

State: North Carolina

Citation	Condition or Requirement
1932(a)(1)(A)	<p>A. <u>Section 1932(a)(1)(A) of the Social Security Act.</u></p> <p>The State of <u>North Carolina</u> enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may <i>not</i> be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of “special needs” beneficiaries (see D.2.iii. - vii. below)</p>
	<p>B. <u>General Description of the Program and Public Process.</u></p> <p>For B.1 and B.2, place a check mark on any or all that apply.</p>
1932(a)(1)(B)(i) 1932(a)(1)(B)(ii) 42 CFR 438.50(b)(1)	<p>1. The State will contract with an</p> <ul style="list-style-type: none"><input type="checkbox"/> i. MCO<input checked="" type="checkbox"/> ii. PCCM (including capitated PCCMs that qualify as PAHPs)<input type="checkbox"/> iii. Both
42 CFR 438.50(b)(2) 42 CFR 438.50(b)(3)	<p>2. The payment method to the contracting entity will be:</p> <ul style="list-style-type: none"><input checked="" type="checkbox"/> i. fee for service;<input type="checkbox"/> ii. capitation;<input checked="" type="checkbox"/> iii. a case management fee;<input type="checkbox"/> iv. a bonus/incentive payment;<input type="checkbox"/> v. a supplemental payment, or<input checked="" type="checkbox"/> vi. other. (Please provide a description below). <p>North Carolina operates a statewide PCCM managed care program for the state’s Medicaid citizens. This managed care program was initiated in 1991 and was successful with the primary goal of increasing access to medical homes for Medicaid recipients. The state contracts directly with primary care providers to serve as medical homes and coordinate care for their enrolled recipients. In 1998, an enhanced PCCM program,</p>

State: North Carolina

Citation

Condition or Requirement

built on the existing infrastructure, established regional networks that created local systems of care designed to achieve long-term quality, cost, access, and utilization objectives in the management of care for Medicaid recipients.

North Carolina continues to operate the original PCCM program; however, most primary care providers are now members of a regional network and a majority of Medicaid recipients are enrolled with a network provider. All primary care providers are paid fee for service.

These regional networks cover all counties. Each network has an administrative entity that contracts with the state. Both the networks and the primary care providers are paid a pm/pm.

The networks provide population health management by:

- Furnishing preventive services and information
- systematic data analysis to target recipients and providers for outreach, education, and intervention
- monitoring system access to care, services, and treatment including linkage to a medical home
- monitoring and building provider capacity
- monitoring quality and effectiveness of interventions to the population
- supporting the medical home through education and outreach to recipients and providers
- facilitating quality improvement activities that educate, support, and monitor providers regarding evidence based care for best practice/National Standards of Care

Networks provide disease management by:

- Advocating for high risk, high acuity recipients to ensure that recipients receive appropriate evidence based care
- Educate recipients about disease states and self management

Population management, disease management and medical coordination of treatment and prevention are provided to recipients enrolled with a network provider and for other high risk, high cost recipients who are not enrolled.

TN No.: 09-006
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TN No.: 06-010

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State: North Carolina

Citation	Condition or Requirement
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Networks and providers receive increases in the pm/pm for subsets of populations that are high risk, high acuity, high cost, and frequently have complex co-morbid conditions so that enhanced care management services can be provided. In addition to the services stated above, enhanced services include but are not limited to comprehensive and integrated package of high risk screening/assessment, triage, and referral, hospital transitions, pharmacy review, medication reconciliation, inpatient and ED diversion with care management across the continuum of care.

DMA shall set forth all payments to the provider including enhanced services reimbursement and enhanced management fees and that the contracts must be reviewed and approved by CMS.

1905(t)
42 CFR 440.168
42 CFR 438.6(c)(5)(iii)(iv)

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.

If applicable to this state plan, place a check mark to affirm the state has met *all* of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

- i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.
- ii. Incentives will be based upon specific activities and targets.
- iii. Incentives will be based upon a fixed period of time.
- iv. Incentives will not be renewed automatically.
- v. Incentives will be made available to both public and private PCCMs.
- vi. Incentives will not be conditioned on intergovernmental transfer agreements.
- vii. Not applicable to this 1932 state plan amendment.

