze implementation date are affected by the enrollment freeze.

Terminate these MIC-N cases using the appropriate termination code.

(1) If the case is ineligible for both Medicaid and NC Health Choice due to income continue to use the termination codes 74 or 09.

(2) If the case is ineligible for both Medicaid and NC Health Choice for a reason other than income, use the appropriate termination code currently in policy.

(3) If the case is ineligible for Medicaid but eligible for NC Health Choice use termination codes 1E (timely) or 6E (adequate). These codes use the same notice text as 79 and 09. These codes must be used during the enrollment freeze for tracking purposes.

Follow procedures in E. to add the children on these cases to the waiting list.

3. NCHC Re-enrollments – Case Eligible for MIC-N.

These cases are not affected by the enrollment freeze.

4. NCHC Re-enrollments – Case Remains Eligible for NCHC

a. Re-enrollments for NC Health Choice will not be affected by the enrollment freeze provided the DMA-5063R is returned by the established deadline (Refer to MA-3420, Re-enrollments) and any applicable fee is paid by the established deadline (Refer to MA-3255, IV.D.2. above). Re-enroll children already enrolled in NC Health Choice provided they continue to meet the eligibility requirements. Children listed on the DMA-5063R received on or after the freeze implementation date that is not currently enrolled cannot be added to the case.

b. Evaluate NC Health Choice cases terminated for failure to return the DMA-5063R for reopen if the form and all information needed to determine eligibility is returned by the 10th calendar day of the month following the month of termination and the case remains NCHC eligible. Reopen the case following the current procedures. The reopen must be keyed by pull night.

(VII.D.4.)

c. Evaluate NC Health Choice cases terminated for failure to pay the fee for reopen if the fee is paid by the 10th calendar day of the month following the month of termination. If the 10th of the month falls on a weekend, allow the recipient until the end of the first business day following the weekend to pay the fee. Reopen the case following current procedures. The reopen must be keyed by pull night.

d. Do not re-enroll the child in NC Health Choice if the NCHC case is terminated for failure to provide the DMA-5063R and the form is received after the 10th calendar day of the month following the month of termination. This is considered a new enrollment and no new children will be enrolled during the enrollment freeze. Register the application as a NC Health Choice application to ensure the county will continue to draw administrative funds.

There are two possible outcomes for terminated NC Health Choice cases when the DMA-5063R is returned after the 10th calendar day to the month:

(1) The first possibility is that the child is ineligible for NC Health Choice due to failure to meet eligibility requirements. In this case, terminate the case using the appropriate termination code for NC Health Choice.

(2) The second possibility is that the child is determined to be eligible for NC Health Choice. In this case, follow procedures in E. to add the child to the waiting list.

e. Follow current procedures for re-enrollments when the DMA-5063R is received timely but the information to process it is received after the 10th calendar day of the month following the month of termination.

(1) The family is required to provide a new DMA-5063. The DMA-5063R is not accepted as the application in these cases.

(2) This is considered a new enrollment and no new children will be enrolled during the enrollment freeze. If the DMA-5063 is returned, follow instructions in VII.C.

f. Children who become eligible for Optional Extended Coverage (L classification) are not affected by the freeze. Children can be transferred to "L."

E. Waiting List

1. A statewide waiting list is created using information from EIS for children who would be otherwise eligible for NC Health Choice except for the lack of funding.

2. Once the cases are identified, children are sequenced chronologically on the waiting list based on the application number in EIS. The application number is assigned sequentially.

(VII.E.)

3. NC Health Choice applications must be keyed timely and the appropriate denial code must be used to ensure the waiting list is accurate. **Children will not be enrolled in NC Health Choice unless they are on the waiting list.**

4. Do not require the family to pay an enrollment fee or drop health insurance before putting the children on the waiting list.

5. Any child, who is determined to be eligible for NC Health Choice during the enrollment freeze either as the result of a new application, reapplication, or an ex parte review, must be added to the waiting list.

   a. Complete an EIS inquiry to determine if the casehead has other children on a NCHC case. If he does, the application for the new child must be type 6. If it is not keyed as a type 6 application, the application cannot be approved in EIS when the application is reactivated.

   b. Key the DSS-8124. The Health Choice indicator must be entered as "Y" to ensure the county continues to draw administrative funds.

   c. Deny the application using the denial code "C4". The DSS-8109 will state, "Your child is eligible for NC Health Choice but the program is not funded to cover more children at this time. If additional funds are made available you will be contacted about enrolling your child in NCHC."

