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State/Territory Name: North Carolina

State Plan Amendment (SPA) #:16-0013

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

March 6, 2017

Mr. Dave Richard
Deputy Secretary for Medical Assistance
North Carolina Department of Health and Human Services
1985 Umstead Drive
Raleigh, NC 27699-2501

RE: SPA 16-0013

Dear Mr. Richard:

Enclosed is an approved copy of North Carolina's state plan amendment (SPA) 16-0013 which was submitted to the Centers for Medicare & Medicaid Services (CMS) on December 15, 2017. SPA 16-0013 amends the current Medicaid State Plan by including references to the federally recognized tribes (Eastern Band of Cherokee Indians), where appropriate, to ensure all duties, roles and responsibilities previously assigned to county divisions of social services are shared with the tribe for individuals living within the tribal boundary.

Based on the information provided, the Medicaid State Plan Amendment NC 16-0013 was approved on March 6, 2071. The effective date of this SPA is April 1, 2017. The signed 179 and the approved plan pages are enclosed.

CMS appreciates the significant amount of work your staff dedicated to preparing this state plan amendment. If you have any questions concerning this SPA, please contact Kenni Howard at 404-562-413 or by email at kenni.howard@cms.hhs.gov.

Sincerely,

//s//

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

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: 16-013

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
April 1, 2017

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)*

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447.201

7. FEDERAL BUDGET IMPACT:

a. FFY 2017 $ 3,839,509
b. FFY 2018 $ 42,468

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

See the attachment

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

See the attachment

10. SUBJECT OF AMENDMENT:

Federally Recognized Tribe

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:
//s//

13. TYPED NAME:
Richard O. Brajer

14. TITLE:
Secretary

15. DATE SUBMITTED:

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: 12/15/16

18. DATE APPROVED: 03/06/17

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
04/01/17

20. SIGNATURE OF REGIONAL OFFICIAL:
//s//

21. TYPED NAME: Jackie Glaze

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children Health Opns

23. REMARKS: Approved with the following changes to blocks # 8 and 9:

Block # 8 changed to read: Attachment 3.1-A.1 Pages13a.1and 13a.2; Supplement 1 Attachment 3.1-A page 1; Supplement 1to attachment 3.1-A, Part G page 5; Attachment 3.1-D pages 1, 2, 3 and 4; Attachment 3.1-F, Pages 1-21; Attachment 4.33-A page 1; Supplement 1 to Attachment 4.40-B, Page 2; Supplement 1 to Attachment 4.40-E page 3.

Block # 9 changed to read: Attachment 3.1-A.1 Pages13a.1and 13a.2; Supplement 1 Attachment 3.1-A page 1, Supplement 1to attachment 3.1-A, Part G page 5; Attachment 3.1-D pages 1, 2, 3 and 4; Attachment 3.1-F, Pages 1-21; Attachment 4.33-A page 1; Supplement 1 to Attachment 4.40-B, Page 2; Supplement 1 to Attachment 4.40-E page 3.

7. Home Health ***(continued)***

c. Medical supplies, equipment, and appliances suitable for use in the home.

1) Medical Supplies

Medical supplies are covered when medically necessary and suitable for use in any setting in which normal life activities take place, as defined at § 440.70(c)(l). Medical supplies must be prescribed by an under an approved plan of care. Providers must be certified to participate in Medicare as a ME supplier or be a Medicaid enrolled home health agency.

7. Home Health *(continued)*

c. Medical supplies, equipment, and appliances suitable for use in the home.

2) Medical Equipment

Medically necessary medical equipment (ME) is covered by the Medicaid program when prescribed by a physician. Prior approval must be obtained from the Division of Medical Assistance, or its designated agent.

Providers must be certified to participate in Medicare as a ME supplier, or be a Medicaid enrolled home health agency.

Only items determined to be medically necessary, effective and efficient are covered.

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

AMOUNT DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

Limitations in the Amount, Duration and Scope of Certain Items of Provided Medical and Remedial Care and Services are Described Below:

