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.

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)
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)).

_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.

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 42 CFR 431.51 1905(a)(4)(C)	4.	__X__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.	__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) 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 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.

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) 42 CFR 438(d)(2)	ii. _X_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. 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.

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)	v. _X_ Children under the age of 19 years who are in foster care or other out-of- the-home placement.
42 CFR 438.50(3)(iii) 1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. _X_ 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. _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

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

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.

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.

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. 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) 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 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, 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 to select a PCP. The report is monitored to determine if SSI beneficiaries are getting enrolled.

The county DSS staff 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.

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 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)
42 CFR 438.50

3. As part of the state's discussion on the default enrollment process, include the following information:

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 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 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

I. 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.

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

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.