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Citation	Condition or Requirement
CFR 438.50(b)(4)	<p data-bbox="532 415 1459 541">4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. (<i>Example: public meeting, advisory groups.</i>)</p> <p data-bbox="591 569 1459 1056">The PCCM program was founded with input from the medical provider community and other agencies involved in public service delivery. Physician and physician professional organizations have always been instrumental in developing initiatives and direction for the program. As community networks were being developed, social service agencies, physicians, and hospitals became participants in planning at the community level how Medicaid recipients could best be served with quality medical care and care management. Each network has a steering committee whose membership includes representatives from the department of social services, local health department, physicians, etc. Networks have also formed local medical management committees whose membership is composed of representatives from the medical community, i.e., physicians, hospital etc. Each network medical director participates on the statewide Medical Management Committee that advises the PCCM program on a statewide level. A provider satisfaction survey will be conducted every three years to maintain continued input from providers who participate in the program but who may not be part of an advisory committee.</p> <p data-bbox="591 1087 1459 1268">Recipients enrolled with the PCCM managed care program have public input through the Division's toll free customer service phone center which is staffed from eight to five, Monday through Friday, by Managed Care customer service representatives. Voice mail is available after hours for callers who wish to leave a message; the appropriate managed care staff person will return calls left on voice mail within two (2) business days.</p> <p data-bbox="591 1299 1459 1421">The local CCNC networks also work with their enrollees on self management strategies for many of the chronic diseases that are managed through the program. This provides an opportunity for the recipient to have involvement in the care management plan being proposed.</p>

State: North Carolina

Citation	Condition or Requirement
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Recipients are also able to submit a concern about the program through a written complaint process.

Enrollees also have public input through a Patient Satisfaction Survey. The survey is used to collect data on satisfaction, access, health status, utilization, and trust. The tool used to collect the data is the CAHPS survey for children and adult. A patient satisfaction survey will be conducted every three (3) years.

The NC Medical Care Advisory Committee reviews all major program changes for the Medicaid program. Recipients have an opportunity to serve on this Committee.

1932(a)(1)(A)

5. The state plan program will X/will not ___ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory ___/ voluntary ___ enrollment will be implemented in the following county/area(s):
- i. county/counties (mandatory) _____
 - ii. county/counties (voluntary) _____
 - iii. area/areas (mandatory) _____
 - iv. area/areas (voluntary) _____

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. ___ The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A)

2. X The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.

1932(a)(1)(A)

3. X The state assures that all the applicable requirements of section 1932.

State: North Carolina

Citation	Condition or Requirement
	(including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.
1932(a)(1)(A) 42 CFR 431.51 1905(a)(4)(C)	4. <u>X</u> The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5. <u>X</u> The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6. ____ The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) CFR 447.362 42 CFR 438.50(c)(6)	7. ____ The state assures that all applicable requirements of 42 CFR 447.362 for 42 payments under any nonrisk contracts will be met.
45 CFR 74.40	8. ____ The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

D. Eligible groups

- 1932(a)(1)(A)(i)
1. List all eligible groups that will be enrolled on a mandatory basis.
 - Work First for Family Assistance (formerly AFDC)
 - Family and Children's Medicaid without Medicaid deductibles (formerly AFDC-related)
 - Medicaid for the Blind and Disabled (MAB, MAD, MSB)
 - Residents of Adult Care Homes (SAD)
 - Qualified Alien

Children under age 19 identified as Children with Special Health Care Needs, dual eligibles, and Indians who are members of a Federally recognized tribes are exempt from mandatory enrollment.
 2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

