AGENTIC ARMOR LLC

NORTH CAROLINA · MEDICAID

North Carolina Medicaid: The Atlas Master Binder

The state's public record is reconciled against the Code of Federal Regulations. The reconciliation runs provision by provision. This binder prints it in full.

October 31, 2026

183 of 196	93.4 percent	501
documents collected and reconciled	of the whole State File Inventory	determinations in the register, none unverified

Determination	Rows
Verified	141
Partial	274
GAP-DETERMINED	71
N-A	10
Prospective	5
Unverified	0
Total	501

STATUS OF RECORD

North Carolina is cured as of October 30, 2026. The cure pass is complete. The register is fully graded. The last two open documents were collected at the closeout. They are the 1115 Special Terms and Conditions and the CAP/DA Appendix K approval NC.0132.R07.10.

This binder is built from public information. It rests on the state's own published record. It rests on the federal regulation text, read at the places cited. What the public record does not hold prints as a gap. This binder names it as a gap.

This binder is an independent product of Agentic Armor LLC. Agentic Armor LLC is not affiliated with CMS or HHS. Neither CMS nor HHS has endorsed it. Neither CMS nor HHS has authorized it.

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North Carolina Medicaid: The Atlas Master Binder · October 31, 2026

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Status of record, October 31, 2026. 183 of 196 documents stand collected and reconciled. That count is 93.4 percent. The register stands fully graded. North Carolina is cured as of October 30, 2026. The two documents that closed the cure are named on the cover in full. The How this binder works section names them in full as well.

How this binder works

What this binder covers

This binder covers one state only. It covers North Carolina Medicaid. It covers the state's public record as reconciled against the Code of Federal Regulations. It prints that record in seven parts. The parts run from the public record gaps to the register in full.

What this binder does not cover

This binder does not cover any other state. It does not cover internal agency material that was never public. It prints the status the record supports. North Carolina is cured as of October 30, 2026, on the closeout named in this section.

The date this binder speaks as of

This binder speaks as of October 30, 2026. This edition is dated October 31, 2026. The register figures carry the cure pass date of October 27, 2026. The closing figures carry the closeout date of October 30, 2026. A later posting can change a figure after that date. Such a change belongs to the next edition.

One source for every part

Each part in this binder prints from the same file as the standalone download of the same name and date. The pages in this binder are the same pages as the pages in each standalone download. Nothing was re-set for the binder. A citation to a page inside a part therefore means the same page content in either form. In this bound volume the part sits behind the front matter and divider pages listed in the contents.

How to use the parts

Read Part 1 first for what the public record does not hold. Parts 2, 3, and 4 work as one set. The Ishikawa diagrams name the causes. The Process Map draws the work end to end. The Companion Guide explains every step the map numbers. Part 5 follows the 1099 reporting line in depth. Part 6 is the Cure Report, publication edition. It carries the verdict the review reached. Part 7 is the register in full. It is the evidence volume behind every count in this binder.

The figures and their date

Every figure in the front matter is stated as of the cure pass of October 27, 2026 and the closeout of October 30, 2026. The same dates hold on the divider pages. The inventory figure is 183 of 196 documents collected and reconciled. That count is 93.4 percent of the whole State File Inventory. The register holds 501 determinations. The grades are Verified 141, Partial 274, GAP-DETERMINED 71, N-A 10, Prospective 5, and Unverified 0. This binder runs to 647 pages in the bound volume.

The two documents that closed the cure

North Carolina was held open at the cure pass by exactly two documents. Both documents are public. Both are named here. They are the 1115 Special Terms and Conditions and the CAP/DA Appendix K approval NC.0132.R07.10. Both were collected at the closeout of October 30, 2026. Each one was read in full at its live address at medicaid.gov. The first is classed MAPPED-TEXT. The second is classed REVIEWED-NO-CFR-CITATION-FOUND. With those two rows reconciled, the inventory stands at 183 of 196. The state stands cured. The status printed on the cover stands.

PART 1 OF 7

The Public Record Gaps

165 pages

PART 1

NC-Public-Record-Gaps-2026-10-31.pdf

This part leads the binder on purpose. It lists in full what the reconciliation could not close on the public record. It names the documents missing outright. It names every determination the public record carries only in part. It names the places where the public record contradicts itself. It closes with the completely unverified count. It also carries a citation index for all 501 determinations. It rests on the register of record as graded on October 27, 2026 and closed at the closeout of October 30, 2026. Each entry also rests on the searches recorded on its face.

Status of record, October 31, 2026. 183 of 196 documents stand collected and reconciled. That count is 93.4 percent. The register stands fully graded. North Carolina is cured as of October 30, 2026. The two documents that closed the cure are named on the cover in full. The How this binder works section names them in full as well.

The pages that follow are the same pages as the standalone download of the same name and date.

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The Public Record Gaps

Missing documents, partial compliance, and conflicting information in the public record

13	274	19
documents missing outright · 71 gap-determined determinations stand behind this section	determinations at partial compliance · grouped under 49 public documents	points where the record contradicts itself · 16 register conflicts and 3 substance conflicts

This document is built entirely from public information. It rests on NC DHHS and Division of Health Benefits publications. It rests on NCTracks. It rests on the State Plan and its attachments. It rests on waiver documents, plan contracts, and manuals. It rests on bulletins and CMS publications. Each source was read against the requirements of Title 42 of the Code of Federal Regulations.

Status, stated plainly. North Carolina is cured as of October 30, 2026. The inventory stands at 183 of 196 rows collected and reconciled. That count is 93.4 percent. The inventory holds 13 true gaps. The last two open documents were collected at the closeout of October 30, 2026. They are named wherever status is stated. The first is H-024, the 1115 Special Terms and Conditions, WFTC overlay version, at medicaid.gov, dated September 25, 2026. The second is H-035, the CAP/DA Appendix K approval NC.0132.R07.10, at medicaid.gov. Both documents were read in full at their live addresses. The register stands at 501 determinations. The grades are 141 Verified, 274 Partial, and 71 gap-determined. The grades also include 10 determined not applicable, 5 Prospective, and 0 Unverified. The cure pass figures carry the October 27, 2026 date. The closing figures carry the October 30, 2026 closeout date.

What this document covers. This document covers the gaps in North Carolina's public record as graded at the cure pass of October 27, 2026 and the closeout of October 30, 2026. The cure pass is the review that graded every register entry against public evidence. The closeout is the pass that collected the last two open documents and closed the cure. What this document does not cover. Sections 1 to 3 do not list the 141 Verified determinations. The public record closes those determinations. This document does not cover internal agency material that was never public. It does not cover any other state. The date this document speaks as of. This document speaks as of October 30, 2026. This edition is dated October 31, 2026. A later posting can change a grade after that date.

The front list names the missing documents plainly. Section 1 lists the places where the public record contradicts itself. Section 2 lists every determination the public record carries only in part. Each one is grouped under the holding document. Section 3 lists the documents missing outright. A closing section states the completely unverified count. An appendix indexes every determination by its section and page.

Version 1 · October 31, 2026

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FRONT LIST · DOCUMENTS MISSING FROM THE PUBLIC RECORD

Named plainly, up front · 13 true gap documents. The two documents that closed the cure are named separately below.

These documents belong in North Carolina's public record. They are not in it, on the searches recorded at the October 27, 2026 cure pass. Each line points to its full entry in Section 3. The 13 documents below are true gaps. No copy was found on any source searched.

Missing document	What is missing, in one line	Full entry
1. Executed base contract, Prepaid Health Plan (Standard Plan) Services Contract #30-190029-DHB (NL-01)	The State posts the RFP form and the amendments. The State does not post an executed copy of the signed Standard Plan contract.	Section 3, entry 1, page 115
2. Executed base contract, BH I/DD Tailored Plan Contract #30-2020-052-DHB (NL-02)	The State posts the restated RFA form and model amendment sections. The State does not post an executed copy of the signed Tailored Plan contract.	Section 3, entry 2, page 116
3. Executed base contract, Medicaid Direct PIHP Contract #30-2022-007-DHB (NL-03)	The posted base contract carries placeholder plan names. It is not an executed copy of the signed Medicaid Direct PIHP contract.	Section 3, entry 3, page 116
4. The complete clinical coverage policy set (NL-04)	The clinical coverage policies live only as an index page plus separate files across category pages. They do not live as one set.	Section 3, entry 4, page 117
5. 2025 NC Medicaid Managed Care Quality Strategy (the document) (NL-06)	A bulletin says the 2025 Quality Strategy document is published on the Quality Management and Improvement page. That page carries no such document.	Section 3, entry 5, page 118
6. NC Medicaid Ombudsman annual report (NL-07)	Newsletters reference the NC Medicaid Ombudsman annual report. No posting that was searched carries the report.	Section 3, entry 6, page 118
7. Enrollment Broker contract (NL-08)	Public documents record the 2018 award of the Enrollment Broker contract to Maximus. No contract document is posted.	Section 3, entry 7, page 119
8. Non-emergency medical transportation (NEMT) broker contract or official broker policy (NL-11)	Current NEMT broker assignments appear only in plan notices and secondary guides. No NEMT broker contract is posted. No official broker policy is posted either.	Section 3, entry 8, page 119
9. Current DSH audit or cost-report settlement document (NL-12)	The search found only a 1997 to 2001 federal review. It did not find a current DSH audit or cost report settlement document.	Section 3, entry 9, page 120
10. Current standalone CMS approval letter for the Section 1915(b) authority (NL-14)	The State posts a draft amendment application. The State does not post the standalone CMS approval letter for the 1915(b) authority.	Section 3, entry 10, page 121
11. North Carolina directed payment preprints (including the HASP preprint) (NL-16)	The NC directed payment preprints exist only as federal downloads. The HASP preprint is among them. No State hosted copy was found.	Section 3, entry 11, page 121

Missing document	What is missing, in one line	Full entry
12. Managed care capitation rate certifications (NL-17)	State letters reference the managed care capitation rate certifications. Association letters reference them too. They are posted nowhere.	Section 3, entry 12, page 122
13. NC Register rulemaking notices specific to 10A NCAC 22 (2025-2026) (NL-18)	The search covered 2025 to 2026. It found no NC Register rulemaking notice specific to 10A NCAC 22.	Section 3, entry 13, page 123

Collected at the closeout: the last two documents

Two documents held the state open at the cure pass of October 27, 2026. Both were collected at the closeout of October 30, 2026. Neither one is a true gap. Each one was read in full at its live address at medicaid.gov through the house browser lane. The closing section carries the full account of how each one landed.

Collected at the closeout	Standing	Where it is carried
H-024 · 1115 Special Terms and Conditions, WFTC overlay version (medicaid.gov, dated September 25, 2026)	Collected at the closeout of October 30, 2026. The document was read in full at its live address and classed MAPPED-TEXT. The closing section carries the full account.	Closing section
H-035 · CAP/DA Appendix K approval NC.0132.R07.10 (medicaid.gov)	Collected at the closeout of October 30, 2026. The document was read in full at its live address and classed REVIEWED-NO-CFR-CITATION-FOUND. The State posts the R07.09 Appendix K, not this approval. The closing section carries the full account.	Closing section

Status, stated plainly. North Carolina is cured as of October 30, 2026. The inventory stands at 183 of 196 rows collected and reconciled. That count is 93.4 percent. The inventory holds 13 true gaps. The last two open documents were collected at the closeout of October 30, 2026. They are named wherever status is stated. The first is H-024, the 1115 Special Terms and Conditions, WFTC overlay version, at medicaid.gov, dated September 25, 2026. The second is H-035, the CAP/DA Appendix K approval NC.0132.R07.10, at medicaid.gov. Both documents were read in full at their live addresses. The register stands at 501 determinations. The grades are 141 Verified, 274 Partial, and 71 gap-determined. The grades also include 10 determined not applicable, 5 Prospective, and 0 Unverified. The cure pass figures carry the October 27, 2026 date. The closing figures carry the October 30, 2026 closeout date.

SECTION 1 · CONFLICTING INFORMATION

Where the public record contradicts itself · 16 register conflicts and 3 substance conflicts

A conflict is a place where the public record contradicts itself. In one form, one public document states a thing. Another public document states the contrary. In another form, a document promises text it does not contain. In a third form, the document of record is behind the program it describes. The first 16 entries are the register conflicts of record, NC-1 to NC-16. Each one prints with its subject and its two positions. Each one also prints its governing position and its disposition. Each conflict holds back a count of determinations. That count comes from the flags in the determinations file of record. It prints on the entry. On that count, only NC-5 is flagged on determinations. It is flagged on 14 of them, all in Part 457. The other 15 register conflicts hold back no flagged determination. They stand as conflicts in the State's published record. The register carries them on its face.

Three further entries state the substance conflicts the cure pass found in the record itself. They cover the cost sharing amounts. They cover the cumulative maximum statement. They cover the Quality Strategy bulletin against the page it names. The fourth substance finding of the cure pass is the posture of NC Health Choice. That finding is register conflict NC-5. It is not counted twice. It appears once, as entry 5 below.

NC-1 · Carolina Complete Health regions (2021 era)

Determinations held back: 0

Section: Conflicting information

Governing position	Current state governs the footprint: after the April 1, 2026 merger, Carolina Complete Health is statewide and Standard Plan choices are four (Lane A §2.2).
Conflicting position	2021-era sources state the plan's regions two ways: 'regions 3, 4, and 5' (NCDHHS/Cherokee release summary) vs 'Regions 3 & 5 only' (HRSA narrative).
Disposition	Historical conflict kept visible; the register and calendar use the current statewide footprint.
Determinations held back	0 determinations are flagged with this conflict in the determinations file of record.

NC-2 · Tailored Plan launch date in NC documents

Determinations held back: 0

Section: Conflicting information

Governing position	Tailored Plans launched July 1, 2024 (NCTracks launch notice; DHB fact sheets).
Conflicting position	Earlier NC documents print October 1, 2023 (EVV Q&A) and an original July 1, 2022 scheduled date (DY5 monitoring report).
Disposition	The 2024 date governs; the earlier printed dates are carried as the delay history, not as operative dates.
Determinations held back	0 determinations are flagged with this conflict in the determinations file of record.

NC-3 · 1115 renewal period, requested vs approved

Determinations held back: 0

Section: Conflicting information

Governing position	Approved: December 10, 2024 - December 9, 2029 (CMS approval; NC 1115 page).
Conflicting position	The renewal application as submitted requested November 1, 2024 - October 31, 2029.
Disposition	Approved dates govern authority; requested dates are application history.
Determinations held back	0 determinations are flagged with this conflict in the determinations file of record.

NC-4 · Division name in federal correspondence

Determinations held back: 0

Section: Conflicting information

Governing position	DMA and DHB combined into the Division of Health Benefits effective August 1, 2018 (NCTracks notice).
Conflicting position	CMS SPA approvals in 2025 still address the 'Division of Medical Assistance.'
Disposition	DHB is the governing name; the CMS addressing is flagged as letterhead lag, not a revival of DMA.
Determinations held back	0 determinations are flagged with this conflict in the determinations file of record.

NC-5 · NC Health Choice, combined vs still listed

Determinations held back: 14

Section: Conflicting information

Governing position	Approximately 55,000 NC Health Choice children moved to NC Medicaid on April 1, 2023, under Session Law 2022-74's direction to combine the programs (NCDHHS, Jan. 30, 2023).
Conflicting position	The State Plan Public Notices page still lists a separate 'NC Health Choice State Plan, Child Health Plan under Title XXI.'
Disposition	Both print. Part 457 obligations are mapped to DHB's NC Health Choice home with this conflict on the face; the binder does not print 'CHIP eliminated in NC.'

Determinations held back	**CFR-457-005** · 42 CFR 457.70 · State plan describes chosen program option · Partial **CFR-457-024** · 42 CFR 457.305 · State plan describes eligibility, enrollment, and screening procedures · Partial **CFR-457-025** · 42 CFR 457.315 · Apply MAGI and household methodologies · Partial **CFR-457-028** · 42 CFR 457.342 · 12-month continuous eligibility for children · N-A-DETERMINED **CFR-457-037** · 42 CFR 457.490 · State plan describes delivery methods and utilization control · Partial **CFR-457-040** · 42 CFR 457.505 · State plan cost-sharing description and compliance methods · Partial **CFR-457-041** · 42 CFR 457.510; 457.515 · State plan describes any premiums or cost-sharing charges · Partial **CFR-457-043** · 42 CFR 457.525 · Public schedule of cost sharing · Partial **CFR-457-044** · 42 CFR 457.540; 457.555 · Cost-sharing limits for children at or below 150% FPL · Partial **CFR-457-045** · 42 CFR 457.560 · 5% cumulative cost-sharing maximum per family · Verified **CFR-457-046** · 42 CFR 457.570 · Disenrollment protections for nonpayment · N-A-DETERMINED **CFR-457-061** · 42 CFR 457.805 · Substitution-of-coverage procedures (crowd-out) · Partial **CFR-457-073** · 42 CFR 457.1120; 457.1130; 457.1140; 457.1150; 457.1160; 457.1170; 457.1180 · Applicant/enrollee review (appeal) process with timeliness standards · Partial **CFR-457-078** · 42 CFR 457.1260 · Managed care grievance and appeal system · Verified

NC-6 · NCDHHS service areas, the sixth area's name

Determinations held back: 0

Section: Conflicting information

Governing position	The Overview page lists six service areas ending 'External Affairs and Licensing and Facilities.'
Conflicting position	The EEO Plan lists the sixth area as 'Health Equity.' Both claim 33 divisions and offices.
Disposition	Kept visible; the binder's structure chapter prints both namings. No register count turns on it.
Determinations held back	0 determinations are flagged with this conflict in the determinations file of record.

NC-7 · Tailored Plan name, Vaya Health vs Vaya Total Care

Determinations held back: 0

Section: Conflicting information

Governing position	NC-published sources (NCTracks launch table; DHB eligibility page) use 'Vaya Health.'
Conflicting position	NC Justice FAQ and some secondary listings use 'Vaya Total Care.'

Disposition	The binder uses 'Vaya Health' and notes the variant.
Determinations held back	0 determinations are flagged with this conflict in the determinations file of record.

NC-8 · Deputy Secretary title and status timing (Bush)

Determinations held back: 0

Section: Conflicting information

Governing position	October 2026 listings and a September 25, 2026 CMS letter use 'Deputy Secretary for NC Medicaid' without 'Interim.'
Conflicting position	A March 19, 2026 DHB letter is signed 'Interim Deputy Secretary'; the April 21, 2026 announcement states the appointment 'remains contingent upon confirmation by the North Carolina General Assembly.' The confirmation outcome date was NOT ESTABLISHED in sources reached.
Disposition	The binder uses the current published title and prints the contingency and the unestablished confirmation date.
Determinations held back	0 determinations are flagged with this conflict in the determinations file of record.

NC-9 · TBI Waiver geography and operator framing

Determinations held back: 0

Section: Conflicting information

Governing position	The TBI Waiver is served through a Tailored Plan and does not operate in all geographic areas (Trillium handbook).
Conflicting position	NC Justice FAQ frames it as 'Alliance Health is the only Tailored Plan that currently offers TBI Waiver services'; the handbook frames it by county list. No single current DHB page states operator and counties together.
Disposition	Both framings print; the waiver chapter carries the gap as a named research item.
Determinations held back	0 determinations are flagged with this conflict in the determinations file of record.

NC-10 · Healthy Opportunities Pilots, authorized vs operating

Determinations held back: 0

Section: Conflicting information

Governing position	The General Assembly did not fund HOP after July 1, 2025, 'causing the program to suspend operations at this time' (NCDHHS HOP page).
Conflicting position	The same page records the 1115 extension, renewal negotiations, and $9 million in SFY27 restart funding; no restart service date was established in sources reached.
Disposition	Authority and operations are printed as separate facts; HOP is never listed as an operating service for the suspension period without the funding qualifier.

Determinations held back	0 determinations are flagged with this conflict in the determinations file of record.

NC-11 · Who files NCFS 1099 data to NCDOR, OSC or the agencies

Determinations held back: 0

Section: Conflicting information

Governing position	Memo NCFS 26-1 (Oct. 13, 2025), the later operational document: 'Individual state agencies are responsible for filing their own 1099 information to the North Carolina Department of Revenue (NCDOR).'
Conflicting position	OSC Policy 1200.02 summary (directory, last updated Jan. 21, 2025): OSC 'will submit the electronic 1099-MISC file to the IRS and the NC Department of Revenue.'
Disposition	Both print in Part II §4.3. The memo governs operations as the later, operational instrument; the policy text is unreconciled on the record reached.
Determinations held back	0 determinations are flagged with this conflict in the determinations file of record.

NC-12 · OSC policy form scope vs. the production it governs

Determinations held back: 0

Section: Conflicting information

Governing position	OSC's tax-year-2026 production is published by form type: NEC, MISC, G (Process Changes memo, Jul. 29, 2026).
Conflicting position	Policy 1200.02 names only an 'electronic 1099-MISC file' as centrally submitted; no conforming policy text was reached.
Disposition	The production documents govern; the policy's narrower scope prints as an open conformance item.
Determinations held back	0 determinations are flagged with this conflict in the determinations file of record.

NC-13 · NCFS go-live date

Determinations held back: 0

Section: Conflicting information

Governing position	OSC's 2023 Key Information sheet: 'October 2, 2023, NCFS Go Live.'
Conflicting position	DHHS's NCFS page: 'on October 10, 2023, North Carolina will deploy its new financial system.'
Disposition	Both dates stand as published; the sources reached do not explain the difference (go-live vs. deployment milestone).
Determinations held back	0 determinations are flagged with this conflict in the determinations file of record.

NC-14 · Fiscal-agent name in live NCTracks FAQ text

Determinations held back: 0

Section: Conflicting information

Governing position	CSRA became GDIT on April 2, 2018 (NCTracks announcement); the current Contact Information document gives GDIT at P.O. Box 300009, Raleigh.
Conflicting position	Live 1099 FAQ text still directs returns and enrollment correspondence to 'CSRA' at the same box.
Disposition	GDIT is the operator of record; the FAQ text is unconformed, printed as found.
Determinations held back	0 determinations are flagged with this conflict in the determinations file of record.

NC-15 · NCTracks 1099 FAQ vintage, mailing example and non-receipt triggers

Determinations held back: 0

Section: Conflicting information

Governing position	Each cycle's mailing date is announced per cycle (2025 cycle: mailed Jan. 20, 2026, announced Dec. 30, 2025).
Conflicting position	The standing FAQs carry a 2020-cycle example ('mailed on or before Jan. 15, 2021') and two different non-receipt triggers (10 business days via Contact Us; 'second Friday of February'); the 2013/2014 announcements used February 10.
Disposition	No single current trigger date is published; the binder prints the per-cycle announcements as governing and the FAQ texts as standing, unreconciled guidance.
Determinations held back	0 determinations are flagged with this conflict in the determinations file of record.

NC-16 · CF/SF framing across NCDOR document vintages

Determinations held back: 0

Section: Conflicting information

Governing position	Current eNC3 FAQ: CF/SF may not be used 'instead of filing these forms directly with the Department'; required statements must be filed directly with NCDOR.
Conflicting position	2018 Specifications: 'Although North Carolina participates in the IRS Combined Federal/State Filing Program,' listed forms 'must be filed directly.'
Disposition	The operative rule is the same (direct filing); the participation framing differs by document age. Both print.
Determinations held back	0 determinations are flagged with this conflict in the determinations file of record.

S-A · Cost sharing amounts: the plan attachments, the Tailored Plan contract, and the plan's own managed care statement

Determinations held back: 5

Section: Conflicting information

One statement	**State Plan Attachments 4.18-A and 4.18-C, and section 4.18.** The attachments carry the cost sharing specification structure at 2005 era amounts: copayments of 3.00 dollars for most services and 2.00 dollars for chiropractic and optical services (Attachment 4.18-A, page 758; Attachment 4.18-C, page 761). Section 4.18(b)(2)(vii), page 113, states in a checked passage that managed care enrollees are not charged deductibles, coinsurance or copayments.
The other statement	**Tailored Plan contract, Table 7 (Medicaid Managed Care Cost Sharing).** Table 7 charges a current managed care copayment of 4.00 dollars per service, and the contract requires the plan to impose the same cost sharing amounts as specified in the State Plans, displayed in that table.
Governing position	No governing amount is named in the determinations file of record. The specification rows grade Verified on the structure the plan attachments carry, with the amount conflict named on the neighboring rows' faces. Which amount a provider charges today is an open question on the register.
Disposition	Conform the plan attachments and the contract table to one current schedule, or record which schedule governs managed care copayments today.
Determinations held back	**CFR-447-012** · 42 CFR 447.52 · Maximum allowable cost sharing + annual CPI-U indexing · Partial **CFR-447-013** · 42 CFR 447.52 · State plan cost-sharing specifications · Verified **CFR-447-014** · 42 CFR 447.52 · MCO contracts honor state-plan cost sharing · Partial **CFR-447-017** · 42 CFR 447.54 · ED non-emergency cost-sharing conditions · Partial **CFR-447-023** · 42 CFR 447.57 · Public schedule and beneficiary/provider notice · Partial

S-B · Cumulative maximum: the plan states there is none; the federal rule requires the 5 percent machinery

Determinations held back: 1

Section: Conflicting information

One statement	**State Plan Attachments 4.18-A and 4.18-C, section E, and section 4.18.** Both attachments print, verbatim, "State policy does not provide for cumulative maximums" (Attachment 4.18-A, page 760; Attachment 4.18-C, page 763), and section 4.18, at pages 115 and 120, records: not applicable, there is no maximum.
The other statement	**42 CFR 447.56.** The federal rule requires the aggregate limit machinery: premiums and cost sharing capped at 5 percent of family income, applied on the rule's stated basis.
Governing position	The federal rule governs the requirement. The determination grades Partial on the one element the record does carry: the claims processing system captures each copayment amount claim by claim (Attachment 4.18-A, section D, page 760), so the amounts that would count toward an aggregate sit in one system.

Disposition	Amend the plan attachments to state the 5 percent aggregate machinery, or produce the instrument that operates it, and withdraw the no maximum statement.
Determinations held back	**CFR-447-021** · 42 CFR 447.56 · 5% aggregate family limit on premiums + cost sharing · Partial

S-C · The 2025 Quality Strategy: the bulletin says it is published; the named page does not carry it

Determinations held back: 2

Section: Conflicting information

One statement	**Division of Health Benefits bulletin, July 1, 2025.** The bulletin records that the 2025 NC Medicaid Managed Care Quality Strategy was approved July 1, 2025 and published on the Quality Management and Improvement page.
The other statement	**The Quality Management and Improvement page, as read in full at the cure pass, and the held record.** The page carries no Quality Strategy document. The strategy the record holds is the 2023 document. The 2025 document is recorded as a true gap at inventory level (NL-06, Section 3, entry 5).
Governing position	The page as read governs the grading: the determinations rest on the stronger public evidence, which is that the 2025 document is not in the public record as held.
Disposition	Post the approved 2025 Quality Strategy where the bulletin says it lives.
Determinations held back	**CFR-438-043** · 42 CFR 438.340 · Managed care State quality strategy · Partial **NC-012** · NC Medicaid Managed Care Quality Strategy (first published 2018; updated 2023); Annual Quality Report · Medicaid Managed Care Quality Strategy, maintenance, and the Annual Quality Report against it · Partial

SECTION 2 · PARTIAL COMPLIANCE

Determinations the public record carries only in part, so compliance cannot be fully verified · 274 determinations under 49 public documents

A Partial determination means public material exists. The material was read. Part of the federal requirement is not covered by it. Compliance therefore cannot be fully verified on the public record as it stands. This section prints all 274 Partial determinations in the register. Each one prints exactly once. No sampling was used.

The grouping method is stated on the section face. The method applies without exception. Each Partial determination is grouped under one holding public document. That document is the document named first in the determination's record location in the determinations file of record. A determination can rest on more than one document. It still appears exactly once, under that first named document. Its full record location stands in the register. No grouping was invented. A group exists only where the record location names the document first.

The accounting runs as follows. The section holds 49 documents and document sets. It holds 274 determinations. Each Partial determination in the register appears exactly once. Under each document, every determination behind it prints with its citation and its topic. It prints the element not covered. It prints its owner level. It prints the action that level owns.

Document	Determinations
Title XIX State Plan, NC State Plan, Medical Assistance Program (full plan)	108
CHIP SPAs NC-23-0008 / NC-23-0010, separate CHIP → Medicaid expansion CHIP	50
NC Medicaid Managed Care Quality Strategy 2023 (cites 42 CFR 438.340(b)(6) stratification; development per 438.340(c) incl. MCAC consultation and EBCI/CIHA tribal consultation)	15
BH I/DD Tailored Plan Contract #30-2020-052-DHB, Amendment 2 model (RFA issued Nov 13, 2020; awards Jul 26, 2021; Amendment 1 revised and restated the contract in its entirety)	14
1115 extension approval package	11
Managed Care Program Annual Report (MCPAR) for North Carolina: Medicaid Direct PIHP, 2024 (submitted Dec 27, 2024)	5
Title XXI Child Health Plan, proposed CHIP managed care amendment 22-0013 (combination plan: Medicaid expansion group + separate child health program)	5
Current external quality review (EQR) technical report	4
Clinical Coverage Policy 8D-1, Psychiatric Residential Treatment Facilities, amended January 1, 2025	4
Tailored Plan Contract #30-2020-052-DHB, Amendment 5(7) (271 pp.; Attachment B covered-services table keyed to State Plan Att. 3.1-A.1 and CCPs 8A/8B/8D series)	3
Prepaid Health Plan Services Contract #30-190029-DHB, Amendment 8 model contract language	3

Document	Determinations
Provider Manual 2026, Standard Plan	3
Health Check Program Guide (EPSDT; NC documents cite the statute, §1905(r) / 42 U.S.C. §1396d(r), not the CFR subpart)	3
CAP/DA waiver renewal approval document (CMS)	3
Access Monitoring Review Plan (AMRP)	3
Medicaid State Plan Public Notices (ten-day postings SPA 26-0001 - 26-0008; 2026 proposed amendments 26-0001 - 26-0003)	2
N.C.G.S. 108A-70.9A, Medicaid recipient appeals (30-day appeal period; aid pending appeal)	2
Medicaid Direct PIHP Contract #30-2022-007-DHB, Amendment 13(14) (incl. Fourth Revised and Restated Attachment E network adequacy standards)	2
Reports page (incl. notice that Comparative Payment Rate Analysis reports are published per the CMS requirement beginning 2026)	2
Prepaid Health Plan Performance Metrics Report, Session Law 2023-134 §9E.20 (Jul 1, 2024 - Jun 30, 2025; incl. plan MLR reporting and HSAG-administered CAHPS)	2
Adult Medicaid Manual MA-2275, PACE (three-party agreement CMS - DHHS/DHB - PACE organization)	2
HHS OIG report, "North Carolina Did Not Report and Return All Medicaid Overpayments for the State's Medicaid Fraud Control Unit Cases" (audit period Oct 1, 2019 - Sept 30, 2021; $41.4M MFCU-determined overpayments; $27.5M federal share)	1
N.C.G.S. 108A-70.9B, Office of Administrative Hearings hears Medicaid appeals (55-day standard)	1
PCS Alignment Demonstration, draft Section 1115 demonstration application (incl. full public notice, Appendix B; tribal consultation, Appendix C)	1
SPA NC-23-0028, expansion FMAP claiming	1
CMS Focused Program Integrity Review of North Carolina, Final Report	1
Session Law 2025-64 (House Bill 546), "An Act to Modernize Various Laws Pertaining to the Medicaid Program", bill summary	1
Non-Emergency Medical Transportation beneficiary page (plan contact table incl. Vaya Partners)	1
NC Managed Care Capitation Rates, Updated Care Management Assumptions for SFY 2026 ($10.86 PMPM built in for care management; no minimum care management fee established)	1
N.C.G.S. 108A-148.1, Healthcare Access and Stabilization Program (HASP) (438.6(c) directed payment preprint; 433.68(f) limit; $3.2B annual estimate from SFY2023-24 in the text as enacted)	1

Document	Determinations
Managed Care Program Annual Report (MCPAR) posting page, NC posted reports for five managed care programs in 2025	1
Provider Operations Manual, Tailored Plan, v2.1 (PRV15-TP)	1
Lessons Learned from North Carolina's MCPAR Reports (analysis of NC's five 2025 MCPARs and sanctions reporting)	1
SPA NC-25-0009, removes NQTLs for psychotherapy/mobile crisis; residential withdrawal services; ABP pages	1
Clinical Coverage Policy 3A, Home Health Services, amended July 1, 2026	1
NC-23-0029 Alternative Benefit Plan SPA, CMS SPA page	1
Clinical Coverage Policy No. 1E-3 as printed on its face, Sterilization Procedures, amended January 1, 2026	1
NC Medicaid CAP/C waiver renewed through 2028 (Mar 1, 2023 - Feb 29, 2028)	1
Claims and Billing page (365-day timely filing; 50 checkwrites per year; EFT required)	1
10A NCAC 22F.0104 (Subchapter 22F, Program Integrity)	1
Provider Playbook Prompt Payment Fact Sheet (directed payments; clean claim definition citing 42 CFR 447.45(b))	1
Physician Assistant fee schedule	1
SPA NC-25-0015, updates 1915(i) authority, Attachment 4.19-B	1
Clinical Coverage Policy No. 9, Outpatient Pharmacy (lock-in program citing 10A NCAC 22F.0704/.0104 and 42 CFR 431.54)	1
N.C.G.S. 108C-3, Medicaid provider screening (categorical risk levels; high-risk designation incl. providers suspended under 42 CFR 455.23 within the previous 12 months)	1
Draft TBI Waiver application (Appendix F cites 42 CFR Part 431 Subpart E fair hearing; concurrent 1915(b) operation through PIHPs)	1
Update: CCP 2A-1, Acute Inpatient Hospital Services, and 1A-4, Cochlear and Auditory Brainstem Implants (cites 42 CFR 456.60 certification rule)	1
NCTracks 2026 Checkwrite Schedule	1
NC Medicaid Annual Report, State Fiscal Year 2025 (SFY2025 expenditures $35,771M actual; Standard Plan managed care $12,013.63M; HASP $6,595.52M; Tailored Plan managed care $6,179.31M)	1

Title XIX State Plan, NC State Plan, Medical Assistance Program (full plan)

Stands behind: 108 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: Title XIX State Plan, NC State Plan, Medical Assistance Program (full plan).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-430-003 · State plan waiver requests and renewals (1915(b), 1915(c), 1916)

Citation: 42 CFR 430.25

Determination: Partial

Not covered	The waiver request and renewal procedure and renewal lead times required by 42 CFR 430.25 are not stated in held evidence; only the existence of the waivers and current applications is carried.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the waiver request and renewal calendar or procedure NC uses for 1915(b), 1915(c) and 1916 authorities.

CFR-430-005 · Quality control program and correction of practice

Citation: 42 CFR 430.32

Determination: Partial

Not covered	The corrective element: how NC analyzes quality control findings and corrects practice or policy in response is not carried in held evidence.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce a MEQC or PERM corrective action record showing findings carried into changed practice.