CITATION	Medical and Remedial Care and Services	
42 CFR 431.53	Item 24.a Transportation	Methodologies for medically necessary ambulance transportation are found in Attachment 3.1-A.1, page 18. Transportation services for categorically needy are defined in Attachment 3.1-A and transportation services for medically needy are defined in Attachment 3.1-B. An amount to reimburse Hospitals, nursing facilities, ICF-DD, and Psychiatric Treatment Facility for non-ambulance non-emergency transportation is included in Medicaid payments to those facilities. Methods of Assuring Transportation The North Carolina Division of Medical Assistance, or its designated agent, shall assure that necessary NEMT services are provided for beneficiaries who have a need for assistance with transportation. The county departments of social services or the federally recognized tribe contracts with vendors to provide NEMT services. For beneficiaries in a facility receiving long term care services, NEMT to and from outpatient services is part of the payment made to the facility (per diem) and is the responsibility of the facility. Medically Needy beneficiaries that do not have enough medical expenses to meet their Medicaid deductible are not eligible for NEMT services. Medically Needy beneficiaries are only authorized for Medicaid the day they meet their Medicaid deductible. The designated agent is the county departments of social services or the federally recognized tribe. The distance to be traveled, transportation methods available, treatment facilities available, and the physical condition and welfare of the beneficiary shall determine the type of NEMT authorized. NEMT services provided is not without qualification.

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: North Carolina

AMOUNT DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

A medical transportation assessment must be completed every twelve months or when there is change of circumstances to determine the eligibility and need for NEMT services.
Transportation is provided by the least expensive mode available and appropriate for the beneficiary, to the nearest appropriate medical provider and for a Medicaid-covered service. The type of transportation available may vary by region because of rural and urban conditions.

Any appropriate means of transportation which can be secured without charge through volunteer organizations, public services, beneficiary relatives or friends will be used. If transportation is not available without charge, payment will be made for the least expensive appropriate means of transportation available, including personal vehicle, multi-**passenger van, wheelchair van, bus, taxi, train, ambulance,** and other forms of public and private conveyance. With the exception of personal vehicles, providers are required to be contracted with the county departments of social services or the federally recognized tribe. Contracts must include specific requirements as determined by North Carolina Division of Medical Assistance. Beneficiaries, family members and volunteers using their own vehicles to provide transportation are provided gas vouchers or mileage reimbursement at the rate defined in Amendment 4.19-B Section 23, Page I g, Paragraph F.

Transportation to in-state or out-of-state locations, that are not within the beneficiary's normal service area, shall be covered when it has been determined, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are not able to be provided by a provider/facility within the state or within the beneficiary's normal service **area.**

Services ancillary to NEMT shall include meals and lodging. Reimbursement for related travel expenses may not exceed the state mileage, subsistence and lodging reimbursement rates.

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

AMOUNT DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

Recipients of NEMT services adhere to Advance Notice Policies, Conduct Policies, and No-show Policies. The county departments of social services and the federally recognized tribes are subject to specific safety and risk management policies regarding their providers and/or drivers.

Attendants, including family members, are entitled to reimbursement of expenses incurred during transportation at the least expensive rate that is appropriate to the beneficiary's circumstances. Attendants, other than family members, may charge for their time when an attendant is medically necessary. Maximum reimbursement for an attendant's time shall not exceed the state hourly wage rate, nor shall an attendant be reimbursed for time spent in travel without the beneficiary. A medical professional who serves as an attendant and administers medical services during the trip may bill Medicaid for that service, but cannot also charge for his time.

Applicants/ beneficiaries are made aware of NEMT services by the following methods:

- Information on applications/re-enrollment forms
- Rights and Responsibilities Handout/Mailing
- Department of Social Services or federally recognized tribe contact
- Beneficiary Handbook
- DMA Website

Compliance with NEMT policy is assured through county, tribal, and state monitoring and state auditing.

Counties or the federally recognized tribe are required to track each trip request from intake through disposition. Effective April 1, 2012, counties are required by policy to audit 2% of the trips made each month using a state compliance monitoring tool. Effective April 1, 2017, the federally recognized tribe is also required by policy to audit 2% of the trips made each month using a state compliance monitoring tool. Reports are maintained at the county or with the federally recognized tribe and must be provided to the state upon request and at a time of state audits.

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

AMOUNT DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

In March 2012, a contract was executed by the state with a vendor to perform audits of the county and tribal NEMT programs based on policy. The state meets at minimum biweekly with the vendor to review findings and take action. Counties or the federally recognized tribe are required to submit a corrective action plan for issues identified through the audits and to payback funds as necessary. Implementation of corrective action plan is monitored and can result in withholding of funding or termination of provider status. The audit does not affect the recipients' coverage.

State Plan under Title XIX of the Social Security Act
State/Territory: North Carolina

TARGETED CASE MANAGEMENT SERVICES
Adults and Children Over 5 Years of Age, or On the CAP-MR/DD Waiver, With Developmental Disabilities Or Traumatic Brain Injury

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

This target group includes the individuals who meet the following criteria:

Adults and children five years of age and older, or children on the CAP-MR/DD HCBS waiver, who are diagnosed with a developmental disability or diagnosed with mental retardation manifested prior to the age of 22, or who have mental or physical impairments similar to developmental disabilities as the result of a traumatic brain injury manifested after age 22.