State: North Carolina

Citation	Condition or Requirement
	Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.
1932(a)(2)(B) 42 CFR 438(d)(1)	<p>i. <u>X</u> Recipients who are also eligible for Medicare.</p> <p>If enrollment is voluntary, describe the circumstances of enrollment. <i>(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)</i></p> <p>At this time, North Carolina is moving toward an opt out process for enrolling these recipients. They can opt out at any time during their enrollment. Dual eligibles will receive a letter informing them of the medical home to whom they will be assigned unless they contact the DSS to request an exemption within 30 days of receipt of the letter. After the 30 day period DSS will begin enrolling those who have not chosen to opt out. The letter will also contain the address and phone number of the PCP and their right to disenroll from the program at any time.</p> <p>The State assures that recipients will be permitted to disenroll from a managed care plan on a month to month basis.</p>
1932(a)(2)(C) 42 CFR 438(d)(2)	<p>ii. <u>X</u> Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.</p> <p>The State assures that recipients will be permitted to disenroll from a managed care plan on a month to month basis.</p>
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	<p>iii. <u>X</u> Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.</p>
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	<p>iv. <u> </u> Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.</p>
1932(a)(2)(A)(v)	<p>v. <u>X</u> Children under the age of 19 years who are in foster care or other out-of-the-home placement.</p>

State: North Carolina

Citation	Condition or Requirement
42 CFR 438.50(3)(iii) 1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. <u>X</u> Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. <u>X</u> Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

The State assures that these recipients will be permitted to disenroll from the PCCM program on a month to month basis.

E. Identification of Mandatory Exempt Groups

- 1932(a)(2)
42 CFR 438.50(d)
1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. (*Examples: children receiving services at a specific clinic or enrolled in a particular program.*)

The State defines these children in terms of special health care needs and program participation in a Children's Developmental Service Agency (CDSA) or Child Special Health Services (CSHS).

The Division of Medical Assistance has instituted a questionnaire, with five (5) 2-part questions, for self-identification of children with Special Health Care Needs at the time of enrollment in Medicaid or Health Choice (SCHIP). This information is captured in the Eligibility Information System (EIS) to assist with reporting and monitoring of Children with Special Health Care Needs CSHCN.

- 1932(a)(2)
42 CFR 438.50(d)
2. Place a check mark to affirm if the state's definition of title V children is determined by:

- i. program participation,
- ii. special health care needs, or
- iii. Both

- 1932(a)(2)
42 CFR 438.50(d)
3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.

- i. yes
- ii. no

State: North Carolina

Citation	Condition or Requirement
1932(a)(2) 42CFR 438.50 (d)	<p>4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: (<i>Examples: eligibility database, self- identification</i>)</p> <p>i. Children under 19 years of age who are eligible for SSI under title XVI;</p> <p>The State identifies this group by Medicaid eligibility category of assistance.</p> <p>ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;</p> <p>The State does not enroll this population in the managed care programs.</p> <p>iii. Children under 19 years of age who are in foster care or other out-of-home placement;</p> <p>The State identifies this group by the Medicaid eligibility category of assistance or living arrangement code.</p> <p>iv. Children under 19 years of age who are receiving foster care or adoption assistance.</p> <p>The State identifies this group by the Medicaid eligibility category of assistance or living arrangement code.</p>
1932(a)(2) 42 CFR 438.50(d)	<p>5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. (<i>Example: self-identification</i>)</p> <p>The Division of Medical Assistance has instituted a questionnaire, for self-identification of children with Special Health Care Needs at the time of enrollment in Medicaid or Health Choice (SCHIP). This information is captured in the Eligibility Information System (EIS) to assist with reporting and monitoring of CSHCN.</p>
1932(a)(2) 42 CFR 438.50(d)	<p>6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: (<i>Examples: usage of aid codes in the eligibility system, self- identification</i>)</p> <p>i. Recipients who are also eligible for Medicare.</p> <p>These recipients are identified by Medicaid eligibility category of assistance.</p>

Citation	Condition or Requirement
	<p>ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.</p> <p>There is no eligibility category group designated for the Native American population; they are eligible for Medicaid under existing program aid categories.</p> <p>When a Native American applies for Medicaid, the caseworker explains the PCCM program and informs him that he can choose to join the program. If he does not choose a provider or if he informs the caseworker that he does not want to be enrolled, he is exempted from participation. Native Americans are not auto-assigned into the program. They are allowed to make an informed choice regarding their participation. If a Native American chooses to enroll in the program, he is informed that he may disenroll at anytime.</p>
42 CFR 438.50	<p>F. <u>List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment</u></p> <p>MQB, SAA, RRF/MRF, CAP cases with a monthly deductible, MAF-D, MAF-W, Nursing Facility Residents, PACE enrollees, and Aliens eligible for emergency Medicaid only are not eligible to enroll.</p>
42 CFR 438.50	<p>G. <u>List all other eligible groups who will be permitted to enroll on a voluntary basis</u></p> <p>MPW (Medicaid for Pregnant Women) Benefit Diversion Recipients Recipients with end stage renal disease Nursing Home Residents</p>