CFR-431-002 · Medicaid Advisory Committee (MAC) and Beneficiary Advisory Council (BAC)

Citation: 42 CFR 431.12

Determination: Partial

Not covered	No held document carries the MAC or BAC charter or bylaws, the BAC beneficiary composition percentages and their phase-in, the requirement that the BAC meet in advance of each MAC meeting, posting of meeting minutes within 30 days, or a MAC annual report
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the MAC and BAC charters or bylaws, member rosters with beneficiary share, meeting schedules and minutes, and the first MAC annual report on the NC Medicaid website

CFR-431-005 · Maintain individual records (retention, electronic format, 30-day access)

Citation: 42 CFR 431.17

Determination: Partial

Not covered	The held text does not state the electronic format element or a timed access commitment for making records available to the Secretary on request; retention is stated only as in accordance with Federal requirements
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the records retention and access standard that states the electronic format of individual records and the timeframe for producing them to CMS on request

CFR-431-012 · 1915(b) freedom-of-choice waiver requests

Citation: 42 CFR 431.55

Determination: Partial

Not covered	The standalone CMS approval letter and waiver document for the Section 1915(b) authority (collection item NL-14) was not located after search, so the waiver's own terms and the 431.55 findings (comparability, access, and cost matters the approval rests on) could not be read
Owner	Division of Health Benefits (DHB)
Action it owns	Obtain and file the CMS 1915(b) approval letter or the successor 1115 authority pages that supersede it, so the freedom-of-choice waiver of record can be read against 431.55

CFR-431-022 · NF and ICF/IID appeals (evidentiary hearing; informal reconsideration)

Citation: 42 CFR 431.151, 431.152, 431.153, 431.154

Determination: Partial

Not covered	The ICF/IID informal reconsideration procedure of 42 CFR 431.154 (an informal reconsideration offered to the facility by a reviewer who was not involved in the survey) is not stated in any held NC rule or plan passage; the held rules carry the evidentiary hearing track only
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the ICF/IID informal reconsideration procedure (who conducts it, how a facility requests it, and its effect on the evidentiary hearing) in rule or in the survey agency procedures

CFR-431-023 · Fair hearing system and informing individuals of hearing procedures

Citation: 42 CFR 431.202, 431.205, 431.206

Determination: Partial

Not covered	Held public materials do not carry the informing duty at the application stage (431.205(a)) for eligibility applicants, nor the hearing channel for county DSS eligibility determinations as written in a current rule; the beneficiary appeals rules at 10A NCAC 22H.0101 and.0104 expired effective September 1, 2025 under G.S. 150B-21.3A
Owner	Division of Health Benefits (DHB), with the Division of Social Services for county eligibility appeals
Action it owns	Republish a current beneficiary appeals rule or manual section covering eligibility appeals end to end (application-stage informing, local hearing, state hearing, and Department service appeals) to replace the expired 22H.0101 and.0104

CFR-431-038 · Quality improvement organization / quality improvement program (Part 462)

Citation: 42 CFR 431.630

Determination: Partial

Not covered	No held document identifies the current QIO (the CMS Beneficiary and Family Centered Care QIO) serving NC or the State's current coordination arrangement under the modern Part 462 QIO program; the only QIO-adjacent evidence is the superseded PRO structure in the plan
Owner	Division of Health Benefits (DHB)
Action it owns	Publish or file the current QIO coordination documentation (the CMS QIO serving NC and the State contact and hospital review arrangement) and consider a plan amendment retiring the PRO-era section 4.14 text

CFR-431-041 · Medicaid eligibility quality control (MEQC) system and pilot projects

Citation: 42 CFR 431.800, 431.806, 431.810, 431.820

Determination: Partial

Not covered	MEQC pilot project specifics under 431.810 to 431.820 (pilot design, sampling methodology, corrective action reporting to CMS) are not stated in held text, and the preprint checkbox alternatives on the plan page (system implemented versus approved pilot) cannot be resolved from the held text layer
Owner	Division of Health Benefits (DHB), with the Office of Compliance and Program Integrity
Action it owns	Publish the MEQC program description (current pilot or system status, sampling, and CMS reporting) so the Subpart P posture can be read directly

CFR-431-042 · Claims processing assessment system

Citation: 42 CFR 431.830, 431.832, 431.834, 431.836

Determination: Partial

Not covered	The held text layer does not show which preprint branch NC elected (operating the assessment system versus the approved MMIS alternative), and no held document describes the assessment system's operation (sample design, error findings, or reporting)
Owner	Division of Health Benefits (DHB)
Action it owns	Confirm on the record which 431.806(c) branch NC stands on and, if the assessment system branch, publish its operating description

CFR-431-043 · Payment error rate measurement (PERM) program

Citation: 42 CFR 431.950, 431.953, 431.958, 431.960, 431.970

Determination: Partial

Not covered	No held document carries current-cycle PERM participation: the State's data submission and universe construction, system access for the federal contractor, error rate findings, corrective action, or FFP recovery under Subpart Q for any cycle after the plan page's checked years
Owner	Division of Health Benefits (DHB)
Action it owns	File the most recent PERM cycle documentation for NC (submission confirmation, error rate letter, and corrective action plan if any) with the cure record

CFR-432-002 · Staff training program

Citation: 42 CFR 432.30

Determination: Partial

Not covered	The content of the staff training program (42 CFR 432.30): what training is provided, to whom, and on what cycle is not described in held evidence; only a bare meets-requirements assurance is carried.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the agency training program description or training plan for Medicaid personnel.

CFR-432-003 · Subprofessional staff and volunteer programs

Citation: 42 CFR 432.31, 432.32

Determination: Partial

Not covered	The subprofessional staff and volunteer program elements (42 CFR 432.31 and 432.32) as operating programs: positions, training and supervision are not described in held evidence.
Owner	Division of Health Benefits (DHB)

Action it owns	Produce the subprofessional and volunteer program description, or state whether NC currently uses either.

CFR-433-001 · Fiscal accountability and records retention

Citation: 42 CFR 433.32

Determination: Partial

Not covered	The specific retention periods of 42 CFR 433.32(b)-(d): 3 years from submission of a final expenditure report, retention beyond 3 years while audit findings are unresolved, and the property record periods. No held instrument states these periods.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish a fiscal records retention schedule stating the 433.32(b)-(d) periods and file it as the governing record for this row.

CFR-433-013 · Third-party liability identification (data exchanges, trauma edits, action plan)

Citation: 42 CFR 433.137, 433.138

Determination: Partial

Not covered	The 433.138(d)(4) State motor vehicle accident report file exchange and the workers compensation exchange in current operation: Attachment 4.22-A states on its face that motor vehicle data matches cannot be done in North Carolina at this time (DMV data elements unavailable) and that workers compensation matches had not been done, with 1991-92 target dates; no held current document shows either exchange operating today.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the current TPL data exchange inventory, including the status of the motor vehicle accident report file and workers compensation exchanges.

CFR-433-014 · TPL payment of claims (cost avoidance; 100-day rule; 60-day recovery)

Citation: 42 CFR 433.139

Determination: Partial

Not covered	The 100-day payment rule of 433.139(b)(3) and the 60-day recovery clock of 433.139(f)(1) (seeking reimbursement within 60 days after the end of the month in which payment was made or the liable third party was identified) are not stated in any held passage; the 1990 attachment's six-month accumulation practice for pay-and-chase claims sits uneasily with the 60-day clock and no later instrument reconciles them.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the current TPL payment policy stating the 100-day rule and the 60-day recovery clock as NC operates them.

CFR-433-016 · Assignment of rights and cooperation in pursuing third parties

Citation: 42 CFR 433.145, 433.146, 433.147, 433.148

Determination: Partial

Not covered	The good cause exemption as specified at 433.147: the plan and manual state only that any individual may be exempt by demonstrating good cause, without the specified criteria (best interests of the child for paternity and support cooperation; anticipated reprisal or physical or emotional harm in other cases), and the 433.148 procedures (notice of the exemption right, findings, and notice to the IV-D agency) are not stated.
Owner	Division of Social Services / county DSS
Action it owns	Publish the good cause criteria and procedures for assignment and cooperation exemptions in the eligibility policy.

CFR-433-017 · Cooperative agreements for third-party collections

Citation: 42 CFR 433.151, 433.152

Determination: Partial

Not covered	The agreement text itself and the current 433.152 specifications inside it (including the limits on medical support enforcement referrals and the information the IV-D agency must provide) were not read; the held evidence is the plan assurance and the checked IV-D box, not the agreement.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the current IV-D cooperative agreement for third party collections.

CFR-434-001 · General contract requirements (all Medicaid contracts)

Citation: 42 CFR 434.4, 434.6

Determination: Partial

Not covered	The general contract requirements of 42 CFR 434.4 and 434.6 stated as requirements across all NC Medicaid contracts; the single plan citation sits inside a managed care amendment.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the standard contract terms or contracting policy that carries the 434.4 and 434.6 requirements for all Medicaid contracts.

CFR-435-002 · Payment for services furnished to individuals with satisfactory immigration status / emergency services for non-qualified aliens

Citation: 42 CFR 435.139, 435.350

Determination: Partial

Not covered	The payment provisions themselves (payment for emergency services under 435.139 and the emergency services payment rule at 435.350, including the scope of emergency services and how claims are identified and paid) are not stated in any held payment or billing document
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the emergency services payment standard for non-qualified aliens (service scope, claim identification, and payment rule) in the applicable clinical coverage policy or billing guide

CFR-435-007 · Citizenship and immigration status; verification and reasonable opportunity period

Citation: 42 CFR 435.406, 435.407, 435.956

Determination: Partial

Not covered	The verification process specifics of 435.407 and the electronic verification and reasonable opportunity period elements of 435.956 (90-day reasonable opportunity period, notice content, and continued furnishing pending verification) are not stated in held text
Owner	Division of Social Services / county DSS (eligibility operations), under Division of Health Benefits policy
Action it owns	Publish the citizenship verification sequence in the eligibility manual, including the reasonable opportunity period, notices, and benefit treatment while verification is pending

CFR-435-010 · MAGI financial methodologies (household composition, household income, 5 percent disregard)

Citation: 42 CFR 435.603

Determination: Partial

Not covered	The MAGI methodology pages themselves (household composition rules, household income counting including the treatment of lump sums and the five percentage point disregard) are not held as readable text; the MAGI SPA is listed on a DHHS notices page (H-002) without its content
Owner	Division of Health Benefits (DHB)
Action it owns	File the approved MAGI methodology SPA pages (or the manual section stating household composition, income counting, and the disregard) with the cure record

CFR-435-015 · State and local agency administration; consistency, simplicity, and outstationing

Citation: 42 CFR 435.901, 435.902, 435.904

Determination: Partial

Not covered	The consistency standard (435.901: policies consistent with the plan, applied uniformly statewide) and the simplicity standard (435.902: administration consistent with simplicity of administration and the best interests of recipients) are not stated in any held document
Owner	NCDHHS Secretary, with the Division of Social Services for county administration
Action it owns	Publish the State supervision standard for county eligibility administration stating the consistency and simplicity requirements of 435.901 and 435.902

CFR-435-018 · Assistance with application and renewal; certified application counselors

Citation: 42 CFR 435.908

Determination: Partial

Not covered	Certified application counselor designation and certification under 435.908 (designation of community organizations, certification and training of staff and volunteers, and conflict of interest standards) is not stated in any held document
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the certified application counselor designation and certification standard, or state that NC does not designate CACs and relies on navigators and county assistance

CFR-435-019 · Automatic entitlement for SSI beneficiaries (no separate application)

Citation: 42 CFR 435.909

Determination: Partial

Not covered	Automatic entitlement as such (an SSI beneficiary is entitled to Medicaid without a separate application, and the mechanics when SSA data and State records differ) is not stated in any held document
Owner	Division of Social Services / county DSS (eligibility operations)
Action it owns	State the automatic entitlement rule in the eligibility manual's SSI section, including treatment of SDX discrepancies

CFR-435-020 · Social security number requirement; verification of eligibility factors

Citation: 42 CFR 435.910, 435.920

Determination: Partial

Not covered	The 435.920 verification specifics (what must be verified at application and redetermination, the sources of record, and the treatment of exceptions for individuals who cannot furnish an SSN, including religious objection and newborn and emergency-only cases beyond the general condition) are not stated element by element in held text
Owner	Division of Social Services / county DSS (eligibility operations)
Action it owns	Publish the SSN and eligibility factor verification table in the eligibility manual covering the 435.920 verification points and SSN exceptions

CFR-435-022 · Timely determination of eligibility (45 and 90 day standards)

Citation: 42 CFR 435.912

Determination: Partial

Not covered	No held document states the timeliness standards themselves: determination as soon as possible and no later than 90 days for disability-based applications and 45 days for all others, a redetermination standard, or the performance standard and corrective action reporting for eligibility timeliness
Owner	Division of Social Services / county DSS (eligibility operations), under Division of Health Benefits policy
Action it owns	Publish the determination timeliness standard and NC's performance tracking for it (average and percentile days to determination, by county) in the eligibility manual and a public report

CFR-435-023 · Effective date of eligibility; case documentation and disposition

Citation: 42 CFR 435.914, 435.915

Determination: Partial

Not covered	Case documentation content and disposition of applications under 435.915 (what the case record must show for each application, including denied and withdrawn applications and the evidence relied on) are not stated in held text
Owner	Division of Social Services / county DSS (eligibility operations)
Action it owns	Publish the case record standard for applications (approval, denial, withdrawal) stating the documentation the file must contain under 435.915

CFR-435-024 · Renewal of eligibility (12-month cycle, ex parte first, pre-populated form, 90-day reconsideration)

Citation: 42 CFR 435.916

Determination: Partial

Not covered	The 90-day reconsideration period (an individual terminated for failure to return the renewal form who returns it within 90 days must have eligibility reconsidered without a new application) is not stated in any held document
Owner	Division of Social Services / county DSS (eligibility operations)
Action it owns	State the 90-day reconsideration rule in the renewal manual section and in the termination notice template

CFR-435-027 · Authorized representative (designation, notices, responsibilities)

Citation: 42 CFR 435.923

Determination: Partial

Not covered	The 435.923 designation mechanics for eligibility (written designation, the representative's authority at application and renewal, and sending notices and forms to the representative) are not stated in a held eligibility document
Owner	Division of Social Services / county DSS (eligibility operations)
Action it owns	State the authorized representative designation rule (form, scope, and notice routing) in the eligibility manual's application section

CFR-435-030 · Continued furnishing of Medicaid to individuals eligible under the plan

Citation: 42 CFR 435.930

Determination: Partial

Not covered	No held document states the 435.930 standards: furnishing Medicaid promptly to eligible individuals, and continuing to furnish it regularly to all eligible individuals until they are found ineligible
Owner	Division of Health Benefits (DHB)
Action it owns	State the 435.930 furnishing standard in the eligibility manual's opening provisions

CFR-435-031 · Verification requirements; IEVS; reasonable compatibility standard

Citation: 42 CFR 435.940, 435.945, 435.948, 435.949, 435.952

Determination: Partial

Not covered	The electronic verification service elements of 435.949 and the reasonable compatibility standard of 435.952 for MAGI determinations (when attested income and electronic data are treated as reasonably compatible, and when paper documentation may be requested) are not stated in held text

Owner	Division of Health Benefits (DHB), with the Division of Social Services
Action it owns	Publish the MAGI verification standard stating the electronic verification sources used and the reasonable compatibility thresholds applied in NC FAST

CFR-435-032 · Standard formats for furnishing and receiving data

Citation: 42 CFR 435.960

Determination: Partial

Not covered	The standardized format requirement of 435.960 as such (that information is requested and exchanged using the Secretary-prescribed formats) is not stated in held text; the formats are evidenced only by the exchanges in use
Owner	Division of Health Benefits (DHB)
Action it owns	State the standard format requirement in the IEVS procedures (plan Attachment 4.32-A successor or the NC FAST data exchange documentation)

CFR-435-034 · FFP limitation for certain non-citizens and public institution inmates

Citation: 42 CFR 435.1008, 435.1010

Determination: Partial

Not covered	The FFP limitation of 435.1008 stated as a payment condition (no FFP for services to the excluded categories) is not stated in any held payment document; the held text carries the eligibility conditions, not the payment limitation
Owner	Division of Health Benefits (DHB)
Action it owns	State the 435.1008 FFP limitation in the claims or eligibility standard so the payment consequence is on the public record alongside the eligibility conditions

CFR-435-036 · Presumptive eligibility (pregnant women; hospitals; other groups)

Citation: 42 CFR 435.1102, 435.1103, 435.1110

Determination: Partial

Not covered	Hospital presumptive eligibility under 42 CFR 435.1110 (qualified hospitals electing to make PE determinations for the populations the State covers) and PE furnishing for any groups beyond pregnant women are not evidenced in held documents
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the hospital presumptive eligibility program standard (participating hospitals, populations, and determination duties) or state that NC has not implemented hospital PE

CFR-435-038 · Medically needy program - definitions, scope, income and resource standards, spend-down

Citation: 42 CFR 435.800, 435.801, 435.811, 435.814, 435.831, 435.832, 435.843, 435.845

Determination: Partial

Not covered	The spend-down budget period specifics of 435.814 and the medically needy resource standard detail of 435.843 and 435.845 were not read element by element in held text (the standards appear as supplement values without the budget period methodology stated)
Owner	Division of Health Benefits (DHB), with the Division of Social Services
Action it owns	State the medically needy budget period and resource standard methodology in the eligibility manual's medically needy section

CFR-438-018 · Conflict of interest safeguards in managed care contracting

Citation: 42 CFR 438.58, 42 CFR 438.602(h)

Determination: Partial

Not covered	The 438.602(h) element (State safeguards addressing former State officials and employees in plan contracting) is not separately pinpointed in any held passage; the held evidence is the plan assurance for 438.58 only.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the conflict of interest safeguards policy covering procurement officials and former employees.

CFR-440-007 · Permitted limits on comparability

Citation: 42 CFR 440.250

Determination: Partial

Not covered	A complete statement of the 440.250 limits NC applies (for example any limit tied to 1915 waivers, section 1925, or section 1932 programs as applied group by group) is not in the held evidence.
Owner	Division of Health Benefits (DHB)
Action it owns	State, in the plan or a policy transmittal, which 440.250 permitted limits NC exercises, group by group.

CFR-440-012 · Transportation assurance for benchmark plan enrollees

Citation: 42 CFR 440.390

Determination: Partial

Not covered	An ABP-specific transportation assurance referencing 440.390 is not on any held ABP page.
Owner	Division of Health Benefits (DHB)

Action it owns	Confirm on the ABP record that ABP enrollees receive NEMT through their Standard Plan, citing 440.390.

CFR-441-002 · FFP prohibitions for institutionalized individuals

Citation: 42 CFR 441.13

Determination: Partial

Not covered	The remaining 441.13 exclusions are not stated in the held evidence, in particular the bar on FFP for services furnished to institutionalized individuals by outside providers and the exclusion of educational and vocational training reimbursement in ICF/IID and psychiatric facilities.
Owner	Division of Health Benefits (DHB)
Action it owns	State the full 441.13 exclusion set in the claims or coverage policy framework, including the outside-provider and educational/vocational elements.

CFR-441-005 · Laboratory services - qualified labs; HIV test records

Citation: 42 CFR 441.17

Determination: Partial

Not covered	The HIV test record element of 441.17 is not evidenced: no held policy states what identifying information must be on file for payment of HIV tests.
Owner	Division of Health Benefits (DHB)
Action it owns	State the HIV test claim record requirements in the laboratory coverage policy or billing guide.

CFR-441-008 · Nurse-midwife services - independent agreements

Citation: 42 CFR 441.21

Determination: Partial

Not covered	Whether NC currently enrolls nurse-midwives under independent provider agreements cannot be determined from the held record; the plan page contradicts itself.
Owner	Division of Health Benefits (DHB)
Action it owns	Conform plan section 3.1(a)(1)(ii) to current practice and file the nurse-midwife enrollment position.

CFR-441-009 · Nurse practitioner services - state plan duties

Citation: 42 CFR 441.22

Determination: Partial

Not covered	The 441.22 assurance that nurse practitioner services are available as a plan service independent of a physician's own enrollment, and any direct payment terms, are not stated in the held pages.
Owner	Division of Health Benefits (DHB)
Action it owns	State the nurse practitioner enrollment and payment position under 441.22 in the practitioner coverage policy.

CFR-441-012 · End-stage renal disease - facility approval

Citation: 42 CFR 441.40

Determination: Partial

Not covered	The Medicare approval cross-check for ESRD facilities is not stated in the held ESRD page.
Owner	Division of Health Benefits (DHB)
Action it owns	State in the ESRD coverage policy that payment is limited to Medicare approved ESRD facilities.

CFR-441-025 · IMD 65+ - individual plan of care with reviews

Citation: 42 CFR 441.102

Determination: Partial

Not covered	The 441.102 plan of care content and its review clocks (90 days, 30 days, quarterly) are not stated in any held document.
Owner	Division of Health Benefits (DHB)
Action it owns	File the mental hospital utilization review procedures showing the 441.102 plan of care and review clocks, or state them in policy.

CFR-442-003 · Effective date of provider agreement

Citation: 42 CFR 442.13

Determination: Partial

Not covered	The effective date rule of 442.13 and any executed agreement showing it applied are not in the held evidence.
Owner	Division of Health Benefits (DHB)
Action it owns	File an executed NF and ICF/IID provider agreement, or state the 442.13 effective date rule in the enrollment policy.

CFR-442-004 · Change of ownership - automatic assignment

Citation: 42 CFR 442.14

Determination: Partial

Not covered	The automatic assignment rule and any change-of-ownership record for a facility are not in the held evidence.
Owner	Division of Health Benefits (DHB)
Action it owns	State the 442.14 assignment rule in the provider enrollment manual and file a worked CHOW example.

CFR-442-005 · ICF/IID agreement duration and survey interval

Citation: 42 CFR 442.15

Determination: Partial

Not covered	The ICF/IID agreement duration and the 15-month ICF/IID survey interval are not stated for ICF/IID facilities in any held document.
Owner	NCDHHS Secretary
Action it owns	File the ICF/IID survey schedule and the agreement duration term, through the Division of Health Services Regulation's certification records.

CFR-442-006 · Agreement as evidence of certification - FFP conditioned

Citation: 42 CFR 442.30

Determination: Partial

Not covered	The 442.30 evidence-of-certification rule and its claims enforcement are not stated in held text.
Owner	Division of Health Benefits (DHB)
Action it owns	State the 442.30 rule in the facility payment policy, with the claim edit that suspends payment on loss of certification.

CFR-442-007 · FFP under retroactive agreement following appeal

Citation: 42 CFR 442.42

Determination: Partial

Not covered	The 442.42 rule and any instance of its application are not in the held evidence.
Owner	Division of Health Benefits (DHB)
Action it owns	Record whether any retroactive facility agreement issued in the period; if none, record the negative.

CFR-442-009 · ICF/IID survey intervals

Citation: 42 CFR 442.109

Determination: Partial

Not covered	ICF/IID survey dates and the statewide average interval computation are not held.
Owner	NCDHHS Secretary
Action it owns	File the ICF/IID survey date record and the FFY statewide average computation through the Division of Health Services Regulation.

CFR-442-010 · Certification with standard-level deficiencies

Citation: 42 CFR 442.110

Determination: Partial

Not covered	The 442.110 certification-with-deficiencies rule for ICF/IIDs, and any certification decision applying it, are not held.
Owner	NCDHHS Secretary
Action it owns	File a recent ICF/IID certification decision showing standard-level deficiencies handled under 442.110, through the survey agency.

CFR-442-011 · Termination of certification for immediate jeopardy

Citation: 42 CFR 442.117

Determination: Partial

Not covered	The 442.117 ICF/IID termination rule and any instance of its use are not evidenced.
Owner	NCDHHS Secretary
Action it owns	File the survey agency's ICF/IID immediate jeopardy procedure, or a termination record under 442.117.

CFR-442-012 · Denial of payments for new admissions to ICF/IID

Citation: 42 CFR 442.118

Determination: Partial

Not covered	The 442.118 notice and correction-opportunity terms for ICF/IIDs, and any instance of the remedy's use on an ICF/IID, are not evidenced.
Owner	Division of Health Benefits (DHB)
Action it owns	File the ICF/IID remedy procedure showing the 442.118 notice and correction terms, or record that the remedy has not been used on an ICF/IID in the period.

CFR-447-001 · Payment reassignment prohibition

Citation: 42 CFR 447.10

Determination: Partial

Not covered	The permitted payees and exceptions of 447.10(a) to (e) and the prohibition on payment to a factor, in operative state-side text.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the permitted-payee and no-factoring terms in the provider agreement or provider manual so the prohibition reads in operative text, not by incorporation alone.

CFR-447-003 · Provider billing limits with third-party liability

Citation: 42 CFR 447.20

Determination: Partial

Not covered	The 447.20(a) to (c) collection limits where a third party is liable, stated as billing rules.
Owner	Division of Health Benefits (DHB)
Action it owns	Add the 447.20 collection limits to the TPL billing guide or the provider billing manual, in the same document that carries the bill-the-carrier-first rule.

CFR-447-004 · No payment for provider-preventable conditions

Citation: 42 CFR 447.26

Determination: Partial

Not covered	Provider reporting of present on admission indicators, and any passage applying the non-payment policy through managed care contracts.
Owner	Division of Health Benefits (DHB)
Action it owns	State the present on admission reporting expectation for hospital claims in the plan or billing guidance, or record why the federal reporting element does not apply to NC's process.

CFR-447-008 · Timely claims payment, 90%/99% standards

Citation: 42 CFR 447.45

Determination: Partial

Not covered	The 90 percent in 30 days and 99 percent in 90 days fee-for-service standards, and any reported NC result against them.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the fee-for-service timely payment standard and the measured result for a stated period, in the same way plan timeliness is already reported in H-062.

CFR-447-012 · Maximum allowable cost sharing + annual CPI-U indexing

Citation: 42 CFR 447.52

Determination: Partial

Not covered	Annual CPI-U indexing of the maximum allowable amounts, and a single current amount set that matches across the plan and the contracts.
Owner	Division of Health Benefits (DHB)
Action it owns	Reconcile the copayment amounts between the plan attachments and the plan contracts, and record how the amounts are checked against the indexed federal maximums.

CFR-447-015 · Denial of service only for nonpayment by able, non-exempt individuals

Citation: 42 CFR 447.52

Determination: Partial

Not covered	The affirmative conditions under which a provider may deny service for nonpayment, stated in NC text.
Owner	Division of Health Benefits (DHB)
Action it owns	Add the able-to-pay and exemption conditions to the provider billing rule or manual, next to the inability guarantee the rule already carries.

CFR-447-017 · ED non-emergency cost-sharing conditions

Citation: 42 CFR 447.54

Determination: Partial

Not covered	The 447.54 conditions that must be met before the non-emergency ED charge may be imposed.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the conditions a hospital must meet before applying the non-emergency ED copayment, in the hospital billing guidance or the plan.

CFR-447-019 · Reduce provider payments by cost-sharing obligation

Citation: 42 CFR 447.56

Determination: Partial

Not covered	The 447.56(c) exceptions to the payment reduction, in NC text.
Owner	Division of Health Benefits (DHB)
Action it owns	State the exceptions to the copayment deduction in the billing guidance that describes the deduction itself.

CFR-447-021 · 5% aggregate family limit on premiums + cost sharing

Citation: 42 CFR 447.56

Determination: Partial

Not covered	The 5 percent aggregate limit itself, family level tracking toward it, and the relief that applies when it is reached.
Owner	Division of Health Benefits (DHB)
Action it owns	Bring the plan attachments into line with the current federal limit: replace the no cumulative maximum statements and build the family level tracking and relief process.

CFR-447-022 · No FFP for uncollected cost sharing

Citation: 42 CFR 447.56

Determination: Partial

Not covered	The no-FFP claiming rule for uncollected cost sharing, stated as a claiming procedure.
Owner	Division of Health Benefits (DHB)
Action it owns	State the claiming treatment of uncollected cost sharing in the agency's financial procedures or the state plan, next to the deduction mechanism.

CFR-447-023 · Public schedule and beneficiary/provider notice

Citation: 42 CFR 447.57

Determination: Partial

Not covered	A current public schedule of cost sharing amounts, and the 447.57 notice for a substantial change, addressed to beneficiaries, providers and the public.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish a current cost sharing schedule as a standalone public document and use it as the single source the plan attachments and contracts point to.

CFR-447-033 · Stakeholder input and CMS submission for rate changes

Citation: 42 CFR 447.204

Determination: Partial

Not covered	The record, in a submission, that access data and stakeholder input were considered for the change.
Owner	Division of Health Benefits (DHB)
Action it owns	Add a standard consideration statement to SPA submissions recording the access data and public input reviewed for the change.

CFR-447-034 · Public notice of significant rate-method changes

Citation: 42 CFR 447.205

Determination: Partial

Not covered	Final adoption notice and publication placement for a specific significant change, completing the notice chain.
Owner	Division of Health Benefits (DHB)
Action it owns	For the next significant rate method change, publish the proposal and the final action as a linked pair and keep both in the notices archive.

CFR-447-036 · Annual rate adequacy findings

Citation: 42 CFR 447.253

Determination: Partial

Not covered	The dated rate adequacy findings for hospital and long term care methods.
Owner	Division of Health Benefits (DHB)
Action it owns	Make and publish the findings when Subpart C methods change, in the SPA packet or a standing findings document.

CFR-447-037 · Ownership-change payment safeguards

Citation: 42 CFR 447.253

Determination: Partial

Not covered	An ownership change safeguard for hospitals, and a class wide statement of the no step-up measure.
Owner	Division of Health Benefits (DHB)
Action it owns	State the ownership change payment rule for hospitals in Attachment 4.19-A or the hospital billing guidance, mirroring the nursing facility text.

CFR-447-038 · Provider appeals procedure for rates

Citation: 42 CFR 447.253

Determination: Partial

Not covered	The incorporated appeal rules (10 NCAC 26K) as held text, and a general nursing facility rate appeal procedure.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the reimbursement review procedure with the plan attachments, or cite its public location in the reconsideration passages.

CFR-447-039 · Uniform cost reports from each provider

Citation: 42 CFR 447.253

Determination: Partial

Not covered	The uniform cost report form or format named for each Subpart C class, including ICFs.
Owner	Division of Health Benefits (DHB)
Action it owns	Name the cost report form for each provider class in the plan attachments, next to the filing deadlines already stated.

CFR-447-040 · Periodic audits of provider records

Citation: 42 CFR 447.253

Determination: Partial

Not covered	A stated periodic audit provision for hospitals and ICFs.
Owner	Division of Health Benefits (DHB)
Action it owns	State the audit cycle for hospital and ICF cost records in the plan or audit guidance, as the nursing facility attachment already does for its class.

CFR-447-041 · Comply with public notice for inpatient/LTC rate changes

Citation: 42 CFR 447.253

Determination: Partial

Not covered	A complete 447.205 notice chain for one inpatient change and one long term care change.
Owner	Division of Health Benefits (DHB)
Action it owns	Keep proposal and final notices for inpatient and long term care changes in the public archive as complete chains, as started for the readmission SPAs.

CFR-447-043 · Inpatient UPL compliance by ownership class

Citation: 42 CFR 447.272

Determination: Partial

Not covered	A performed inpatient UPL demonstration by ownership class for a stated year.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the annual inpatient UPL demonstration, or a summary by ownership class, with the hospital rate documentation.

CFR-447-044 · Swing-bed hospitals paid under NF methodology

Citation: 42 CFR 447.280

Determination: Partial

Not covered	The swing bed payment formula stated as the previous calendar year average nursing facility routine rate.
Owner	Division of Health Benefits (DHB)
Action it owns	State the swing bed rate basis in one passage that ties it to the nursing facility methodology the provision names.

CFR-447-045 · Annual DSH data submission to CMS

Citation: 42 CFR 447.294

Determination: Partial

Not covered	The annual DSH data submission to CMS, or a document describing it, its contents and its date.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the annual DSH data submission, or a transmittal record showing its contents and date, with the DSH program documents.

CFR-447-046 · Hospital-specific DSH limit methodology

Citation: 42 CFR 447.295

Determination: Partial

Not covered	One stated hospital specific DSH limit methodology covering all DSH hospital classes.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the hospital specific limit calculation as one methodology document covering every DSH class, or add the consolidating passage to Attachment 4.19-A.

CFR-447-048 · Annual per-hospital DSH report with audit

Citation: 42 CFR 447.299

Determination: Partial

Not covered	The annual per hospital DSH report and an independent certified audit for a stated DSH year.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the most recent DSH audit and the per hospital report it supports, or record where they are filed and how they may be obtained.

CFR-447-049 · Maintain DSH supporting documentation

Citation: 42 CFR 447.299

Determination: Partial

Not covered	The DSH records maintenance and production duty, stated in terms.
Owner	Division of Health Benefits (DHB)
Action it owns	State the DSH records retention and production rule in the DSH program documents, with the retention period.

CFR-447-050 · Return/redisclose DSH overpayments within 2 years

Citation: 42 CFR 447.299

Determination: Partial

Not covered	The two year discovery frame and the return treatment for overpayments that cannot be redistributed.
Owner	Division of Health Benefits (DHB)
Action it owns	Add the discovery period and the return rule to the DSH audit passage in Attachment 4.19-A, next to the redistribution order it already carries.

CFR-447-052 · Adhere to upper limits; no FFP above them

Citation: 42 CFR 447.304

Determination: Partial

Not covered	The claiming consequence (no Federal payment above the limits) and UPL coverage for the remaining Subpart F classes.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the UPL demonstrations by class with the rate documentation, and state the claiming consequence in the financial procedures.

CFR-447-053 · Outpatient hospital/clinic UPL by ownership class

Citation: 42 CFR 447.321

Determination: Partial

Not covered	A performed outpatient UPL demonstration by ownership class covering base payments.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the outpatient UPL demonstration by ownership class with the hospital rate documentation.

CFR-447-054 · Other facility services charge limits

Citation: 42 CFR 447.325

Determination: Partial

Not covered	The customary and prevailing charge measure of 447.325, stated and applied.
Owner	Division of Health Benefits (DHB)
Action it owns	State the charge based limit in the facility payment sections that rely on it, or record why the fee schedule and cost methods make it inoperative.

CFR-447-055 · Nonrisk prepaid capitation payment cap

Citation: 42 CFR 447.362

Determination: Partial

Not covered	The 447.362 cap formula and any performance of it for NC's nonrisk payments.
Owner	Division of Health Benefits (DHB)
Action it owns	Record the cap comparison for the PCCM medical home payments in the program's rate documentation.

CFR-447-056 · RHC payment at reasonable cost

Citation: 42 CFR 447.371

Determination: Partial

Not covered	Reasonable cost determination for the individual clinic in the provision's terms, including clinics without a base year cost report.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the revised Attachment 4.19-B section 2 pages with the SPA approvals so the RHC methodology can be read in the plan, not only in a bulletin.

CFR-447-059 · Submit quarterly drug utilization data to CMS

Citation: 42 CFR 447.511

Determination: Partial

Not covered	The quarterly submission to CMS, its deadline and its data content, stated or shown.
Owner	Division of Health Benefits (DHB)
Action it owns	Record the quarterly utilization submission (form, deadline, responsible unit) in the pharmacy program documentation.

CFR-447-064 · Apply drug upper limits to facility and capitation settings

Citation: 42 CFR 447.516

Determination: Partial

Not covered	Application of the upper limits in facility settings and in capitation rate development for drugs.
Owner	Division of Health Benefits (DHB)
Action it owns	State how the drug upper limits flow into facility bundled payments and into capitation, in the pharmacy and rate documentation.

CFR-447-066 · Cost-based data for drug reimbursement changes

Citation: 42 CFR 447.518

Determination: Partial

Not covered	The cost based data package submitted with a significant drug payment change.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the AAC survey and dispensing fee cost data with the next drug payment SPA, as the supporting package.

CFR-447-067 · Annual VBP supplemental-rebate data (if participating)

Citation: 42 CFR 447.518

Determination: Partial

Not covered	A VBP supplemental rebate agreement, or affirmative evidence NC has none, and the annual data report if one exists.
Owner	Division of Health Benefits (DHB)
Action it owns	Confirm on the record whether any NC supplemental rebate agreement is a value based arrangement; if one is, publish its annual data report.

CFR-455-002 · Provider fraud certification statements on claims

Citation: 42 CFR 455.18-455.19

Determination: Partial

Not covered	The provider certification statement on claims and the fiscal agent certification statement (42 CFR 455.18 and 455.19) as documents NC actually uses; only the plan's range assurance covers them, unread at the element level in any operating document.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the provider agreement or claim certification language carrying the 455.18 statement and the fiscal agent statement under 455.19.

CFR-455-003 · Beneficiary verification that services were received

Citation: 42 CFR 455.20

Determination: Partial

Not covered	A program-wide beneficiary verification method under 42 CFR 455.20 (written statements to a sample of beneficiaries and follow-up where services are not confirmed); held evidence covers one waiver service's sign-to-confirm practice only.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the beneficiary verification procedure or a sample verification mailing and its follow-up protocol.

CFR-455-005 · Suspension of payments on credible allegation of fraud

Citation: 42 CFR 455.23

Determination: Partial

Not covered	The 455.23 procedural elements: timely written notice to the provider, documentation of good cause exceptions where payments are not suspended or are partially suspended, and suspension duration review. No held passage states them, and the former state rule on withholding was repealed in 2018.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the payment suspension procedure or template notice carrying the 455.23 notice, good cause and duration elements.

CFR-455-006 · Ownership/control disclosure at enrollment, revalidation, and ownership changes

Citation: 42 CFR 455.104

Determination: Partial

Not covered	The complete 455.104 disclosure set (ownership and control thresholds, managing employees and agents, subcontractor ownership) and its application at initial enrollment and reenrollment in NCTracks; held text covers owner identity at application and ownership changes, plus a revalidation statement.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the NCTracks enrollment disclosure screens or instructions carrying the full 455.104 data set.

CFR-455-007 · Business transaction disclosure on request

Citation: 42 CFR 455.105

Determination: Partial

Not covered	The business transaction disclosure duty of 42 CFR 455.105 as a stated requirement (significant business transactions, on request, within the regulatory timeframe); held text mentions the section number only, inside revalidation and general procedure statements.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the provider agreement clause or disclosure form carrying the 455.105 business transaction duty.