Recipients included in the 1915 c Innovations waiver will be excluded. They will receive coordination of services under 42 CFR 438.208.

X Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 60 consecutive days of a covered stay in a medical institution Reimbursement is made to the Community Case Management Provider rather than the medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):

___ Entire State

_X_ Only in the following geographic areas: Recipients with eligibility in the counties or tribal boundaries covered under Fee for Service Medicaid are eligible for this service.

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

___ Services are provided in accordance with §1902(a)(10)(B) of the Act.

X Services are not comparable in amount duration and scope (§1915(g)(1)).

State Plan under Title XIX of the Social Security Act
State/Territory: North Carolina
TARGETED CASE MANAGEMENT SERVICES
Persons with HIV Disease

Provider Certification

In the absence of State licensure laws governing the qualifications and standards of practice for HIV case management providers, the State Division of Medical Assistance will be responsible for the certification process. DMA agrees to implement methods and procedures for certifying providers of HIV case management services as qualified to render services according to professionally recognized standards for quality care. This will ensure that HIV case management services are provided by qualified providers in accordance with section 1902(a)(23) of the Social Security Act. The initial certification is valid for one year.

To be certified and to qualify for reimbursement a provider shall submit a complete and signed application to DMA to include documentation of requirements indicated in the application. The application shall include the following information as identified under *Administrative, Case Management and Human Resource Requirements:*

Administrative Requirements

- A list of counties and tribal boundaries to be served;
- Hours of operation, the agency shall maintain regularly scheduled hours of operation;
- Emergency after hours' response plan;
- A list of potential community resources for the entire service area;
- A copy of Articles of Incorporation, unless the agency is a local government unit or a federally recognized tribe;

The agency shall meet the following requirements:

- Have a physical business site at the time of application. The business site shall be verified by a site visit. This site cannot be in a private residence or vehicle.
- Submit a copy of the agency's organizational chart
- Submit a list of person who have five percent or more ownership in all or any one agency
- Submit a business plan that provides specific information for development costs and projected monthly revenue and expense statement for the 12 months subsequent to the approval of the application and actual revenue and expense statement for the 12 months preceding the application date. This plan must:
    - Include assumed consumer base, services, revenues and expenses;
    - Outline management of initial expenses;
    - Identify the individuals responsible for the operation of the agency and shall include their respective resumes;
    - Show a program development enhancement timetable; and include existing financial resources

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of North Carolina 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 and/or primary care case management entities without being out of compliance with provisions of section 1902 of the Act on state wideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may *not* 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)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

____ i. MCO
__X__ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

__X__ i. fee for service;
____ ii. capitation;
__X__ iii. a case management fee;
__X__ iv. a bonus/incentive payment;
____ v. a supplemental payment, or
__X__ vi. other. (Please provide a description below).

Providers serving as a Pregnancy Medical Home are paid an incentive pay for performing an initial prenatal screening using a standardized tool and for an incentive payment for a postpartum visit.

Citation	Condition or Requirement

In addition, providers are paid an enhanced fee for vaginal deliveries. Providers are exempted from the requirement to obtain prior approval for ultrasounds. Pregnancy Medical Home providers are not paid a PM/PM.

North Carolina is transitioning from a basic PCCM program, Carolina ACCESS, to an enhanced PCCM program, Community Care of North Carolina (CCNC). CCNC is a composite of regional networks operating statewide. The state currently contracts with each network to carry out the functions of the program. To operationalize this transition, the state will contract with North Carolina Community Care Networks, Inc. (NCCCN) to administratively oversee the networks, and by holding NCCCN contractually responsible, to ensure regional networks and CCNC affiliated providers meet program goals and performance measures.

NCCCN is a physician-led private non-profit organization with the expertise and resources to ensure a healthcare delivery system that is cost efficient and driven to achieve patient centered quality health care. With this transition, the state will no longer contract directly with the networks. NCCCN will enter into contracts with each of the networks to continue operation of CCNC. Each network builds private and public partnerships where community providers and resources plan cooperatively for meeting patient needs. Health care management is provided at the community level, allowing local solutions to achieve desired outcomes. Because health care is planned and provided at the community level, larger community health issues can be addressed. NCCCN will ensure standardized performance and utilization metrics are implemented and achieved state-wide.

The state will continue to require a PCCM contract with providers to serve as health homes for Medicaid, Health Choice and targeted populations. To participate as a health home in CCNC, providers must also contract with NCCCN and the network with which it affiliates.

