Table of Contents

State/Territory Name: North Carolina

State Plan Amendment (SPA) #: 21-0022

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

December 29, 2021

Dave Richard
Deputy Secretary, NC Medicaid
North Carolina Department of Health and Human Services
2501 Mail Service Center
Raleigh, NC 27699-2501

Re: North Carolina State Plan Amendment 21-0022

Dear Mr. Richard:

We reviewed your proposed Medicaid State Plan Amendment, NC 21-0022, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on September 29, 2021. This amendment proposes to allow health plans to require cost sharing for certain beneficiaries under managed care. This carries over a policy for the same group under the state's fee-for-service programs, and as such will not increase costs or utilization.

CMS approved NC 21-0022 on December 28, 2021, with an effective date of July 1, 2021.

If you have any questions regarding this amendment, please contact William Pak at (404) 562-7407 or via email at William.Pak@cms.hhs.gov.

Sincerely,

[redacted] Digitally signed by James G. Scott -S
Date: 2021.12.29 13:09:39 -06'00'

James G. Scott, Director
Division of Program Operations
Medicaid and CHIP Operations Group

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 21-0022

2. STATE: NC

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2021

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

1916 and 1916A ~~1932(a)(1)(A)~~ of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2021 $0.00
b. FFY 2022 $0.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Medicaid Premiums Cost Sharing Templates G1 – G3 (New)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): ~~Medicaid Premiums Cost Sharing Templates G1 – G3 (New)~~ Section 4.18, Page 54, 55, 56, 56a, 56b, 56c, 56d, 56e, 56f; Attachment 4.18-A, Page 1,3; Attachment 4.18-C, Page 1,3

10. SUBJECT OF AMENDMENT:
Medicaid Premium Cost Sharing

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Secretary

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Mandy K Cohen

13. TYPED NAME:
Mandy Cohen, MD, MPH

14. TITLE:
Secretary

15. DATE SUBMITTED: 9/29/2021

16. RETURN TO:
Office of the Secretary
Department of Health and Human Services
2001 Mail Service Center
Raleigh, NC 27699-20014

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 29, 2021

18. DATE APPROVED: December 28, 2021

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2021

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]
Digitally signed by James G. Scott -S
Date: 2021.12.29 13:10:16 -06'00'

21. TYPED NAME: James G. Scott

22. TITLE: Director, Division of Program Operations

23. REMARKS:
Pen and ink change authorized in box 6 and box 9 on 12/20/21 and 12/29/21 to add correct statutory regulation and appropriate superseding pages.

Medicaid Premiums and Cost Sharing

State Name: North Carolina

OMB Control Number: 0938-1148

Transmittal Number: NC - 21 - 0022

Cost Sharing Requirements — G1

1916
1916A
42 CFR 447.50 through 447.57 (excluding 447.55)

The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid. Yes

☑ The state assures that it administers cost sharing in accordance with sections 1916 and 1916A of the Social Security Act and 42 CFR 447.50 through 447.57.

General Provisions

☑ The cost sharing amounts established by the state for services are always less than the amount the agency pays for the service.

■ No provider may deny services to an eligible individual on account of the individual's inability to pay cost sharing, except as elected by the state in accordance with 42 CFR 447.52(e)(1).

■ The process used by the state to inform providers whether cost sharing for a specific item or service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the cost sharing charge, as a condition for receiving the item or service, is (check all that apply):

- ☒ The state includes an indicator in the Medicaid Management Information System (MMIS)
- ☐ The state includes an indicator in the Eligibility and Enrollment System
- ☐ The state includes an indicator in the Eligibility Verification System
- ☐ The state includes an indicator on the Medicaid card, which the beneficiary presents to the provider
- ☐ Other process

■ Contracts with managed care organizations (MCOs) provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in 42 CFR 447.50 through 447.57.

Cost Sharing for Non-Emergency Services Provided in a Hospital Emergency Department

The state imposes cost sharing for non-emergency services provided in a hospital emergency department. Yes

☑ The state ensures that before providing non-emergency services and imposing cost sharing for such services, that the hospitals providing care:

- ■ Conduct an appropriate medical screening under 42 CFR 489.24, subpart G to determine that the individual does not need emergency services;
- ■ Inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;
- ■ Provide the individual with the name and location of an available and accessible alternative non-emergency services provider;

Medicaid Premiums and Cost Sharing

■ Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and

■ Provide a referral to coordinate scheduling for treatment by the alternative provider.

☑ The state assures that it has a process in place to identify hospital emergency department services as non-emergency for purposes of imposing cost sharing. This process does not limit a hospital's obligations for screening and stabilizing treatment of an emergency medical condition under section 1867 of the Act; or modify any obligations under either state or federal standards relating to the application of a prudent-layperson standard for payment or coverage of emergency medical services by any managed care organization.

The process for identifying emergency department services as non-emergency for purposes of imposing cost sharing is:

The state maintains a list of codes that will be periodically updated.

Cost Sharing for Drugs

The state charges cost sharing for drugs. Yes

The state has established differential cost sharing for preferred and non-preferred drugs. No

■ All drugs will be considered preferred drugs.

Beneficiary and Public Notice Requirements

☑ Consistent with 42 CFR 447.57, the state makes available a public schedule describing current cost sharing requirements in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to the notice. Prior to submitting a SPA which establishes or substantially modifies existing cost sharing amounts or policies, the state provides the public with advance notice of the SPA, specifying the amount of cost sharing and who is subject to the charges, and provides reasonable opportunity for stakeholder comment. Documentation demonstrating that the notice requirements have been met are submitted with the SPA. The state also provides opportunity for additional public notice if cost sharing is substantially modified during the SPA approval process.