CFR-455-014 · Mandatory termination/denial triggers

Citation: 42 CFR 455.416 (with 455.417)

Determination: Partial

Not covered	The mandatory termination and denial triggers of 42 CFR 455.416(a)-(d) and the 455.417 element, stated as NC requirements; held evidence is a single assurance citing the section for all terminations and denials.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the enrollment denial and termination standard or NCTracks instruction listing the 455.416 mandatory triggers.

CFR-455-017 · Pre- and post-enrollment site visits; unannounced inspections

Citation: 42 CFR 455.432

Determination: Partial

Not covered	The unannounced character of pre-enrollment and post-enrollment site visits under 42 CFR 455.432; held operating text describes visits scheduled through a contractor, and no held passage states visits are unannounced.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the site visit protocol showing whether enrollment site visits are unannounced and how the contractor scheduling step preserves that.

CFR-455-019 · Federal database checks, including monthly LEIE/EPLS

Citation: 42 CFR 455.436

Determination: Partial

Not covered	The monthly frequency for LEIE and EPLS checks after enrollment required by 42 CFR 455.436; held passages establish the checks and the databases at enrollment and reenrollment, not the monthly ongoing cycle.
Owner	Division of Health Benefits (DHB)

Action it owns	Produce the database check schedule or system description showing monthly LEIE and EPLS checks for enrolled providers and their owners and managing employees.

CFR-455-025 · RAC provider appeal rights; RAC requirement exceptions

Citation: 42 CFR 455.512, 455.516

Determination: Partial

Not covered	The 42 CFR 455.516 element: the exceptions to RAC requirements and any NC exception in force are not addressed in held evidence.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the RAC contract's appeal and exceptions terms, or state which 455.516 exceptions NC relies on.

CFR-456-001 · Statewide surveillance and utilization control program

Citation: 42 CFR 456.2-456.4

Determination: Partial

Not covered	A statewide SURS and utilization control program description covering all Medicaid services; held evidence is the plan's subpart attestations plus SURS tooling described for PCS and waiver populations only.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the statewide utilization control program description or SURS program documentation covering all service settings.

CFR-456-007 · Hospital individual written plan of care

Citation: 42 CFR 456.80, 456.181 (hospitals)

Determination: Partial

Not covered	The individual written plan of care for hospital and mental hospital inpatients (42 CFR 456.80 and 456.181): preparer, contents and periodic review are not stated in held evidence.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the hospital policy or UR documentation carrying the inpatient plan of care requirement.

CFR-456-009 · Mental hospital certification, evaluations, and plan of care

Citation: 42 CFR 456.160, 456.170, 456.180, 456.181

Determination: Partial

Not covered	Mental hospital certification, evaluation and plan of care elements (42 CFR 456.160, 456.170, 456.180, 456.181) as NC requirements; held evidence is the Subpart D attestation only.
Owner	Division of Mental Health, Developmental Disabilities and Substance Use Services
Action it owns	Produce the mental hospital utilization and plan of care documentation used for Medicaid patients in state and private psychiatric facilities.

CFR-456-010 · Written UR plan required for inpatient mental hospital services

Citation: 42 CFR 456.201-456.245

Determination: Partial

Not covered	The written UR plan requirement and its content for inpatient mental hospital services (42 CFR 456.201-456.245); held evidence is the plan's Subpart D attestation only.
Owner	Division of Mental Health, Developmental Disabilities and Substance Use Services
Action it owns	Produce a mental hospital UR plan or the state standard against which such plans are reviewed.

CFR-456-011 · ICF certification, evaluations, and plan of care

Citation: 42 CFR 456.360, 456.370, 456.380, 456.381

Determination: Partial

Not covered	ICF certification, evaluation and plan of care elements (42 CFR 456.360, 456.370, 456.380, 456.381) as NC requirements; held evidence is subpart attestation only.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the ICF/IID utilization and plan of care documentation carrying the Subpart E and F elements.

CFR-456-012 · Medicaid agency review of need for ICF admission; alternative-services exploration

Citation: 42 CFR 456.371-456.372

Determination: Partial

Not covered	Exploration of alternative services to ICF care, and the described agency review process (reviewer, criteria, timing) under 42 CFR 456.371-456.372; held evidence shows prior approval for ICF admissions only.
Owner	Division of Health Benefits (DHB)

Action it owns	Produce the ICF admission review procedure showing the alternatives exploration step.

CFR-456-013 · ICF UR plan and continued stay review

Citation: 42 CFR 456.401-456.438

Determination: Partial

Not covered	The ICF UR plan and continued stay review elements (42 CFR 456.401-456.438): plan content, review intervals and adverse decision notice are not stated in held evidence.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce an ICF UR plan or the survey/review standard covering continued stay review in ICFs.

CFR-456-014 · Under-21 inpatient psychiatric admission certification and plan of care

Citation: 42 CFR 456.481-456.482

Determination: Partial

Not covered	Certification of need and plan of care for under-21 inpatient psychiatric admission (42 CFR 456.481 and 456.482): certifying team, certification content and plan elements are not stated in held evidence.
Owner	Division of Mental Health, Developmental Disabilities and Substance Use Services
Action it owns	Produce the PRTF admission certification and plan of care documentation used for Medicaid patients under 21.

CFR-456-015 · UR plans as a condition for FFP

Citation: 42 CFR 456.501

Determination: Partial

Not covered	The FFP condition of 42 CFR 456.501 stated or applied in NC: no held document conditions payment on UR plan compliance.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce any provider agreement or payment policy language conditioning FFP on a compliant UR plan.

CFR-456-018 · Annual inspections of care in ICFs and IMDs

Citation: 42 CFR 456.600-456.613

Determination: Partial

Not covered	Annual cadence, team composition and review steps for inspections of care under 42 CFR 456.600-456.613; held evidence is the plan's framework attestation and PRO contract statement.

Owner	Division of Health Benefits (DHB)
Action it owns	Produce a current inspection of care report or the Subpart I inspection schedule for ICFs and IMDs.

CHIP SPAs NC-23-0008 / NC-23-0010, separate CHIP → Medicaid expansion CHIP

Stands behind: 50 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: CHIP SPAs NC-23-0008 / NC-23-0010, separate CHIP → Medicaid expansion CHIP.
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-457-003 · State plan amendments, triggers and amended budget

Citation: 42 CFR 457.60

Determination: Partial

Not covered	A plan-level procedure or commitment covering the 457.60 amendment triggers (changes in Federal law, regulation, policy or court decision; changes in State law, organization, policy or program operation) with an amended budget submitted on amendment.
Owner	Division of Health Benefits (DHB)
Action it owns	State the 457.60 amendment-trigger and amended-budget procedure in a plan amendment or administrative record filed for the Title XXI program.

CFR-457-004 · Plan amendment effective-date limits and public notice

Citation: 42 CFR 457.65

Determination: Partial

Not covered	The 457.65(a) effective-date limits stated as a governing commitment, and the 457.65 tribal notification element for eligibility or benefit amendments.
Owner	Division of Health Benefits (DHB)
Action it owns	Add the 457.65(a) timing limits and the tribal notice step to the SPA procedure described at plan section 9.9.2.

CFR-457-005 · State plan describes chosen program option

Citation: 42 CFR 457.70

Determination: Partial

Not covered	A conformed section 1.1 description of the chosen option: the combination plan narrative at section 1.1.3 was not struck or updated when the program converted to a Medicaid expansion CHIP.
Owner	Division of Health Benefits (DHB)
Action it owns	Submit a conforming Title XXI plan amendment striking the combination plan narrative at section 1.1.3 so the plan describes only the Medicaid expansion option.

CFR-457-006 · State plan describes current coverage and coordination

Citation: 42 CFR 457.80

Determination: Partial

Not covered	The 457.80(a) description of the extent and manner in which children in the State currently have creditable health coverage, distinguished by income level and other relevant factors.
Owner	Division of Health Benefits (DHB)
Action it owns	Complete plan section 2.1 with current creditable coverage data by income level, race, ethnicity and geography, or file the equivalent baseline description for the Title XXI record.

CFR-457-008 · Enrollment assistance and plain-language information

Citation: 42 CFR 457.110

Determination: Partial

Not covered	The 457.110 plain-language, language-access and alternative-format standards stated as commitments for CHIP program information and application assistance.
Owner	Division of Health Benefits (DHB)
Action it owns	State the 457.110 information standards (plain language, prevalent languages, alternative formats, oral interpretation) for the Title XXI program in the plan or a filed program record.

CFR-457-013 · Correct practices after federal/state program reviews

Citation: 42 CFR 457.200

Determination: Partial

Not covered	A State commitment or record of implementing correct practices required by Federal or State program reviews under 457.200.
Owner	Division of Health Benefits (DHB)

Action it owns	File the Title XXI program-review response procedure, or a review outcome record, showing how DHB implements correct practices identified by Federal or State reviews of the CHIP program.

CFR-457-018 · FFP unavailable for uncollected cost sharing and ineligible individuals

Citation: 42 CFR 457.224

Determination: Partial

Not covered	A claiming control or assurance that FFP is not claimed for expenditures for individuals ineligible under the Title XXI program.
Owner	Division of Health Benefits (DHB)
Action it owns	State the ineligible-individual claiming exclusion for Title XXI expenditures in the plan or the CMS-21 claiming procedure.

CFR-457-019 · Fiscal policies: accounting system and record retention

Citation: 42 CFR 457.226

Determination: Partial

Not covered	The 457.226 fiscal policy elements: description of the accounting system for Title XXI funds and the record retention standard applied to CHIP program records.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the Title XXI fiscal policies statement covering the accounting system and record retention applied to CHIP funds and records.

CFR-457-021 · Overpayment adjustments and OIG fraud referrals

Citation: 42 CFR 457.232

Determination: Partial

Not covered	The State-side 457.232 procedure for FFP adjustment on provider overpayments outside managed care and for referral of suspected provider fraud to the OIG.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the Title XXI overpayment adjustment and OIG fraud referral procedure covering fee for service as well as managed care recoveries.

CFR-457-022 · Assure audit of provider services cost records

Citation: 42 CFR 457.236

Determination: Partial

Not covered	An assurance or record that audits of the cost records of providers of services under the Title XXI program are conducted as the Secretary requires, beyond managed care encounter and financial data audits.

Owner	Division of Health Benefits (DHB)
Action it owns	State the provider cost record audit assurance for the Title XXI program, covering fee for service providers.

CFR-457-023 · Documentation of payment rates available to HHS

Citation: 42 CFR 457.238

Determination: Partial

Not covered	A statement that documentation of Title XXI payment rates and rate-setting methods is maintained and available to HHS on request.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the rate documentation availability statement for Title XXI payment rates, or the rate documentation itself.

CFR-457-024 · State plan describes eligibility, enrollment, and screening procedures

Citation: 42 CFR 457.305

Determination: Partial

Not covered	A single conformed 457.305 description distinguishing the operative Medicaid expansion standards from the retained separate program standards at section 4.1.
Owner	Division of Health Benefits (DHB)
Action it owns	Conform plan section 4 so the eligibility, enrollment and screening description states the Medicaid expansion standards as operative and removes or retires the separate program standards.

CFR-457-025 · Apply MAGI and household methodologies

Citation: 42 CFR 457.315

Determination: Partial

Not covered	The 457.315 MAGI and household methodology stated for the Medicaid expansion population as such, including any non-MAGI or household composition exceptions applied.
Owner	Division of Health Benefits (DHB)
Action it owns	State the MAGI methodology for the expansion groups in the Title XXI plan section 4.0 or a filed eligibility record.

CFR-457-026 · Use single streamlined application

Citation: 42 CFR 457.330

Determination: Partial

Not covered	The 457.330 application standards: identification of the single streamlined application used (model or approved alternative) and the data elements it collects across insurance affordability programs.
Owner	Division of Health Benefits (DHB)
Action it owns	Identify the single streamlined application of record for the CHIP program and its approval basis in a filed program record.

CFR-457-027 · Application notices, timeliness, coordinated notices, effective-date method

Citation: 42 CFR 457.340

Determination: Partial

Not covered	The 457.340(e) and (f) coordinated notice elements: coordinated content and combined eligibility notices across insurance affordability programs.
Owner	Division of Health Benefits (DHB)
Action it owns	Describe the coordinated and combined notice practice for CHIP applicants in the plan or the 457.348 agreement record.

CFR-457-029 · Periodic renewal of CHIP eligibility

Citation: 42 CFR 457.343

Determination: Partial

Not covered	The 457.343 renewal procedure stated in the regulation's terms (ex parte renewal from available information, pre-populated form, notice content and response period) for the expansion population.
Owner	Division of Health Benefits (DHB)
Action it owns	State the CHIP renewal procedure in the plan or eligibility record in 457.343 terms for the expansion population.

CFR-457-030 · Prompt redetermination on changes in circumstances

Citation: 42 CFR 457.344

Determination: Partial

Not covered	A general 457.344 prompt redetermination procedure for reported or discovered changes in circumstances, stated for the CHIP program.
Owner	Division of Health Benefits (DHB)

Action it owns	State the change-in-circumstance redetermination procedure for the Title XXI program in the plan or a filed eligibility record.

CFR-457-031 · Accept eligibility determinations/accounts from other insurance affordability programs

Citation: 42 CFR 457.348

Determination: Partial

Not covered	The 457.348(a) interagency agreement and the electronic account transfer and determination-acceptance standards between insurance affordability programs.
Owner	Division of Health Benefits (DHB)
Action it owns	File the 457.348 coordination agreement, or describe the account transfer arrangement, for the Title XXI program.

CFR-457-033 · Coordination with appeals entities across insurance affordability programs

Citation: 42 CFR 457.351

Determination: Partial

Not covered	Coordination of the CHIP appeals process with other insurance affordability program appeals entities under 457.351, including the coordination agreement terms.
Owner	Division of Health Benefits (DHB)
Action it owns	Describe the appeals coordination arrangement for the Title XXI program, or file the coordination terms in the 457.348 agreement record.

CFR-457-034 · Monitor and evaluate the screening process

Citation: 42 CFR 457.353

Determination: Partial

Not covered	A described method for monitoring and evaluating the 457.350 screening process and acting on its results.
Owner	Division of Health Benefits (DHB)
Action it owns	Describe the screening process monitoring method (measures, review cycle, corrective use) in the plan or a quality record.

CFR-457-035 · Deemed newborn coverage to first birthday

Citation: 42 CFR 457.360

Determination: Partial

Not covered	A description of deemed newborn coverage to the first birthday for children born to mothers covered under the Title XXI program, or a statement of where that coverage sits after the conversion.

Owner	Division of Health Benefits (DHB)
Action it owns	State where deemed newborn coverage for this population is documented (Title XIX plan or Title XXI plan) in the register record.

CFR-457-036 · Eligibility verification and verification plan

Citation: 42 CFR 457.380

Determination: Partial

Not covered	The 457.380 verification plan document, or a plan description adopting the 435.940 to 435.965 verification standards for the CHIP program.
Owner	Division of Health Benefits (DHB)
Action it owns	File the CHIP verification plan or add a plan description adopting the Medicaid verification framework for Title XXI determinations.

CFR-457-037 · State plan describes delivery methods and utilization control

Citation: 42 CFR 457.490

Determination: Partial

Not covered	A 457.490 delivery methods and utilization control description conformed to the Medicaid expansion structure, covering delivery through the Medicaid managed care contracts under which expansion children are now served.
Owner	Division of Health Benefits (DHB)
Action it owns	Conform plan section 3 to describe delivery and utilization control for the expansion population through the Medicaid PHP contracts.

CFR-457-039 · Mental health and substance use disorder parity

Citation: 42 CFR 457.496

Determination: Partial

Not covered	Parity compliance documentation for the Medicaid expansion CHIP population under the operative Medicaid managed care parity framework (42 CFR Part 438 Subpart K).
Owner	Division of Health Benefits (DHB)
Action it owns	File the parity analysis covering expansion CHIP children in Medicaid managed care, or cross-reference it in the Title XXI record.

CFR-457-040 · State plan cost-sharing description and compliance methods

Citation: 42 CFR 457.505

Determination: Partial

Not covered	A conformed 457.505 cost sharing description for the Medicaid expansion CHIP stating that no cost sharing is imposed, replacing the retained separate program schedule at section 8.2.
Owner	Division of Health Benefits (DHB)
Action it owns	Submit a conforming plan amendment restating section 8 for the expansion program (no cost sharing imposed).

CFR-457-041 · State plan describes any premiums or cost-sharing charges

Citation: 42 CFR 457.510; 457.515

Determination: Partial

Not covered	A conformed description of premiums and enrollment charges for the expansion program (none imposed), with the 457.515 protections stated for the current structure.
Owner	Division of Health Benefits (DHB)
Action it owns	Restate the premiums and charges description in the conformed section 8 amendment for the expansion program.

CFR-457-043 · Public schedule of cost sharing

Citation: 42 CFR 457.525

Determination: Partial

Not covered	A current public schedule or public statement of cost sharing for the expansion CHIP showing the charges in effect (none), the groups subject, and the cumulative maximum position.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the current cost sharing position for expansion CHIP children (no charges imposed) on the program web pages and handbook.

CFR-457-044 · Cost-sharing limits for children at or below 150% FPL

Citation: 42 CFR 457.540; 457.555

Determination: Partial

Not covered	A conformed statement of cost sharing limits for children at or below 150% FPL in the expansion program, resolving the retained 133% to 159% FPL copayment band at section 8.2.
Owner	Division of Health Benefits (DHB)

Action it owns	Resolve the section 8.2 income band conflict in the conformed section 8 amendment, stating the limits applicable at or below 150% FPL.

CFR-457-047 · Conditions for allotment and Federal payment

Citation: 42 CFR 457.606

Determination: Partial

Not covered	State-side records of the 457.606 conditions for allotment and Federal payment as applied to NC (payment terms, reallotment treatment).
Owner	Division of Health Benefits (DHB)
Action it owns	File the allotment and payment conditions record for the Title XXI program with the register evidence.

CFR-457-049 · Enhanced FMAP rate and conditions

Citation: 42 CFR 457.622

Determination: Partial

Not covered	The full set of 457.622 enhanced FMAP conditions evidenced as State findings, beyond the rate application in the budget and the (b)(5) finding at section 8.8.4.
Owner	Division of Health Benefits (DHB)
Action it owns	File the enhanced FMAP conditions record for the Title XXI program, or state the remaining conditions in a plan amendment.

CFR-457-050 · Prevention of duplicate payments (third-party liability)

Citation: 42 CFR 457.626

Determination: Partial

Not covered	Third party liability identification and pursuit procedures for Title XXI expenditures beyond the 457.626(a)(1) finding.
Owner	Division of Health Benefits (DHB)
Action it owns	Describe the CHIP third party liability identification and recovery procedure in the plan or a filed program record.

CFR-457-051 · Quarterly grant awards and budget requests

Citation: 42 CFR 457.630

Determination: Partial

Not covered	Quarterly grant award and budget request records for the Title XXI program under 457.630.
Owner	Division of Health Benefits (DHB)

Action it owns	File the most recent quarterly Title XXI budget request and grant award notices with the register evidence.

CFR-457-056 · Quarterly expenditure/statistical reports and annual unduplicated count

Citation: 42 CFR 457.740

Determination: Partial

Not covered	The quarterly expenditure and statistical reports and the annual unduplicated count of children served required by 457.740, as submitted records.
Owner	Division of Health Benefits (DHB)
Action it owns	File the most recent quarterly CHIP statistical report and the annual unduplicated count with the register evidence.

CFR-457-058 · Public provider directory API

Citation: 42 CFR 457.760

Determination: Partial

Not covered	The State-maintained public provider directory API required by 457.760 for the CHIP program.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the CHIP provider directory API documentation or state how the Medicaid provider directory API of record covers Title XXI providers.

CFR-457-059 · Child Core Set quality measure reporting

Citation: 42 CFR 457.770

Determination: Partial

Not covered	Annual Child Core Set reporting to CMS under 457.770 for the CHIP program, as a submitted record.
Owner	Division of Health Benefits (DHB)
Action it owns	File the most recent Child Core Set submission for the CHIP program with the register evidence.

CFR-457-060 · Prior authorization: denial reasons, PA API, public metrics

Citation: 42 CFR 457.732

Determination: Partial

Not covered	The 457.732 prior authorization package for CHIP: specific denial reasons to the regulation's standard, the PA API, and publicly reported PA metrics.
Owner	Division of Health Benefits (DHB)

Action it owns	Publish the CHIP prior authorization API and PA metrics, and state the denial-reason standard applied to CHIP PA responses.

CFR-457-061 · Substitution-of-coverage procedures (crowd-out)

Citation: 42 CFR 457.805

Determination: Partial

Not covered	A statement of how the 457.805 anti-substitution procedures operate for the Medicaid expansion population after April 1, 2023.
Owner	Division of Health Benefits (DHB)
Action it owns	State the operative anti-substitution procedure for expansion children in the conformed plan or a filed program record.

CFR-457-063 · Proper/efficient administration and eligibility safeguards

Citation: 42 CFR 457.910

Determination: Partial

Not covered	The 457.910 administration safeguards stated as a set (methods of administration, personnel standards, and safeguards for eligibility determinations) for the Title XXI program.
Owner	Division of Health Benefits (DHB)
Action it owns	State the 457.910 safeguards for the CHIP program in the plan or an administrative record.

CFR-457-064 · Fraud detection, investigation, and law enforcement referral

Citation: 42 CFR 457.915; 457.925; 457.930

Determination: Partial

Not covered	State-side fraud detection, investigation and law enforcement referral procedures for the CHIP fee for service program under 457.915, 457.925 and 457.930.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the CHIP fraud detection and investigation procedure, including MFCU and law enforcement referral practice for fee for service.

CFR-457-066 · Procurement assurance and open competition

Citation: 42 CFR 457.940

Determination: Partial

Not covered	A description of the procurement standards applied to Title XXI contracting beyond the 457.940(b) assurance sentence.
Owner	Division of Health Benefits (DHB)

Action it owns	Describe the procurement standards for CHIP contracting in the plan or a filed administrative record.

CFR-457-067 · FFS entity certification, fraud awareness, and data access

Citation: 42 CFR 457.950

Determination: Partial

Not covered	FFS entity certification, fraud awareness and data access provisions for the CHIP program under 457.950.
Owner	Division of Health Benefits (DHB)
Action it owns	State the fiscal agent certification and fraud awareness provisions applicable to CHIP fee for service administration.

CFR-457-068 · Case record content, 3-year retention, 30-day availability

Citation: 42 CFR 457.965

Determination: Partial

Not covered	The 457.965 case record content list, the 3-year retention standard, and the 30-day availability commitment for CHIP case records.
Owner	Division of Health Benefits (DHB)
Action it owns	State the CHIP case record content and retention standard in the plan or the eligibility record.

CFR-457-069 · Systems to verify claims where enhanced FMAP applies

Citation: 42 CFR 457.980

Determination: Partial

Not covered	A description of the claims identification system that separates enhanced FMAP claims for the expansion population from other claims.
Owner	Division of Health Benefits (DHB)
Action it owns	Describe the eFMAP claims identification mechanism for the Title XXI program in a filed fiscal record.

CFR-457-070 · Professional-advice integrity and physician incentive plan limits

Citation: 42 CFR 457.985

Determination: Partial

Not covered	The 42 CFR 422.206(a) professional advice integrity element of 457.985, and any physician incentive plan limits outside managed care contracts.
Owner	Division of Health Benefits (DHB)

Action it owns	State the 422.206(a) element for CHIP contracting, or confirm no physician incentive plans operate in the CHIP program.

CFR-457-071 · Provider/supplier screening, oversight, and reporting

Citation: 42 CFR 457.990

Determination: Partial

Not covered	Provider screening, oversight and reporting for CHIP providers under Part 455 Subpart E as imported by 457.990 (risk levels, site visits, revalidation screening).
Owner	Division of Health Benefits (DHB)
Action it owns	State how Part 455 Subpart E screening applies to CHIP providers, or cross-reference the Medicaid screening record in the Title XXI file.

CFR-457-072 · Privacy protections for enrollee records

Citation: 42 CFR 457.1110

Determination: Partial

Not covered	State-side privacy safeguards for CHIP applicant and enrollee information meeting Part 431 Subpart F, stated for the Title XXI program.
Owner	Division of Health Benefits (DHB)
Action it owns	State the privacy safeguards applied to Title XXI applicant and enrollee information in the plan or a filed administrative record.

CFR-457-073 · Applicant/enrollee review (appeal) process with timeliness standards

Citation: 42 CFR 457.1120; 457.1130; 457.1140; 457.1150; 457.1160; 457.1170; 457.1180

Determination: Partial

Not covered	The continuation of benefits element of the 457.1120 series (the plan states services are not maintained during review), and subsection-level timeliness standards for eligibility and enrollment reviews distinct from health services reviews.
Owner	Division of Health Benefits (DHB)
Action it owns	Reconcile the plan section 12 continuation statement with the subpart K continuation element and state the per-subsection timeliness standards for the expansion population, whose reviews now run through Medicaid fair hearings.

CFR-457-074 · Managed care contract submission and contract requirements

Citation: 42 CFR 457.1201

Determination: Partial

Not covered	The managed care contract instrument of record for the expansion CHIP population and evidence of its submission to CMS under 457.1201.

Owner	Division of Health Benefits (DHB)
Action it owns	Identify the contract instrument covering expansion CHIP children and file its CMS submission record for Title XXI.

CFR-457-075 · Network adequacy analysis and annual enrollee survey posting

Citation: 42 CFR 457.1207; 457.1230

Determination: Partial

Not covered	The annual enrollee experience survey for CHIP managed care enrollees and public posting of its results.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the enrollee experience survey results covering expansion CHIP children in managed care, or state where they are posted.

CFR-457-076 · Managed care quality: QAPI, accreditation, ratings, quality strategy

Citation: 42 CFR 457.1240

Determination: Partial

Not covered	Accreditation review and public quality ratings for CHIP managed care plans under 457.1240.
Owner	EQRO
Action it owns	Publish accreditation status and quality ratings for the plans serving expansion CHIP children, or state where they are posted.

NC Medicaid Managed Care Quality Strategy 2023 (cites 42 CFR 438.340(b)(6) stratification; development per 438.340(c) incl. MCAC consultation and EBCI/CIHA tribal consultation)

Stands behind: 15 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: NC Medicaid Managed Care Quality Strategy 2023 (cites 42 CFR 438.340(b)(6) stratification; development per 438.340(c) incl. MCAC consultation and EBCI/CIHA tribal consultation).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-438-013 · Standard managed care definitions and model enrollee materials

Citation: 42 CFR 438.10(c)(4)-(5)

Determination: Partial

Not covered	The 438.10(c)(4) element as written: State-developed definitions of managed care terms, developed in consultation with the Medical Care Advisory Committee or a similar committee, and the State's model enrollee notices; and whether use of the model handbook and notices is required of plans (438.10(c)(5)) is not stated in the held passages.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the State's managed care definitions and the model handbook and notices, and state whether plans must use them.

CFR-438-015 · Managed care enrollment system and informational notices

Citation: 42 CFR 438.54

Determination: Partial

Not covered	The informational notice to each potential enrollee at the time they first become eligible, with the 438.54 content, as a document: the enrollment broker contract that would carry it was not found in the public record (NL-08 search record: only the 2018 Maximus award is documented).
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the potential enrollee informational notice and the enrollment broker contract.

CFR-438-016 · Choice counseling for potential enrollees and disenrollees

Citation: 42 CFR 438.54, 42 CFR 438.71(c)

Determination: Partial

Not covered	Choice counseling for enrollees who disenroll, as 438.71(c) and 438.56(c) contemplate (counseling offered in connection with disenrollment for cause and at plan termination), is not stated as a service in any held passage, and the enrollment broker contract terms are not in the public record (NL-08).
Owner	Division of Health Benefits (DHB)
Action it owns	State the choice counseling offered to disenrolling members in the enrollment policy and publish the broker contract.

CFR-438-017 · Disenrollment determinations, timeframes, and fair hearing

Citation: 42 CFR 438.56

Determination: Partial

Not covered	438.56 elements not pinpointed: the State's determination timeframes for disenrollment requests, the fair hearing right when a disenrollment request is denied, stated as part of this system, and plan-requested disenrollment grounds and procedure for Standard Plans.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the disenrollment determination timeframes and the fair hearing notice given on denial.

CFR-438-020 · Continued services after contract termination or disenrollment

Citation: 42 CFR 438.62(a)

Determination: Partial

Not covered	438.62(a) at the plan level: the State's arrangement to provide for continued services to enrollees when a plan contract is terminated or the plan becomes insolvent (as distinct from provider terminations) is not stated in any held passage.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the plan-termination continuity arrangement required by 438.62(a).

CFR-438-021 · Managed care monitoring system

Citation: 42 CFR 438.66(a)-(c)

Determination: Partial

Not covered	No single held instrument describes the 438.66(a)-(c) monitoring system as a system covering every enumerated domain in terms, in particular the beneficiary support system and LTSS-specific monitoring areas; the description is spread across the Quality Strategy, the MCPARs and the performance report.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish a single monitoring system description mapped to the 438.66(c) domains.

CFR-438-025 · Network adequacy standards, development and enforcement

Citation: 42 CFR 438.68(a)-(c)

Determination: Partial

Not covered	The complete 438.68(b)(1)-(2) type set as distinct quantitative standards: the held standards do not separately state standards for every federal type (for example pediatric specialty types and LTSS provider types as distinct standards), and the published results show plans below the 95 percent standard in multiple cells (for example child allergy and immunology at 33 percent in one region for one plan) with no held documentation of the enforcement consequence (see CFR-438-033).
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the standards mapped type-by-type to 438.68(b) and the enforcement taken where a plan misses a standard.

CFR-438-031 · Assurance of adequate capacity and services to CMS

Citation: 42 CFR 438.207(d)

Determination: Partial

Not covered	The State's own act under 438.207(c)-(d): submission of an assurance of compliance to CMS, in CMS's prescribed format, with documentation of a network adequacy analysis for each plan, was not read in any held document.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the most recent 438.207 assurance submission to CMS with its per-plan analysis documentation.

CFR-438-036 · Grievance and appeal system via contract

Citation: 42 CFR 438.228, 42 CFR 438.400-438.424

Determination: Partial

Not covered	Subpart F elements not pinpointed in a Medicaid-side passage, including effectuation of reversed appeal decisions within 72 hours for services not yet furnished (438.424(a)): the only passage stating that clock is the Title XXI plan assurance (H-022 section 3.9.27).
Owner	Division of Health Benefits (DHB)
Action it owns	Pinpoint the Subpart F effectuation and aid-pending clocks in the managed care contracts or policy.

CFR-438-037 · State-established method for grievance resolution notices

Citation: 42 CFR 438.408

Determination: Partial

Not covered	The state-established method for the resolution notices themselves under 438.408 (the notice method and its language, format and content standards, tied to 438.10) as a document: the held passages state timeframes and that content is Department-specified, but the specified method was not read.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the Department-specified grievance and appeal resolution notice method and templates.

CFR-438-043 · Managed care State quality strategy

Citation: 42 CFR 438.340

Determination: Partial

Not covered	Currency and posting of the current strategy: CMS approved the 2025 Quality Strategy and a July 1, 2025 bulletin stated NCDHHS published it on the Quality Management and Improvement page, but that page carries no Quality Strategy document link and the 2025 document could not be acquired from any host (NL-06 search record). The held strategy of record remains the 2023 edition, so the current strategy as published cannot be read.
Owner	Division of Health Benefits (DHB)
Action it owns	Post the CMS-approved 2025 Quality Strategy at the location the bulletin named.

CFR-438-049 · Screen, enroll, and revalidate all network providers

Citation: 42 CFR 438.602(b), 42 CFR 438.608(b)

Determination: Partial

Not covered	Revalidation of network providers on the 438.602(b) cycle as an evidenced State act, in particular for providers who serve only through a plan network, is not pinpointed in the held passages; the passages carry screening and enrollment, not the revalidation cadence.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the revalidation cycle and completion reporting for network-only providers.

CFR-438-051 · Ownership and control disclosure review

Citation: 42 CFR 438.602(c), 42 CFR 438.608(c)

Determination: Partial

Not covered	Two elements fail or are unevidenced: the State's review of plan-level ownership and control disclosures under 438.602(c) and 438.608(c) as an evidenced act was not read; and the related website posting of 5 percent or more ownership interests is affirmatively not made (the State answered No at MCPAR indicator BX.9a, H-064 p. 10).
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the plan-level disclosure review practice and make the 438.602(g)(3) ownership posting.

CFR-438-059 · Intermediate sanctions regime, establishment and imposition

Citation: 42 CFR 438.700, 42 CFR 438.702

Determination: Partial

Not covered	The sanctions actually imposed in the held record are liquidated damages under the contract; no held passage shows an intermediate sanction under 438.702 itself having been imposed, and the MCPAR analysis notes that, apart from corrective action plans, none of the reported sanctions fell in the non-monetary categories (H-138 p. 15).
Owner	Division of Health Benefits (DHB)
Action it owns	Report intermediate sanctions separately from liquidated damages in the MCPARs and state when each will be used.

CFR-438-063 · State plan sanctions-monitoring plan

Citation: 42 CFR 438.726

Determination: Partial

Not covered	The State plan specification itself: the held Title XIX plan text was searched for 438.726 and for a sanctions monitoring plan and neither was found; the plan's Section 4.29 covers conflicts of interest, and the only sanctions-adjacent plan page is an obsolete PCCM-era page citing 438.730 (H-001 p. 1136).
Owner	Division of Health Benefits (DHB)
Action it owns	Amend the State plan or publish the specification that carries 438.726 for the managed care program.

BH I/DD Tailored Plan Contract #30-2020-052-DHB, Amendment 2 model (RFA issued Nov 13, 2020; awards Jul 26, 2021; Amendment 1 revised and restated the contract in its entirety)

Stands behind: 14 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: BH I/DD Tailored Plan Contract #30-2020-052-DHB, Amendment 2 model (RFA issued Nov 13, 2020; awards Jul 26, 2021; Amendment 1 revised and restated the contract in its entirety).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-438-001 · MCO/PIHP/PAHP contract CMS review and approval; capitation rates in contract

Citation: 42 CFR 438.3(a), 438.3(c)(1)

Determination: Partial

Not covered	CMS approval of the contracts themselves under 438.3(a) is not in the held record, and the executed Standard Plan contract is not in the public record: the State posts the contract only in RFP form with blank offeror and award blocks, plus an amendment series (NL-01 search record). The approval element and the capitation rates as executed in contract therefore cannot be verified.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the CMS contract approval letters and the executed contracts for each managed care program.

CFR-438-002 · Standard contract provisions in all managed care contracts

Citation: 42 CFR 438.3(b)-(u)

Determination: Partial

Not covered	Elements not pinpointed in any held passage, including physician incentive plan standards (438.3(i)) and the State and Federal audit and inspection clause as a contract term; and the executed-instance limit: the held instruments are model contracts and amendments, not executed contracts (NL-01 through NL-03).
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the executed contracts so each 438.3 provision can be verified as executed, and pinpoint the physician incentive and audit clauses.

CFR-438-003 · Actuarially sound capitation rates

Citation: 42 CFR 438.4

Determination: Partial

Not covered	The actuarial certification itself: certifications are referenced but never posted, so no held document shows an actuary certifying the current rates as actuarially sound under 438.4 (NL-17 search record). The held record also contains an unresolved dispute over a 1.5 percent rate reduction (association letter to CMS, Dec. 10, 2025, in the NL-17 record).
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the capitation rate certifications for the current rating period.

CFR-438-010 · Medical loss ratio, plan calculation, reporting, and remittance

Citation: 42 CFR 438.8

Determination: Partial

Not covered	Remittance as it actually occurred: if the Department-defined MLR is below the minimum threshold the Tailored Plan contract lets the plan remit a rebate, contribute to health-related resources, or take a third option (H-053 p. 60), and the State report records that four PHPs were below the Department-defined threshold for expansion populations in SFY 2024 without stating what was remitted or contributed; the Standard Plan MLR clause itself sits in the unheld base contract.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish, by plan and year, the MLR remittances or approved contributions collected when a plan falls below the threshold.

CFR-438-014 · Annual disenrollment-rights notice to enrollees

Citation: 42 CFR 438.10(f)(2)

Determination: Partial

Not covered	The annual disenrollment-rights notice itself under 438.10(f)(2): no held passage states that enrollees receive notice of their disenrollment rights at least annually (or its timing relative to enrollment periods).
Owner	Division of Health Benefits (DHB)
Action it owns	Add the annual disenrollment-rights notice to the member communications cycle and publish the notice.