Providers serving as Carolina Access (CA) PCPs are encouraged to join a network to establish their role as a health home for Medicaid and Health Choice beneficiaries. If a CA provider chooses not to affiliate with a network, the enrolled beneficiaries who are in a mandatory group will be required to choose a CCNC provider. Beneficiaries who are voluntary for enrollment can choose to enroll with a network affiliated provider or can choose to opt out of CCNC. The state is sensitive to the possibility that this could create a temporary access to care issue and the state has created a process that identifies beneficiaries for whom there is no PCP available within 30 miles of their residence. In these situations, the state and NCCCN will work cooperatively to develop and ensure appropriate access; however, beneficiaries will remain exempt until access is available.

Citation	Condition or Requirement

NCCCN Responsibilities:

Using a patient centered team approach, NCCCN utilizes human and organizational resources to develop and implement a population management approach with enhanced and coordinated care for enrolled beneficiaries through:

- prevention and screenings;
- standardization of evidence-based best practices;
- community-based care coordination;
- care management;
- patient monitoring;
- investments in health information technology;
- health information exchange;
- data analytics for population stratification and prioritization;
- medication reconciliation;
- transitional care support;
- self-management coaching;
- reimbursement incentives to increase the quality and efficiency of care for patient populations;
- disease management; and
- linkages to community resources.

To accomplish this, NCCCN provides:

- Standardized, clinical, and budgetary coordination;
- Oversight and reporting;
- Locating, coordinating and monitoring the health care services of enrolled populations;
- Comprehensive statewide quantitative performance goals and deliverables;
- Utilization management;
- Quality of care analytics;
- Access to care measures;
- Financial budgeting, forecasting, and reporting methodologies;
- Predictable cost containment methodologies;
- Outcome driven clinical and financial metrics; and
- Training, education, mentorship and supervision.

Citation	Condition or Requirement

Network Responsibilities:

Each network operates under the direction of a network director, clinical director, and network steering committee. The steering committee is composed of community leaders and organizations involved in planning for or providing services to Medicaid and Health Choice beneficiaries. Networks ensure that there is a sufficient panel of primary care providers to serve enrolled populations within the regional catchment area. A local medical director and board provide clinical direction and supervision to the network on initiatives agreed upon by DMA and NCCCN. Networks hire or contract with professionals who have expertise to lead and support each initiative. These experts include but are not limited to:

- Medical Director who chairs a Medical Management Committee;
- Care managers (nurses and social workers);
- Network and Clinical Pharmacists;
- Psychiatrists;
- Pregnancy Home Nurse Coordinator;
- CC4C Coordinator;
- Health Check program Coordinator; and
- Palliative Care Coordinator.

Networks establish uniform processes for functions that include but not limited to:

- Enrollee complaints;
- Performance measures;
- Use of CMIS and data reporting to identify patients at highest risk and who could benefit from care management services;
- Development of patient centered care plans in coordination with the primary care provider;
- Transitional support;
- Training of staff to develop skills to provide care management services; and
- Population management strategies (disease and care management pathways and expectations).

Citation	Condition or Requirement

Provider Responsibilities:

Medicaid enrolled providers can qualify to be a primary care provider in the CCNC program when the conditions of the contract with the network and NCCCN are met and maintained. These requirements include but are not limited to the following:

- The provision of coordinated and comprehensive care;
- Compliance with CCNC initiatives and promotion of service integration and self-management;
- The application of evidence based best practice in coordination with network and care managers;
- Coordination with care managers in developing and carrying out patient plans of care;
- Cooperation and collaboration with NCCCN and networks to implement initiatives;
- Serving as a patient centered health home;
- Implementing strategies of population based strategies of care;
- Using the Informatics Center for reports and analytics to improve patient care;
- Carrying out disease management activities of NCCCN; and
- Demonstrating improvement in quality and cost of care.

To affect positive changes in the delivery of prenatal care and pregnancy outcomes; North Carolina established a medical home for pregnant Medicaid beneficiaries called a Pregnancy Medical Home (PMH). Case management services for Medicaid pregnant women are part of the managed care model. The CCNC networks receive a PM/PM to work directly with PMHs and to provide population management and care/case management for this population.

A PMH provider may also be a CCNC-PCP but it is not required. A PMH must agree to a set of performance measures which are different from the measures for CCNC PCPs. The following are examples and may change over time based on best practices and data-:

- Obtain and maintain a Cesarean Section rate of 20% or below;
- No elective inductions before 39 weeks;
- Engage in the 17 P program; and
- Complete high risk screenings on beneficiaries.

