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State/Territory Name: North Carolina

State Plan Amendment (SPA) #: 19-0007

This file contains the following documents in the order listed:

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

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

Atlanta Regional Operations Group

October 24, 2019

Mr. Dave Richard
Deputy Secretary
Division of Medical Assistance
North Carolina Department of Health and Human Services
2501 Mail Service Center
Raleigh, North Carolina 27699-2501

Dear Mr. Richard:

We have reviewed the proposed amendment to the North Carolina State Plan (SPA) NC 19-0007 which was submitted on September 11, 2019. This submission allows NC Medicaid to update its language to reflect PCCM changes in anticipation of statewide managed care delivery launch.

Based on the information provided, we have approved Medicaid State Plan Amendment NC 19-0007 on October 23, 2019. The effective date of this amendment is November 1, 2019.

Should you have questions or need further assistance, please contact Donald Graves at (919) 828-2999, or Charles Friedrich at (404) 562-7404.

Sincerely,

/s/

Davida R. Kimble
Acting Deputy Director
Division of Medicaid Field Operations South

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**	1. TRANSMITTAL NUMBER: 19-0007	2. STATE NC
FOR: HEALTH CARE FINANCING ADMINISTRATION	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** November 1, 2019	

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 438.6 (c)	7. FEDERAL BUDGET IMPACT: a. FFY 2020 $4,657,442 b. FFY 2021 $9,729,082
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-F, pages 2-9; 11-12; 15-19; and 21.	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 3.1-F, pages 2-9; 11-12; 15-19; and 21.

10. SUBJECT OF AMENDMENT:

Primary Care Case Management (PCCM)

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/	16. RETURN TO: Office of the Secretary Department of Health and Human Services 2001 Mail Service Center Raleigh, NC 27699-20014
13. TYPED NAME: Mandy Cohen, MD, MPH	
14. TITLE: Secretary	
15. DATE SUBMITTED: 09/11/19	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 09/11/19	18. DATE APPROVED: 10/23/19
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 11/01/19	20. SIGNATURE OF REGIONAL OFFICIAL: /s/
21. TYPED NAME: Davida R. Kimble	22. TITLE: Acting Deputy Director Division of Medicaid Field Operations South

23. REMARKS:

Citation	Condition or Requirement
	The state will contract with a PCCM entity that contracts with providers to serve as medical homes for Medicaid, Health Choice and targeted populations.

Citation	Condition or Requirement

PCCM Responsibilities:

Using a patient centered team approach, the PCCM entity 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, the PCCM entity 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

PCCM Responsibilities:

The PCCM entity ensures that there is a sufficient panel of primary care providers to serve enrolled populations within the regional catchment area.

The PCCM entity establishes uniform processes for functions that include but not limited to:

- Enrollee complaints;
- Performance measures;
- Use of a data platform, analytics and 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 PCCM program when the conditions of the contract with the PCCM entity are met and maintained. These requirements include but are not limited to the following:

- The provision of coordinated and comprehensive care;
- Compliance with PCCM entity 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 PCCM entity and networks to implement initiatives;
- Serving as a patient centered medical home;
- Implementing strategies of population based strategies of care;
- Using the PCCM entity data platform for reports and analytics to improve patient care;
- Carrying out disease management activities of the PCCM entity; and
- Demonstrating improvement in quality and cost of care.

Pregnancy Management Program (PMP)

To affect positive changes in the delivery of prenatal care and pregnancy outcomes, North Carolina established a medical home for pregnant Medicaid beneficiaries now called the Pregnancy Management Program (PMP). Case management services for Medicaid pregnant women are part of the managed care model. The PCCM entity receives a PM/PM to work directly with PMPs and to provide population management and care/case management for this population.

A PMP provider may also be a PCP but it is not required. A PMP must agree to a set of performance measures which are different from the measures for PCPs.

Citation	Condition or Requirement

A provider who agrees to be a PMP 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 PMP. In addition, providers are paid an enhanced fee for vaginal deliveries. Providers are exempted from the requirement to obtain prior approval for ultrasounds.

PMP 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.

Care Management for At Risk Children (CMARC)

The PCCM entity operates the Care Management for At Risk Children program (CMARC) which provides care/case management for high risk and high cost children aged birth up to age 5. Eligible children receive population management, care management, and coordination of treatment and prevention. This program is outcome driven and measured.

Citation	Condition or Requirement

DMA shall set forth all payments to the provider including enhanced services reimbursement and enhanced management fees and that the contract 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. A provider satisfaction survey 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.

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 year.

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
	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.)* In 2011, 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 medical home within a 35 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. Auto-assignment is made to a medical home with which there is an historical relationship if that can be determined. If there is no relationship with a medical home, the beneficiary is assigned to a medical home within 35 miles of the beneficiary's residence. The State assures that these beneficiaries will be permitted to change PCPs 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

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)
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 medical 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 medical 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 medical 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 enrollment 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 medical home. If no relationship can be determined, the beneficiary is assigned to a medical home within a 35 mile radius of the beneficiary's residence.

Counties and the federally recognized tribe receive a monthly enrollment report that provides the name of the medical home. Our eligibility and enrollment platform also maintains a history of enrollment (exemption or medical home).

The state allows providers to have their patients complete an enrollment form which is then sent to the county department of social services, 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 medical home based upon equitable distribution among participating PCPs available in the beneficiary's county of residence or tribal boundary and within a 35 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 and enrollment platform, 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.

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, beneficiaries are auto-assigned to a medical home that is accepting new patients within a 35 mile radius.

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.

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
		Care Management 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.