CFR-438-053 · Whistleblower intake and investigation

Citation: 42 CFR 438.602(f)

Determination: Partial

Not covered	The State-side system of 438.602(f): procedures for receiving whistleblower reports, protecting the identity of whistleblowers, and investigating, run by the State, are not described in any held passage; the held evidence is a plan policy deliverable, not the State's intake and investigation process.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the State's whistleblower intake, identity protection and investigation procedures.

CFR-438-054 · Required plan data submissions and CEO/CFO certification

Citation: 42 CFR 438.604, 42 CFR 438.606

Determination: Partial

Not covered	The 438.604(a) data categories as a complete set in a Medicaid-side instrument: the fullest enumeration read is the Title XXI plan assurance list (H-022 section 3.10.12); and certification practice under the Standard Plan base contract cannot be read because the base contract is not in the public record (NL-01).
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the data submission and certification schedule for each program.

CFR-438-058 · Response to prohibited affiliations

Citation: 42 CFR 438.610(d)

Determination: Partial

Not covered	438.610(d) as a State act: upon receiving notice from the Secretary that a plan employs or contracts with an excluded individual or entity (or one owned or managed by such a person), the State must terminate the plan contract or require the plan to terminate the affiliation within the specified period. No held passage states the State's response procedure or timeframe.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the State's 438.610(d) response procedure and timeframe.

CFR-438-064 · Exclusion of prohibited entities from contracts (FFP condition)

Citation: 42 CFR 438.808

Determination: Partial

Not covered	438.808 as a State contract-eligibility condition across its entity classes (entities that could be excluded under section 1128(b)(8) as controlled by a sanctioned individual, and entities with substantial contractual relationships with excluded entities) stated as the State's own rule, beyond the plan-level clause read.
Owner	Division of Health Benefits (DHB)
Action it owns	State the 438.808 eligibility condition in the contracting policy for all three entity classes.

CFR-438-066 · Marketing material review with advisory committee consultation

Citation: 42 CFR 438.104(c)

Determination: Partial

Not covered	The 438.104(c) element itself: consultation with the Medical Care Advisory Committee, or an advisory committee with similar membership, in the State's review of marketing materials. No held passage states that consultation; the held evidence shows Department approval timing only.
Owner	Division of Health Benefits (DHB)
Action it owns	Add MCAC consultation to the marketing review procedure and publish it.

CFR-447-014 · MCO contracts honor state-plan cost sharing

Citation: 42 CFR 447.52

Determination: Partial

Not covered	The Standard Plan contract term honoring state plan cost sharing, and reconciliation of the plan page that says managed care enrollees are not charged.
Owner	Division of Health Benefits (DHB)
Action it owns	Reconcile section 4.18(b)(2)(vii) with the Tailored Plan cost sharing table by SPA or contract clarification, and place the Standard Plan cost sharing term in the held record.

CFR-447-018 · Cost-sharing and premium exemptions

Citation: 42 CFR 447.56

Determination: Partial

Not covered	A single current exemption list that governs fee-for-service, reconciled with the contract list.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish one current cost sharing exemption list for fee-for-service and confirm the contracts mirror it category for category.

CFR-447-060 · Report MCO drug utilization separately

Citation: 42 CFR 447.511

Determination: Partial

Not covered	The State's separate reporting to CMS of managed care drug utilization data.
Owner	Division of Health Benefits (DHB)
Action it owns	State, in the rebate program documentation, how managed care utilization reaches CMS separately from fee-for-service, for both retail and physician administered drugs.

CFR-447-068 · NDC coding for physician-administered drugs; invoice rebates

Citation: 42 CFR 447.520

Determination: Partial

Not covered	The fee-for-service claim level NDC requirement for physician administered drugs, stated for rebate invoicing.
Owner	Division of Health Benefits (DHB)
Action it owns	State the NDC claim requirement for physician administered drugs in the FFS billing guidance, as the Tailored Plan contract already does for its network.

1115 extension approval package

Stands behind: 11 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: 1115 extension approval package.
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-430-004 · Quarterly grant reporting (CMS-37 estimates, CMS-64 expenditures)

Citation: 42 CFR 430.30

Determination: Partial

Not covered	A general state-side statement of the quarterly CMS-37 estimate and CMS-64 expenditure reporting cycle for the Title XIX grant as a whole (42 CFR 430.30) is not in the held evidence; coverage is demonstration-specific (H-025) and case-specific (H-131).
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the quarterly grant reporting procedure or a filed CMS-37 and CMS-64 pair showing the standing quarterly cycle.

CFR-431-032 · Section 1115 evaluation requirements

Citation: 42 CFR 431.424

Determination: Partial

Not covered	The approved Evaluation Design document for the Reform Demonstration and its website publication date (due within 30 days of CMS approval under 431.424) are not held, so the design's hypotheses, measures, and data sources could not be read
Owner	Division of Health Benefits (DHB)
Action it owns	File the CMS-approved Evaluation Design and its posting date with the cure record

CFR-431-033 · Section 1115 annual monitoring report

Citation: 42 CFR 431.428

Determination: Partial

Not covered	The annual monitoring report document itself is not held as a file, so its content elements under 431.428 (including enrollment data, grievances and appeals, and the forum comment summary) could not be read in the report
Owner	Division of Health Benefits (DHB)
Action it owns	File the current annual monitoring report document with the cure record

CFR-433-008 · Waivers for non-broad-based/non-uniform provider taxes

Citation: 42 CFR 433.72

Determination: Partial

Not covered	The waiver document itself and the 433.72(b) statistical showing (that the net impact of the tax is generally redistributive, with the P-value or equivalent test result) for any specific NC tax; no held passage identifies which NC taxes, if any, currently operate under a waiver.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the waiver approvals and the redistributive test results for each non-broad-based or non-uniform tax.

CFR-433-009 · MMIS/E&E Advance Planning Documents and approval

Citation: 42 CFR 433.112, 433.114

Determination: Partial

Not covered	The Advance Planning Documents themselves and the CMS approvals under 433.112 and 433.114 for the MMIS and E&E systems, including the approval conditions. No APD or approval letter is held.
Owner	Division of Health Benefits (DHB)

Action it owns	Publish the current APDs and CMS approval letters for the MMIS and the eligibility and enrollment system.

CFR-435-021 · Consideration of eligibility on all bases; LIS leads data as MSP application

Citation: 42 CFR 435.911, 435.916

Determination: Partial

Not covered	The 435.911 rule that SSA low-income subsidy leads data transmitted to the State must be treated as an application for Medicare Savings Programs is not stated in held text; MA-2311 addresses LIS determinations the applicant brings to the agency, not leads data received from SSA
Owner	Division of Social Services / county DSS (eligibility operations), under Division of Health Benefits policy
Action it owns	State the LIS leads rule in MA-2311 or the MSP manual section: SSA leads data received by the State is screened, and where it constitutes an MSP application, processed and noticed as one

CFR-435-025 · Notice of agency decisions; electronic notices

Citation: 42 CFR 435.917, 435.918

Determination: Partial

Not covered	The full 435.917(b) notice content list for eligibility decisions and the 435.918 electronic notice mechanics (individual election and consent, posting to a secure account, and opt-out) are not stated in a held general eligibility notice document; MA-2420 is referenced in held manuals but is not itself held
Owner	Division of Health Benefits (DHB), with the Division of Social Services
Action it owns	File MA-2420 (or its current successor notice manual) with the cure record and state the electronic notice election mechanics in it

CFR-435-026 · Timely and adequate notice and action on changes in circumstances

Citation: 42 CFR 435.919

Determination: Partial

Not covered	For the general eligibility population, the 435.919 response framework (acting promptly on changes, the returned mail and address update procedures, and reconsideration without a new application when a change is reported within the reconsideration window) is not stated in held text
Owner	Division of Social Services / county DSS (eligibility operations)
Action it owns	Publish the change-in-circumstances standard covering response times, returned mail and address updates, and reconsideration, for the general program

CFR-438-005 · Rate certification submission and documentation

Citation: 42 CFR 438.7

Determination: Partial

Not covered	The certification submission itself under 438.7 (the actuary's certification with rate documentation, submitted concurrently with the contract submission): no certification document was found on any host searched (NL-17 search record), so the content, timing and documentation elements cannot be read.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the rate certification submissions for the current rating period.

CFR-440-013 · Mental health / substance use disorder parity in ABPs

Citation: 42 CFR 440.395

Determination: Partial

Not covered	Completed ABP parity compliance documentation across all classifications is not held; on the STC's own terms the removal of noncompliant limits was still awaiting a CMS satisfactory-completion determination, so full 440.395 compliance is not evidenced.
Owner	Division of Health Benefits (DHB)
Action it owns	File the completed ABP parity documentation and the CMS determination under STC 9.19(h) when issued.

NC-011 · Section 1115 Demonstration, quarterly monitoring reports

Citation: NC Medicaid 1115 Demonstration (11-W-00313/4) monitoring, as published on the Quality page

Determination: Partial

Not covered	A filed quarterly monitoring report for the demonstration; held evidence carries the STC requirement and due dates only.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the most recent filed quarterly monitoring report for 11-W-00313/4.

Managed Care Program Annual Report (MCPAR) for North Carolina: Medicaid Direct PIHP, 2024 (submitted Dec 27, 2024)

Stands behind: 5 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: Managed Care Program Annual Report (MCPAR) for North Carolina: Medicaid Direct PIHP, 2024 (submitted Dec 27, 2024).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.

What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-431-016 · Prior authorization - denial reasons and prior auth API

Citation: 42 CFR 431.80

Determination: Partial

Not covered	No held document states the State's fee-for-service requirement to give a specific denial reason for prior authorization denials, the public posting of prior authorization approval, denial, and timeliness metrics, or the Prior Authorization API (federal compliance date January 1, 2027)
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the fee-for-service prior authorization standard stating specific denial reasons and decision timeframes, post the first annual prior authorization metrics, and publish the Prior Authorization API implementation documentation

CFR-438-029 · Beneficiary support system

Citation: 42 CFR 438.71

Determination: Partial

Not covered	438.71 elements not pinpointed: the LTSS-specific support elements (a separate access point for LTSS users and education on grievance and appeal rights for LTSS), the system's data reporting to the State, and its annual reporting; the Ombudsman annual report that would evidence them was not found in the public record (NL-07 search record).
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the beneficiary support system's LTSS access point, its data reports, and the Ombudsman annual report.

CFR-438-050 · Monthly federal database checks on plans, subcontractors, owners, agents

Citation: 42 CFR 438.602(d)

Determination: Partial

Not covered	The monthly cadence of 438.602(d) for the plan, subcontractor and owner checks themselves: the MCPAR describes those checks as routine without stating they are monthly; the monthly cadence read in the record attaches to provider screening.
Owner	Division of Health Benefits (DHB)
Action it owns	State the cadence of the plan-level federal database checks in the MCPAR or program integrity policy.

CFR-438-052 · Independent audit of encounter and financial data (triennial)

Citation: 42 CFR 438.602(e)

Determination: Partial

Not covered	The audit as 438.602(e) writes it: an independent audit, at least once every 3 years, of the accuracy, truthfulness and completeness of both encounter and financial data, for each program. The held answer evidences validation activity in one reporting year for one program (Medicaid Direct PIHP) and an internal audit review of validation reports, not a triennial independent audit report covering financial data for all programs.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the triennial independent audit reports for encounter and financial data by program.

CFR-438-057 · Overpayment recovery policies, annual report, and rate-setting use

Citation: 42 CFR 438.608(d)

Determination: Partial

Not covered	The annual report of plan overpayment recoveries as submitted onward, and the rate-setting use of recoveries documented inside an actual rate certification: the certifications are not held (NL-17), so the (d)(3) use element is carried only by the contract coordination clause, not by a certification read.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the annual overpayment recoveries report and show recovery use in the next rate certification.

Title XXI Child Health Plan, proposed CHIP managed care amendment 22-0013 (combination plan: Medicaid expansion group + separate child health program)

Stands behind: 5 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: Title XXI Child Health Plan, proposed CHIP managed care amendment 22-0013 (combination plan: Medicaid expansion group + separate child health program).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-438-011 · State oversight of minimum MLR, CMS summary and federal share repayment

Citation: 42 CFR 438.74

Determination: Partial

Not covered	The summary description actually submitted to CMS with a rate certification under 438.74(a) is not held, and no held passage carries the 438.74(b) element: repayment to CMS of the Federal share of a remittance at the applicable FMAP.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the 438.74(a) summary descriptions as submitted, and state the Federal share repayment practice for remittances.

CFR-438-038 · Grievance and appeal recordkeeping and State review

Citation: 42 CFR 438.416

Determination: Partial

Not covered	The 438.416 record as maintained by the plans (the log with the regulation's content elements) and the State's review of those records, as distinct from the reported aggregates, were not read in a Medicaid-side instrument.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the grievance and appeal record specification and the State's record review practice.

CFR-438-042 · Accreditation status review and posting

Citation: 42 CFR 438.332

Determination: Partial

Not covered	The posting itself on the Medicaid managed care website: no held passage shows the accreditation status page as posted for the Medicaid plans, and the assurance of record sits in the Title XXI plan.
Owner	Division of Health Benefits (DHB)
Action it owns	Post each Medicaid plan's accreditation status, entity, program and level on the managed care website.

CFR-438-061 · Notice of sanction and pre-termination hearing

Citation: 42 CFR 438.710

Determination: Partial

Not covered	The Medicaid-side instrument: the held assurance sits in the Title XXI plan, and the hearing particulars of 438.710(b) (notice of intent stating the reason and the time and place of the hearing, and the post-hearing decision notice) were not read in an NC Medicaid document.
Owner	Division of Health Benefits (DHB)

Action it owns	Pinpoint the 438.710 notice and hearing procedure in the Medicaid contracts or policy.

CFR-438-062 · Notice to CMS of sanctions imposed or lifted

Citation: 42 CFR 438.724

Determination: Partial

Not covered	An actual 438.724 notice: no held document shows notice to CMS within 30 days of a sanction's imposition or lifting, naming the plan, the kind of sanction and the reason, for any of the sanctions the MCPARs report.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the 438.724 notices given to CMS for the sanctions reported in the 2024 and 2025 MCPARs.

Current external quality review (EQR) technical report

Stands behind: 4 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: Current external quality review (EQR) technical report.
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-438-027 · Annual secret shopper surveys (provider directories and wait times)

Citation: 42 CFR 438.68(f)

Determination: Partial

Not covered	438.68(f) requires the annual surveys to cover mental health, substance use disorder, primary care, and OB/GYN providers plus a State-selected specialist type, testing both directory accuracy and wait times: the held EQR description does not name mental health or SUD provider types among those surveyed, and describes the activity within the report period rather than as an annual standard.
Owner	the EQRO
Action it owns	Extend the annual secret shopper survey to mental health and SUD provider types and publish the survey design and results.

CFR-438-044 · External quality review, annual EQR by qualified EQRO

Citation: 42 CFR 438.350, 42 CFR 438.354, 42 CFR 438.356

Determination: Partial

Not covered	The EQRO qualification and contract elements: 438.354 (EQRO qualifications) and 438.356 (required EQRO contract provisions, including independence from the plans reviewed) are not stated in any held document; the EQRO contract is not held.
Owner	the EQRO
Action it owns	Publish the EQRO contract or a summary showing the 438.354 qualifications and 438.356 provisions.

CFR-438-045 · EQR annual technical report, finalization, posting, CMS notice

Citation: 42 CFR 438.364

Determination: Partial

Not covered	Two elements are not evidenced: notice to CMS in CMS's prescribed form and manner within 14 calendar days of web posting (438.364(d)), and the April 30 submission element, which the report's own Appendix F records as 'NA' (item 1, p. 223).
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the CMS notice record for the current technical report and confirm the submission date against April 30.

CFR-438-046 · EQR exemptions and nonduplication identification

Citation: 42 CFR 438.362, 42 CFR 438.360(c)

Determination: Partial

Not covered	Nonduplication under 438.360(c): no held document identifies any accreditation or other review the State uses in lieu of an EQR activity, or states that none is used; and because no exemption was granted in the period, the 438.362 exemption determination (two-year period, findings of good standing) is not documented anywhere in the held record.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the State's nonduplication position and, if any exemption is ever granted, the 438.362 determination.

Clinical Coverage Policy 8D-1, Psychiatric Residential Treatment Facilities, amended January 1, 2025

Stands behind: 4 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: Clinical Coverage Policy 8D-1, Psychiatric Residential Treatment Facilities, amended January 1, 2025.

What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-441-029 · Certification of need for under-21 psychiatric services

Citation: 42 CFR 441.152-441.153

Determination: Partial

Not covered	The emergency admission rule of 441.153(c) (certification by the team responsible for the plan of care within 14 days after admission) is not stated. The independent team qualities in 441.153(a) (competence in diagnosis and treatment of mental illness, preferably in child psychiatry, and knowledge of the individual situation) are not stated beyond a qualified physician and a direction to meet all federal requirements. The rule for an individual who applies for Medicaid while in the facility, including coverage of any period before application for which claims are made under 441.153(b), is addressed only by the statements that the CON be done concurrently with the application and not be retroactive. No held policy states the certification regime for under-21 inpatient psychiatric admissions outside PRTFs.
Owner	Division of Health Benefits (DHB)
Action it owns	File the inpatient psychiatric policy text, or amend CCP 8D-1, to state the 441.153 emergency 14-day rule, the team competence and knowledge qualities, and the certification rule for non-PRTF under-21 inpatient psychiatric admissions.

CFR-441-030 · Active treatment - plan within 14 days of admission

Citation: 42 CFR 441.154

Determination: Partial

Not covered	No held text states the 441.154 active treatment rule in terms: implementation of a professionally developed and supervised individual plan of care, developed and implemented no later than 14 days after admission, designed to achieve discharge from inpatient status at the earliest possible time. The Person-Centered Plan required at authorization is not stated to be the 441.155 individual plan of care, and no 14-day development or implementation clock is stated.
Owner	Division of Health Benefits (DHB)
Action it owns	State the 14-day active treatment plan rule in CCP 8D-1 or the inpatient psychiatric policy, or identify the document that carries it.

CFR-441-031 · Under-21 psychiatric plan of care - 30-day reviews

Citation: 42 CFR 441.155

Determination: Partial

Not covered	The 30-day review cycle of 441.155(c) (review every 30 days by the team specified in 441.156, to determine that services being provided are or were required on an inpatient basis and to recommend changes in the plan) is not stated; the concurrent reviews in CCP 8D-1 carry no stated interval and are utilization reviews, not team plan reviews. Also not stated: that the plan be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the beneficiary situation, that it be developed in consultation with the beneficiary and the parents, legal guardians or others in whose care the beneficiary will be released, and post-discharge coordination with the beneficiary family, school and community.
Owner	Division of Health Benefits (DHB)
Action it owns	State the plan of care content elements and the 30-day team review cycle in CCP 8D-1 or the inpatient psychiatric policy.

CFR-441-032 · Team developing the plan of care - composition

Citation: 42 CFR 441.156

Determination: Partial

Not covered	The composition of the interdisciplinary team that develops the individual plan of care is not stated: none of the 441.156(c) leadership alternatives beyond psychiatrist direction, none of the additional members required by 441.156(d) (a psychiatric social worker; a registered nurse with specialized training or one year of experience in treating mentally ill individuals; an occupational therapist who is licensed where required and has specialized training or one year of experience in treating mentally ill individuals; or a psychologist with a master degree in clinical psychology or certified by the State or the State psychological association), the team capabilities listed in 441.156(b), or that the team must be employed by, or provide services to patients in, the facility.
Owner	Division of Health Benefits (DHB)
Action it owns	State the 441.156 team composition for the individual plan of care in CCP 8D-1 or the inpatient psychiatric policy.

Tailored Plan Contract #30-2020-052-DHB, Amendment 5(7) (271 pp.; Attachment B covered-services table keyed to State Plan Att. 3.1-A.1 and CCPs 8A/8B/8D series)

Stands behind: 3 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: Tailored Plan Contract #30-2020-052-DHB, Amendment 5(7) (271 pp.; Attachment B covered-services table keyed to State Plan Att. 3.1-A.1 and CCPs 8A/8B/8D series).

What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-438-008 · In lieu of services and settings (ILOS), State determination, oversight, reporting, evaluation

Citation: 42 CFR 438.3(e)(2), 42 CFR 438.16

Determination: Partial

Not covered	The 438.16 State oversight elements as a documented system: the State's ILOS determinations with cost-effectiveness documentation, tracking against the 2.5 percent of capitation limit, the annual report to CMS, and the ILOS evaluation requirements are not carried in any held passage.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the ILOS determinations, the annual ILOS report to CMS, and the evaluation results.

CFR-438-009 · Monthly capitation for IMD short stays (ages 21-64)

Citation: 42 CFR 438.6(e)

Determination: Partial

Not covered	The capitation mechanic of 438.6(e) as written: that the monthly capitation payment is made for an enrollee with a short stay of no more than 15 days in the month, as an in-lieu-of State Plan service, is not stated in the held passages; and the held record does not distinguish stays paid under 438.6(e) from stays paid under the separate 1115 IMD authority.
Owner	Division of Health Benefits (DHB)
Action it owns	State in the contracts or policy which authority (438.6(e) or the 1115 IMD authority) each class of IMD stay is paid under.

CFR-438-055 · Enrollee encounter data submission to CMS (T-MSIS)

Citation: 42 CFR 438.818

Determination: Partial

Not covered	The enrollee encounter data submission to CMS as a recurring evidenced act under 438.818, with the data elements and completeness the section requires, is not shown in any held document; the held evidence is the plan-to-State flow plus assurances.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the T-MSIS encounter submission reporting for the managed care programs.

Prepaid Health Plan Services Contract #30-190029-DHB, Amendment 8 model contract language

Stands behind: 3 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: Prepaid Health Plan Services Contract #30-190029-DHB, Amendment 8 model contract language.
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-438-023 · Readiness reviews for new programs, plans, or eligibility groups

Citation: 42 CFR 438.66(d)

Determination: Partial

Not covered	The readiness review results as a submitted record for each contracting event in the window: no readiness review report is held, and no held document shows a review for the Children and Families Specialty Plan launch or states the 438.66(d) timing standard (review completed before the contracting event) as the State's own standard.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the readiness review reports for recent launches.

CFR-440-004 · Prior authorization decision timeframes

Citation: 42 CFR 440.230(e)(1)-(2)

Determination: Partial

Not covered	The state-side fee-for-service (NC Medicaid Direct) prior authorization decision timeframes and the expedited-request clock under 440.230(e) are not stated in any held document; the contracts read carry the managed care 438.210(d) clocks only.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the fee-for-service prior authorization decision timeframe standard implementing 440.230(e) for NC Medicaid Direct, with the expedited and standard clocks stated in a clinical coverage policy or provider manual.

NC-009 · PHP medical loss ratio, 88 percent minimum; annual reporting aligned to the rating year

Citation: N.C.G.S. §108D-65; PHP Contract MLR provisions

Determination: Partial

Not covered	The text of N.C.G.S. 108D-65 (the statutory 88 percent minimum and the annual reporting duty aligned to the rating year); held evidence is contract thresholds and reports, which vary by rating group around the 88.0 percent total.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the text of G.S. 108D-65 as applied, or the MLR report template that ties plan reporting to the statutory rating year.

Provider Manual 2026, Standard Plan

Stands behind: 3 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: Provider Manual 2026, Standard Plan.
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-441-014 · EPSDT informing - within 60 days of eligibility, annually

Citation: 42 CFR 441.56(a)

Determination: Partial

Not covered	The 60-day initial informing cycle, the annual re-informing cycle for non-utilizing families, and the required informing content of 441.56(a) are not stated in any held document; the Health Check Program Guide (H-163) is provider-facing and does not carry them either.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the EPSDT informing policy stating the 60-day and annual cycles and the required content, including how Medicaid Direct families are informed.

CFR-441-023 · EPSDT transportation and scheduling assistance

Citation: 42 CFR 441.62

Determination: Partial

Not covered	The offer element of 441.62 (transportation and scheduling assistance offered to every EPSDT family, not only described as a service category) is not evidenced.
Owner	Division of Health Benefits (DHB)

Action it owns	State the EPSDT transportation and scheduling assistance offer in the beneficiary-facing EPSDT material and the Health Check Guide.

CFR-456-008 · Written UR plan required for inpatient hospital services

Citation: 42 CFR 456.101-456.145

Determination: Partial

Not covered	The content elements of a hospital UR plan under 42 CFR 456.101-456.145 (committee, admission and continued stay review, denial notice); held evidence carries only the 482.30 crosswalk condition and the plan's general Subpart C attestation.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce a hospital UR plan or the state review standard that checks UR plans against Subpart C content.

Health Check Program Guide (EPSDT; NC documents cite the statute, §1905(r) / 42 U.S.C. §1396d(r), not the CFR subpart)

Stands behind: 3 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: Health Check Program Guide (EPSDT; NC documents cite the statute, §1905(r) / 42 U.S.C. §1396d(r), not the CFR subpart).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-441-017 · EPSDT accountability - records and manuals

Citation: 42 CFR 441.56(d)

Determination: Partial

Not covered	Agency records of informing, screening and treatment activity, and any filed CMS-416 report, are not held; the quality strategy states the CMS-416 requirement but is not the report.
Owner	Division of Health Benefits (DHB)
Action it owns	File the EPSDT program record set (informing, screening and treatment records description) and the most recent CMS-416 on the row's record.

CFR-441-020 · EPSDT screening on request; avoid duplicates

Citation: 42 CFR 441.59

Determination: Partial

Not covered	No held document states the practice of verifying the most recent screening (for example through records or the periodicity history) before providing a duplicate screening on request.
Owner	Division of Health Benefits (DHB)
Action it owns	Add the duplicate-screening verification step to the Health Check Guide's interperiodic screening section.

CFR-441-022 · EPSDT provider availability and program coordination

Citation: 42 CFR 441.61

Determination: Partial

Not covered	Formal coordination with the named federal programs and any EPSDT provider sufficiency showing are not in the held evidence; plan Attachment 4.16-A (cooperative arrangements with Title V grantees) is listed in the plan contents but its text was not read as carrying EPSDT-specific coordination.
Owner	Division of Health Benefits (DHB)
Action it owns	File the EPSDT coordination arrangements and the provider availability assessment for the row's record.

CAP/DA waiver renewal approval document (CMS)

Stands behind: 3 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: CAP/DA waiver renewal approval document (CMS).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-441-047 · 1915(c) waiver - financial accountability and independent audit

Citation: 42 CFR 441.302(b)

Determination: Partial

Not covered	An independent audit of the waiver program or of provider agencies, as 441.302(b) contemplates, is expressly not required for CAP/DA on the held application's face, and no independent waiver audit report is held for any NC waiver.

Owner	Division of Health Benefits (DHB)
Action it owns	Reconcile Appendix I-1 with 441.302(b): either commission the independent audit the assurance contemplates or amend the application text, and file the most recent waiver audit.

CFR-456-004 · Sample-basis evaluation of services

Citation: 42 CFR 456.22

Determination: Partial

Not covered	A program-wide sample-basis evaluation method under 42 CFR 456.22; held evidence is a sampling practice described for waiver and PCS post-payment review only.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the utilization review sampling methodology used across programs.

CFR-456-005 · Post-payment review process with utilization profiles

Citation: 42 CFR 456.23

Determination: Partial

Not covered	The general post-payment review process with utilization profiles under 42 CFR 456.23, beyond waiver/PCS sampling and recipient SUR surveillance.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the post-payment review procedure showing how utilization profiles are built and acted on.

Access Monitoring Review Plan (AMRP)

Stands behind: 3 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: Access Monitoring Review Plan (AMRP).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-447-030 · Rate-reduction/restructuring access analysis with SPA

Citation: 42 CFR 447.203

Determination: Partial

Not covered	An access analysis, in the provision's terms, submitted with a payment reduction or restructuring SPA.

Owner	Division of Health Benefits (DHB)
Action it owns	Attach the access analysis to the next reduction or restructuring submission and place the October 2025 episode's analysis, if one was made, in the record.

CFR-447-031 · Ongoing access input mechanisms + records

Citation: 42 CFR 447.203

Determination: Partial

Not covered	An inventory of the ongoing access input mechanisms and the records they produce, as a system.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the access input mechanism inventory with the AMRP, naming each channel, what records it creates, and where they are kept.

NC-012 · Medicaid Managed Care Quality Strategy, maintenance, and the Annual Quality Report against it

Citation: NC Medicaid Managed Care Quality Strategy (first published 2018; updated 2023); Annual Quality Report

Determination: Partial

Not covered	The current (2025) Quality Strategy document itself, and the Annual Quality Report against the strategy; held evidence carries the strategy's history through the 2023 update and a bulletin claim of a 2025 approval that the publication page does not support.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish or produce the CMS-approved 2025 Quality Strategy document and the current Annual Quality Report.

Medicaid State Plan Public Notices (ten-day postings SPA 26-0001 - 26-0008; 2026 proposed amendments 26-0001 - 26-0003)

Stands behind: 2 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: Medicaid State Plan Public Notices (ten-day postings SPA 26-0001 - 26-0008; 2026 proposed amendments 26-0001 - 26-0003).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-430-002 · Respond to CMS requests on pending plan material

Citation: 42 CFR 430.16

Determination: Partial

Not covered	The state-side procedure and timeframe for responding to CMS requests on pending plan material (42 CFR 430.16) is not stated in any held document.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce or publish the SPA correspondence procedure showing how DHB answers CMS requests for additional information on pending plan material and the clock it works to.

CFR-440-011 · Public notice before Alternative Benefit Plan SPA

Citation: 42 CFR 440.386

Determination: Partial

Not covered	The text of a public notice for an ABP SPA showing the 440.386 required contents and the comment record is not held.
Owner	Division of Health Benefits (DHB)
Action it owns	File the posted notice face and comment record for the most recent ABP SPA (25-0009) on the row's record.

N.C.G.S. 108A-70.9A, Medicaid recipient appeals (30-day appeal period; aid pending appeal)

Stands behind: 2 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: N.C.G.S. 108A-70.9A, Medicaid recipient appeals (30-day appeal period; aid pending appeal).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-431-024 · Notice content, advance notice, and exceptions

Citation: 42 CFR 431.210, 431.211, 431.213, 431.214

Determination: Partial

Not covered	The 431.213 exception categories (for example, confirmed fraud referral, death of the recipient, change in law under 431.214, and admission to an institution where freedom of choice is not at issue) are not stated in any held NC document
Owner	Division of Health Benefits (DHB)

Action it owns	Publish the advance notice exceptions in the appeals manual section or rule so the 431.213 and 431.214 categories are stated alongside the 10-day rule

CFR-431-025 · Grant of hearing, time limits, group hearings, dismissal, expedited appeals

Citation: 42 CFR 431.220, 431.221, 431.222, 431.223, 431.224

Determination: Partial

Not covered	Group hearings under 42 CFR 431.222 (a single hearing where the sole issue is one of law, regulation, or policy) are not provided for in any held NC statute, rule, or agreement
Owner	Division of Health Benefits (DHB), with the Office of Administrative Hearings
Action it owns	State the group hearing option in the appeals procedures so identically situated recipients raising a common question of law or policy can be heard together under 431.222

Medicaid Direct PIHP Contract #30-2022-007-DHB, Amendment 13(14) (incl. Fourth Revised and Restated Attachment E network adequacy standards)

Stands behind: 2 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: Medicaid Direct PIHP Contract #30-2022-007-DHB, Amendment 13(14) (incl. Fourth Revised and Restated Attachment E network adequacy standards).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-438-026 · Appointment wait time standards

Citation: 42 CFR 438.68(e)

Determination: Partial

Not covered	The 438.68(e) standards as written for the physical health side: routine outpatient mental health and SUD appointments within 10 business days and primary care and OB/GYN appointments within 15 business days, stated as standards in a Standard Plan or Tailored Plan instrument. No held passage states Standard Plan appointment wait time standards in those terms.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the Standard Plan and Tailored Plan appointment wait time standards mapped to 438.68(e).

CFR-438-035 · Flow-through termination of providers terminated elsewhere

Citation: 42 CFR 438.214(d)(2)

Determination: Partial

Not covered	438.214(d)(2) as written: prompt termination of a provider's participation, with notice to the State, when the provider is terminated by the State, by Medicare, or by another State's Medicaid or CHIP program (the cross-program flow-through trigger). The held passages cover plan-initiated fraud and quality terminations, not the flow-through.
Owner	the contracted plan or entity named
Action it owns	Add the cross-program flow-through termination clause, with State notice, to the standard provider contract provisions.

Reports page (incl. notice that Comparative Payment Rate Analysis reports are published per the CMS requirement beginning 2026)

Stands behind: 2 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: Reports page (incl. notice that Comparative Payment Rate Analysis reports are published per the CMS requirement beginning 2026).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-438-032 · Provider payment analysis (percent of Medicare) in capacity assurances

Citation: 42 CFR 438.207(b)(3), 438.207(d)(2)

Determination: Partial

Not covered	The analysis itself: no held document contains the provider payment analysis (payment as a percentage of Medicare by service) that 438.207(b)(3) requires to accompany the capacity assurance, and the first biennial analysis was not read.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the first comparative payment rate analysis with percentages of Medicare by service.

CFR-447-028 · Comparative payment rate analysis + disclosure every 2 years

Citation: 42 CFR 447.203

Determination: Partial

Not covered	The comparative analysis report itself, and the HCBS average hourly payment rate disclosure.

Owner	Division of Health Benefits (DHB)
Action it owns	Publish the first comparative payment rate analysis as a readable document and add the HCBS hourly rate disclosure to the same posting.

Prepaid Health Plan Performance Metrics Report, Session Law 2023-134 §9E.20 (Jul 1, 2024 - Jun 30, 2025; incl. plan MLR reporting and HSAG-administered CAHPS)

Stands behind: 2 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: Prepaid Health Plan Performance Metrics Report, Session Law 2023-134 §9E.20 (Jul 1, 2024 - Jun 30, 2025; incl. plan MLR reporting and HSAG-administered CAHPS).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-438-048 · Medicaid managed care quality rating system (MAC QRS)

Citation: 42 CFR 438.505, 42 CFR 438.510, 42 CFR 438.515, 42 CFR 438.520, 42 CFR 438.535

Determination: Partial

Not covered	The Medicaid managed care quality rating system of 438.505-438.535 as such: adoption of the CMS MAC QRS framework or a CMS-approved alternative methodology (438.515), calculation of ratings on the mandatory QRS measure set, and display of the QRS ratings on the 438.10(c)(3) website in the QRS structure. The stars read in the held record are NCQA CAHPS benchmarking, not MAC QRS ratings.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the State's MAC QRS implementation position: the framework adopted, the measure set, and where ratings will display.

CFR-447-010 · Timely-payment compliance reporting

Citation: 42 CFR 447.45

Determination: Partial

Not covered	The agency's fee-for-service timely payment compliance reporting under 447.45(f).
Owner	Division of Health Benefits (DHB)
Action it owns	Include fee-for-service timely payment results in the annual reporting set, or publish the compliance documentation the agency furnishes to CMS.

Adult Medicaid Manual MA-2275, PACE (three-party agreement CMS - DHHS/DHB - PACE organization)

Stands behind: 2 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: Adult Medicaid Manual MA-2275, PACE (three-party agreement CMS - DHHS/DHB - PACE organization).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-460-001 · State assurance on PACE organization applications and expansions

Citation: 42 CFR 460.12(b)

Determination: Partial

Not covered	The state assurance to CMS on PACE organization applications and service area expansions (42 CFR 460.12(b)); the held manual describes the operating program, not the assurance NC gives CMS on an application.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce a state assurance letter or the PACE application file showing NC's assurance to CMS for an approved organization or expansion.

CFR-460-003 · PACE agreement content: Medicaid rate, service area, data requirements

Citation: 42 CFR 460.32

Determination: Partial

Not covered	The data and reporting requirements element of the PACE agreement content (42 CFR 460.32): what the PACE organization must report to the state and CMS is not stated in held evidence. The Medicaid rate is carried only as state-paid capitation, with no rate amount or rate-setting term.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce a PACE program agreement showing the rate, service area and data requirement terms together.

HHS OIG report, "North Carolina Did Not Report and Return All Medicaid Overpayments for the State's Medicaid Fraud Control Unit Cases" (audit period Oct 1, 2019 - Sept 30, 2021; $41.4M MFCU-determined overpayments; $27.5M federal share)

Stands behind: 1 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: HHS OIG report, "North Carolina Did Not Report and Return All Medicaid Overpayments for the State's Medicaid Fraud Control Unit Cases" (audit period Oct 1, 2019 - Sept 30, 2021; $41.4M MFCU-determined overpayments; $27.5M federal share).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-430-006 · Respond to OIG audit findings

Citation: 42 CFR 430.33

Determination: Partial

Not covered	A general state-side procedure for responding to OIG audit findings is not in held evidence; only this single audit response is documented.
Owner	NCDHHS Secretary
Action it owns	Produce the department-level procedure for receiving, answering and closing OIG audit findings, or the response file for a second audit.