State: North Carolina

Citation	Condition or Requirement
	H. <u>Enrollment process.</u>
1932(a)(4) 42 CFR 438.50	1. Definitions <ul style="list-style-type: none">i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience or through contact with the recipient.ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.
1932(a)(4) 42 CFR 438.50	2. State process for enrollment by default. <p>Describe how the state's default enrollment process will preserve:</p> <ul style="list-style-type: none">i. the existing provider-recipient relationship (as defined in H.1.i). <p>Caseworkers at the local department of social services are the primary people who provide information about the program to potential enrollees and enroll them into the program.</p> <p>The state provides an enrollment form to the county departments of social services. It is required to be completed at enrollment or change of medical home. It is signed by the recipient or recipient's guardian to verify that they were given freedom of choice and the primary care provider listed on the enrollment form is the provider of choice. If the recipient provides the name of their chosen medical home by phone, the caseworker is permitted to complete the form and file it in the recipient's record without signature. The caseworkers in each local county Department of Social Services (DSS) are responsible for auto-assignments on an individual basis when recipients have not selected a provider.</p>

State: North Carolina

Citation

Condition or Requirement

The State assures that default enrollment will be based first upon maintaining existing provider/patient relationships. Income maintenance caseworkers at the local department of social services are primarily responsible for linking recipients to a medical home; however, DMA managed care staff and designees also have the ability to link recipients. Inquiries are made for potential default enrollment as to current provider-patient relationships when recipients do not select a PCP at the time of the visit. Some beneficiaries, particularly Supplemental Security Income (SSI) recipients, do not visit the social services office for Medicaid application and/or reapplication. In these cases, written materials describing the managed care options are mailed to them along with a deadline for notification of their PCP selection.

Attempts are made to contact beneficiaries by telephone or letter if they do not respond within the time frame; inquiries are made about existing relationships with providers when contact is made.

Counties receive a monthly enrollment report that provides the name of the medical home. EIS (Eligibility Information System) also maintains a history of enrollment (exemption or medical home).

The state allows providers to have their patients complete an enrollment form which is then sent to the county department of social services, DMA managed care staff, or designee for enrollment.

The provider is required to provide education about the PCCM program and explain freedom of choice.

- ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

Recipients are notified of managed care programs when they apply for Medicaid or when they are due for their eligibility review. Because SSI recipients do not apply for Medicaid, they are listed on a report. When they become eligible for Medicaid, a letter is sent to them asking them to contact DSS to select a PCP. The report is monitored to determine if SSI recipients are getting enrolled.

The county DSS staff has the responsibility to review the SSI exempt report and auto-assign all recipients over the age of 19 who have been on the report for 30 days or more. Counties then send a letter to the recipient informing them of their PCP along with a copy of the recipient handbook.

Citation	Condition or Requirement
1932(a)(4) 42 CFR 438.50	<p data-bbox="591 417 1458 600">iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). <i>(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)</i></p> <p data-bbox="678 632 1458 720">If it is not possible to obtain provider-patient history, beneficiaries are assigned to providers based upon equitable distribution among participating PCPs available in the recipient's county of residence.</p> <p data-bbox="678 751 1458 873">Caseworkers are told to look at the provider restrictions, e.g. patients 21 and under or established patients only, listed in the State Eligibility Information System (EIS), and geographical proximity to the provider before auto assigning a recipient.</p> <p data-bbox="532 905 1458 961">3. As part of the state's discussion on the default enrollment process, include the following information:</p> <p data-bbox="591 993 1458 1050">i. The state will ___/will not <u>X</u> use a lock-in for managed care managed care.</p> <p data-bbox="591 1081 1458 1138">ii. The time frame for recipients to choose a health plan before being auto-assigned will be 30 days.</p> <p data-bbox="591 1169 1458 1226">iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. <i>(Example: state generated correspondence.)</i></p> <p data-bbox="688 1260 1458 1451">Recipients are notified of managed care programs when they apply for Medicaid or when they are due for their eligibility review. Because SSI recipients do not apply for Medicaid, they are listed on a report. When they become eligible for Medicaid, a letter is sent to them asking them to contact DSS to select a PCP. The report is monitored to determine if SSI recipients are getting enrolled.</p> <p data-bbox="688 1482 1458 1606">The county DSS staff has the responsibility to review the SSI exempt report and auto-assign all recipients over the age of 19 who have been on the report for 30 days or more. Counties then send a letter to the recipient informing them of their PCP along with a copy of the recipient handbook.</p>