Citation	Condition or Requirement

A provider who agrees to be a PMH is paid fee for service and receives an incentive and enhanced delivery rate for each Medicaid beneficiary. The provider does not receive a PM/PM for being a PMH.

PMH providers are assigned a pregnancy care manager to work with their high risk pregnant population. These high risk pregnant women receive services based upon their level of need. This program is outcome driven and measured. The following are examples of the performance measures and may change over time:

- Increase number of high risk patients that receive a comprehensive assessment;
- Increase the postpartum visit rate; and
- Increase the percent of eligible at-risk women that receive the 17P injections.

Case management services for the pregnant woman population was previously fee for service and is now being moved to the managed care model.

CCNC operates the Care Coordination for Children program (CC4C) which provides care/case management for high risk and high cost children aged birth up to age 5, excluding Early Intervention. Eligible children receive population management, care management, and coordination of treatment and prevention. This program is outcome driven and measured. The following are examples of the performance measures and may change over time:

- Increase rate of first visits by NICU graduates within 1 month of discharge;
- Increase rate of comprehensive assessments completed; and
- Increase number of children who have a medical home that have special health care needs and/or are in foster care.

Case management services for high risk children aged birth up to age 5 was previously fee for service and is now being moved to the managed care model.

North Carolina expanded the use of the regional networks to provide these activities to high risk and high cost children or pregnant women not enrolled with a network. The networks are also paid a pm/pm for these services when provided to non-enrolled beneficiaries.

State: North Carolina

Citation	Condition or Requirement

The PM/PM for care/case management of the pregnant women and children birth up to age 5 was based on the current fee for service cost of the maternal care coordination targeted case management program and the child service coordination case management program. The total expenditures in the base year were divided by the total beneficiary population to establish the PM/PM rate. These rates were actuarially certified as being developed in accordance with generally accepted actuarial practices and are appropriate for the Medicaid covered populations and services under the managed care contract and PMPM rates

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)
incentive
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, 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)).

__X__ 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.

__X__ 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.

__X__ v. Incentives will be made available to both public and private PCCMs.

__X__ vi. Incentives will not be conditioned on intergovernmental transfer agreements.

____ vii. Not applicable to this 1932 state plan amendment.

Citation	Condition or Requirement
CFR 438.50(b)(4)	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. *(Example: public meeting, advisory groups.)* 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 beneficiaries 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, physicians, etc. Networks also have 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 using an external vendor will be conducted every two years to maintain continued input from providers who participate in the program but who may not be part of an advisory committee. Beneficiaries enrolled with the PCCM managed care program have public input through the state's toll free customer service phone center which is staffed from eight to five, Monday through Friday. The toll free number for the state customer service center is 1-800-662-7030. 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 beneficiary to have involvement in the care management plan being proposed. In addition, the health home/PCP works closely with the high risk enrollee and their family in the development of a health care team and patient-centered care plan to support the enrollee in managing their chronic condition(s), as appropriate.

Citation	Condition or Requirement
	Beneficiaries are also able to submit a concern about the program through a written complaint process. Enrollees 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 adults. A patient satisfaction survey will be conducted by an external vendor every three (3) years. The NC Medical Care Advisory Committee reviews all major program changes for the Medicaid program. Beneficiaries 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 recipient to receive their benefits through managed care entities will be met.
1932(a)(1)(A	4. __X__ The state assures that all the applicable requirements of 42 CFR 431.51 42 CFR 431.51regarding freedom of choice for family planning services and supplies as 1905(a)(4)(C) 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. __X__ 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) 438.6(c) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6. ____The state assures that all applicable requirements of 42 CFR for payments under any risk contracts will be met.
1932(a)(1)(A) 447.362 for 42 CFR 447.362 42 CFR 438.50(c)(6)	7. ____The state assures that all applicable requirements of 42 CFR 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 Aged, Blind and Disabled (MAA, MAB, MAD, MSB)
- Residents of Adult Care Homes (SAD, SAA)
- Special Assistance In-Home (SAIH)
- Qualified Alien
- Health Choice (North Carolina's S-CHIP program)

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 mandatory exempt.