N.C.G.S. 108A-70.9B, Office of Administrative Hearings hears Medicaid appeals (55-day standard)

Stands behind: 1 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: N.C.G.S. 108A-70.9B, Office of Administrative Hearings hears Medicaid appeals (55-day standard).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-431-027 · Hearing conduct, decisions, and corrective action

Citation: 42 CFR 431.240, 431.241, 431.242, 431.244, 431.245, 431.246

Determination: Partial

Not covered	Post-decision corrective action under 42 CFR 431.246 (prompt corrective payments and retroactive relief when the decision is favorable to the claimant) is not stated in held text; the held materials carry reinstatement pending appeal, not corrective action after a favorable final decision. The 90-day decision period of 431.244(f) appears as an agreement term, while the statute's own language is 55 days to the extent possible and decision without unnecessary delay
Owner	Division of Health Benefits (DHB), with the Office of Administrative Hearings
Action it owns	State the corrective action duty in the appeals procedures: when a hearing decision is favorable, the agency will take prompt corrective action including retroactive payments, within the 431.244(f) and 431.246 framework

PCS Alignment Demonstration, draft Section 1115 demonstration application (incl. full public notice, Appendix B; tribal consultation, Appendix C)

Stands behind: 1 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: PCS Alignment Demonstration, draft Section 1115 demonstration application (incl. full public notice, Appendix B; tribal consultation, Appendix C).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-431-030 · Section 1115 demonstration application requirements

Citation: 42 CFR 431.412

Determination: Partial

Not covered	The Reform Demonstration renewal application document itself is not held, so its 431.412(b) elements (hypotheses, budget neutrality and expenditure detail, eligibility and benefit descriptions) could not be read element by element; only the draft PCS application could
Owner	Division of Health Benefits (DHB)
Action it owns	File the Reform renewal application document with the cure record so the application content can be graded against 431.412(b) directly

SPA NC-23-0028, expansion FMAP claiming

Stands behind: 1 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: SPA NC-23-0028, expansion FMAP claiming.
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-433-019 · Adult group threshold methodology for increased FMAP

Citation: 42 CFR 433.202, 433.204, 433.206

Determination: Partial

Not covered	The checkbox selections and figures are not legible in the held text layer (every option prints as an unmarked box), and the contents of Attachments B through E were not read in the held copy; whether NC claims under the 433.202 threshold methodology or the standard methodology, and at what threshold percentage, cannot be confirmed from the held text.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish a legible Supplement 18 with its attachments so the methodology elections and threshold figures can be read.

CMS Focused Program Integrity Review of North Carolina, Final Report

Stands behind: 1 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: CMS Focused Program Integrity Review of North Carolina, Final Report.
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-433-020 · Provider overpayment recovery within 1 year of discovery

Citation: 42 CFR 433.300, 433.302, 433.304, 433.310, 433.312, 433.316

Determination: Partial

Not covered	The State-side clock of 433.316 for fee-for-service overpayments: recovery or a showing of recovery effort within 1 year of discovery, before the Federal share must be refunded, is not stated in any held instrument for the FFS program; the held overpayment evidence is managed care contract machinery and a 2016 federal review.

Owner	Division of Health Benefits (DHB)
Action it owns	Publish the fee-for-service overpayment recovery policy stating the 433.316 one-year clock and refund practice.

Session Law 2025-64 (House Bill 546), "An Act to Modernize Various Laws Pertaining to the Medicaid Program", bill summary

Stands behind: 1 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: Session Law 2025-64 (House Bill 546), "An Act to Modernize Various Laws Pertaining to the Medicaid Program", bill summary.
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-435-004 · Continuous eligibility for pregnant women and for hospitalized children

Citation: 42 CFR 435.170, 435.172

Determination: Partial

Not covered	Continuous eligibility for a hospitalized child under 42 CFR 435.172 (the child remains eligible through the end of a hospital stay that began before eligibility would otherwise end) is not stated in any held document
Owner	Division of Health Benefits (DHB)
Action it owns	State the hospitalized-child continuous eligibility rule in the eligibility manual or plan so the 435.172 element is on the public record

Non-Emergency Medical Transportation beneficiary page (plan contact table incl. Vaya Partners)

Stands behind: 1 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: Non-Emergency Medical Transportation beneficiary page (plan contact table incl. Vaya Partners).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-435-016 · Availability of program information; opportunity to apply without delay

Citation: 42 CFR 435.905, 435.906

Determination: Partial

Not covered	The 435.905(b) standard as such (program information in plain language, accessible to persons with limited English proficiency and individuals with disabilities, available in paper and electronic formats) and the 435.906 rule (opportunity to apply without delay, no requirement to appear in person) are not stated for the general eligibility program in held text
Owner	Division of Health Benefits (DHB), with the Division of Social Services
Action it owns	State the 435.905(b) information standard and the 435.906 apply-without-delay rule in the eligibility manual's opening section

NC Managed Care Capitation Rates, Updated Care Management Assumptions for SFY 2026 ($10.86 PMPM built in for care management; no minimum care management fee established)

Stands behind: 1 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: NC Managed Care Capitation Rates, Updated Care Management Assumptions for SFY 2026 ($10.86 PMPM built in for care management; no minimum care management fee established).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-438-004 · Rate development standards; base data provision

Citation: 42 CFR 438.5(b)-(c)

Determination: Partial

Not covered	Rate development standards as a documented method under 438.5(b) (base data selection, trend, adjustments, risk adjustment applied budget-neutrally) and the 438.5(c) duty to provide the base data to plans on request: no held passage carries either element.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the rate development documentation for the current rating period, including base data and risk adjustment method.

N.C.G.S. 108A-148.1, Healthcare Access and Stabilization Program (HASP) (438.6(c) directed payment preprint; 433.68(f) limit; $3.2B annual estimate from SFY2023-24 in the text as enacted)

Stands behind: 1 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: N.C.G.S. 108A-148.1, Healthcare Access and Stabilization Program (HASP) (438.6(c) directed payment preprint; 433.68(f) limit; $3.2B annual estimate from SFY2023-24 in the text as enacted).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-438-006 · State directed payments, prior approval, documentation, reporting, evaluation

Citation: 42 CFR 438.6(c)

Determination: Partial

Not covered	The preprints and CMS approval letters for each directed payment are not on any State, EQRO or plan host (NL-16 search record: medicaid.gov downloads only, no HASP preprint PDF surfaced), and the 438.6(c) evaluation plan and annual evaluation reports are not held.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the directed payment preprints, approval letters and evaluation reports on a State host.

Managed Care Program Annual Report (MCPAR) posting page, NC posted reports for five managed care programs in 2025

Stands behind: 1 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: Managed Care Program Annual Report (MCPAR) posting page, NC posted reports for five managed care programs in 2025.
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-438-012 · Beneficiary information website and transparency postings

Citation: 42 CFR 438.10(c)(3), 42 CFR 438.602(g)

Determination: Partial

Not covered	The 438.602(g)(3) posting is affirmatively not made: in its own MCPAR the State answered No to posting the names of individuals and entities with 5 percent or more ownership or control interest in the plans and subcontractors (H-064 indicator BX.9a). The full 438.10(c)(3) content list was also not read as posted.
Owner	Division of Health Benefits (DHB)
Action it owns	Post the 5 percent ownership and control names required by 438.602(g)(3) on the managed care website.

Provider Operations Manual, Tailored Plan, v2.1 (PRV15-TP)

Stands behind: 1 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: Provider Operations Manual, Tailored Plan, v2.1 (PRV15-TP).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-438-030 · LTSS stakeholder engagement

Citation: 42 CFR 438.70

Determination: Partial

Not covered	438.70 as written is a State duty: the State must engage individuals who use LTSS, providers, and other stakeholders in the design, implementation and oversight of the managed care program. The held evidence is one plan's advisory committee structure under 438.110 (a member advisory committee requirement), with no State-level LTSS stakeholder group, and no consultation record, documented for the program as a whole or for the other plans.
Owner	Division of Health Benefits (DHB)
Action it owns	Establish and document State-level LTSS stakeholder engagement for the managed care program as a whole, or publish how the plan-level committees discharge the 438.70 duty for the State.

Lessons Learned from North Carolina's MCPAR Reports (analysis of NC's five 2025 MCPARs and sanctions reporting)

Stands behind: 1 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: Lessons Learned from North Carolina's MCPAR Reports (analysis of NC's five 2025 MCPARs and sanctions reporting).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-438-060 · Temporary management of MCO

Citation: 42 CFR 438.706

Determination: Partial

Not covered	The 438.706 elements beyond availability: the mandatory appointment triggers, the notice to enrollees and their right to disenroll without cause during temporary management, and the conditions for ending it. No instance of temporary management appears in the held record; the MCPAR analysis recommends the State study non-monetary sanctions including temporary management, indicating none were reported (H-138 p. 15).
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the temporary management procedure, including enrollee notice and disenrollment rights.

SPA NC-25-0009, removes NQTLs for psychotherapy/mobile crisis; residential withdrawal services; ABP pages

Stands behind: 1 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: SPA NC-25-0009, removes NQTLs for psychotherapy/mobile crisis; residential withdrawal services; ABP pages.
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-438-065 · Mental health parity compliance documentation and website posting

Citation: 42 CFR 438.915

Determination: Partial

Not covered	The 438.915 documentation itself: the State's documentation of how it ensures compliance with the parity requirements across the MCO, PIHP, PAHP and fee-for-service delivery systems (the comparative analyses), and its posting on the State website, are not in the held record; the held SPA addresses the alternative benefit plan package, not managed care parity documentation.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the 438.915 parity compliance documentation for the managed care delivery systems.

Clinical Coverage Policy 3A, Home Health Services, amended July 1, 2026

Stands behind: 1 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: Clinical Coverage Policy 3A, Home Health Services, amended July 1, 2026.
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-440-009 · Face-to-face encounter before home health / medical equipment

Citation: 42 CFR 440.70(f)

Determination: Partial

Not covered	Two elements are not stated in terms in the text read: the duty in 440.70(f)(4) for a non-physician practitioner who may not perform the encounter independently to communicate the clinical findings to the ordering physician, and the medical equipment window in 440.70(f)(2) (encounter no more than 6 months before the start of services). The DME text read states the examination must precede the order for power wheelchairs but states no 6-month window and no general medical equipment encounter rule.
Owner	Division of Health Benefits (DHB)
Action it owns	State in CCP 3A the (f)(4) communication step for practitioner-conducted encounters, and state the (f)(2) 6-month window for medical equipment in the DME policy set.

NC-23-0029 Alternative Benefit Plan SPA, CMS SPA page

Stands behind: 1 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: NC-23-0029 Alternative Benefit Plan SPA, CMS SPA page.
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-440-010 · EPSDT and other required benefits in benchmark/ABP coverage

Citation: 42 CFR 440.345

Determination: Partial

Not covered	EPSDT coverage for 19 and 20 year old ABP enrollees under 440.345(a) is not stated in any held ABP page; family planning and other 440.345 benefit assurances are likewise not stated on a held ABP page.
Owner	Division of Health Benefits (DHB)
Action it owns	File the approved ABP attachment pages showing the 440.345 assurances, including EPSDT for enrollees under 21.

Clinical Coverage Policy No. 1E-3 as printed on its face, Sterilization Procedures, amended January 1, 2026

Stands behind: 1 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: Clinical Coverage Policy No. 1E-3 as printed on its face, Sterilization Procedures, amended January 1, 2026.
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-441-043 · Sterilization informed consent - required content and prohibitions

Citation: 42 CFR 441.257

Determination: Partial

Not covered	The oral advisory content of 441.257(a)(1) is not reproduced in any text read: advice that the individual is free to withhold or withdraw consent at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits; a description of available alternative methods of family planning and birth control; advice that the sterilization procedure is considered to be irreversible; a thorough explanation of the specific sterilization procedure to be performed; a full description of the discomforts and risks, including the type and possible effects of any anesthetic to be used; a full description of the benefits or advantages that may be expected; and advice that the sterilization will not be performed for at least 30 days except under the stated exceptions. Also not stated in the policy text: the offer to answer questions, suitable arrangements to communicate the information to an individual who is blind, deaf or otherwise handicapped, and permission for a witness of the individual choice to be present when consent is obtained. The policy incorporates 441.257 by citation and links the federal consent form at Attachments B and C, but the form own text is not in the acquired file and was not read.
Owner	Division of Health Benefits (DHB)
Action it owns	File the text of the current federal Consent for Sterilization form as used in NC, or state the 441.257(a)(1) advisories in the sterilization policy, so the oral informing content is on the record.

NC Medicaid CAP/C waiver renewed through 2028 (Mar 1, 2023 - Feb 29, 2028)

Stands behind: 1 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: NC Medicaid CAP/C waiver renewed through 2028 (Mar 1, 2023 - Feb 29, 2028).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-441-052 · 1915(c) waiver - duration and renewal

Citation: 42 CFR 441.304

Determination: Partial

Not covered	No held instrument shows an initial 3-year approval period for a current NC waiver, the other half of 441.304; every held approval is a renewal, and the CAP/DA renewal's CMS approval letter is not held, so its approved period could not be read.
Owner	Division of Health Benefits (DHB)

Action it owns	File the CMS approval letters for the current 1915(c) renewals, including CAP/DA, so approved periods are on the record.

Claims and Billing page (365-day timely filing; 50 checkwrites per year; EFT required)

Stands behind: 1 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: Claims and Billing page (365-day timely filing; 50 checkwrites per year; EFT required).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-447-007 · Timely claims payment, claims submission deadline

Citation: 42 CFR 447.45

Determination: Partial

Not covered	The full set of exceptions to the submission deadline in 447.45(c).
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the complete exception list with the timely filing rule on the claims and billing page, so a provider can see when a claim over 365 days may still be paid.

10A NCAC 22F.0104 (Subchapter 22F, Program Integrity)

Stands behind: 1 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: 10A NCAC 22F.0104 (Subchapter 22F, Program Integrity).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-447-009 · Prepayment and postpayment claims review

Citation: 42 CFR 447.45

Determination: Partial

Not covered	Prepayment review of all claims with the full 447.45(e) check list, and a stated postpayment review system.

Owner	Division of Health Benefits (DHB)
Action it owns	Publish the claims review description that lists the prepayment checks performed on all claims and the postpayment review scope, or point to the existing document that does.

Provider Playbook Prompt Payment Fact Sheet (directed payments; clean claim definition citing 42 CFR 447.45(b))

Stands behind: 1 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: Provider Playbook Prompt Payment Fact Sheet (directed payments; clean claim definition citing 42 CFR 447.45(b)).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-447-011 · MCO contract prompt-payment terms

Citation: 42 CFR 447.46

Determination: Partial

Not covered	The 90 percent and 99 percent clean claim terms of 447.46 in contract text, and the executed base contract itself.
Owner	Division of Health Benefits (DHB)
Action it owns	Confirm the percentage terms in the executed contracts and publish the contract section that carries them, or amend the fact sheet to state them.

Physician Assistant fee schedule

Stands behind: 1 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: Physician Assistant fee schedule.
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-447-027 · Publish all FFS fee-schedule rates online

Citation: 42 CFR 447.203

Determination: Partial

Not covered	Evidence that the published set covers all fee-for-service services and rates, in current form.
Owner	Division of Health Benefits (DHB)
Action it owns	Place the fee schedule index, or a current schedule for each provider type, in the public record so completeness can be checked rather than sampled.

SPA NC-25-0015, updates 1915(i) authority, Attachment 4.19-B

Stands behind: 1 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: SPA NC-25-0015, updates 1915(i) authority, Attachment 4.19-B.
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-447-042 · Related information submitted with assurances

Citation: 42 CFR 447.255

Determination: Partial

Not covered	The rate and expenditure estimates and related information that accompany a Subpart C assurance submission.
Owner	Division of Health Benefits (DHB)
Action it owns	Include the rate estimate worksheet in the held packet for the next Subpart C SPA, or publish the submission's related information with the notice.

Clinical Coverage Policy No. 9, Outpatient Pharmacy (lock-in program citing 10A NCAC 22F.0704/.0104 and 42 CFR 431.54)

Stands behind: 1 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: Clinical Coverage Policy No. 9, Outpatient Pharmacy (lock-in program citing 10A NCAC 22F.0704/.0104 and 42 CFR 431.54).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.

What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-447-058 · Invoice manufacturers within 60 days of quarter end

Citation: 42 CFR 447.511

Determination: Partial

Not covered	The manufacturer invoice, its form, and the 60 day deadline after quarter end.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the rebate invoicing procedure, or the administrator contract terms that carry it, in the pharmacy program documentation.

N.C.G.S. 108C-3, Medicaid provider screening (categorical risk levels; high-risk designation incl. providers suspended under 42 CFR 455.23 within the previous 12 months)

Stands behind: 1 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: N.C.G.S. 108C-3, Medicaid provider screening (categorical risk levels; high-risk designation incl. providers suspended under 42 CFR 455.23 within the previous 12 months).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-447-069 · No FFP for payments to providers under credible fraud investigation

Citation: 42 CFR 447.90

Determination: Partial

Not covered	The no-FFP claiming rule for suspended providers, and its good cause exceptions, in NC text.
Owner	Division of Health Benefits (DHB)
Action it owns	State the claiming treatment of payments to a suspended provider in the program integrity or financial procedures, including the good cause exceptions.

Draft TBI Waiver application (Appendix F cites 42 CFR Part 431 Subpart E fair hearing; concurrent 1915(b) operation through PIHPs)

Stands behind: 1 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: Draft TBI Waiver application (Appendix F cites 42 CFR Part 431 Subpart E fair hearing; concurrent 1915(b) operation through PIHPs).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-455-008 · Criminal conviction disclosure; OIG notification within 20 working days

Citation: 42 CFR 455.106

Determination: Partial

Not covered	The 455.106 disclosure and 20-working-day OIG notification chain as it applies in fee-for-service and NCTracks enrollment generally; held text carries it only as an LME-PIHP contract term described in a draft waiver application.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the enrollment-channel disclosure requirement and OIG notification log or procedure carrying the 20-working-day clock outside the PIHP contracts.

Update: CCP 2A-1, Acute Inpatient Hospital Services, and 1A-4, Cochlear and Auditory Brainstem Implants (cites 42 CFR 456.60 certification rule)

Stands behind: 1 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: Update: CCP 2A-1, Acute Inpatient Hospital Services, and 1A-4, Cochlear and Auditory Brainstem Implants (cites 42 CFR 456.60 certification rule).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-456-006 · Hospital certification/recertification of need for inpatient care

Citation: 42 CFR 456.60

Determination: Partial

Not covered	Certification timing, recertification intervals and recertifier qualifications under 42 CFR 456.60 beyond the rule that only a physician performs initial certification.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce CCP 2A-1 itself, showing the certification and recertification terms.

NCTracks 2026 Checkwrite Schedule

Stands behind: 1 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: NCTracks 2026 Checkwrite Schedule.
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

CFR-162-003 · Standard electronic health care transactions

Citation: 45 CFR 162 Subparts K-R (162.1102, 162.1202, 162.1302, 162.1402, 162.1502, 162.1602, 162.1702, 162.1802)

Determination: Partial

Not covered	The complete adopted standard transaction set of 45 CFR Part 162 Subparts K-R as NC's set; held evidence shows individual transactions in use (837, 835, 820, 277P, 275, NCPDP) without the full set or the remaining subparts.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the NCTracks companion guide set or EDI manual listing the standard transactions NC conducts.

NC Medicaid Annual Report, State Fiscal Year 2025 (SFY2025 expenditures $35,771M actual; Standard Plan managed care $12,013.63M; HASP $6,595.52M; Tailored Plan managed care $6,179.31M)

Stands behind: 1 determinations

What it is	The public document named first in the record location of the determinations below, in the determinations file of record: NC Medicaid Annual Report, State Fiscal Year 2025 (SFY2025 expenditures $35,771M actual; Standard Plan managed care $12,013.63M; HASP $6,595.52M; Tailored Plan managed care $6,179.31M).
What it establishes	Each determination below was read against this document. It was also read against the other documents named on its record location. Each one was found carried in part. The record states the requirement's frame. In each case a named element is not covered.
What it does not cover	This document does not cover the elements named on each determination below. Each element prints with its owner level. Each element also prints the action that level owns.

NC-007 · NC Medicaid Annual Report and Annual Report Tables (state fiscal year)

Citation: Medicaid Annual Reports and Tables page (Finance Section contact)

Determination: Partial

Not covered	The Annual Report Tables companion publication; held evidence carries the Annual Report narrative and exhibits only.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the current Annual Report Tables document or the page section that publishes it.

SECTION 3 · MISSING OUTRIGHT

The documents that belong in the public record and are not in it · 13 true gap documents · 71 gap-determined determinations

13	71	3	68
true gap documents on this list	gap-determined determinations behind this section	gap-determined determinations assigned under a document on their own face	gap-determined determinations in the closing grouped list of this section

Section 3 lists the documents that belong in North Carolina's public record. Those documents are not in it. The unit of the section is the missing document, not the register row. Determinations that reference one missing document are grouped under it. The section therefore reads as documents a record keeper can go and get.

The count runs as follows. The section holds 13 missing documents. They are the true gaps of the 196 row inventory. Behind them stand the register's 71 gap-determined determinations. Three of those rows name their missing document on their own faces. Those rows print under the document they name. One prints under the capitation rate certifications (NL-17). Two print under the current DSH audit (NL-12). The remaining 68 print in the closing grouped list of this section. That list is grouped by Code of Federal Regulations part. Every gap-determined determination appears exactly once in that accounting. Each entry states what the document is. Each entry states why the document belongs in the public record. Each entry states what the document blocks. Each entry also carries an owner. Each entry also carries the action for it. When a document on this list is produced and filed, the determinations behind it can be re-graded at the next pass.

1 · Executed base contract, Prepaid Health Plan (Standard Plan) Services Contract #30-190029-DHB (NL-01)

Citations: 42 CFR 438.3(a), 438.3(c)(1) · 42 CFR 438.3(b)-(u) · 42 CFR 438.604, 42 CFR 438.606 · 42 CFR 438.706 (+2 more)

Stands behind: No gap-determined determination is assigned to this document alone; 6 determinations reference this document in the register

What it is	State posts the Standard Plan contract only in RFP form: the Revised and Restated RFP (issued Aug. 9, 2018, restated Jan.
Why public	The model form is public. The amendment series is public. The executed contract is the operative instrument of a public program. A contract for public services is a public record, because public funds pay for it. Managed care determinations that rest on the model form say so on their faces. They say so because the instance that actually binds each Standard Plan cannot be read.

What it blocks	These determinations reference this document in the register. They therefore state what its absence holds back. The gap-determined rows assigned to this document on their own faces print as cards after this entry. Those rows are not repeated in this list. **CFR-438-001** · 42 CFR 438.3(a), 438.3(c)(1) · MCO/PIHP/PAHP contract CMS review and approval; capitation rates in contract **CFR-438-002** · 42 CFR 438.3(b)-(u) · Standard contract provisions in all managed care contracts **CFR-438-054** · 42 CFR 438.604, 42 CFR 438.606 · Required plan data submissions and CEO/CFO certification **CFR-438-060** · 42 CFR 438.706 · Temporary management of MCO **CFR-447-011** · 42 CFR 447.46 · MCO contract prompt-payment terms **CFR-447-014** · 42 CFR 447.52 · MCO contracts honor state-plan cost sharing
Owner	The reconciliation desk, under the daily watch (standing acquisition list)
Action it owns	Acquire this document for the public record file when a public copy is posted, and re-grade the determinations that reference it at the next pass.

2 · Executed base contract, BH I/DD Tailored Plan Contract #30-2020-052-DHB (NL-02)

Citations: 42 CFR 438.214(b)

Stands behind: No gap-determined determination is assigned to this document alone; 1 determinations reference this document in the register

What it is	State posts the Tailored Plan contract only as the First Revised and Restated RFA (original RFA Nov. 13, 2020) with Amendment 1 model sections dated Nov.
Why public	The model form is public. The amendment series is public. The executed contract is the operative instrument of a public program. A contract for public services is a public record, because public funds pay for it. Managed care determinations that rest on the model form say so on their faces. They say so because the instance that actually binds each Tailored Plan cannot be read.
What it blocks	These determinations reference this document in the register. They therefore state what its absence holds back. The gap-determined rows assigned to this document on their own faces print as cards after this entry. Those rows are not repeated in this list. **CFR-438-034** · 42 CFR 438.214(b) · Uniform credentialing and recredentialing policy
Owner	The reconciliation desk, under the daily watch (standing acquisition list)
Action it owns	Acquire this document for the public record file when a public copy is posted, and re-grade the determinations that reference it at the next pass.

3 · Executed base contract, Medicaid Direct PIHP Contract #30-2022-007-DHB (NL-03)

Citations: 42 CFR 438.3(a), 438.3(c)(1) · 42 CFR 438.3(b)-(u)

Stands behind: No gap-determined determination is assigned to this document alone; 2 determinations reference this document in the register

What it is	The posted base contract (386 pages) is titled Contract #30-2022-007-DHB-X with the plan name and ID as X placeholders; it is the base contract instrument in model form, not an executed copy naming a PIHP. No executed copy located.

Why public	The model form is public. The executed contract is the operative instrument of a public program. A contract for public services is a public record, because public funds pay for it. Managed care determinations that rest on the model form say so on their faces. They say so because the instance that actually binds each PIHP cannot be read.
What it blocks	These determinations reference this document in the register. They therefore state what its absence holds back. The gap-determined rows assigned to this document on their own faces print as cards after this entry. Those rows are not repeated in this list. **CFR-438-001** · 42 CFR 438.3(a), 438.3(c)(1) · MCO/PIHP/PAHP contract CMS review and approval; capitation rates in contract **CFR-438-002** · 42 CFR 438.3(b)-(u) · Standard contract provisions in all managed care contracts
Owner	The reconciliation desk, under the daily watch (standing acquisition list)
Action it owns	Acquire this document for the public record file when a public copy is posted, and re-grade the determinations that reference it at the next pass.

4 · The complete clinical coverage policy set (NL-04)

Citations:

Stands behind: No gap-determined determination is assigned to this document alone; 0 determinations reference this document in the register

What it is	No single complete-set document exists to acquire: the set lives only as the index page plus dozens of separate policy PDFs across category pages, and the full set was not enumerated as one document on any host searched. Sources searched (log-C4): NC Medicaid Program Specific Clinical Coverage Policies index (held as H-074) and its category pages; NC Medicaid providers pages; web search for a complete policy set document
Why public	Clinical coverage policies are the published rules providers are held to. Members are held to them and protected by them as well. The set lives only as an index page plus dozens of separate files across category pages. A set in that form cannot be read as one public record. It cannot be cited as one public record. It cannot be watched for change as one public record. Determinations that rest on individual policies rest on the files that happen to be held.
What it blocks	No determination in the determinations file references this document by its inventory code. It stands as a gap at inventory level. The document itself is missing. The determinations in its area are graded on the substitute evidence the register names. They are also graded on the partial evidence the register names.
Owner	The reconciliation desk, under the daily watch (standing acquisition list)
Action it owns	Acquire this document for the public record file when a public copy is posted, and re-grade the determinations that reference it at the next pass.

5 · 2025 NC Medicaid Managed Care Quality Strategy (the document) (NL-06)

Citations: 42 CFR 438.340 · NC Medicaid Managed Care Quality Strategy (first published 2018; updated 2023); Annual Quality Report

Stands behind: No gap-determined determination is assigned to this document alone; 2 determinations reference this document in the register

What it is	The July 1, 2025 bulletin states CMS approved the 2025 strategy and that NCDHHS published it on the Quality Management and Improvement page, but that page carries no Quality Strategy document link; searches surface only the 2023 strategy (held H-122), a 2022 draft, the Dec. 9, 2024 public comment bulletin, and the 2024 Quality Strategy Evaluation.
Why public	Federal rules call for a current quality strategy (42 CFR 438.340). Its triennial review fell due in this window. The agency's own bulletin directs the public to the page where it says the approved strategy lives. The public cannot read that document there. A document the agency announces and the public cannot read is a gap in the public record on the agency's own terms.
What it blocks	These determinations reference this document in the register. They therefore state what its absence holds back. The gap-determined rows assigned to this document on their own faces print as cards after this entry. Those rows are not repeated in this list. **CFR-438-043** · 42 CFR 438.340 · Managed care State quality strategy **NC-012** · NC Medicaid Managed Care Quality Strategy (first published 2018; updated 2023); Annual Quality Report · Medicaid Managed Care Quality Strategy, maintenance, and the Annual Quality Report against it
Owner	The reconciliation desk, under the daily watch (standing acquisition list)
Action it owns	Acquire this document for the public record file when a public copy is posted, and re-grade the determinations that reference it at the next pass.

6 · NC Medicaid Ombudsman annual report (NL-07)

Citations: 42 CFR 438.71

Stands behind: No gap-determined determination is assigned to this document alone; 1 determinations reference this document in the register

What it is	NCMO newsletters and a plan CFAC page reference a published 2023 Annual Report, but no report document is posted on the ombudsman site or on NCDHHS or NC Medicaid postings; the only NCDHHS ombudsman annual report found is the separate State Long-Term Care Ombudsman Program 2023 report (Division of Aging), which is not this item. Sources searched (log-C4): ncmedicaidombudsman.org homepage and site pages; NCMO newsletters Dec.
Why public	The Ombudsman is the members' public advocate in the managed care program. Its annual report is the standing public account of what members brought to it. The report is also the standing public account of what it did. Newsletters and plan pages refer to a published 2023 report. No public posting carries that report.

What it blocks	These determinations reference this document in the register. They therefore state what its absence holds back. The gap-determined rows assigned to this document on their own faces print as cards after this entry. Those rows are not repeated in this list. **CFR-438-029** · 42 CFR 438.71 · Beneficiary support system
Owner	The reconciliation desk, under the daily watch (standing acquisition list)
Action it owns	Acquire this document for the public record file when a public copy is posted, and re-grade the determinations that reference it at the next pass.

7 · Enrollment Broker contract (NL-08)

Citations: 42 CFR 438.54 · 42 CFR 438.54, 42 CFR 438.71(c)

Stands behind: No gap-determined determination is assigned to this document alone; 2 determinations reference this document in the register

What it is	Only the award is documented: DHHS award to Maximus in Aug. 2018, RFP 30-180090 (issued Mar.
Why public	The Enrollment Broker is the contractor members deal with when they choose a plan. Members also deal with it when they enroll in a plan. Public funds pay for that contract. The award is documented in public. The contract itself is not. That contract states its duties, its standards, and its price.
What it blocks	These determinations reference this document in the register. They therefore state what its absence holds back. The gap-determined rows assigned to this document on their own faces print as cards after this entry. Those rows are not repeated in this list. **CFR-438-015** · 42 CFR 438.54 · Managed care enrollment system and informational notices **CFR-438-016** · 42 CFR 438.54, 42 CFR 438.71(c) · Choice counseling for potential enrollees and disenrollees
Owner	The reconciliation desk, under the daily watch (standing acquisition list)
Action it owns	Acquire this document for the public record file when a public copy is posted, and re-grade the determinations that reference it at the next pass.

8 · Non-emergency medical transportation (NEMT) broker contract or official broker policy (NL-11)

Citations:

Stands behind: No gap-determined determination is assigned to this document alone; 0 determinations reference this document in the register

What it is	No broker contract and no current official document naming the brokers: the state policy and member page do not name brokers, the July 2021 blog naming ModivCare and One Call is superseded, and current assignments (Modivcare for most plans; MTM for UnitedHealthcare from Jan. 1, 2026 and Carolina Complete Health from Apr.

Why public	Transportation to care is a covered benefit. Members claim it through the brokers. A member needs to know which broker serves which plan. A record keeper needs to know it too. Each one needs the contract terms the broker serves on. That program information belongs in an official document. It should not rest on plan notices and secondary guides alone.
What it blocks	No determination in the determinations file references this document by its inventory code. It stands as a gap at inventory level. The document itself is missing. The determinations in its area are graded on the substitute evidence the register names. They are also graded on the partial evidence the register names.
Owner	The reconciliation desk, under the daily watch (standing acquisition list)
Action it owns	Acquire this document for the public record file when a public copy is posted, and re-grade the determinations that reference it at the next pass.

9 · Current DSH audit or cost-report settlement document (NL-12)

Citations: 42 CFR 447.294 · 42 CFR 447.299

Stands behind: 2 gap-determined determinations assigned to this document on its own face; 4 determinations reference this document in the register

What it is	Only historical material found: HHS OIG review of NC DSH payments for FY1997 to 2001 (Apr. 2003, A-04-01-00003).
Why public	DSH payments are among the largest supplemental payments in the program. A federal rule requires an independent certified audit of them (42 CFR 455.304). The current audit or settlement document is the public record that those payments were examined. The record holds only a 1997 to 2001 federal review. It also holds the methodology instruments.
What it blocks	These determinations reference this document in the register. They therefore state what its absence holds back. The gap-determined rows assigned to this document on their own faces print as cards after this entry. Those rows are not repeated in this list. **CFR-447-045** · 42 CFR 447.294 · Annual DSH data submission to CMS **CFR-447-048** · 42 CFR 447.299 · Annual per-hospital DSH report with audit
Owner	The reconciliation desk, under the daily watch (standing acquisition list)
Action it owns	Acquire this document for the public record file when a public copy is posted, and re-grade the determinations that reference it at the next pass.

Gap-determined determinations assigned to NL-12 on their own faces

CFR-447-047 · Quarterly aggregate DSH payment reports

Citation: 42 CFR 447.299

Determination: GAP-DETERMINED

Not covered	The whole requirement: quarterly submission to CMS of aggregate DSH payments to each individual public and private hospital grouping the provision specifies.
Owner	Division of Health Benefits (DHB)

Action it owns	Publish the quarterly DSH payment reports, or the transmittal record for them, with the DSH program documents.

CFR-455-010 · Independent certified audit of DSH payments

Citation: 42 CFR 455.304

Determination: GAP-DETERMINED

Not covered	The entire provision: no held document carries the independent certified audit of DSH payments or its findings (42 CFR 455.304).
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the most recent independent certified DSH audit report or the audit contract deliverable.

10 · Current standalone CMS approval letter for the Section 1915(b) authority (NL-14)

Citations: 42 CFR 431.55

Stands behind: No gap-determined determination is assigned to this document alone; 1 determinations reference this document in the register

What it is	No standalone approval letter on any state, EQRO, or plan host; the state posts only a draft amendment application. The approved waiver application NC.0002.R06.01 (effective Jan.
Why public	The 1915(b) authority is the legal basis on which the State requires enrollment in its managed care arrangements. It is also the legal basis for its PIHP arrangements. The standalone CMS approval letter is the instrument that states the authority. The letter also states its period. The State posts a draft amendment application in its place.
What it blocks	These determinations reference this document in the register. They therefore state what its absence holds back. The gap-determined rows assigned to this document on their own faces print as cards after this entry. Those rows are not repeated in this list. **CFR-431-012** · 42 CFR 431.55 · 1915(b) freedom-of-choice waiver requests
Owner	The reconciliation desk, under the daily watch (standing acquisition list)
Action it owns	Acquire this document for the public record file when a public copy is posted, and re-grade the determinations that reference it at the next pass.

11 · North Carolina directed payment preprints (including the HASP preprint) (NL-16)

Citations: 42 CFR 438.6(c)

Stands behind: No gap-determined determination is assigned to this document alone; 1 determinations reference this document in the register

What it is	Preprints and CMS approval letters exist only as medicaid.gov managed care downloads (control names include NC_Fee_NF_Amend_20250701-20260630, approved Jan. 13, 2026); no state, EQRO, or plan hosted copy of any preprint, and no HASP preprint PDF, surfaced.

Why public	Directed payments move public money through plan payments on CMS approved terms. The HASP preprint concerns the program the State's own statute carries at an estimated 3.2 billion dollars a year. The preprints are the public terms of those payments. Their approval letters are part of those public terms. No State hosted copy of any preprint was found. No EQRO hosted copy was found. No plan hosted copy was found.
What it blocks	These determinations reference this document in the register. They therefore state what its absence holds back. The gap-determined rows assigned to this document on their own faces print as cards after this entry. Those rows are not repeated in this list. **CFR-438-006** · 42 CFR 438.6(c) · State directed payments, prior approval, documentation, reporting, evaluation
Owner	The reconciliation desk, under the daily watch (standing acquisition list)
Action it owns	Acquire this document for the public record file when a public copy is posted, and re-grade the determinations that reference it at the next pass.