6. Applications must be keyed into EIS and denied using the "C4" code for these reasons.

   a. The waiting list is built using the application number of the application dispositioned with a denial code of "C4."

   b. Based on the "C4" code, casehead payees will receive a letter informing them of the waiting list due to the freeze. See Figure 9. The letter will be mailed separately from the denial notice.

F. Children with Comprehensive Medical Insurance Coverage

Continue to evaluate for comprehensive medical insurance at application. If a child is still covered under comprehensive insurance, inform families that, due to the enrollment freeze, they should not drop comprehensive medical insurance at this time. Once they are notified that the child's application has been reactivated and all other eligibility factors are met, they should notify the insurance company of their wish to drop insurance.

VIII. REACTIVATING CHILDREN ON THE WAITING LIST

When additional funding is available, children can be reactivated from the waiting list. The state notifies counties via a terminal message that children may be reactivated. Follow these steps to reactivate children on the waiting list.

A. Reactivating Applications in EIS

1. Reactivated applications are identified using the waiting list database. EIS reactivates the applications using the information in the database.

2. The reactivated application contains the same individuals who were listed on the original "C4" denied application.

3. Applications originally keyed as type 6 add-on applications are reactivated as type 6 add-on applications using the same case ID number that was used on the original "C4" denied application. All other reactivated applications are opened as new applications and have a new case ID number.

4. Reactivated applications have an indicator for identification purposes that is invisible to the county. The indicator allows the identified cases to be approved at the county level once eligibility is established.

5. These applications appear on the county application management report but are administrative applications.

6. (Figure 8) is mailed by the State to each casehead in a reactivated application.

7. A report titled DHREHC NCHC APPLICATIONS REACTIV found in NCXPTR lists reactivated applications by county. The report is sorted alphabetically by casehead. The State mails one copy of the report to each county.

B. Notifying Clients and Requesting Information

Income and basic information must be re-evaluated for reactivated applications. The information is obtained from the reactivation notice the applicant completes. DMA notifies counties via terminal message when applications are reactivated.

1. Mailing Reactivation Notice

   a. The State mails to each casehead a Notice of Reactivation letter (Figure 8). The letter notifies the casehead about the reactivation of the application. It asks the casehead:

(VIII.B.1.a.)

(1) If there has been a change in income since he applied. The casehead's statement of income on the letter is acceptable if he indicates a change in income.

(2) Confirm his current address and whether the child has health insurance.

b. The casehead has 12 calendar days to return the letter. If the 12th day falls on a weekend or holiday, allow until the end of the first business day following the weekend or holiday for the return of the letter. If the casehead does not respond by the deadline:

(1) Research agency records, both paper and computer, to ensure the letter was mailed to the most current address.

(2) Mail a second letter Figure 8. Mark "Second Request" at the top of the letter. Attach a DMA-5097 (DMA5097, Spanish), Request for Information, to the letter.

(3) Allow twelve calendar days from the date mailed for return of the second letter.

c. If the letter is returned to the agency because the casehead and child no longer live at the address:

(1) If a forwarding address is provided, mail the notice to that address.

(2) If no forwarding address is provided, check the original application for a phone number. Attempt to contact the casehead by phone to verify the current address.

(3) If no forwarding address or phone number is available, search all agency records, both paper and computer, for a current address. See MA-3410, Terminations and Deletions, for the definition of current address.

d. If no current address or phone number can be located, document all attempts to locate the casehead and deny the application.

2. Reactivation Notice Returned Complete

When the letter is returned complete (all questions, except date, are answered, income statements are complete and not questionable and the form is signed), process the reactivated application.

(VIII.B.2)

a. If the casehead reports no change in income, process the application using the income on file.

b. If the casehead reports a change in income and includes a complete statement regarding the changed income, use that statement to process the reactivated application.

(1) If the child is eligible for Medicaid using the changed income, approve the application under the appropriate Medicaid program.

(2) If the child is eligible for NCHC using the changed income, approve for NCHC.

(3) If the child is ineligible for NCHC based on the changed income, deny the reactivated application using the appropriate denial code.

c. A casehead and his family may have moved since the original application was filed, and they may no longer live in the county where they applied. The county on whose report the casehead appears is responsible for dispositioning a reactivated application. After approving the case, follow transfer procedures in MA-3340, County Residence.

3. Reactivation Notice Returned Incomplete

If the Notification of Reactivation letter is returned but is incomplete (not all questions are answered, income statement is incomplete or questionable or the form is not signed), use the DMA-5097 (DMA-5097, Spanish), Request for Information, to request the missing information. Make at least two requests with at least 12 calendar days between the requests.