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)	i.	_X_ Recipients who are also eligible for Medicare. If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)* North Carolina moved to an opt-out process for enrolling dual eligible beneficiaries. Dual beneficiaries receive a letter informing them of the name, address, and phone number of the health home to which they have been assigned unless they contact the local department of social services. Assignment is based on an historical relationship with a provider and if no relationship can be determined, the beneficiary is assigned to a health home within a 30 mile radius of the beneficiary's home. The letter also informs them of their right to disenroll, change their medical home, and enroll on a month to month basis. The State assures that beneficiaries will be permitted to change medical homes or disenroll from a managed care plan on a month to month basis.
1932(a)(2)(C)	ii.	_X_ Indians who are members of Federally recognized Tribes except when 42 CFR 438(d)(2) 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. Native Americans are not part of the opt-out process. When making application for medical assistance, they are informed that they may enroll, disenroll, or change their medical home on a month to month basis if they opt to enroll. The State assures that beneficiaries will be permitted to change medical homes or disenroll from a managed care plan on a month to month basis.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii.	_X_ Children under the age of 19 years, who are eligible for supplemental Security Income (SSI) under title XVI.

State: North Carolina

Citation		Condition or Requirement
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv.	____Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v.	_X_Children under the age of 19 years who are in foster care or other out-of- the-home placement.
1932(a)(2)(A)(iv) care or 42 CFR 438.50(3)(iv)	vi.	_X_Children under the age of 19 years who are receiving foster adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii.	_X_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.

With the exception of children receiving foster care services or adoption assistance, North Carolina has moved to an-opt out process for enrolling children with special health care needs. Parents/guardians of these children receive a letter informing them of the name, address, and phone number of the health home to which assignment has been made unless they contact the local department of social services. Auto-assignment is made to a health home with which there is an historical relationship if that can be determined. If there is no relationship with a health home, the beneficiary is assigned to a health home within 30 miles of the beneficiary's residence. The letter also informs them of their right to disenroll, change their health home, and enroll at any time.

As a result of law P.L. 110-351/H.R.6893, Fostering Connections to Success and Increasing Adoption Act of 2008, the division works closely with the North Carolina Pediatric Society, practicing pediatricians and the North Carolina Division of Social Services to enroll foster children into health homes created by the PCCM program to plan for continued medical care of children with special health care needs.

The State assures that these beneficiaries will be permitted to change health homes or 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.)*

Citation	Condition or Requirement

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).

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
_X_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, and Coordinated care system.

_X_ i. yes
___ii. no

1932(a)(2)

4. Describe how the state identifies the following groups of children who are exempt 42CFR 438.50 (d)from mandatory enrollment: *(Examples: eligibility database, self- identification)*

i. Children under 19 years of age who are eligible for SSI under title XVI;

The State identifies this group by Medicaid eligibility category of assistance.

ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;

The State does not enroll this population in the managed care programs.

iii. Children under 19 years of age who are in foster care or other out-of-home placement;

The State identifies this group by the Medicaid eligibility category of assistance or living arrangement code.

iv. Children under 19 years of age who are receiving foster care or adoption assistance.

The State identifies this group by the Medicaid eligibility category of assistance or living arrangement code.

State: North Carolina

Citation	Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	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. *(Example: self-identification)* The state has eliminated the self-identification for special needs. Children having special needs are identified according to CFR 438.50(d)(3)
1932(a)(2) 42 CFR 438.50(d)	6. Describe how the state identifies the following groups who are exempt from mandatory enrollments into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)* i. Beneficiaries who are also eligible for Medicare. These beneficiaries are identified by Medicaid eligibility category of assistance. 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. There is no eligibility category group designated for the Native American population; they are eligible for Medicaid under existing program aid categories.

State: North Carolina

Citation		Condition or Requirement
42 CFR 438.50	F.	List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment MQB, RRF/MRF, CAP cases with a monthly deductible, MAF-D, MAF-W, PACE enrollees, and Aliens eligible for emergency Medicaid only are not eligible to enroll.
42 CFR 438.50	G.	List all other eligible groups who will be permitted to enroll on a voluntary basis MPW (Medicaid for Pregnant Women) Benefit Diversion Beneficiaries Beneficiaries with end stage renal disease
	H.	Enrollment process.
1932(a)(4) FR 438.50		1. Definitions
		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 beneficiaries if it has experience in serving the Medicaid population.
1932(a)(4) 42 CFR 438.50		2. State process for enrollment by default: Describe how the state's default enrollment process will preserve:
		i. The existing provider-beneficiary relationship (as defined in H.1.i). 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.

Citation	Condition or Requirement

The state provides an enrollment form to the county departments of social services and the federally recognized tribe. It is required to be completed at enrollment or change of health home. It is signed by the beneficiary or beneficiary'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 beneficiary provides the name of their chosen health home by phone, the caseworker is permitted to complete the form and file it in the beneficiary's record without signature. The caseworkers in each local county Department of Social Services (DSS) or the tribal office of the federally recognized tribe are responsible for auto-assignments on an individual basis when beneficiaries have not selected a provider.