12 · Managed care capitation rate certifications (NL-17)

Citations: 42 CFR 438.4 · 42 CFR 438.7 · 42 CFR 438.608(d)

Stands behind: 1 gap-determined determinations assigned to this document on its own face; 4 determinations reference this document in the register

What it is	Certifications are referenced but never posted: the SFY2026 capitation assumptions blog (held H-059), an Aug. 11, 2025 NCDHHS letter to legislative leaders citing SFY2026 rates from contracted actuaries and an $819 million rebase need, and a Dec.
Why public	Capitation rates are the price the public pays each plan for each member. The actuarial certification is the document that states the rates were developed on the federal standard. State letters reference the certifications. Association letters reference them too. A referenced fiscal document of this size belongs in the public record it is referenced from.
What it blocks	These determinations reference this document in the register. They therefore state what its absence holds back. The gap-determined rows assigned to this document on their own faces print as cards after this entry. Those rows are not repeated in this list. **CFR-438-003** · 42 CFR 438.4 · Actuarially sound capitation rates **CFR-438-005** · 42 CFR 438.7 · Rate certification submission and documentation **CFR-438-057** · 42 CFR 438.608(d) · Overpayment recovery policies, annual report, and rate-setting use
Owner	The reconciliation desk, under the daily watch (standing acquisition list)
Action it owns	Acquire this document for the public record file when a public copy is posted, and re-grade the determinations that reference it at the next pass.

Gap-determined determinations assigned to NL-17 on their own faces

CFR-447-020 · Include cost sharing in MCO capitation

Citation: 42 CFR 447.56

Determination: GAP-DETERMINED

Not covered	The whole requirement as an evidenced calculation: a rate certification or rate development document showing cost sharing taken into account in capitation.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the capitation rate certification, or a rate development summary that states how member cost sharing is reflected in the rates.

13 · NC Register rulemaking notices specific to 10A NCAC 22 (2025-2026) (NL-18)

Citations:

Stands behind: No gap-determined determination is assigned to this document alone; 0 determinations reference this document in the register

What it is	No Register proposed-rule notice specific to 10A NCAC 22 found for 2025 to 2026; the only Chapter 21 and 22 activity in the window is the DHB periodic review initial determination comment period (Jan. 22 to Mar.
Why public	Rulemaking notices are the public process by which the rules in 10A NCAC 22 change. The notice tells providers a rule is proposed. It tells members the same thing. It also tells both groups how to be heard. The public record of how the current rules came to be cannot be read from the Register itself without the Register notices. The same gap covers what was proposed in 2025 and 2026.
What it blocks	No determination in the determinations file references this document by its inventory code. It stands as a gap at inventory level. The document itself is missing. The determinations in its area are graded on the substitute evidence the register names. They are also graded on the partial evidence the register names.
Owner	The reconciliation desk, under the daily watch (standing acquisition list)
Action it owns	Acquire this document for the public record file when a public copy is posted, and re-grade the determinations that reference it at the next pass.

Closing grouped list: the remaining gap-determined determinations

The 68 gap-determined determinations not assigned to one of the 13 documents on their own faces, grouped by Code of Federal Regulations part. With the 3 assigned above, all 71 gap-determined determinations in the register are accounted for exactly once in this section.

Part 162 · 3 determinations

CFR-162-001 · Health plan must use provider NPIs on standard transactions

Citation: 45 CFR 162.412

Determination: GAP-DETERMINED

Not covered	The entire provision: no held document states that a health plan must use provider NPIs in standard transactions (45 CFR 162.412).
Owner	Division of Health Benefits (DHB)
Action it owns	Produce an NCTracks or PHP companion guide or trading partner term stating NPI use in standard transactions.

CFR-162-002 · Must conduct transactions as standard transactions on request

Citation: 45 CFR 162.925(a)

Determination: GAP-DETERMINED

Not covered	The entire provision: the on-request standard transaction conduct duty (45 CFR 162.925(a)) is not stated in held evidence.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the EDI operations policy or trading partner agreement stating the standard transaction conduct duties.

CFR-162-004 · Standard medical code sets

Citation: 45 CFR 162.1002 (Subpart J)

Determination: GAP-DETERMINED

Not covered	The entire provision: the standard medical code set requirement (45 CFR 162.1002, Subpart J) is not stated in held evidence.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the companion guide or policy language adopting the standard code sets for NC transactions.

Part 430 · 4 determinations

CFR-430-007 · Deferred FFP claims, furnish documentation

Citation: 42 CFR 430.40

Determination: GAP-DETERMINED

Not covered	The entire provision: no held document addresses furnishing documentation on a deferred FFP claim (42 CFR 430.40).
Owner	Division of Health Benefits (DHB)

Action it owns	Produce any deferral correspondence file or the finance procedure for answering a CMS deferral with documentation.

CFR-430-008 · Disallowance reconsideration process

Citation: 42 CFR 430.42

Determination: GAP-DETERMINED

Not covered	The entire provision: no held document addresses requesting reconsideration of a CMS disallowance (42 CFR 430.42).
Owner	NCDHHS Secretary
Action it owns	Produce any disallowance reconsideration filing or the procedure NC would follow on receipt of a disallowance notice.

CFR-430-009 · Repay unallowable Federal payments (installment schedules)

Citation: 42 CFR 430.48

Determination: GAP-DETERMINED

Not covered	The entire provision: no held document addresses repayment of unallowable federal payments or installment schedules under 42 CFR 430.48.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce any repayment agreement or schedule with CMS for unallowable FFP, or the finance procedure governing one.

CFR-430-010 · Corrective action plans for eligibility redetermination noncompliance

Citation: 42 CFR 430.49

Determination: GAP-DETERMINED

Not covered	The entire provision: no held document addresses a corrective action plan for eligibility redetermination noncompliance (42 CFR 430.49).
Owner	Division of Health Benefits (DHB)
Action it owns	Produce any CMS corrective action plan correspondence on eligibility redeterminations, or state on the record that none has been required.

Part 431 · 4 determinations

CFR-431-013 · Patient Access API (beneficiary data access)

Citation: 42 CFR 431.60

Determination: GAP-DETERMINED

Not covered	No NC public document in the held corpus states that the State maintains a Patient Access API for fee-for-service beneficiaries, the data content it must expose, or its availability terms. The only Patient Access API references found are inside the managed care MCPAR reporting template carried in H-064 and the MCPAR lessons analysis, where Patient Access API usage is a plan reporting topic beginning June 2026, not a State fee-for-service API.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the State's Patient Access API documentation for NC Medicaid Direct (endpoint, data content, beneficiary access terms) or the CMS-facing attestation that the API is maintained

CFR-431-014 · Provider Access API and Payer-to-Payer data exchange

Citation: 42 CFR 431.61

Determination: GAP-DETERMINED

Not covered	No NC public document in the held corpus states that the State maintains a Provider Access API or exchanges beneficiary data with a prior or concurrent payer on beneficiary request under 42 CFR 431.61.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the State's Provider Access API and Payer-to-Payer exchange documentation or implementation plan with dates, ahead of the January 1, 2027 federal compliance date for the exchange element

CFR-431-015 · Provider directory API

Citation: 42 CFR 431.70

Determination: GAP-DETERMINED

Not covered	No NC public document in the held corpus states that provider directory information for the fee-for-service program is made available through a standards-based API as 42 CFR 431.70 requires. Held documents carry plan-level provider directories and directory content specifications in the Tailored Plan contracts, and provider manuals pointing to plan directories, but no State provider directory API.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the State provider directory API documentation (endpoint and the directory data elements of 431.70) for NC Medicaid Direct

CFR-431-018 · Provider agreement effective dates

Citation: 42 CFR 431.108

Determination: GAP-DETERMINED

Not covered	No held NC document states the 42 CFR 431.108 rule for when a provider agreement takes effect. Provider enrollment and reverification materials in the corpus address application windows, fees, and due dates, but not the effective date of the provider agreement itself.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the provider enrollment standard or provider agreement term that states the agreement's effective date rule under 42 CFR 431.108

Part 432 · 1 determinations

CFR-432-004 · Report training and administrative costs

Citation: 42 CFR 432.55

Determination: GAP-DETERMINED

Not covered	The entire provision: no held document addresses the reporting of training and administrative costs (42 CFR 432.55).
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the cost report or claim schedule on which training and administrative costs are reported for federal participation.

Part 433 · 8 determinations

CFR-433-005 · Refund FFP for uncashed/cancelled checks; interest on retained disallowances

Citation: 42 CFR 433.38, 433.40

Determination: GAP-DETERMINED

Not covered	No NC evidence for 433.38 or 433.40 was found in the held public corpus. The only CMS-64 mentions located are unrelated to voided checks or disallowance interest (an FQHC/RHC reimbursement bulletin, DSH and cost report pages).
Owner	Division of Health Benefits (DHB)
Action it owns	Adopt and publish the quarterly voided-check FFP refund procedure and the disallowance interest procedure, or produce the CMS-64 adjustment records that carry them.

CFR-433-007 · Report provider donations and health care-related taxes

Citation: 42 CFR 433.74

Determination: GAP-DETERMINED

Not covered	No NC evidence of the 433.74 report was found. Closest material: the 1115 demonstration STCs attest that health care related taxes are broad-based and uniform and that provider donations are bona fide (H-025 STC 17.6), and the HASP statute references 433.68(f) (H-111); neither is a quarterly summary report of donations and taxes with supporting documentation.
Owner	Division of Health Benefits (DHB)
Action it owns	File and publish the quarterly 433.74 summary reports on provider related donations and health care related taxes, with supporting documentation.

CFR-433-010 · Operate approved MMIS (EOB notices, profiles, fraud referrals)

Citation: 42 CFR 433.116

Determination: GAP-DETERMINED

Not covered	No NC evidence carrying the operating conditions of 433.116 was found. Mentions of explanations of benefits in the corpus are provider remittance and drug utilization contexts, not the 433.116 beneficiary notice, provider profile, and fraud referral conditions.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the NCTracks operating documentation that carries the 433.116 conditions (beneficiary notices, provider profiles, suspected fraud referrals).

CFR-433-011 · MMIS reapproval, FFP reductions, appeals, and access

Citation: 42 CFR 433.120, 433.121, 433.122, 433.123, 433.127, 433.131

Determination: GAP-DETERMINED

Not covered	No NC evidence for MMIS reapproval, FFP reduction, appeal of reductions, or CMS and state access under 433.120-433.131 was found in the held public corpus.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the most recent MMIS reapproval record and the access provisions for CMS and state personnel.

CFR-433-012 · Replacement MMIS, APD and transition plan

Citation: 42 CFR 433.117

Determination: GAP-DETERMINED

Not covered	No NC evidence of a replacement-system APD or transition plan under 433.117 was found. The held record documents the current systems and their contracts, not a replacement APD, a transition plan, or CMS approval of either.

Owner	Division of Health Benefits (DHB)
Action it owns	Publish any current replacement APD and CMS-approved transition plan, or state on the record that no replacement is in progress.

CFR-433-015 · Repay Federal share of third-party collections

Citation: 42 CFR 433.140

Determination: GAP-DETERMINED

Not covered	No NC evidence of the 433.140 repayment measure was found. The TPL policy manual (NL-09) contains no reference to the Federal share or to repayment, and the State Plan TPL pages state the collection system without the FMAP-based repayment element.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the procedure by which the Federal share of third party collections, at the State's FMAP, is repaid and credited.

CFR-433-018 · Incentive payments and distribution of third-party collections

Citation: 42 CFR 433.153, 433.154

Determination: GAP-DETERMINED

Not covered	No NC evidence of the 433.153 incentive payment (15 percent of collections, payable from the Federal share) or of the 433.154 distribution order was found in the held public corpus.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the incentive payment and distribution procedure for third party collections, including any payments to assisting jurisdictions or political subdivisions.

CFR-433-021 · Refund Federal share of provider overpayments (CMS-64)

Citation: 42 CFR 433.318, 433.320

Determination: GAP-DETERMINED

Not covered	No NC evidence of the 433.318 and 433.320 credit rules was found. CMS-64 mentions in the corpus are an FQHC/RHC reimbursement bulletin (H-092), DSH and cost report pages, and the HHS OIG report at H-131 (audit period Oct 1, 2019 to Sept 30, 2021), which records $30.4 million in MFCU-determined overpayments not reported and returned on the Form CMS-64 and $11.0 million not reported within the required timeframe; none of these states that the Federal share of an overpayment is credited on the CMS-64 for the quarter of recovery or the quarter in which the one-year period ends, whether or not the overpayment is recovered.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the CMS-64 crediting procedure for the Federal share of provider overpayments.

Part 434 · 3 determinations

CFR-434-002 · Fiscal agent contract requirements

Citation: 42 CFR 434.10

Determination: GAP-DETERMINED

Not covered	The entire provision: no held document addresses the fiscal agent contract or its required terms (42 CFR 434.10).
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the NCTracks fiscal agent contract or its federal requirements exhibit.

CFR-434-003 · Private nonmedical institution contracts

Citation: 42 CFR 434.12

Determination: GAP-DETERMINED

Not covered	The entire provision: no held document addresses private nonmedical institution contracts (42 CFR 434.12).
Owner	Division of Health Benefits (DHB)
Action it owns	State whether NC contracts with any private nonmedical institution and, if so, produce the contract terms carrying 434.12.

CFR-434-004 · Health insuring organization contracts

Citation: 42 CFR 434.40

Determination: GAP-DETERMINED

Not covered	The entire provision: no current held document addresses health insuring organization contracts (42 CFR 434.40).
Owner	Division of Health Benefits (DHB)
Action it owns	State on the record whether any NC Medicaid contract is with a health insuring organization as 434.40 defines it.

Part 435 · 4 determinations

CFR-435-006 · Applicant's choice of category

Citation: 42 CFR 435.404

Determination: GAP-DETERMINED

Not covered	No held NC document states the rule that an applicant who is eligible under more than one category may have eligibility determined under the category of the applicant's choice. The plan's group lists and conditions attachments do not carry it, and no eligibility manual section on choice of category is held.

Owner	Division of Social Services / county DSS (eligibility operations), under Division of Health Benefits policy
Action it owns	Publish the choice-of-category rule in the Adult Medicaid manual so applicants eligible under multiple categories have the 435.404 election on the record

CFR-435-013 · Protected groups - SSI-related December 1973 eligibles

Citation: 42 CFR 435.640

Determination: GAP-DETERMINED

Not covered	No held NC document carries the December 1973 protected group at 42 CFR 435.640. The December 1973 references that do appear in the plan are the distinct essential spouse group at 435.131 (Attachment 2.2-A, PDF p.251) and unrelated cost-of-living material, not the 435.640 cohort (individuals eligible in December 1973 under a State plan more liberal than SSI who remained continuously eligible).
Owner	Division of Health Benefits (DHB)
Action it owns	Confirm whether any member of the December 1973 cohort remains on the rolls; if none, record the group as exhausted so the register can carry a determined status rather than a gap

CFR-435-029 · PHE unwinding reporting requirements; FMAP reduction for noncompliance

Citation: 42 CFR 435.927, 435.928

Determination: GAP-DETERMINED

Not covered	No held NC document carries the unwinding data reporting duty of 435.927 or the FMAP reduction exposure of 435.928. SPA NC-23-0028 (H-012), the expansion packet that covers the unwinding period operationally (including transitions at the end of the 12-month postpartum period), contains no unwinding data reporting submission, and no document in the full map cites either section.
Owner	Division of Health Benefits (DHB)
Action it owns	File NC's unwinding reporting submissions to CMS (the monthly unwinding data reports) with the cure record so the closed-period duty can be graded on documents

CFR-435-033 · Redetermination of eligibility when SSI eligibility is lost

Citation: 42 CFR 435.1003

Determination: GAP-DETERMINED

Not covered	No held NC document states the duty to redetermine Medicaid eligibility on all other bases, without requiring a new application, when an individual loses SSI eligibility. The protected groups at 435.130 and 435.135 carried in Attachment 2.2-A address different cohorts (mandatory and optional protected groups from earlier program changes), not the 435.1003 redetermination duty.
Owner	Division of Social Services / county DSS (eligibility operations)

Action it owns	State the SSI-loss redetermination rule in the eligibility manual's SSI section (redetermine on all bases, no new application, notice of the outcome)

Part 437 · 4 determinations

CFR-437-001 · Annual Child, Adult, and Health Home Core Set reporting

Citation: 42 CFR 437.15(a)

Determination: GAP-DETERMINED

Not covered	The entire provision: no held document carries annual Child, Adult or Health Home Core Set reporting under 42 CFR 437.15(a).
Owner	Division of Health Benefits (DHB)
Action it owns	Produce NC's annual Core Set submission to CMS or the reporting file that supports it.

CFR-437-002 · Stratified Core Set reporting (race, ethnicity, sex, age, rural/urban, disability, language)

Citation: 42 CFR 437.10(d)

Determination: GAP-DETERMINED

Not covered	The entire provision: no held document carries stratification of Core Set measures by race, ethnicity, sex, age, rural or urban status, disability or language (42 CFR 437.10(d)).
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the stratified Core Set output or the data specification that produces it.

CFR-437-003 · Exemption request for Core Set population reporting

Citation: 42 CFR 437.15(a)(6)

Determination: GAP-DETERMINED

Not covered	The entire provision: no held document addresses an exemption request for Core Set population reporting (42 CFR 437.15(a)(6)).
Owner	Division of Health Benefits (DHB)
Action it owns	State whether NC has requested or needs a Core Set population reporting exemption and produce any request filed.

CFR-437-004 · State plan provisions on Core Set reporting and health home provider reporting

Citation: 42 CFR 437.20(a)

Determination: GAP-DETERMINED

Not covered	The entire provision: the state plan carries no Core Set reporting or health home provider reporting provision as 42 CFR 437.20(a) contemplates.

Owner	Division of Health Benefits (DHB)
Action it owns	Produce the plan pages or SPA that carry Core Set reporting, or state that none has been submitted.

Part 438 · 2 determinations

CFR-438-033 · Remedy plans to improve access

Citation: 42 CFR 438.207(f)

Determination: GAP-DETERMINED

Not covered	No NC evidence of a remedy plan under 438.207(f) was found. The record shows the predicate conditions (published network results with plans below standard in multiple cells, H-062 pp. 10-11) and a general corrective machinery (Notices of Deficiency and corrective action plans for compliance deficiencies, H-122 p. 64), but no remedy plan required of a plan to improve access to a provider type, and no access CAP tied to the published shortfalls.
Owner	Division of Health Benefits (DHB)
Action it owns	Require and publish remedy plans where a plan misses a network adequacy standard, starting with the shortfalls in the April 2025 results.

CFR-438-047 · EQRO contract CMS approval before claiming 75% FFP

Citation: 42 CFR 438.370(c)

Determination: GAP-DETERMINED

Not covered	No NC evidence that the EQRO contract was submitted to and approved by CMS before claiming the 75 percent FFP rate under 438.370(c), and no evidence of the rate at which NC claims EQRO costs, was found in the held public corpus.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the CMS approval of the EQRO contract and the FFP rate claimed for EQRO activities.

Part 441 · 15 determinations

CFR-441-001 · FFP continuation after provider agreement termination

Citation: 42 CFR 441.11

Determination: GAP-DETERMINED

Not covered	No governing document producible: no held NC document states the 441.11 rule that FFP remains available for up to 30 days after a provider agreement terminates or expires where the state made a good faith effort to transfer beneficiaries to other qualified providers. Provider termination and sanction language was found in the plan (section 4.30) and in 10A NCAC 22F, but none of it carries the 30-day FFP continuation or the transfer-effort condition.

Owner	Division of Health Benefits (DHB)
Action it owns	State the 441.11 continuation rule in the provider enrollment or provider agreement framework, or file termination records showing the 30-day wind-down and transfer efforts for terminations in the period.

CFR-441-004 · Home health agency surety bonds - FFP prohibition

Citation: 42 CFR 441.16

Determination: GAP-DETERMINED

Not covered	No governing document producible: no held NC document states that a home health agency must post a surety bond as a condition of participation, or that FFP is unavailable for services of an agency that has not posted the required bond. The plan home health pages and the home health SPA are silent on surety bonds.
Owner	Division of Health Benefits (DHB)
Action it owns	File HHA enrollment records showing surety bonds on file, or state the bond requirement in the home health coverage policy.

CFR-441-018 · EPSDT timeliness - 6-month outer limit for treatment

Citation: 42 CFR 441.56(e)

Determination: GAP-DETERMINED

Not covered	No governing document producible: no held NC document states the 441.56(e) timeliness standard, that diagnosis and treatment be initiated generally within 6 months of a screening request. The Health Check Guide requires referral and follow-up but sets no outer time limit; the provider manual reminder program tracks due dates against the periodicity schedule, not a screening-to-treatment interval.
Owner	Division of Health Benefits (DHB)
Action it owns	State the EPSDT timeliness standard, including the 6-month outer limit, in the Health Check Guide or EPSDT policy.

CFR-441-026 · IMD 65+ - alternate plans of care

Citation: 42 CFR 441.103

Determination: GAP-DETERMINED

Not covered	No governing document producible: no held NC document addresses alternate plans of care for individuals 65 or over who would otherwise require IMD care, the Subpart C alternative under which care is furnished in alternative settings under an alternate plan when IMD care is not the appropriate setting.
Owner	Division of Health Benefits (DHB)
Action it owns	State whether NC uses alternate plans of care under 441.103 and, if so, file the governing procedure.

CFR-441-027 · Comprehensive mental health program - annual report

Citation: 42 CFR 441.106

Determination: GAP-DETERMINED

Not covered	No governing document producible: no held NC document is, or references, the annual progress report on a comprehensive mental health program for the aged that 441.106 requires be filed with CMS, and no held document shows such a report filed for any year in the period.
Owner	Division of Mental Health, Developmental Disabilities and Substance Use Services
Action it owns	File the most recent 441.106 annual report, or record whether the duty is discharged through another CMS report.

CFR-441-033 · Maintenance of effort - under-21 psychiatric FFP

Citation: 42 CFR 441.180-441.182

Determination: GAP-DETERMINED

Not covered	No governing document producible: no held NC document addresses the maintenance of effort conditions on FFP for inpatient psychiatric services for individuals under 21 (the nonfederal expenditure comparison of 441.181), the quarterly computations, or the cost data submissions of 441.182.
Owner	Division of Health Benefits (DHB)
Action it owns	File the maintenance of effort computations and cost data submissions for the under-21 psychiatric benefit, or record the basis on which the condition is met.

CFR-441-034 · PRTF emergency preparedness

Citation: 42 CFR 441.184

Determination: GAP-DETERMINED

Not covered	No governing document producible: no held NC document states a PRTF emergency plan, policies and procedures, communication plan, or the biennial review, training and exercise duties of 441.184. The under-21 service definition incorporates 42 CFR Part 483 Subpart G for facility requirements (H-018) but does not carry the emergency preparedness elements, which sit at 483.73 as applied to PRTFs by 441.184.
Owner	Division of Health Benefits (DHB)
Action it owns	File PRTF emergency preparedness documentation or the survey protocol showing 483.73 review for PRTFs.

CFR-441-037 · Abortion documentation - 3-year retention

Citation: 42 CFR 441.208

Determination: GAP-DETERMINED

Not covered	No governing document producible: the newly acquired abortion policy was read in full and states no retention period for abortion certifications and documentation. Its only retention passage is the general compliance duty in section 7.1(a) to comply with applicable agreements, laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements, with no period stated. No other held document states a 3-year retention rule for abortion certifications and documentation.
Owner	Division of Health Benefits (DHB)
Action it owns	File the retention schedule entry covering abortion certifications, or state the 3-year rule in the abortion clinical coverage policy (CCP 1E-2 as printed on its face).

CFR-441-053 · 1915(c) waiver termination - 30-day notices

Citation: 42 CFR 441.307

Determination: GAP-DETERMINED

Not covered	No governing document producible: no held NC document is, or references, a waiver termination notice to CMS or to beneficiaries under 441.307. No NC 1915(c) waiver termination in the period is documented in the corpus either, so neither the notice duty's performance nor a negative record is held.
Owner	Division of Health Benefits (DHB)
Action it owns	Record the negative for the period (no 1915(c) waiver terminated), or file any termination notices given.

CFR-441-055 · Incident management system assessment report - every 24 months

Citation: 42 CFR 441.311(b)(1)

Determination: GAP-DETERMINED

Not covered	No governing document producible: no held NC document is, or references, an incident management system assessment report submitted to CMS under 441.311(b)(1). The waiver applications document the incident systems themselves (NL-15 Appendix G; H-041 IRIS reporting), but a system description in a waiver application is not the periodic assessment report this provision requires.
Owner	Division of Health Benefits (DHB)
Action it owns	File the most recent incident management system assessment report submitted to CMS, or record the first report's due date and owner.

CFR-441-056 · Critical incident annual report

Citation: 42 CFR 441.311(b)(2)

Determination: GAP-DETERMINED

Not covered	No governing document producible: no held NC document is, or references, an annual critical incident report to CMS under 441.311(b)(2) carrying the investigation, completion and corrective action percentages the provision requires. Incident data flows documented in the waiver applications run to the state and its plans (quarterly incident reports in H-041), not to CMS in this form.
Owner	Division of Health Benefits (DHB)
Action it owns	File the annual critical incident report submitted to CMS, or record its due date and owner.

CFR-441-057 · Person-centered planning annual report

Citation: 42 CFR 441.311(b)(3)

Determination: GAP-DETERMINED

Not covered	No governing document producible: no held NC document is, or references, an annual person-centered planning report to CMS under 441.311(b)(3). Person-centered planning is documented inside the waiver applications and the 1915(i) SPA pages, but no periodic report of planning metrics or waiver impact data to CMS is held.
Owner	Division of Health Benefits (DHB)
Action it owns	File the annual person-centered planning report submitted to CMS, or record its due date and owner.

CFR-441-058 · HCBS Quality Measure Set - biennial reporting and performance targets

Citation: 42 CFR 441.311(c), 441.312

Determination: GAP-DETERMINED

Not covered	No governing document producible: no held NC document is, or references, a biennial HCBS Quality Measure Set submission to CMS under 441.311(c) and 441.312, or state performance targets and quality improvement strategies set under that framework. NC quality documents that are held (the 2023 Quality Strategy, H-122; the AMH measure set, H-125; the EQR technical report, NL-05) are managed care quality instruments and do not present the HCBS Quality Measure Set reporting.
Owner	Division of Health Benefits (DHB)
Action it owns	File the HCBS Quality Measure Set submission and the state's performance targets, or record the first submission's due date.

CFR-441-059 · HCBS access reporting - waiting lists and service access

Citation: 42 CFR 441.311(d)

Determination: GAP-DETERMINED

Not covered	No governing document producible: no held NC document is, or references, an annual access report to CMS under 441.311(d) covering waiting list maintenance, counts and average wait times, approval-to-service-start intervals, or the share of authorized hours provided. A waiting list figure appears in the CAP/DA application only inside a public comment urging higher participant limits (1,816 individuals, per the commenter), which is not a state access report and was not relied on.
Owner	Division of Health Benefits (DHB)
Action it owns	File the annual HCBS access report submitted to CMS, or record its due date and the waiting list data owner.

CFR-441-060 · Payment adequacy annual reporting

Citation: 42 CFR 441.311(e)

Determination: GAP-DETERMINED

Not covered	No governing document producible: no held NC document is, or references, an annual payment adequacy report to CMS under 441.311(e) carrying provider compensation data for homemaker, home health aide or personal care services. The register record itself notes this is a new requirement (89 FR 40866, May 10, 2024) with evidence to come; no submission is in the corpus.
Owner	Division of Health Benefits (DHB)
Action it owns	File the payment adequacy submission to CMS when made, and record the data collection owner now.

Part 442 · 1 determinations

CFR-442-008 · Payment transparency reporting - NF and ICF/IID

Citation: 42 CFR 442.43

Determination: GAP-DETERMINED

Not covered	No governing document producible: no held NC document is, or references, a facility-level payment transparency submission to CMS under 442.43 (the share of Medicaid payments spent on compensation for direct care workers and support staff, reported by facility for nursing facilities and ICF/IIDs). The register record identifies this as a new requirement from the May 2024 rule (89 FR 40870) with evidence to come; no submission, data collection instrument, or due date statement is in the corpus.
Owner	Division of Health Benefits (DHB)
Action it owns	Record the first 442.43 submission's due date and data owner, and file the submission when made.

Part 447 · 7 determinations

CFR-447-005 · Withholding Federal share to recover Medicare overpayments

Citation: 42 CFR 447.30

Determination: GAP-DETERMINED

Not covered	The whole requirement: any NC document addressing CMS-ordered reduction of Medicaid payments to recover a Medicare overpayment.
Owner	Division of Health Benefits (DHB)
Action it owns	Record the agency procedure for a CMS withholding order under 447.30, or confirm in writing that no such order has been received and where the procedure would sit.

CFR-447-006 · State request to withhold Medicare for Medicaid overpayments

Citation: 42 CFR 447.31

Determination: GAP-DETERMINED

Not covered	The whole requirement: the 447.31 request procedure, its notice to the provider, and any NC instance of using it.
Owner	Division of Health Benefits (DHB)
Action it owns	Record whether NC has ever made a 447.31 request and, if the tool is to remain available, publish the internal procedure and notice the provider would receive.

CFR-447-029 · HCBS interested-parties advisory group

Citation: 42 CFR 447.203

Determination: GAP-DETERMINED

Not covered	The whole requirement: establishment of the advisory group, its composition, and its meeting and rate review activity.
Owner	Division of Health Benefits (DHB)
Action it owns	Establish the advisory group, or identify the existing body that performs its function and publish its charge, membership and meeting record.

CFR-447-032 · Corrective action plan for access deficiencies

Citation: 42 CFR 447.203

Determination: GAP-DETERMINED

Not covered	The whole requirement as an evidenced performance: a corrective action plan with specific steps and timelines, tied to an identified access deficiency.
Owner	Division of Health Benefits (DHB)
Action it owns	When the next access analysis identifies a deficiency, file the corrective action plan with CMS and publish it with the analysis that triggered it.

CFR-447-057 · Remit Federal share of increased rebate savings

Citation: 42 CFR 447.509

Determination: GAP-DETERMINED

Not covered	The whole requirement: remittance, via the Federal offset of rebates, of the savings from the increased rebate percentages.
Owner	Division of Health Benefits (DHB)
Action it owns	Record the claiming treatment of the increased rebate savings in the pharmacy financial procedures, or point to the CMS-64 line where the offset appears.

CFR-447-061 · Certify drug data submissions

Citation: 42 CFR 447.511

Determination: GAP-DETERMINED

Not covered	The whole requirement: certification of each quarterly drug utilization submission by an authorized official.
Owner	Division of Health Benefits (DHB)
Action it owns	Add the certification step to the documented quarterly submission procedure, naming the certifying official and the delegation, if any.

CFR-447-065 · Annual/triennial drug payment findings and assurances

Citation: 42 CFR 447.518

Determination: GAP-DETERMINED

Not covered	The whole requirement: the periodic and change triggered findings and satisfactory assurances on drug payment levels.
Owner	Division of Health Benefits (DHB)
Action it owns	Make and file the findings and assurances at the next significant drug payment change, and place the document in the public SPA record.

Part 455 · 1 determinations

CFR-455-009 · Disclosure of affiliations with excluded/problematic providers

Citation: 42 CFR 455.107

Determination: GAP-DETERMINED

Not covered	The entire provision: no held document addresses disclosure of affiliations under 42 CFR 455.107 at enrollment, revalidation or change reporting.
Owner	Division of Health Benefits (DHB)

Action it owns	Produce the NCTracks affiliation disclosure question set or enrollment instruction carrying 455.107.

Part 456 · 4 determinations

CFR-456-002 · Written criteria for evaluating appropriateness and quality

Citation: 42 CFR 456.5

Determination: GAP-DETERMINED

Not covered	The entire provision: the written reviewer criteria set under 42 CFR 456.5 is not in the held evidence.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the written criteria set used in utilization and quality review, or the review contractor's criteria manual.

CFR-456-003 · Interagency agreement for professional medical review

Citation: 42 CFR 456.6

Determination: GAP-DETERMINED

Not covered	The entire provision: no held document carries an interagency or equivalent agreement for professional medical review under 42 CFR 456.6.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce any agreement under which professional medical review is performed for the agency, or state that none is in place.

CFR-456-017 · Remote facility variances from UR time requirements

Citation: 42 CFR 456.520-456.525

Determination: GAP-DETERMINED

Not covered	The entire provision: no held document addresses a variance for a remote facility from UR timing requirements (42 CFR 456.520-456.525).
Owner	Division of Health Benefits (DHB)
Action it owns	State whether any NC facility holds a remote facility variance from UR time requirements and produce it if so.

CFR-456-019 · Quarterly satisfactory showing of effective institutional UR

Citation: 42 CFR 456.652, 456.654

Determination: GAP-DETERMINED

Not covered	The entire provision: no held document addresses the quarterly satisfactory showing (42 CFR 456.652 and 456.654).

Owner	Division of Health Benefits (DHB)
Action it owns	Produce a quarterly satisfactory showing submission or state whether CMS has waived or discontinued the requirement for NC.

Part 457 · 5 determinations

CFR-457-014 · Audit exceptions, concurrence, appeal, FFP adjustment

Citation: 42 CFR 457.202

Determination: GAP-DETERMINED

Not covered	The whole 457.202 procedure as a Title XXI element: State concurrence in audit exceptions, submission of facts supporting clearance, appeal, and FFP adjustment for unresolved exceptions.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish or file the Title XXI audit exception procedure and any audit exception dispositions for the CHIP program.

CFR-457-015 · Corrective action evidence within 30 days of preliminary noncompliance notice

Citation: 42 CFR 457.204

Determination: GAP-DETERMINED

Not covered	The 457.204 corrective action evidence procedure and any instance record: evidence of action taken, being taken, or to be taken within 30 days of a preliminary noncompliance notice.
Owner	Division of Health Benefits (DHB)
Action it owns	File the CHIP corrective action response procedure and any preliminary noncompliance correspondence for the Title XXI program.

CFR-457-016 · Refund FFP for uncashed (>180 days) and voided checks

Citation: 42 CFR 457.216

Determination: GAP-DETERMINED

Not covered	The 457.216 refund procedure: identification of uncashed (over 180 days) and voided checks and refund of the Federal share for the CHIP program.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the CHIP uncashed and voided check refund procedure and the most recent refund amounts claimed on the CMS-21.

CFR-457-020 · Approved cost allocation plan on file

Citation: 42 CFR 457.228

Determination: GAP-DETERMINED

Not covered	The approved cost allocation plan itself, or any record that one is on file with the Division of Cost Allocation for Title XXI administrative costs.
Owner	NCDHHS Secretary
Action it owns	File or publish the approved cost allocation plan covering Title XXI administrative cost allocation.

CFR-457-054 · Patient Access API for CHIP beneficiaries

Citation: 42 CFR 457.730

Determination: GAP-DETERMINED

Not covered	The whole 457.730 Patient Access API for the CHIP program: implementation, accessible content classes, and technical requirements.
Owner	Division of Health Benefits (DHB)
Action it owns	Publish the CHIP Patient Access API documentation (endpoint, developer resources, accessible content) or state how the Medicaid API of record covers Title XXI beneficiaries.

Part 460 · 1 determinations

CFR-460-004 · State enforcement: CAP, payment withholding, termination of PACE agreement

Citation: 42 CFR 460.48; 460.50

Determination: GAP-DETERMINED

Not covered	The entire provision: corrective action, sanctions, payment withholding and termination of the PACE agreement (42 CFR 460.48 and 460.50) are not addressed in held evidence.
Owner	Division of Health Benefits (DHB)
Action it owns	Produce the enforcement article of a NC PACE program agreement or the PACE monitoring and sanctions procedure.

State register rows · 1 determinations

NC-001 · Medicaid Bulletin issuance and Monthly Bulletin Digest compilation

Citation: NC Medicaid Bulletin Digests page; bulletin renovation note (articles added weekly in blog format)

Determination: GAP-DETERMINED

Not covered	The entire row: bulletin issuance procedure and Monthly Bulletin Digest compilation are not documented in held evidence.

Owner	Division of Health Benefits (DHB)
Action it owns	Produce a Monthly Bulletin Digest issue or the bulletin issuance procedure page.

CLOSING SECTION · THE COMPLETELY UNVERIFIED

Determinations no public evidence has been read against at all

0	183 of 196	13	2
completely unverified determinations in the register of 501	inventory rows collected and reconciled · 93.4 percent	true gap documents, listed in Section 3	documents landed at the closeout of October 30, 2026: H-024 and H-035

The completely unverified count for North Carolina is 0. Every one of the 501 determinations in the register was graded against public evidence. That evidence was read at the place cited. Some determinations were determined on the closed reasons the register prints. All of that grading work happened at the October 27, 2026 cure pass. No determination stands ungraded. None is carried as unverified.