4. Notice of Reactivation Lists Children Not Included on the Original Application

a. Mail or give the family a DMA-5063 (DMA-5063 Spanish) to apply for the other child. Inform the casehead that he must apply for this child.

b. When the casehead returns the DMA-5063 for the additional child, process that application following policy in the application processing sections. The child, if eligible for NCHC, will be added to the waiting list.

(VIII.B.)

5. Notice of Reactivation Indicates Child Moved to Another Household

It is possible that a child has moved into another household since the original application was made. If the Notice of Reactivation indicates that the child has moved into another household:

a. Research the case. See VIII.C. below.

b. If the same child appears in multiple reactivated applications, follow instructions in VIII.C.3.

c. If the child does not appear in another reactivated application with the new casehead:

(1) Request income from any financially responsible person in the new household using the DMA-5097 (DMA-5097, Spanish).

(2) Based on the new household's income, evaluate eligibility first for Medicaid. If ineligible for Medicaid, the child must be evaluated for Health Choice. Because this income was never verified, a statement of income is not acceptable to process these Health Choice cases. Income in these cases must be verified following policy in MA-3300, Income.

(3) Before disposing of the case, change the address on the DSS-8124 to the current address for the child. If the child is eligible with the new casehead, follow instructions in EIS 3101 to change the casehead once the case is approved.

C. Researching Cases

Using the information from the NCXPTR report, DHREHC NCHC APPLICATIONS REACTIV, and information in EIS, research the reactivated applications prior to disposition to determine if any child on the original application has been subsequently approved in another aid program/category or if the child or casehead appears multiple times in the reactivated applications.

1. Reactivated Child in Ongoing Case

If the child on a reactivated application has already been approved and is active in an ongoing case:

(VIII.C.1.)

a. Deny the application if all children on the reactivated application are now authorized in an ongoing case, or

b. Delete the active child from the reactivated application if there are children on the reactivated application who are not authorized in an ongoing case. Delete the active child on the DSS-8125 at the time the reactivated application is approved for the other children. The individual termination date is the same as the date of the reactivated application.

2. Reactivated Child in Another Pending Application (Not A Reactivated Application)

a. Children in Pending NCHC Application

(1) If the reactivated application is approved prior to the 45th day of the pending application, deny the pending application.

(2) If the reactivated application is denied prior to the 45th day of the pending application, process the pending application. If the freeze is still in effect for new enrollments and the children are eligible for NCHC, deny with a C4.

(3) If the reactivated application is not processed by the 45th day of the pending application, process the pending application. Continue to process the reactivated application.

b. Children in Pending Medicaid or Work First Application

Unless ineligibility is established, do not dispose of the reactivated NCHC application until the pending Medicaid or Work First application has been dispositioned. Reactivated applications may pend for more than 45 days in these situations.

(1) If the pending Medicaid or Work First application is approved, deny the reactivated NCHC application.

(2) If the pending Medicaid or Work First application is denied, process the reactivated NCHC application.

3. Same Reactivated Child in Multiple Reactivated Applications

A casehead may apply for the same child more than once during a freeze. Counties are directed to disposition each application and, if appropriate, deny each using the "C4" denial code. This means that the same child may appear in multiple reactivated applications and the casehead could receive more than one Notice of Reactivation.

(VIII.C.3.)

a. Use the information from the most recent application on record and the Notice of Reactivation to process the reactivated application.

b. If the same children appear together in multiple reactivated applications, deny all but one of the reactivated applications.

   For example, Sue Smith applied January 3 for her children, John, Jane and Jimmy. She applied again on March 1 for the same children. Ms. Smith may have two reactivated applications. Deny one application. Use information from the March 1 application to process the reactivated application.

c. If a child appears in multiple reactivated applications but with different children and casehead:

   (1) Determine where the child is currently living.

   (2) Include the child on the payee's case where he currently lives. Use information from that payee's application to process the case.

   (3) Delete the child from the other reactivated applications. Key the individual termination date on the DSS-8125 at the time the remaining children on the reactivated application are approved. The individual termination date is the date of the reactivated application.

   For example, Jill Johnson applied January 5 for her children, Barry, Sara and Will. Barry left the household and went to live with his father, Sam. Sam Johnson applied for Barry on March 1. Barry will appear on both reactivated applications. Barry is still living with his father. Process the reactivated application for Barry based on information from the March 1 application. When NCHC is approved for Sara and Will, delete Barry from that application.

4. Same Casehead in Multiple Reactivated Applications

A casehead may also apply more than once during the freeze but for different children. This means that the same casehead can appear multiple times on the report with different children. The casehead can have only one NCHC case in EIS.

a. Deny all reactivated applications with the same casehead.

b. Key a DSS-8124 administrative application to reopen the reactivated application. The application type is 1. The application date is the same as the denied reactivated application.