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 beneficiaries to a health home; however, certain DMA staff and designees also have the ability to link beneficiaries. Inquiries are made for potential default enrollment as to current provider-patient relationships when beneficiaries do not select a PCP at the time of the visit. Some beneficiaries, particularly Supplemental Security Income (SSI) beneficiaries, 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. If the beneficiary cannot be contacted, they are auto-assigned and notified of their enrollment and rights. Assignments are based on an historical relationship with a health home. If no relationship can be determined, the beneficiary is assigned to a health home within a 30-mile radius of the beneficiary's residence.

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

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

Citation	Condition or Requirement
	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 beneficiaries (as defined in H.2.ii).
	Beneficiaries are notified of managed care programs when they apply for Medicaid or when they are due for their eligibility review. Because SSI beneficiaries 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 or the federally recognized tribe to select a PCP. The report is monitored to determine if SSI beneficiaries are getting enrolled.
	The county DSS staff or the tribal office of the federally recognized tribe has the responsibility to review the SSI exempt report and auto-assign all beneficiaries over the age of 19 who have been on the report for 30 days or more. Counties or the federally recognized tribe then send a letter to the beneficiary informing them of their PCP along with a copy of the beneficiary handbook.
	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). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*
	If it is not possible to obtain provider-patient history, beneficiaries are assigned to a health home based upon equitable distribution among participating PCPs available in the beneficiary's county of residence or tribal boundary and within a 30-mile radius of the beneficiary's home.
	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 beneficiary.
1932(a)(4)	3. As part of the state's discussion on the default enrollment process, include 42 CFR 438.50 the following information:

State: North Carolina

Citation	Condition or Requirement

i. The state will____/will not X use a lock-in for managed care managed care.

ii. The time frame for recipients to choose a health plan before being auto-assigned will be 30 days.

iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*

Beneficiaries are notified of managed care programs when they apply for Medicaid or when they are due for their eligibility review. Because SSI beneficiaries 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 beneficiaries are getting enrolled.

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

iv. Describe the state's process for notifying the Medicaid beneficiaries who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

The State assures that beneficiaries will be permitted to disenroll from a managed care plan on a month to month basis.

v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

Caseworkers at the local DSS or local office of the federally recognized tribe are trained to make every effort to support a Provider/ patient relationship with the auto-assignment. If a relationship is not present, caseworkers are instructed to auto-assign beneficiaries to a health home that is accepting new patients within a 30 mile radius. This is done on a case by case basis.

Citation	Condition or Requirement

i. Describe how the state will monitor any changes in the rate of default assignment. (Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker.)

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.

Caseworkers are instructed to identify on the Medicaid enrollment application when a beneficiary is auto-assigned to a medical home.

1932(a)(4)
42 CFR 438.50

l. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. _X_ The state assures it has an enrollment system that allows beneficiaries 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.

2. _X_ The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid beneficiaries 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).

3. _X_ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

___ This provision is not applicable to this 1932 State Plan Amendment.

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 beneficiary has a choice of at least two primary care providers within the entity. (California only.)

_X_ This provision is not applicable to this 1932 State Plan Amendment.

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.

State: North Carolina

Citation	Condition or Requirement

_X_ This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will___ /will not_X_ use lock-in for managed care.

2. The lock-in will apply for ____ months (up to 12 months).

3. Place a check mark to affirm state compliance.

_X_ The state assures that recipient requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe any additional circumstances of "cause" for disenrollment (if any).

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

_X_ 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.)

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
Anesthesiology
At Risk Case Management
CAP Services
Certified Nurse Anesthetist
Dental
CDSAs
Mental Health for adults
Pathology Services
School Services
Inpatient care with ED admission
Services in hospital Emergency Department
Limited eye care services
Family Planning
Head Start Programs
Hearing Aids
Hospice
Laboratory Services
Optical Supplies/Visual Aids
Pharmacy

State: North Carolina

Citation	Condition or Requirement
	Care Management by CCNC network Services provided by health departments Radiology services billed with Radiologist provider number

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 X 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 recipient. 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.

Procedure: ABUSE, NEGLECT, MISAPPROPRIATION OF PROPERTY; REFERRALS

1. Referrals are received from providers by phone or mail.

   a. Fill out a referral form upon receipt. Fill out as completely as possible to include names of alleged perpetrator(s), victim(s), witnesses, nature of allegation, date and time of incident, injuries (if any), result of provider's investigation (substantiated/unsubstantiated), and provider's action.

   b. Determine if allegation has been reported to the county Department of Social Services, the federally recognized tribe, local law enforcement agency or other agency. Obtain as much information as possible from the reporter regarding investigations by these agencies.

   c. Request additional information as needed (i.e. copy of facility investigation, statements of victim, witnesses and alleged perpetrator, incident report, termination notice, orientation and in service documentation of alleged perpetrator) and indicate items requested on the referral form.

   d. Make an entry into the referral log.

   e. When additional information is received from the provider, Department of Social Services, federally recognized tribe, police or other agency, attach information with referral form and update log.