North Carolina is cured as of October 30, 2026. Two documents held the state open at the cure pass. Both documents were collected at the closeout of October 30, 2026. No collection item stands open. The two documents and how they landed are stated in full below.

H-024 · the 1115 Special Terms and Conditions, collected at the closeout

Four routes were worked in order. Direct download from medicaid.gov was refused. No Internet Archive snapshot exists for the address. No state agency copy exists to take. The document was then read in full at its live address through the house browser lane, the remedy of record this house used during the October 27, 2026 cure. The document carries the CMS approval letter of September 25, 2026 to Melanie Bush. It names demonstration project 11-W-00313/4. Its cover records the Whole Family Transition to Care conforming change under section 71109, adding STC 4.3.b(iii). The change runs from October 1, 2026 through December 9, 2029. The full fetched text was searched for every citation to Title 42 and Title 45 of the Code of Federal Regulations. Every match was read in place. The row is classed MAPPED-TEXT. One limit rides with the class. The browser lane returns text without a file, so no source file is held for this document. The row's hash is the hash of its saved read evidence note, and the row says so.

H-035 · the CAP/DA Appendix K approval NC.0132.R07.10, collected at the closeout

The same four routes were worked in the same order. Direct download was refused. No Internet Archive snapshot exists for the address. The State posts the R07.09 Appendix K for CAP/DA. It does not post the R07.10 amendment this document names, so no agency copy exists to take. The document was read in full at its live address through the house browser lane. It is the Appendix K for CAP/DA, control number NC.0132.R07.10. It covers the Hurricane Helene response. Jay Ludlam signed it on June 20, 2025. It runs from September 25, 2024 to June 30, 2025. The full fetched text was read end to end. A search for Code of Federal Regulations citations returns zero matches. The row is classed REVIEWED-NO-CFR-CITATION-FOUND. The same limit rides with this class. No source file is held, and the row's hash is the hash of its saved read evidence note.

The flag count and the qualifications, closed at the closeout

> The NC-5 conflict flag count is closed at 14 rows. The determinations file of record carries the flag on exactly 14 rows. The built register carries it on the same 14 rows. All 14 sit in Part 457. The count of 11 in the October 27, 2026 cure report prose was an undercount. The register governs. Three qualifications stood open at the second seat. All three are dispositioned. CFR-433-021 is closed, with its basis completed to carry the H-131 OIG report mention. CFR-457-046 rides as a named qualification, with its basis verified complete and pinpointed, and it is the first retest in the next audit rotation. CFR-441-021 is confirmed and closed, on the methods text read directly from the page image.

Closing note

The sections divide the open register three ways. A fourth statement covers what is not open at all. Section 1 holds 19 conflicts. Of those conflicts, 16 come from the register of record. The other 3 were found in the substance of the record. Each entry names the determinations it holds back. Those names are counted from the flags and faces of the determinations file. Section 2 holds all 274 Partial determinations. They are grouped under 49 public documents. Section 3 holds 13 documents missing outright. All 71 gap-determined determinations are accounted for exactly once in that section. Three sit under their documents. The other 68 sit in the closing grouped list. The closing section holds 0 completely unverified determinations. It also holds the account of the two documents that closed the cure, H-024 and H-035, collected on October 30, 2026.

The register's 141 Verified determinations are not listed in Sections 1 to 3. The public record closes them. The governing document was read at the place cited. It carries the requirement as written. A Verified determination can still be named in a conflict. It can also be named under a missing document. In those cases it prints there. It also prints in the appendix. Two further groups are not listed in those sections. The first group is the 10 determinations determined not applicable. For those determinations the requirement does not reach this program. The second group is the 5 Prospective determinations, dated ahead. All 501 determinations stand in the register of record. Their full bases stand there with them.

Every document in this document passed the same test. Every determination passed the same test. Each one belongs in the public record. Internal agency material that was never public does not appear here.

Built entirely from public information. Agentic Armor LLC.

How to use this document

Read the front list first for the missing documents in one view. Use Section 1 to see where the record argues with itself. Read that section before relying on any single document in the record. Use Section 2 as a work list by document. Each group is one public document. That document is the one to supply the missing elements for. Each card under a group names the element to supply. It names the level that owns the element. It names the action that level owns. Use Section 3 as an acquisition list. Each entry is one document to get. The closing grouped list is the full accounting of the gap-determined register behind it. Use the appendix to find any determination by its register number. The appendix then takes you to its page. Figures carry the October 27, 2026 cure pass date. The closing figures carry the October 30, 2026 closeout date. A later posting can change a grade at the next pass.

APPENDIX · CITATION INDEX

Every determination in the register, with its section and page in this document

This appendix lists all 501 determinations, in register order. The Section column names the place the determination principally appears in this document. A determination held back by a conflict sits in Section 1, unless it is graded Partial or gap-determined. Every Partial determination sits in Section 2. Every gap-determined determination sits in Section 3. Determinations named under a missing document also sit in Section 3. The appendix itself is the place for determinations the public record closes. It is also the place for determinations determined elsewhere. Those determinations are not listed in Sections 1 to 3. The Page column gives the page of that appearance in the finished document.

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CFR-430-004	42 CFR 430.30	Partial	Section 2 · Partial compliance	74
CFR-430-005	42 CFR 430.32	Partial	Section 2 · Partial compliance	21
CFR-430-006	42 CFR 430.33	Partial	Section 2 · Partial compliance	97
CFR-430-007	42 CFR 430.40	GAP-DETERMINED	Section 3 · Missing outright	124
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CFR-430-009	42 CFR 430.48	GAP-DETERMINED	Section 3 · Missing outright	125
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CFR-457-020	42 CFR 457.228	GAP-DETERMINED	Section 3 · Missing outright	143
CFR-457-021	42 CFR 457.232	Partial	Section 2 · Partial compliance	53
CFR-457-022	42 CFR 457.236	Partial	Section 2 · Partial compliance	53
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CFR-457-024	42 CFR 457.305	Partial	Section 2 · Partial compliance	54
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CFR-457-052	42 CFR 457.710	Verified	Appendix only	163
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CFR-457-054	42 CFR 457.730	GAP-DETERMINED	Section 3 · Missing outright	143
CFR-457-055	42 CFR 457.731	Prospective	Appendix only	163
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CFR-457-057	42 CFR 457.750	Verified	Appendix only	163
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CFR-457-059	42 CFR 457.770	Partial	Section 2 · Partial compliance	60
CFR-457-060	42 CFR 457.732	Partial	Section 2 · Partial compliance	60
CFR-457-061	42 CFR 457.805	Partial	Section 2 · Partial compliance	61
CFR-457-062	42 CFR 457.810	N-A-DETERMINED	Appendix only	163
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CFR-457-064	42 CFR 457.915; 457.925; 457.930	Partial	Section 2 · Partial compliance	61
CFR-457-065	42 CFR 457.935	Verified	Appendix only	163
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CFR-457-076	42 CFR 457.1240	Partial	Section 2 · Partial compliance	64
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CFR-457-078	42 CFR 457.1260	Verified	Section 1 · Conflicting information	12
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CFR-460-002	42 CFR 460.30	Verified	Appendix only	164
CFR-460-003	42 CFR 460.32	Partial	Section 2 · Partial compliance	96
CFR-460-004	42 CFR 460.48; 460.50	GAP-DETERMINED	Section 3 · Missing outright	143
CFR-162-001	45 CFR 162.412	GAP-DETERMINED	Section 3 · Missing outright	124
CFR-162-002	45 CFR 162.925(a)	GAP-DETERMINED	Section 3 · Missing outright	124
CFR-162-003	45 CFR 162 Subparts K-R (162.1102, 162.1202, 162.1302, 162.1402, 162.1502, 162.1602, 162.1702, 162.1802)	Partial	Section 2 · Partial compliance	113
CFR-162-004	45 CFR 162.1002 (Subpart J)	GAP-DETERMINED	Section 3 · Missing outright	124
NC-001	NC Medicaid Bulletin Digests page; bulletin renovation note (articles added weekly in blog format)	GAP-DETERMINED	Section 3 · Missing outright	143
NC-002	Medicaid State Plan Public Notices page ('Ten-Day Posting for Submission to CMS')	Verified	Appendix only	164
NC-003	N.C.G.S. §108A-54.2	Verified	Appendix only	164
NC-004	NCTracks Provider Recredentialing pages; NC Medicaid reverification notices (42 CFR 455.414 as cited by NC)	Verified	Appendix only	164
NC-005	N.C.G.S. §108C-2.1(a)-(b) (as quoted in the NCTracks recredentialing FAQ)	Verified	Appendix only	164

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NC-007	Medicaid Annual Reports and Tables page (Finance Section contact)	Partial	Section 2 · Partial compliance	114
NC-008	Session Law 2023-134, §9E.20	Verified	Appendix only	165
NC-009	N.C.G.S. §108D-65; PHP Contract MLR provisions	Partial	Section 2 · Partial compliance	87
NC-010	Quality Management and Improvement page (EQR Technical Reports, 2020-2021 through 2024-2025)	Verified	Appendix only	165
NC-011	NC Medicaid 1115 Demonstration (11-W-00313/4) monitoring, as published on the Quality page	Partial	Section 2 · Partial compliance	77
NC-012	NC Medicaid Managed Care Quality Strategy (first published 2018; updated 2023); Annual Quality Report	Partial	Section 2 · Partial compliance	91

PART 2 OF 7

Ishikawa Set

11 pages

PART 2

NC-Ishikawa-Set-2026-10-31.pdf

This part holds four cause and effect diagrams. Each diagram takes up one live causal question the review left open. The questions cover the absent executed contracts. They cover the cost sharing contradiction. They cover the unpublished 2025 Quality Strategy. They cover the 2025 rate cut and its reversal, which carry no access analysis. Each diagram prints in the house Ishikawa form. Each one rests on the findings of record in the Cure Report. Each one also rests on the graded register.

Status of record, October 31, 2026. 183 of 196 documents stand collected and reconciled. That count is 93.4 percent. The register stands fully graded. North Carolina is cured as of October 30, 2026. The two documents that closed the cure are named on the cover in full. The How this binder works section names them in full as well.

The pages that follow are the same pages as the standalone download of the same name and date.

NC · Ishikawa Set

Cause-and-effect analysis for North Carolina's four live causal questions

Document control: NC · Ishikawa Set · October 31, 2026 · Edition: V2 (reissued on the cured record; the four diagrams are unchanged from V1 of October 27, 2026). Built in the house Ishikawa form of the ORP Ishikawa Set of the same date, on the findings of record in the NC Cure Report of October 27, 2026 and the cured determinations register (the determinations file of record for October 27, 2026).

Status, stated where status belongs: North Carolina is **cured as of October 30, 2026**. The cure pass is complete and the register is fully graded (501 entries, zero Unverified). The document axis stands at 183 of 196 collected and reconciled, 93.4 percent, with 13 true gaps. The last two documents, H-024 (the 1115 Special Terms and Conditions, WFTC overlay version) and H-035 (the CAP/DA Appendix K approval NC.0132.R07.10), were collected at the closeout of October 30, 2026. Each one was read in full at its live address at medicaid.gov.

How these diagrams are built (the discipline of record). The effect is stated plainly, with its dates, on the diagram's face. Every cause is labeled **EVIDENCED** (named in a record, source cited in the text) or **HYPOTHESIZED** (plausible, to be confirmed). The two are never blended, in words or in line style: a solid twig for evidenced, a dashed twig for hypothesized, so the diagram survives grayscale and plain copying. In this set every cause is EVIDENCED: each one rests on a named cure finding, a named gap ID, or named register rows, and no cause is drawn from general knowledge of NC Medicaid. The dashed style therefore appears in each diagram's legend only, marked as unused in this set. Each bone ends in the countermeasure that kills that family, or says plainly that none exists yet. A diagram is retired when the effect re-measures clean; the re-measurement prints on it and the retired diagram is filed as a receipt. All figures are aggregate. No provider or member identifiers appear anywhere in this set, and no provider PII or PHI appears in any diagram or note.

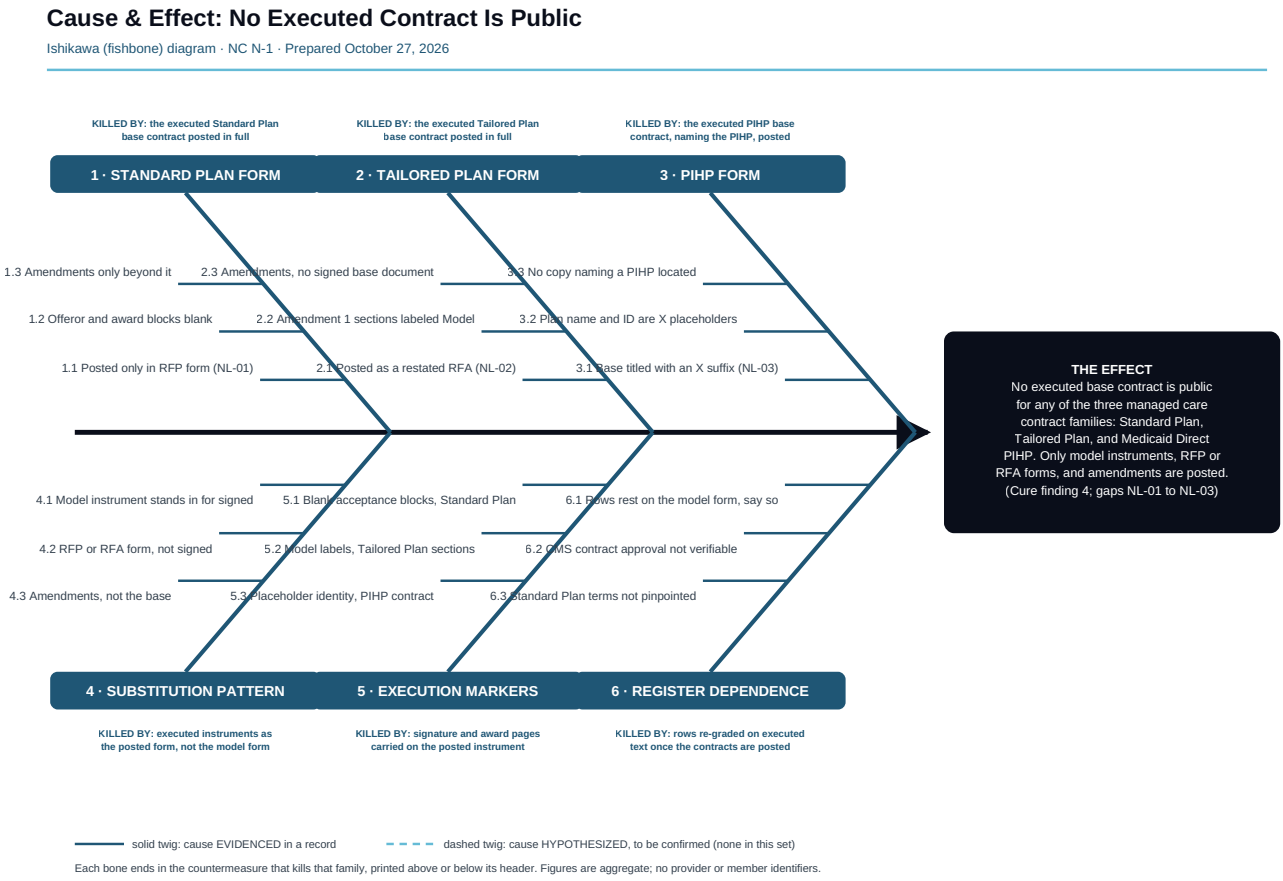
Organization, as the record carries it. The agency is the NC Department of Health and Human Services; the Medicaid agency of record is the Division of Health Benefits (DHB), whose homes of record in the cure corpus include DHB Managed Care, DHB Policy, DHB Finance, DHB Quality, DHB Provider Ops, and the Office of Compliance and Program Integrity. NCTracks is operated by GDIT. Plans are the Standard Plan PHPs and the Tailored Plans. Eligibility runs through county departments of social services and NC FAST. Fair hearings sit with the NC Office of Administrative Hearings. No role beyond that structure is used in this set.

The set answers the four causal questions the cure record carries:

- **N-1** · Why no executed base contract is public for any of NC's three managed care contract families.
- **N-2** · Why the governing record contradicts itself on cost-sharing amounts and cumulative maximums.
- **N-3** · Why the 2025 Quality Strategy is not on the page the bulletin says carries it.
- **N-4** · Why the October 2025 rate cut and its December 2025 reversal carry no access analysis in the public record.

N-1 · Why No Executed Base Contract Is Public for Any Managed Care Contract Family

The effect, on the face of the diagram. No executed base contract is public for any of North Carolina's three managed care contract families: the Standard Plan PHP contract, the Tailored Plan contract, and the Medicaid Direct PIHP contract. For all three alike, the state posts the model instrument, the RFP or RFA form, and the amendment series; no signed executed base contract is posted for any of the three. Source: NC Cure Report finding 4; document gaps NL-01, NL-02, and NL-03, each recorded as a true gap on a documented search (the collection record).



Bone	Cause	Label	Source
1 · Standard Plan form	1.1 The Standard Plan contract is posted only in RFP form: the Revised and Restated RFP (issued August 9, 2018, restated January 25, 2019) is labeled the contract, contract number 30-190029-DHB	EVIDENCED	Gap NL-01; search record
	1.2 The RFP's offeror and award acceptance blocks are blank	EVIDENCED	Gap NL-01
	1.3 Only an amendment series is posted beyond the RFP form	EVIDENCED	Gap NL-01; cure finding 4
2 · Tailored Plan form		EVIDENCED	Gap NL-02; search record

Bone	Cause	Label	Source
	2.1 The Tailored Plan contract is posted as the First Revised and Restated RFA (original RFA November 13, 2020), contract number 30-2020-052-DHB		
	2.2 Amendment 1 model sections (dated November 3, 2022) are labeled Model; Amendment 2 confirms Amendment 1 restated the contract in full, but no single signed executed base document is posted	EVIDENCED	Gap NL-02
	2.3 Later amendments are posted; the executed base is not	EVIDENCED	Gap NL-02; cure finding 4
3 · PIHP form	3.1 The posted Medicaid Direct PIHP base contract (386 pages) is titled Contract number 30-2022-007-DHB-X	EVIDENCED	Gap NL-03; search record
	3.2 The plan name and ID in the posted base are X placeholders; the document is the base instrument in model form, not an executed copy naming a PIHP	EVIDENCED	Gap NL-03
	3.3 No executed copy was located on the Health Plans page, in the posted contract document, or on a web search of the contract number	EVIDENCED	Gap NL-03
4 · Substitution pattern	4.1 Across all three families, the model instrument stands in for the signed contract	EVIDENCED	Cure finding 4
	4.2 Across all three families, the RFP or RFA form stands in for the signed contract	EVIDENCED	Cure finding 4; NL-01, NL-02
	4.3 Across all three families, the amendment series stands in for the base contract	EVIDENCED	Cure finding 4
5 · Execution markers	5.1 Blank acceptance blocks on the Standard Plan instrument	EVIDENCED	Gap NL-01
	5.2 Model labels on the Tailored Plan restated sections	EVIDENCED	Gap NL-02
	5.3 Placeholder identity on the PIHP instrument	EVIDENCED	Gap NL-03
6 · Register dependence	6.1 Every managed care row that rests on the model form says so on its face	EVIDENCED	Cure finding 4
	6.2 CMS approval of the contracts themselves under 42 CFR 438.3(a), and the capitation rates as executed in contract, cannot be verified from the held record	EVIDENCED	Register row CFR-438-001 (Partial)
	6.3 Standard contract provisions are pinpointed in model contracts and amendments, not executed contracts; the Standard Plan cost-sharing term in particular is not held	EVIDENCED	Register rows CFR-438-002 and CFR-447-014 (both Partial)

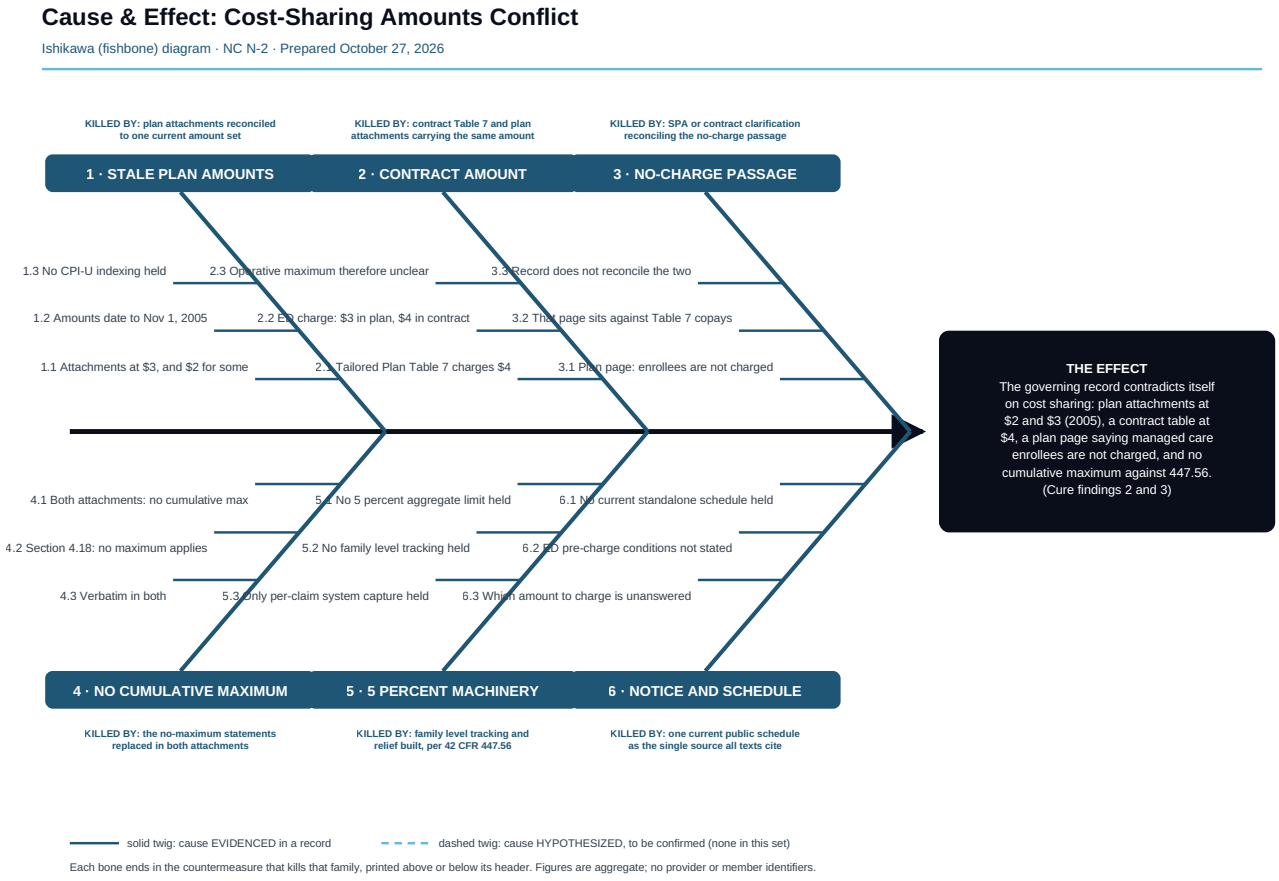
Countermeasures, one per bone. 1: Post the executed Standard Plan base contract, contract number 30-190029-DHB, in full. 2: Post the executed Tailored Plan base contract, contract number 30-2020-052-DHB, in full. 3: Post the executed Medicaid Direct PIHP base contract, naming the PIHP, in full. 4: Make the executed instrument the posted form for each family, so the model, the RFP or RFA form, and the amendments point to a signed base instead of replacing it. 5: Carry the signature and award pages on the posted instrument, so execution is visible on the

document's face. 6: Re-grade the rows that rest on the model form (CFR-438-001, CFR-438-002, CFR-447-014, and every row flagged for NL-01, NL-02, or NL-03) on the executed text at the next grading pass; the cure report names the executed contract instances in the post-cure upgrade queue for exactly this purpose.

Retirement condition. The diagram retires when an executed base contract for each of the three families is posted and held, gaps NL-01, NL-02, and NL-03 close on the document axis, and the dependent register rows re-grade on executed text; the three posting locations print on its face.

N-2 · Why the Cost-Sharing Record Contradicts Itself

The effect, on the face of the diagram. The governing record contradicts itself on cost sharing. The State Plan Attachments 4.18-A and 4.18-C carry 2005-era amounts ($2 and $3); the Tailored Plan contract Table 7 charges $4; a plan passage states managed care enrollees are not charged; and both attachments state verbatim that the state provides no cumulative maximums, against the 5 percent aggregate limit of 42 CFR 447.56. Sources: NC Cure Report findings 2 and 3; register rows CFR-447-012, CFR-447-013, CFR-447-014, CFR-447-017, CFR-447-021, and CFR-447-023.



Bone	Cause	Label	Source
1 · Stale plan amounts		EVIDENCED	Row CFR-447-012; H-001, State Plan

Bone	Cause	Label	Source
	1.1 Attachment 4.18-A (p.758) sets copayments of $3 for most services and $2 for chiropractic and optical services; Attachment 4.18-C (p.761) is the same for the medically needy		
	1.2 The attachment amounts date to TN 05-016, effective November 1, 2005	EVIDENCED	Row CFR-447-012
	1.3 No held passage carries annual CPI-U indexing of the maximum amounts, or any mechanism that updates the stated amounts against the federal maximums	EVIDENCED	Row CFR-447-012 (uncovered element)
2 · Contract amount	2.1 The Tailored Plan contract Table 7 (H-052) sets a current managed care copayment of $4 per service	EVIDENCED	Rows CFR-447-012 and CFR-447-014
	2.2 The non-emergency ED charge is $3 in Attachment 4.18-A and $4 in Table 7	EVIDENCED	Row CFR-447-017
	2.3 The operative maximum is therefore unclear on the record's face: the row asks which amount a provider is to charge today, and when the plan amounts were last updated	EVIDENCED	Row CFR-447-012 (open question)
3 · No-charge passage	3.1 Section 4.18(b)(2)(vii) (p.113) checks the box that managed care enrollees are not charged deductibles, coinsurance, or copayments	EVIDENCED	Row CFR-447-014
	3.2 That passage sits against the Tailored Plan Table 7 imposing copayments	EVIDENCED	Row CFR-447-014
	3.3 The held record does not reconcile the two	EVIDENCED	Row CFR-447-014 (uncovered element)
4 · No cumulative maximum	4.1 Attachment 4.18-A, section E (p.760), and Attachment 4.18-C, section E (p.763), both state, verbatim, "State policy does not provide for cumulative maximums"	EVIDENCED	Rows CFR-447-021 and CFR-447-013
	4.2 Section 4.18 (pp.115 and 120) records "Not applicable, there is no maximum"	EVIDENCED	Row CFR-447-021
	4.3 The specification rows grade Verified on the structure, with the amount conflict named on the neighboring rows' faces	EVIDENCED	Row CFR-447-013 (Verified); cure finding 2
5 · 5 percent machinery	5.1 No held passage carries the 5 percent of family income aggregate limit of 42 CFR 447.56	EVIDENCED	Row CFR-447-021 (Partial)
	5.2 No held passage carries family level tracking of accumulated premiums and cost sharing toward the limit, or relief when the limit is reached	EVIDENCED	Row CFR-447-021 (uncovered element)
	5.3 What is held is capture only: cost sharing is applied claim by claim and the claims processing system deducts the copayment amount (Attachment 4.18-A, section D, p.760), so the row grades Partial on the capture mechanism only, with the conflict as its central defect	EVIDENCED	Row CFR-447-021
6 · Notice and schedule	6.1 No held artifact is a current standalone public schedule of premiums and cost sharing in the form 42 CFR 447.57 requires;	EVIDENCED	Row CFR-447-023 (Partial)

Bone	Cause	Label	Source
	the plan attachment amounts are 2005 figures and conflict with the $4 contract copayment		
	6.2 The pre-imposition conditions of 42 CFR 447.54 for the non-emergency ED charge (medical screening first, a determination the condition is not an emergency, notice of the charge and of an accessible alternative provider, and referral) are not stated in any held passage	EVIDENCED	Row CFR-447-017 (uncovered element)
	6.3 The Standard Plan contract term honoring state plan cost sharing is not held at all, because the executed Standard Plan contract is not public (see N-1)	EVIDENCED	Row CFR-447-014; gap NL-01

Countermeasures, one per bone. 1: DHB reconciles the copayment amounts between the plan attachments and the plan contracts, and records how the amounts are checked against the indexed federal maximums (the action on row CFR-447-012). 2: Table 7 and the plan attachments are brought to one amount set, so the contract and the plan cannot charge differently. 3: DHB reconciles section 4.18(b)(2)(vii) with the Tailored Plan cost sharing table by SPA or contract clarification, and places the Standard Plan cost sharing term in the held record (the action on row CFR-447-014). 4: DHB brings the plan attachments into line with the current federal limit and replaces the no cumulative maximum statements (the action on row CFR-447-021). 5: The family level tracking and relief process is built, so the state can say how it would know when a family's premiums and copayments reach 5 percent of family income (the question on row CFR-447-021). 6: DHB publishes a current cost sharing schedule as a standalone public document and uses it as the single source the plan attachments and contracts point to (the action on row CFR-447-023), and publishes the conditions a hospital must meet before applying the non-emergency ED copayment (the action on row CFR-447-017).

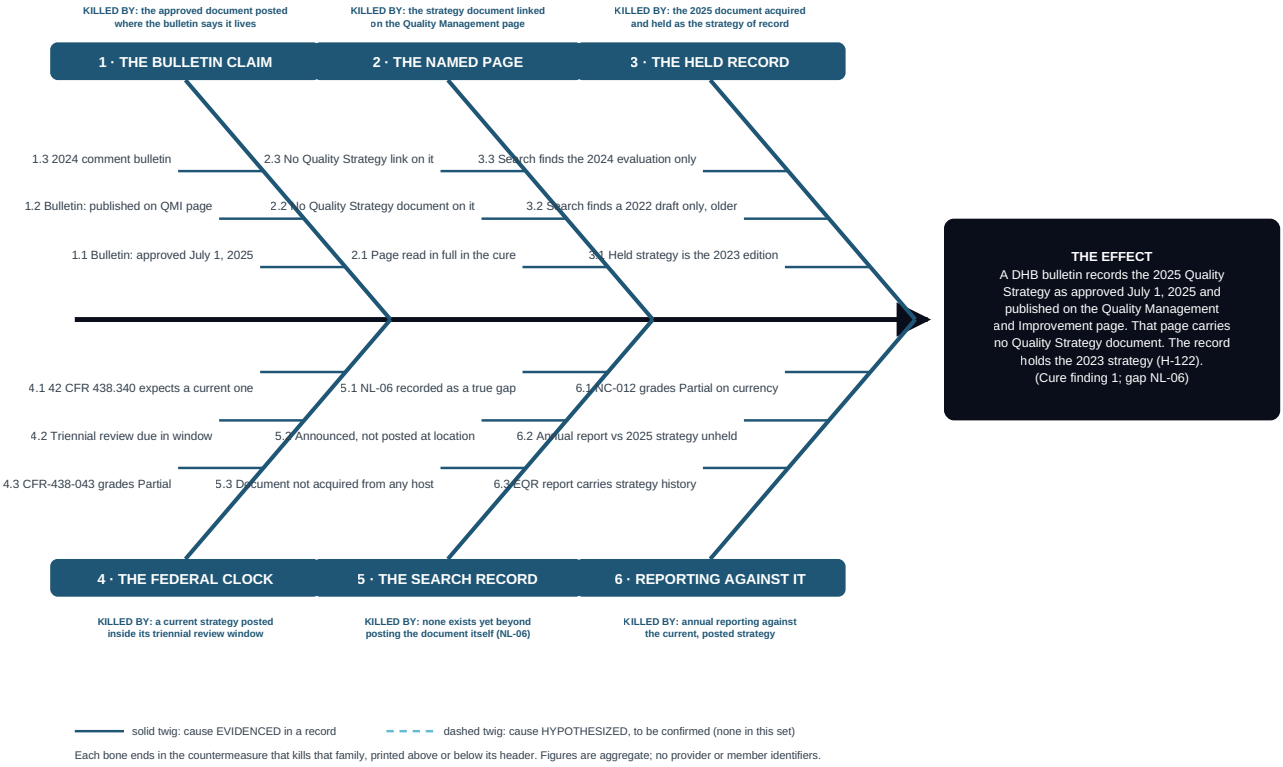
Retirement condition. The diagram retires when one current amount set matches across the plan attachments and the contracts, the no-charge passage and the no cumulative maximum statements are replaced on the plan's face, the 5 percent tracking and relief process is held, and rows CFR-447-012, CFR-447-014, CFR-447-017, CFR-447-021, and CFR-447-023 re-grade on the reconciled record; the reconciled amounts print on its face.

N-3 · Why the 2025 Quality Strategy Is Not on the Page That Claims It

The effect, on the face of the diagram. A Division of Health Benefits bulletin records that the 2025 NC Medicaid Managed Care Quality Strategy was approved July 1, 2025 and published on the Quality Management and Improvement page. The cure read that page in full: it carries no Quality Strategy document. The strategy the record holds is the 2023 document (H-122). Federal rules call for a current quality strategy (42 CFR 438.340), and its triennial review fell due in this window. Source: NC Cure Report finding 1; document gap NL-06; register rows CFR-438-043 and NC-012.

Cause & Effect: The 2025 Quality Strategy Is Missing

Ishikawa (fishbone) diagram · NC N-3 · Prepared October 27, 2026



Each bone ends in the countermeasure that kills that family, printed above or below its header. Figures are aggregate; no provider or member identifiers.

Bone	Cause	Label	Source
1 · The bulletin claim	1.1 A DHB bulletin records CMS approval of the 2025 Quality Strategy on July 1, 2025	EVIDENCED	Gap NL-06; row CFR-438-043
	1.2 The same bulletin states NCDHHS published the strategy on the Quality Management and Improvement page	EVIDENCED	Gap NL-06; cure finding 1
	1.3 The earlier record is a December 9, 2024 public comment bulletin, a step toward a strategy, not the published document	EVIDENCED	Gap NL-06 search record
2 · The named page	2.1 The cure read the Quality Management and Improvement page in full	EVIDENCED	Gap NL-06; cure finding 1
	2.2 The page carries no Quality Strategy document	EVIDENCED	Cure finding 1
	2.3 The page carries no Quality Strategy document link	EVIDENCED	Gap NL-06 (row CFR-438-043 flag)
3 · The held record	3.1 The strategy the record holds is the 2023 document (H-122), which states its own development and consultation steps at pp.1 and 17	EVIDENCED	Row CFR-438-043; H-122
	3.2 Searches surface only the 2023 strategy, a 2022 draft, the December 2024 comment bulletin, and the 2024 Quality Strategy Evaluation	EVIDENCED	Gap NL-06 search record
	3.3 The 2025 document could not be acquired from any host	EVIDENCED	

Bone	Cause	Label	Source
			Row CFR-438-043 (uncovered element)
4 · The federal clock	4.1 42 CFR 438.340 calls for a current managed care quality strategy	EVIDENCED	Cure finding 1; row CFR-438-043
	4.2 The strategy's triennial review fell due in this window	EVIDENCED	Cure finding 1
	4.3 Register row CFR-438-043 grades Partial, on currency and posting, not on the strategy's existence	EVIDENCED	Row CFR-438-043
5 · The search record	5.1 The document is recorded as a true gap, NL-06, one of the 13 true gaps on the document axis	EVIDENCED	Gap NL-06; cure finding 1
	5.2 The gap's own statement: the document is referenced and announced, not posted at the stated location	EVIDENCED	Gap NL-06 disposition note
	5.3 The searches behind the gap are documented: the named page read in full, the July 1, 2025 bulletin opened, and web searches for the 2025 strategy and its expected site location	EVIDENCED	Gap NL-06; search record
6 · Reporting against it	6.1 Register row NC-012 grades Partial: the strategy's history is carried through the 2023 update, and the current version is not producible from the public record	EVIDENCED	Row NC-012
	6.2 The Annual Quality Report against the current strategy is not held	EVIDENCED	Row NC-012 (uncovered element)
	6.3 The 2024-2025 EQR technical report (NL-05, acquired in the cure) carries a Quality Strategy section in its program overview, history rather than the current document	EVIDENCED	Row NC-012

Countermeasures, one per bone. 1: Post the approved strategy where the bulletin says it lives; the cure report names this as a finding the agency can act on directly (the action on row CFR-438-043: post the CMS-approved 2025 Quality Strategy at the location the bulletin named). 2: The Quality Management and Improvement page carries the document itself, linked under its own name. 3: The 2025 document enters the held record and becomes the strategy of record, superseding the 2023 edition (H-122) for currency purposes. 4: The posting closes the triennial window on the public record, not only in the approval record. 5: None exists yet beyond the posting itself: NL-06 stays a recorded true gap, with its owner and question on the register's face, until the document is posted. 6: Annual quality reporting is published against the current strategy, so row NC-012 can re-grade on a produced report.