Other Relevant Information

The State has copayments for covered Outpatient Pharmacy medications for adults (21 and older) in the traditional Medicaid program. Those copayments are $3 per prescription.

Children (< age 21), pregnant women, members in hospice, Tribal members, NC BCCCP members, children in foster care, and people in institutions in the traditional Medicaid program have $0 copayment for all prescriptions.

PRA Disclosure Statement

Medicaid Premiums and Cost Sharing

State Name: North Carolina

OMB Control Number: 0938-1148

Transmittal Number: NC - 21 - 0022

Cost Sharing Amounts - Targeting G2c

1916
1916A
42 CFR 447.52 through 54

The state targets cost sharing to a specific group or groups of individuals. Yes

Population Name (optional):

Eligibility Group(s) Included: All Eligibility Groups With Exception of BCCM Beneficiaries

Incomes Greater than 0 TO Incomes Less than or Equal to 250% FPL

Add	Service	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	Physician, Outpatient, Podiatrists	3.00	$	Visit	Reduce over-utilization	Remove
Add	Generic and Brand Prescriptions	3.00	$	Prescription	Reduce over-utilization	Remove
Add	Chiropractic, Optical Services and Supplies	2.00	$	Visit	Reduce over-utilization	Remove
Add	Optometrist, Non-Emergency and Emergency Department Visits	3.00	$	Visit	Reduce over-utilization	Remove

The state permits providers to require individuals to pay cost sharing as a condition for receiving items or services, subject to the conditions specified at 42 CFR 447.52(e)(1). This is only permitted for non-exempt individuals with family income above 100% FPL. No

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state targets cost sharing for non-preferred drugs to specific groups of individuals (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals. No

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department to specific individuals (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals. No

Remove Population

Add Population

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119

Medicaid Premiums and Cost Sharing

State Name: North Carolina

OMB Control Number: 0938-1148

Transmittal Number: NC - 21 - 0022

Cost Sharing Limitations	G3

42 CFR 447.56
1916
1916A

☑ The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

☐ Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).

☐ Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:

- ☐ 133% FPL; and
- ☐ If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.

☐ Disabled or blind individuals under age 18 eligible for the following eligibility groups:

- ☐ SSI Beneficiaries (42 CFR 435.120).
- ☐ Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
- ☐ Individuals Receiving Mandatory State Supplements (42 CFR 435.130).

☐ Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.

☐ Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).

☐ Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.

☐ Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.

☐ An individual receiving hospice care, as defined in section 1905(o) of the Act.

☐ Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.

☐ Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

Medicaid Premiums and Cost Sharing

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over. Yes

Indicate below the age of the exemption:

- ○ Under age 19
- ○ Under age 20
- ◉ Under age 21
- ○ Other reasonable category

The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs. Yes

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- ■ Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- ■ Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- ■ Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- ■ Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specificially identified in the state plan as not being related to pregnancy.
- ■ Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- ■ To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:
  - ☒ The state accepts self-attestation
  - ☐ The state runs periodic claims reviews
  - ☒ The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
  - ☐ The Eligibility and Enrollment and MMIS systems flag exempt recipients

☒ Other procedure

Description:

Require proof of tribal enrollment for federally recognized tribal members.

Additional description of procedures used is provided below (optional):

☐ To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):

☒ The MMIS system flags recipients who are exempt

☐ The Eligibility and Enrollment System flags recipients who are exempt

☐ The Medicaid card indicates if beneficiary is exempt

☐ The Eligibility Verification System notifies providers when a beneficiary is exempt

☒ Other procedure

Description:

All beneficiaries who qualify for Local Management Entities – Managed Care Organizations (LME-MCOs) manage the care of beneficiaries who receive services for mental health, developmental disabilities or substance use disorders.

Additional description of procedures used is provided below (optional):

Payments to Providers

☑ The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid. Yes

☑ The state calculates its payments to managed care organizations to include cost sharing established under the state plan for beneficiaries not exempt from cost sharing, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

Aggregate Limits

Medicaid Premiums and Cost Sharing

☑ Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.

■ The percentage of family income used for the aggregate limit is:

- ◉ 5%
- ○ 4%
- ○ 3%
- ○ 2%
- ○ 1%
- ○ Other: [ ] %

■ The state calculates family income for the purpose of the aggregate limit on the following basis:

- ○ Quarterly
- ◉ Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation. **Yes**

■ Describe the mechanism by which the state tracks each family's incurred premiums and cost sharing (check all that apply):

☒ As claims are submitted for dates of services within the family's current monthly or quarterly cap period, the state applies the incurred cost sharing for that service to the family's aggregate limit. Once the family reaches the aggregate limit, based on incurred cost sharing and any applicable premiums, the state notifies the family and providers that the family has reached their aggregate limit for the current monthly or quarterly cap period, and are no longer subject to premiums or cost sharing.

☒ Managed care organization(s) track each family's incurred cost sharing, as follows:

Health plans provide a monthly cost sharing report to the state. The state reconciles quarterly reports with state carved out services.

☐ Other process:

■ Describe how the state informs beneficiaries and providers of the beneficiaries' aggregate family limit and notifies beneficiaries and providers when a beneficiary has incurred premiums and cost sharing up to the aggregate family limit and individual family members are no longer subject to premiums or cost sharing for the remainder of the family's current monthly or quarterly cap period:

As soon as the beneficiary meets the cost sharing limit, the MMIS records the status and providers receive that information through the MMIS and health plan billing system. Letters are also sent to beneficiaries and providers.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period. **No**

☐ Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

Beneficiaries can contact beneficiary services and is reviewed on a case by case basis.

☐ Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

Beneficiaries can contact beneficiary services and is reviewed on a case by case basis.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5). No

PRA Disclosure Statement

V.20160722