2. Determination of investigation by Abuse, Neglect and Misappropriation of Property Team.

   a. After review of referral and information received, the Program Manager will determine whether the allegation will be investigated by the Team.

   b. If an investigation is to be done, the referral is assigned a control number and entered into investigation log.

   c. If no investigation is to be done, the reason will be noted on the referral form. All related documents will then be attached and filed in the Abuse, Neglect and misappropriation of Property miscellaneous file.

   d. Mail letters to acknowledge information received and to indicate planned actions to the provider.

response has been unsatisfactory to the complainant, a complaint will be recorded for investigation by the CIB during the second contact. If complainants have any hesitancy in talking with facility management, a complaint will always be taken during the initial contact.

II. Upon receipt, complaints are directed to the Branch Head or her designee who will:

A. Review the complaint.

B. Label the complaint with the complaint category (ies).

C. Write a letter to the complainant acknowledging receipt of the complaint.

D. Decide whether all or portions of the complaint should be referred to other agencies/groups, etc.

1. Complaints alleging abuse, neglect, or exploitation of a specifically named patient are immediately referred to the County Department of Social Services, or federally recognized tribe, or Adult Protective Services, in accordance with the agreement between Division of Facility Services and Division of Social Services or federally recognized tribe. In accordance with G.S. 108A-103 the Division of Social Services (DSS) will make "a prompt and thorough evaluation to determine whether the individual is in need of protective services." When in the course of the DSS investigation it becomes apparent that the abuse, neglect, or exploitation will be substantiated, the county DSS director or federally recognized tribe will immediately notify DFS by phone. The CIB will assess data from the DSS or federally recognized tribe to determine

North Carolina Department of Health and Human Services
Division of Social Services

Methods of Administration
For
Title VI Compliance
Of the
Civil Rights Act of 1964

Name of Program: MEDICAL ASSISTANCE (TITLE XIX MEDICAID) - CONTINUED

B. Vendors

All vendors are advised of Title VI requirements at the time of admission to the program. Each vendor receives semi-annual visits from Medical Services staff at which time they are reminded of Title VI requirements. Vouchers contain a compliance agreement.

Copies of Title VI information sent to vendors is being drafted and will be forwarded to the Region IV Office for Civil Rights. This information is mailed to all vendors and is reviewed by the Provider Representative upon an on-site visit.

C. Clients and Applicants

The responsibility for giving Title VI information to clients and applicants is delegated to county department of social services or federally recognized tribe intake workers, eligibility specialists, and social workers. Clients and applicants are advised that if they feel they are the subject of discrimination, they may receive an administrative hearing at the county level, or they may request a formal hearing from a state staff appeals and hearings officer. If they wish to file a written complaint of discrimination, forms are provided at the county level. They may call the complaint in on the Department of Health and Human Services "Hotline" or they may write to the state office or to the Regional or National Department of Health, Education, and Welfare. When this information has been provided, a notation to that effect is entered in the client's record. The client and/or applicant is given a booklet of program information which includes Title VI information. There is no scheduled periodic reissuance of this in-client is reminded of rights under Title VI.

D. Public

Booklets which contain information in reference to services available to clients and applicants are available in lobbies and waiting rooms of county departments of social services or the tribal office of the federally recognized tribe. These booklets contain a Title VI statement. The Division of Social Services issues a statement of non-discrimination news release to all news media. Social Services staff are advised to mention Title VI policy when meeting with community groups and making presentations.

III. Maintaining and Assuring Compliance

A. Reviews of Hospitals and Nursing Homes

The Division of Facility Services has six staff persons to review these facilities via annual on-site visits. These reviews include information as to the following:

The service area and population by race
Principal administrator
Licensed bed capacity
Number of rooms: private, semi-private and wards
Room occupancy inspection (patient count)
Physicians and dentists in the service area with racial breakdown

Division of Social Services

Methods of Administration
For
Title VI Compliance
Of the
Civil Rights Act of 1964

Name of Program: MEDICAL ASSISTANCE (TITLE XIX MEDICAID) - CONTINUED

Staff privileges by race
Courtesy titles
Training programs with minority participation
Title VI and open admissions information
Patient(room transfers)
Board chairman and racial makeup of boards