(VIII.C.4.)

c. This reopened application includes all the children for whom the casehead applied and whose application has been reactivated.

For example, Beth White applied for her child, Ben, on January 11. On February 15, she applied for another child, Jessica. Both applications are reactivated by EIS. Deny both applications and key one DSS-8124 that includes Ben and Jessica.

d. Key the DSS-8125 for approval. An on-line error message will appear stating that the application cannot be approved. Put the form on hold. Contact Medicaid EIS and provide the form numbers of the DSS-8124 and DSS-8125 as well as the county number. These cases will be processed at the state level. Do not take any further action on the forms or they will not process.

5. Add-on Applications

Some cases on the waiting list may be keyed as add-on applications to existing NCHC cases. These cases are reactivated as type 6, add-on applications.

Research these cases to ensure the existing NCHC case is still active.

a. If the NCHC case to which the child was being added is still active, process the reactivated application as an add-on.

b. If the application was placed on the waiting list as an application type 1 or 2 instead of type 6, deny the application. Register another application as a type 6. Contact EIS for assistance with these cases.

c. If the NCHC case to which the child was being added has been closed:

(1) Deny the reactivated application.

(2) Key a DSS-8124 administrative application. The date of application is the same as the denied reactivated application. The application type is 1.

d. If the case ID of the NCHC case to which the child was being added is now linked to a non-NCHC case:

(1) Deny the reactivated application.

(2) Key a DSS-8124 administrative application. The date of application is the same as the date of the denied reactivated application. The application type is 1.

e. Anytime the county denies the reactivated application and keys the administrative DSS-8124, the State must process the case. Follow directions in VIII.C.4 above to have the case processed.

(VIII.)

D. Processing the NCHC Reactivated Application

There are three possible outcomes for the reactivated NCHC applications.

1. Withdrawal

Withdraw the application if the casehead contacts the DSS and states he/she no longer wants the assistance. The caseworker must document the reason for withdrawal and the alternatives to withdrawal that were discussed with the client. Follow instructions in the application processing sections.

2. Denial

a. Deny any time ineligibility is established (for example, changed income exceeds the income limit).

b. Deny when the casehead fails to provide information on:

(1) The 45th day when the reactivation notice and at least one DMA-5097 were sent or two DMA-5097's with at least 12 calendar days between them were sent prior to the 45 day processing standard, or

(2) The first work day after the 12th calendar day when the second DMA-5097 is sent requesting the information after the reactivation notice or two DMA-5097's with at least 12 calendar days between them and the 12th calendar day exceeds the 45 day processing standard.

c. Failure to provide information includes:

(1) The casehead fails to return the Notice of Reactivation,

(2) The casehead reports a change in income but has not provided a complete statement of the changed income,

(3) The casehead does not report on the status of health insurance for all of the children originally included on the application.

(a) Delete children for whom the status of health insurance is not reported when the family fails to respond to the requests for information.

(b) If the status of health insurance is not reported for any of the children and the casehead does not respond, deny the application.

(VIII.D.2.c.)

(4) The casehead does not list all of the children who were included on the original application.

(a) Delete children not listed when the casehead fails to respond to the requests for information.

(b) If none of the children are listed on the Notice of Reactivation and the casehead does not respond, deny the reactivated case.

(5) The casehead fails to sign the reactivation notice.

d. Follow current NCHC policy for denying cases due to failure to pay the enrollment fee or when the child has comprehensive health insurance.

e. If the Notice of Reactivation letter or any other information requested is returned after the case is denied, send a DMA-5063 (DMA-5063 Spanish). Advise the casehead that the child has been dropped from the waiting list and that he must reapply.

3. Approval

a. Approve the case if the casehead returns the Notice of Reactivation letter, remains eligible, pays the enrollment fee, if applicable, and does not have health insurance on the child.

b. Authorize the case when all the eligibility requirements are met but no earlier than the first of the month of the reactivated application. The certification period will begin the same month the case is authorized and will be twelve months.

E. Reports

In addition to the NCHC reports already received by the counties, the following reports will be generated. Both reports are available in NCXPTR.

1. DHREHC NCHC LIMITED FUNDING

This report lists applications denied with code "C4". The report is run monthly on the 5th work night. Copies of the report are not mailed to the county.

2. DHREHC NCHC APPLICATIONS REACTIV

This report lists the reactivated applications by county. Each county will receive one paper copy of the report. The report is sorted alphabetically by casehead, not by the order the child appeared on the waiting list.