Citation	Condition or Requirement
	<p>iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. (<i>Examples: state generated correspondence, HMO enrollment packets etc.</i>)</p> <p>The State assures that recipients will be permitted to disenroll from a managed care plan on a month to month basis.</p>
	<p>v. Describe the default assignment algorithm used for auto-assignment. (<i>Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.</i>)</p> <p>Caseworkers at the local DSS are trained to make every effort to support a Provider/ patient relationship with the auto-assignment. If a relationship is not present, then caseworkers are instructed to auto-assign recipients to a provider on a case by case basis who is accepting new patients within a 30 mile radius. Aged, blind, and disabled recipients will be assigned to network providers if there is not already an existing patient/doctor relationship that has been established.</p>
	<p>vi. Describe how the state will monitor any changes in the rate of default assignment. (<i>Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker.</i>)</p> <p>MMIS produces a monthly provider availability report that is reviewed by the regional managed care consultant to determine if a provider is reaching his or her enrollment limit.</p> <p>Caseworkers are instructed to identify on the Medicaid enrollment application when a recipient is auto-assigned to a medical home.</p>
1932(a)(4) 42 CFR 438.50	<p>I. <u>State assurances on the enrollment process</u></p> <p>Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.</p> <p>1. <u>X</u> The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.</p> <p>2. <u>X</u> The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).</p>

State: North Carolina

Citation	Condition or Requirement
	<p>3. <input checked="" type="checkbox"/> The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.</p> <p>___ This provision is not applicable to this 1932 State Plan Amendment.</p>
	<p>4. ___ The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)</p> <p><input checked="" type="checkbox"/> This provision is not applicable to this 1932 State Plan Amendment.</p>
	<p>5. ___ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.</p> <p><input checked="" type="checkbox"/> This provision is not applicable to this 1932 State Plan Amendment.</p>
1932(a)(4) 42 CFR 438.50	<p>J. <u>Disenrollment</u></p> <p>1. The state will ___/will not <input checked="" type="checkbox"/> use lock-in for managed care.</p> <p>2. The lock-in will apply for ___ months (up to 12 months).</p> <p>3. Place a check mark to affirm state compliance.</p> <p><input checked="" type="checkbox"/> The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).</p> <p>4. Describe any additional circumstances of “cause” for disenrollment (if any).</p>
	<p>K. <u>Information requirements for beneficiaries</u></p> <p>Place a check mark to affirm state compliance.</p>
1932(a)(5) 42 CFR 438.50 42 CFR 438.10	<p><input checked="" type="checkbox"/> The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)</p>

Citation	Condition or Requirement
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1932(a)(5)(D)
1905(t) L. List all services that are excluded for each model (MCO & PCCM)

The following PCCM exempt services do not require PCP authorization:

- | | |
|---------------------------------------|---|
| Ambulance | Services in hospital Emergency Department |
| Anesthesiology | Eye exam for glasses |
| At Risk Case Management | Family Planning |
| CAP Services | Head Start Programs |
| Certified Nurse Anesthetist | Health Department services |
| Child Care Coordination | Hearing Aids |
| Dental | Hospice |
| CDSAs | Laboratory Services |
| Maternity Care Coordination | Mental Health |
| Optical Supplies/Visual Aids | Pathology Services |
| Pharmacy | School Services |
| X-Ray services not done in a hospital | |

1932 (a)(1)(A)(ii) M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will ___/will not intentionally limit the number of entities it contracts under a 1932 state plan option.
2. ___ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.
3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. (*Example: a limited number of providers and/or enrollees.*)
4. ___ The selective contracting provision in not applicable to this state plan.