Retirement condition. The diagram retires when the CMS-approved 2025 Quality Strategy document is posted on the Quality Management and Improvement page and held, gap NL-06 closes, and rows CFR-438-043 and NC-012 re-grade on the posted document; the posting location and date print on its face.

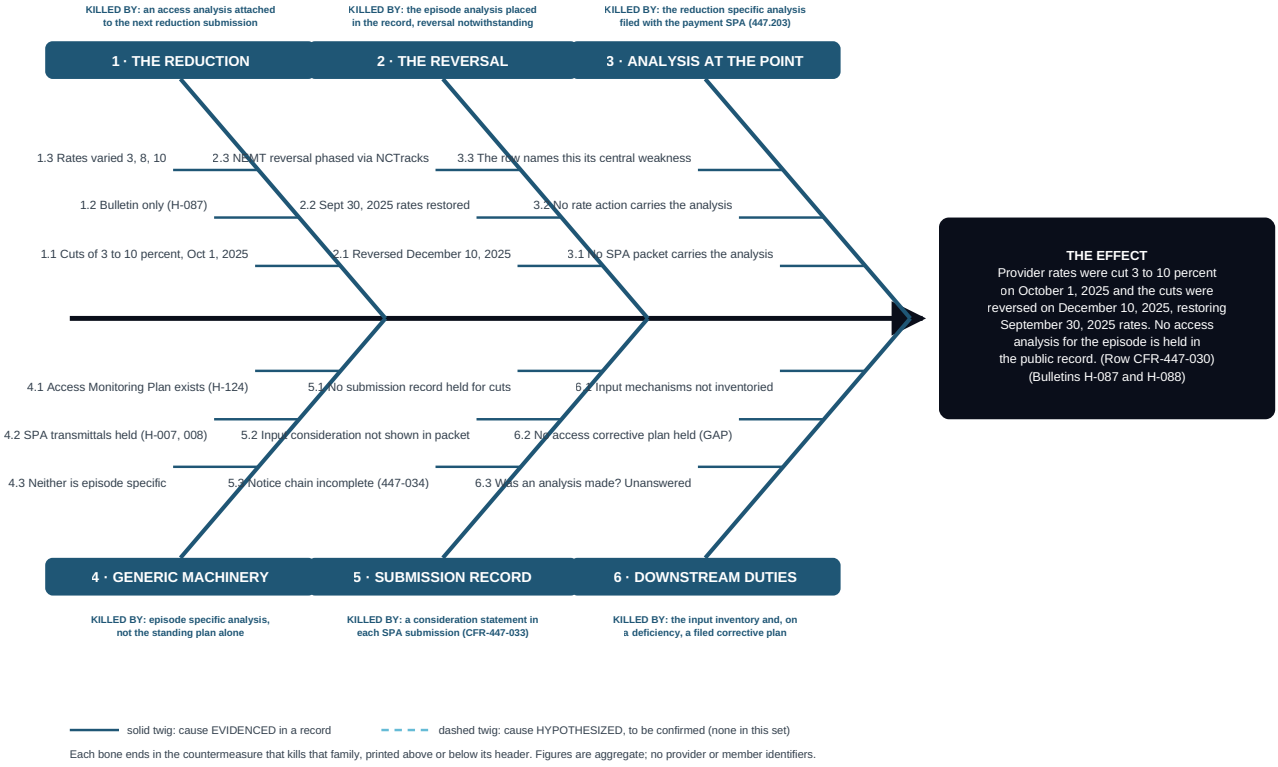
N-4 · Why the 2025 Rate Cut and Reversal Carry No Access Analysis

The effect, on the face of the diagram. On October 1, 2025, NC Medicaid provider rate reductions of 3 to 10 percent took effect. On December 10, 2025, the reductions were reversed, restoring the September 30, 2025 rates. No access analysis for the episode is held in the public record: the reduction is documented by bulletin only, and no held SPA packet or rate action carries the reduction specific access analysis that 42 CFR 447.203 engages. Sources:

register row CFR-447-030 (Partial, 42 CFR 447.203), which names this episode as its central weakness and flags it RATE-CUT-EPISODE-2025; the rate reduction and reversal bulletins held as H-087 (as replaced December 10, 2025) and H-088 (NEMT); supported by rows CFR-447-031, CFR-447-032, CFR-447-033, and CFR-447-034. This diagram rests on that register footing and on no other: the cure report's findings of substance do not carry the episode as a numbered finding, and the diagram says so rather than borrowing one.

Cause & Effect: Rate Cut and Reversal, No Analysis

Ishikawa (fishbone) diagram · NC N-4 · Prepared October 27, 2026



Each bone ends in the countermeasure that kills that family, printed above or below its header. Figures are aggregate; no provider or member identifiers.

Bone	Cause	Label	Source
1 · The reduction	1.1 Provider rate reductions of 3 to 10 percent took effect October 1, 2025, varying by fee schedule (examples of record: 3 percent on many schedules, 8 percent for inpatient behavioral health, 10 percent for ambulatory surgical centers)	EVIDENCED	Row CFR-447-030; bulletin H-087
	1.2 The episode is documented by bulletin only: the reduction bulletin was published September 25, 2025 and replaced in full by the December 10, 2025 update	EVIDENCED	Row CFR-447-030; H-087 as replaced
	1.3 The bulletin states the reductions were implemented by DHB to maintain the program within the funding allocated by the NC General Assembly	EVIDENCED	Bulletin H-087
2 · The reversal	2.1 The reductions were reversed on December 10, 2025	EVIDENCED	Row CFR-447-030; H-087 as replaced
		EVIDENCED	Row CFR-447-030

Bone	Cause	Label	Source
	2.2 The reversal restores the September 30, 2025 rates, so the current rate state is the pre-reduction state		
	2.3 For NEMT, the reversal applies in phases through NCTracks: system updates first, new prior authorizations at the restored rates from December 17, 2025, then adjustment of authorizations issued during the reduction window	EVIDENCED	Bulletin H-088
3 · Analysis at the point	3.1 No held SPA packet carries the reduction specific access analysis	EVIDENCED	Row CFR-447-030
	3.2 No held rate action carries it either; the row names this the provision's central weakness, the analysis element missing exactly where the provision engages	EVIDENCED	Row CFR-447-030
	3.3 The uncovered element, in the provision's terms: an access analysis submitted with a payment reduction or restructuring SPA	EVIDENCED	Row CFR-447-030 (uncovered element)
4 · Generic machinery	4.1 NC maintains an Access Monitoring Review Plan (H-124) analyzing access for fee-for-service services under 42 CFR 447.203(b), with provider counts, utilization, and rate comparisons	EVIDENCED	Row CFR-447-030
	4.2 Payment SPAs move through the transmittal process in the held record (H-007 and H-008, CMS-179 forms read)	EVIDENCED	Row CFR-447-030
	4.3 Neither the standing plan nor the transmittal specimens is specific to the October 2025 episode	EVIDENCED	Row CFR-447-030 (basis)
5 · Submission record	5.1 For the October 2025 reductions, no submission record at all is held	EVIDENCED	Row CFR-447-033 (Partial, 42 CFR 447.204)
	5.2 No held packet shows the submission side of the input duty: that the agency considered access data and stakeholder input and included that consideration with the SPA	EVIDENCED	Row CFR-447-033 (uncovered element)
	5.3 Rate change bulletins publish changes with effective dates and amounts, but a single change cannot be followed from proposal to final action entirely on held documents; the final adoption notice and publication placement are uncovered	EVIDENCED	Row CFR-447-034 (Partial, 42 CFR 447.205)
6 · Downstream duties	6.1 The ongoing access input mechanisms are evidenced in pieces, not inventoried as a system with the records they produce and how input feeds rate decisions	EVIDENCED	Row CFR-447-031 (Partial)
	6.2 No held document is or describes a corrective action plan for an access deficiency, and none identifies an access deficiency that would have triggered one; the row grades GAP-DETERMINED	EVIDENCED	Row CFR-447-032 (GAP-DETERMINED)
	6.3 The register's own question for the episode stands unanswered on the record: was an access analysis prepared for the October 1, 2025 reductions, and if so where is it published?	EVIDENCED	Row CFR-447-030 (open question)

Countermeasures, one per bone. 1: The next reduction or restructuring submission carries its access analysis with it, as a document, not a bulletin reference (the action on row CFR-447-030). 2: The October 2025 episode's analysis, if one was made, is placed in the record; the reversal does not retire the question (the action on row CFR-447-030). 3: The analysis is attached to the next reduction or restructuring SPA in the provision's terms, closing the uncovered element on row CFR-447-030. 4: The standing Access Monitoring Review Plan is used as the base the episode analysis builds on, and the episode analysis is published with it, so generic machinery stops standing in for episode evidence. 5: A standard consideration statement is added to SPA submissions recording the access data and public input reviewed for the change (the action on row CFR-447-033), and the next significant change is published as a linked proposal and final action pair (the action on row CFR-447-034). 6: DHB publishes the access input mechanism inventory with the Access Monitoring Review Plan, naming each channel, what records it creates, and where they are kept (the action on row CFR-447-031); when the next access analysis identifies a deficiency, the corrective action plan is filed with CMS and published with the analysis that triggered it (the action on row CFR-447-032).

Retirement condition. The diagram retires when the October 2025 episode's access analysis is placed in the public record, or the next reduction or restructuring SPA is submitted with its access analysis attached and published, and row CFR-447-030 re-grades on that document; the analysis's location prints on its face.

End of set. The diagrams state the causes as the cure record holds them on October 27, 2026. North Carolina is cured as of October 30, 2026, on the closeout that collected the last two documents, H-024 and H-035. That status is printed here as it is printed in the cure report. Every cause in this set is evidenced; as new evidence lands, each re-issue is dated and nothing here is silently edited.

PART 3 OF 7

Process Map

13 pages

PART 3

NC-Process-Map-2026-10-31.pdf

This part holds the end to end process map of North Carolina Medicaid. The map runs lane by lane. It starts at authority and policy. It then runs through eligibility, provider enrollment, care delivery, payment, and oversight. Step numbers on the map match the step numbers in the Companion Guide that follows it. The two parts therefore travel together. The map rests on the public record read at the review of October 27, 2026, confirmed at the closeout of October 30, 2026. It names its open items on its own face. It names its seams there too, rather than drawing them as if known.

Status of record, October 31, 2026. 183 of 196 documents stand collected and reconciled. That count is 93.4 percent. The register stands fully graded. North Carolina is cured as of October 30, 2026. The two documents that closed the cure are named on the cover in full. The How this binder works section names them in full as well.

The pages that follow are the same pages as the standalone download of the same name and date.

North Carolina Medicaid · End-to-End Process Map

PROCESS MAP · COMPANION TO THE COMPANION GUIDE (STEP NUMBERS MATCH)

Document control · Title: North Carolina Medicaid · End-to-End Process Map · Date: October 31, 2026 · Edition: Second edition · Form: PDF, Letter, room left for hand markup · Status figures current as of: the cure closeout of October 30, 2026

How to read this map. Each row is one actor (a "swim lane"). Each box is one step. The number on the box is its step number in the Companion Guide, where what the step needs and what it hands on are written out. Read the steps in number order by phase: A, then B, then C, then D, then E. Phase F is quality, integrity, appeals, and federal oversight; it runs alongside every other phase and receives from all of them. Steps that rest on a record the cure pass could not close carry an open item marker (OI) where they sit. Parts the record does not cover are listed at the end as named open items and seams, and are never drawn as if known.

The program in one line. North Carolina Medicaid is administered by the Division of Health Benefits (DHB) inside the North Carolina Department of Health and Human Services (NC DHHS), the single state agency. Eligibility is determined by the 100 county departments of social services in NC FAST, under state supervision. Most care is paid through managed care: the Standard Plan prepaid health plans, the Behavioral Health and Intellectual and Developmental Disabilities Tailored Plans, and the Children and Families Specialty Plan. The rest is paid through NC Medicaid Direct, the fee for service remainder, with the EBCI Tribal Option for eligible members of the Eastern Band of Cherokee Indians. Claims and provider enrollment for the fee for service program run through NCTracks, operated by GDIT as fiscal agent. Fair hearings are conducted by the North Carolina Office of Administrative Hearings (OAH), outside the Department.

Status of record, stated plainly. North Carolina is cured as of October 30, 2026. The cure pass of October 27, 2026 graded all 501 register entries (Verified 141 · Partial 274 · GAP-DETERMINED 71 · N-A-DETERMINED 10 · Prospective 5 · Unverified 0) and dispositioned the whole document inventory. The closeout of October 30, 2026 collected the last two documents and closed the cure. The document inventory stands at 183 of 196 rows collected and reconciled, 93.4 percent, with 13 true gaps. The two documents collected at the closeout are named here and wherever status is stated in this package: **H-024**, the Section 1115 Special Terms and Conditions, and **H-035**, the CAP/DA Appendix K approval NC.0132.R07.10. Each one was read in full at its live address at medicaid.gov.

The map

Who does it (one row per actor)	A · Authority, policy, and the federal interface	B · Eligibility and choice	C · Provider enrollment and systems readiness	D · Care delivery and claims	E · Payment, finance, and recovery	F · Quality, integrity, appeals, and oversight
NC DHHS and DHB, agency level (the single state agency; obligations above any single unit)	**A1** Hold and maintain the State Plan; submit State Plan Amendments (SPAs) to CMS, with the 10 day public posting on the State Plan Public Notices page before submission (entry NC-002). **A5** Hold the Section 1115 Reform				**E1** Answer for federal financial participation: state payment, CMS-64 claiming, and the finance procedures the register asks this level to publish (OI-NC-09).	**F4** Agency side of appeals: notice content and timing before adverse action, aid paid pending appeal, and corrective action on a hearing decision, for DHHS and DHB and, for eligibility determinations, the county

Who does it (one row per actor)	A · Authority, policy, and the federal interface	B · Eligibility and choice	C · Provider enrollment and systems readiness	D · Care delivery and claims	E · Payment, finance, and recovery	F · Quality, integrity, appeals, and oversight
	Demonstration authority (11-W-00313/4), renewed December 10, 2024 to December 9, 2029. Healthy Opportunities Pilots authority and operations are separate facts: operations suspended after July 1, 2025 for lack of funding, with restart funding and negotiations on the same page and no restart service date established (OI-NC-14).					departments of social services.
DHB Coverage Policy function (the register label; no formal section label is published)	**A2** Make coverage policy by the North Carolina procedure of record: G.S. 108A-54.2, with 45 days publication and comment and 15 days re-notice if a policy is modified (entry NC-003). Clinical coverage policies are the working instruments of this lane.					
DHB Finance Section (the published section; contact and owner for the Annual Reports and Tables)					**E1** (shared with agency level) Run the payment and claiming cycle for the fee for service program on the NCTracks checkwrite (see D5). **E2** Rates and capitation: rate certifications for the current rating period are referenced in the record and posted nowhere (OI-NC-05). No monthly prepaid health plan capitation payment day is published in any source reached; none is drawn (OI-NC-15). **E5** Publish the fiscal reporting of record: the Medicaid Annual Report and Tables on a state fiscal year basis (entry	

Who does it (one row per actor)	A · Authority, policy, and the federal interface	B · Eligibility and choice	C · Provider enrollment and systems readiness	D · Care delivery and claims	E · Payment, finance, and recovery	F · Quality, integrity, appeals, and oversight
					NC-007), medical loss ratio reporting against the 88 percent statutory floor at G.S. 108D-65 (entry NC-009), and the PHP Performance Metrics report to the General Assembly (entry NC-008). **E4** Vendor payments run through NCFS, the state financial system under the State Controller, not through NCTracks; the 1099 filing design changes at tax year 2026 (see the Guide, systems).	
DHB NC Health Choice (Title XXI, CHIP)	**A4** Hold the residual Title XXI structure inside DHB. About 55,000 Health Choice children moved to NC Medicaid on April 1, 2023 under Session Law 2022-74; the State Plan Public Notices page still lists a separate NC Health Choice State Plan. Both facts print (register conflict NC-5). The binder record does not call CHIP eliminated in North Carolina.					
DHB Waivers, with the Tailored Plans	**A3** Hold the waiver authorities: Section 1915(c) Innovations and Traumatic Brain Injury (TBI) waivers served through the Tailored Plans; Community Alternatives Program (CAP) waivers, including CAP/DA, run through NC Medicaid Direct. Appendix K flexibilities operate only as approved. The CAP/DA Appendix K approval NC.0132.R07.10 is			**D2** (shared with the Tailored Plans) Waiver services deliver inside the Tailored Plan and Medicaid Direct lanes; the TBI Waiver does not operate in all geographic areas, and its operator and county framing is a named research item on the record (register conflict NC-9).		

Who does it (one row per actor)	A · Authority, policy, and the federal interface	B · Eligibility and choice	C · Provider enrollment and systems readiness	D · Care delivery and claims	E · Payment, finance, and recovery	F · Quality, integrity, appeals, and oversight
	document H-035 (OI-NC-02, closed at the closeout of October 30, 2026, when the approval was read in full at its live address); the state posts the R07.09 Appendix K, not this approval.					
County departments of social services, eligibility (100 counties; state supervised; NC FAST)		**B1** Take the application and determine eligibility in NC FAST, under state supervision, for the categories the federal eligibility titles and the state manuals carry. Redetermine on the cycles and events the manuals state. **B2** Record the determination in NC FAST, the eligibility system of record. The mechanism by which an NC FAST determination reaches NCTracks and the plans is not stated in the sources reached; the seam is named, not drawn (OI-NC-16).				**F4** (shared) As the determining agency for eligibility, carry the agency side notice and aid pending appeal duties at F4.
NC Medicaid Enrollment Broker, with the NC Medicaid Ombudsman		**B3** Enrollment Broker: help the beneficiary choose or change a health plan (published line 833-870-5500). The contract of record was awarded to MAXIMUS in 2018; the current contractor identity beyond that award was not established in sources reached, and the Enrollment Broker contract itself is one of the instruments the record does not hold (OI-NC-07). **B4** NC Medicaid				

Who does it (one row per actor)	A · Authority, policy, and the federal interface	B · Eligibility and choice	C · Provider enrollment and systems readiness	D · Care delivery and claims	E · Payment, finance, and recovery	F · Quality, integrity, appeals, and oversight
		Ombudsman: beneficiary assistance (published line 877-201-3750). Neither the Broker nor the Ombudsman is published as the Subpart E hearing authority; that authority sits at OAH (see F3).				
DHB Provider Operations (Provider Enrollment, the published function)			**C1** Hold the provider enrollment function: the named contact for provider enrollment issues and the owner of the process NCTracks executes, including screening under 42 CFR Part 455 Subpart E.			
NCTracks, operated by GDIT as fiscal agent (Systems; DHB is program owner)			**C2** Execute enrollment and reverification through the NCTracks provider portal: actively enrolled providers finish reverification at least every five years (42 CFR 455.414); notifications begin 70 days before the due date; the application fee, the federal amount plus $100 under G.S. 108C-2.1, is charged again at each five year recredentialing. **C3** Publish the Active Provider Reverification Report, refreshed monthly with twelve months of due dates (entry NC-004). **C4** Carry the interoperability duties: Patient Access API, Provider Access API, provider directory API, and payer to payer exchange documentation. The register grades the API documentation rows GAP-DETERMINED; the January	**D5** Adjudicate fee for service claims and pay on the published weekly checkwrite: claims cutoff Thursday (portal to 11:59 p.m., batch by 6:00 p.m.), checkwrite normally the following Tuesday, electronic funds transfer effective Wednesday, shifting on the published holiday and quarter and year end rule (entry NC-006).		

Who does it (one row per actor)	A · Authority, policy, and the federal interface	B · Eligibility and choice	C · Provider enrollment and systems readiness	D · Care delivery and claims	E · Payment, finance, and recovery	F · Quality, integrity, appeals, and oversight
			1, 2027 federal date stands on the rows (OI-NC-10).			
DHB Managed Care Oversight (oversight sits with the Deputy Secretary for NC Medicaid, by the leadership page of record)		**B5** Route each beneficiary to the delivery system their population carries: Standard Plan for most, Tailored Plan for the behavioral health and I/DD populations, Medicaid Direct for those outside managed care, and the EBCI Tribal Option for those who elect it and are eligible.		**F6** Monitor the plans: the monitoring system, network adequacy remedies, encounter data, and the external quality review contract. Executed contracts are not public for any managed care contract family (OI-NC-03); the CMS approval of the EQRO contract is a named gap on the register (CFR-438-047).		**F6** See column D: plan monitoring and remedies are this lane's standing act in every phase.
Standard Plan prepaid health plans (five of record: AmeriHealth Caritas North Carolina, Carolina Complete Health, Healthy Blue, UnitedHealthcare Community Plan, and WellCare of North Carolina)				**D1** Deliver covered services to enrolled members, administer the benefit under the Standard Plan contract, and submit encounter data. Of record is also of record's limit: on April 1, 2026 WellCare of North Carolina merged into Carolina Complete Health, and beneficiaries now choose among four Standard Plans, with Carolina Complete Health statewide (register conflict NC-1). The five names above are the plans of record for the contract family; the operating choice since April 1, 2026 is four.	**E2** (shared) Receive capitation under rates whose certifications are not posted (OI-NC-05).	
Tailored Plans, with the Children and Families Specialty Plan (four Tailored Plans of record: Alliance Health, Partners Health Management, Trillium Health Resources, and Vaya Health; three				**D2** Deliver integrated physical health, behavioral health, and long term services to about 200,000 beneficiaries with serious mental illness, severe substance use disorders, intellectual and developmental disabilities, or traumatic brain injury, including Innovations and		

Who does it (one row per actor)	A · Authority, policy, and the federal interface	B · Eligibility and choice	C · Provider enrollment and systems readiness	D · Care delivery and claims	E · Payment, finance, and recovery	F · Quality, integrity, appeals, and oversight
operating since October 1, 2026)				TBI waiver enrollees. Tailored Plans launched July 1, 2024. On October 1, 2026 Vaya Health and Partners Health Management merged (named Vaya Partners in the cure report), taking the operating Tailored Plans from four to three. In the same row of products: the Children and Families Specialty Plan, Healthy Blue Care Together, operated by Blue Cross and Blue Shield of North Carolina for children and youth in the child welfare system, launched December 1, 2025.		
NC Medicaid Direct and the EBCI Tribal Option				**D3** Medicaid Direct: the fee for service remainder. Beneficiaries outside managed care remain in Medicaid Direct, where Community Care of North Carolina still provides care management for much of the population, and the CAP waivers run. EBCI Tribal Option: the primary care case management entity created by the Cherokee Indian Hospital Authority, launched July 1, 2021, the first Indian managed care entity of its kind in the nation, available to eligible tribal members who elect it.		
DHB Pharmacy, with the Pharmacy Benefit Administrator (PBA)				**D4** Pharmacy for NC Medicaid Direct runs through the PBA: from May 2, 2026, Prime Therapeutics State Government Solutions LLC supports pharmacy benefit operations for Medicaid Direct, covering formulary,	**E3** (shared with TPL lane in part) Drug rebate administration sits with the PBA under DHB pharmacy policy (see D4).	

Who does it (one row per actor)	A · Authority, policy, and the federal interface	B · Eligibility and choice	C · Provider enrollment and systems readiness	D · Care delivery and claims	E · Payment, finance, and recovery	F · Quality, integrity, appeals, and oversight
				drug rebate administration, point of sale claims, drug utilization review, prior authorization, PHP Lock-In oversight, and reporting. DHB keeps all clinical policies and reimbursement methodologies for point of sale pharmacy, and NCTracks pharmacy functionality is to be discontinued for this purpose. Pharmacy inside the prepaid health plans runs through the plans' own arrangements; no plan pharmacy benefit manager is named in the sources reached, and none is drawn (OI-NC-11).		
DHB Quality Management and Improvement (QMI)						**F1** Hold the quality record: the Managed Care Quality Strategy, the Annual Quality Report, the External Quality Review (EQR) technical report (EQRO of record: Health Services Advisory Group, HSAG; current report 2024 to 2025, acquired in the cure pass), encounter data validation, medical loss ratio material, and Core Set reporting. The 2025 Quality Strategy is the lane's open wound: a DHB bulletin records it approved July 1, 2025 and published on this unit's page; the cure pass read that page in full and the document is not there. The strategy the record holds is the 2023 document. The item is a true gap, NL-06 (OI-NC-04).

Who does it (one row per actor)	A · Authority, policy, and the federal interface	B · Eligibility and choice	C · Provider enrollment and systems readiness	D · Care delivery and claims	E · Payment, finance, and recovery	F · Quality, integrity, appeals, and oversight
DHB Third Party Recovery (Third Party Liability, TPL)					**E3** Identify third party coverage, pursue recovery, and repay the federal share on the procedures the register asks this lane to publish (CFR-433-015 and CFR-433-018 stand GAP-DETERMINED). The working manuals of record are MA-2400, Third Party Liability, whose text was last reissued January 1, 2011, its currency flagged in the cure pass, and MA-2285, Estate Recovery. Recoveries run through the state's vendor arrangement; no vendor name is carried in the sources reached for this lane. OCPI carries a documented secondary TPL role on an EBCI facing document; both homes print in the register.	
DHB Office of Compliance and Program Integrity (OCPI)						**F2** Hold program integrity: fraud control, the Payment Error Rate Measurement and Medicaid Eligibility Quality Control cycles, and the control and audit duties of 42 CFR Part 456 that the register splits to this lane (the quality assessment and drug use review duties of the same Part sit with Quality and Pharmacy).
North Carolina Office of Administrative Hearings (OAH)						**F3** Conduct Medicaid state fair hearings and recipient appeals as an Administrative Law Judge hearing: authority at G.S. 108A-70.9A and 108A-70.9B (contested recipient appeals involving DHHS) and G.S. Chapter 108D (appeals involving an MCO), procedure at 26 NCAC 03 .0401 to .0402. On the DHHS track the

Who does it (one row per actor)	A · Authority, policy, and the federal interface	B · Eligibility and choice	C · Provider enrollment and systems readiness	D · Care delivery and claims	E · Payment, finance, and recovery	F · Quality, integrity, appeals, and oversight
						beneficiary returns the hearing request to OAH within 30 days of the adverse decision; the MCO track uses the State Fair Hearing Request. County DSS handles eligibility appeals at the first level; the Subpart E hearing function itself is homed here, on the determination of October 21, 2026. One companion instrument remains not found, a DHHS side designation of OAH, and the determination does not rest on it (OI-NC-12).
CMS, federal interface	**A6** Receive SPAs, waiver applications and renewals, and demonstration material; approve, defer, or disallow. The Section 1115 Special Terms and Conditions for the current demonstration period are document H-024, dated September 25, 2026 (OI-NC-01, closed at the closeout of October 30, 2026, when the document was read in full at its live address; the CMS demonstration page held as H-027 confirms the document).					**F5** Federal oversight of the running program: Section 1115 quarterly and annual monitoring reports (entry NC-011), EQR and quality reporting, and T-MSIS. North Carolina's own T-MSIS submission cadence was not published in sources reached (OI-NC-15).

How the steps connect

A1 and A6 are the two ends of one act: the state plan and its amendments move from the agency level to CMS and back as approvals. A2 turns federal and state authority into the coverage policies every later lane works from. A3 and A4 fix the waiver and Title XXI authorities inside which D2, D3, and B5 route people. B1 and B2 make the eligibility record; B3, B4, and B5 turn that record into an enrollment in a delivery system. C1 to C4 make the provider and systems record that D1 to D5 bill and adjudicate against: no provider is payable in the fee for service lane until C2 has enrolled them, and no claim in that lane pays except on the D5 checkwrite. E1 to E5 close the money:

capitation and fee for service payment out, rebates and third party recovery back, the federal share claimed and reported. F1 to F6 receive from every phase: F1 reads the encounters and quality data D1 to D3 produce; F2 reads the payment record E1 to E5 produce; F3 and F4 are the two halves of one appeal, the hearing at OAH and the notice and aid duties at the agency that acted; F5 carries the whole program back to CMS; F6 holds the plans to the contracts A1's lane let.

Touchpoints (named, not covered as separate maps): T1 · Provider revalidation and reverification (C2, C3): the same federal apparatus carries each plan's network provider enrollment status, and plan lanes depend on it without owning it. T2 · The 1099 productions: provider payments through NCTracks and vendor payments through NCFS each feed a tax reporting production documented in the October 21 binder set, Part II; this map carries only the payment steps (D5, E4) that feed them. T3 · The NC Medicaid Ombudsman annual report and the NEMT broker arrangement are instruments the record does not hold (OI-NC-08); the functions they would document are drawn only as far as B4 and the benefit descriptions carry them.

The operationalization layer: what each lane must produce, post, or decide for the public record to close

Register counts are the cure pass counts of October 27, 2026, confirmed unchanged at the closeout of October 30, 2026, by the register's own NC home for each lane. A lane closes when the instrument named in its third column is public; until then the open item in its fourth column is the work.

Lane (register home)	Entries and cure verdicts, October 27, 2026, confirmed October 30, 2026	What this lane must produce, post, or decide	Open items landing in this lane
Agency level, NC DHHS and DHB (AGENCY-LEVEL)	49 · Verified 26, Partial 16, GAP-DETERMINED 7	The state plan and SPA record, the deferral and disallowance procedures, and any repayment or corrective action instruments, published as they occur	OI-NC-01 (H-024, with CMS), OI-NC-09
DHB Policy (DHB-POLICY)	62 · Verified 25, Partial 23, GAP-DETERMINED 12, N-A-DETERMINED 1, Prospective 1	The clinical coverage policies in full text, the EPSDT and benefit standards the register names, and the annual reports this function files with CMS	OI-NC-09
DHB Finance (DHB-FINANCE)	74 · Verified 11, Partial 50, GAP-DETERMINED 12, N-A-DETERMINED 1	The capitation rate certifications, the CMS-64 crediting and refund procedures, the MMIS reapproval and advance planning document record, and the current DSH audit or settlement document	OI-NC-05, OI-NC-06, OI-NC-09
DHB Managed Care (DHB-MANAGED-CARE)	76 · Verified 12, Partial 58, GAP-DETERMINED 6	Executed contract instances for the Standard Plan, Tailored Plan, and Medicaid Direct PIHP families, the EQRO contract's CMS approval, network adequacy remedy plans, the fiscal agent contract's federal requirements exhibit	OI-NC-03, OI-NC-07, OI-NC-08
DHB CHIP (DHB-CHIP)	74 · Verified 19, Partial 48, GAP-DETERMINED 4, N-A-DETERMINED 3	The Title XXI audit, refund, and cost allocation instruments, and a conformed statement of the Health Choice structure after the 2023 combination	OI-NC-13 (CFR-457-046 is the register's first retest)
DHB Provider Operations (DHB-PROVIDER-OPS)	32 · Verified 14, Partial 15, GAP-DETERMINED 3	The enrollment disclosure question set carrying 42 CFR 455.107, and the independent certified DSH audit report or its audit contract deliverable	OI-NC-09
DHB OCPI (DHB-OCPI)	27 · Verified 7, Partial 16, GAP-DETERMINED 3, N-A-DETERMINED 1	Any professional review agreement, the utilization review variance record, and the quarterly satisfactory showing record, or a statement that none exists	OI-NC-09
DHB Pharmacy (DHB-PHARMACY)	15 · Verified 6, Partial 6, GAP-DETERMINED 3	The pharmacy financial procedures: rebate claiming treatment, the quarterly submission certification step, and the findings and assurances at the next significant drug payment change	OI-NC-11
DHB Quality (DHB-QUALITY)	12 · Verified 1, Partial 6, GAP-DETERMINED 5	Post the CMS approved 2025 Quality Strategy where the bulletin says it lives, and produce the Core Set submissions and the written utilization and quality review criteria	OI-NC-04
DHB TPL (DHB-TPL)			OI-NC-09

Lane (register home)	Entries and cure verdicts, October 27, 2026, confirmed October 30, 2026	What this lane must produce, post, or decide	Open items landing in this lane
	7 · Verified 1, Partial 4, GAP-DETERMINED 2	The federal share repayment procedure and the incentive payment and distribution procedure for third party collections; a current TPL manual to replace the 2011 reissue	
DHB Waivers (DHB-WAIVERS)	18 · Verified 6, Partial 2, GAP-DETERMINED 3, N-A-DETERMINED 4, Prospective 3	The Appendix K approval record for CAP/DA, the HCBS quality, access, and incident submissions as their dates arrive	OI-NC-02 (H-035)
Eligibility, county DSS and NC FAST (ELIGIBILITY-NC)	38 · Verified 12, Partial 22, GAP-DETERMINED 4	The eligibility manual statements the register names (choice of category, SSI loss redetermination), and the unwinding reporting submissions filed with the cure record	OI-NC-16
Systems, NCTracks (SYSTEMS-NCTRACKS)	13 · Verified 1, Partial 4, GAP-DETERMINED 7, Prospective 1	Publish the Patient Access, Provider Access, and directory API documentation, and the EDI companion guides and trading partner terms	OI-NC-10
OAH Hearings (OAH-HEARINGS)	4 · Partial 4	The hearing system record itself: all four Subpart E entries graded Partial, the lane with no Verified row and no gap, a standing invitation to produce the instrument that closes them	OI-NC-12

Named open items and seams · parts not covered, step by step (not drawn as if known)

- **OI-NC-01 · H-024, the Section 1115 Special Terms and Conditions.** Closed at the closeout of October 30, 2026. The document was read in full at its live address at medicaid.gov and classed MAPPED-TEXT. Lands at A5, A6.
- **OI-NC-02 · H-035, the CAP/DA Appendix K approval NC.0132.R07.10.** Closed at the closeout of October 30, 2026, like H-024. The document was read in full at its live address at medicaid.gov and classed REVIEWED-NO-CFR-CITATION-FOUND. The state posts the R07.09 Appendix K, not this approval. Lands at A3, D2, and the Waivers lane of the operationalization table.
- **OI-NC-03 · Executed managed care contracts are not public for any of the three contract families.** Standard Plan, Tailored Plan, and Medicaid Direct PIHP alike: the state posts the model instrument, the RFP or RFA form, and the amendment series; no signed executed base contract is posted for any of the three. Three of the 13 true gaps. Lands at F6, D1, D2, D3.
- **OI-NC-04 · The 2025 Quality Strategy is not where the bulletin says it is.** Approved July 1, 2025 by the bulletin's account and published, by the same account, on the Quality Management and Improvement page; read in full in the cure pass, the page carries no Quality Strategy document. True gap NL-06. The strategy of record is the 2023 document, against 42 CFR 438.340's call for a current strategy. Lands at F1.
- **OI-NC-05 · Capitation rate certifications are referenced and posted nowhere.** Named in state and association letters; no certification is public. Register actions at CFR-438-003, CFR-438-005, and CFR-447-020. Lands at E2.
- **OI-NC-06 · Directed payment preprints, including the HASP preprint, are CMS downloads only,** on the host that refuses this machine; the current DSH audit or settlement document and the standalone CMS 1915(b) approval letter are likewise not held. Lands at E2, A3.
- **OI-NC-07 · The Enrollment Broker contract is not held,** and the broker's current contractor identity beyond the 2018 MAXIMUS award was not established in sources reached. Lands at B3.

- **OI-NC-08 · The NEMT broker contract and the Ombudsman annual report are not held.** No NEMT broker is named in the sources reached for this package; none is drawn. Lands at B4, D3.
- **OI-NC-09 · The 13 true gaps and the 71 GAP-DETERMINED register rows behind the standing acquisition list,** including the NC Register rulemaking notices for 10A NCAC 22, each gap a closed, owned item on the register's face with its searches recorded, not an open search. Lands across the operationalization table.
- **OI-NC-10 · The interoperability API documentation is GAP-DETERMINED** (CFR-431-013, CFR-431-014, CFR-431-015, CFR-457-054, and the 45 CFR Part 162 companion guide rows CFR-162-001, CFR-162-002, CFR-162-004), against a January 1, 2027 federal date for the access APIs. Lands at C4.
- **OI-NC-11 · No plan pharmacy benefit manager is named in the record.** The PBA of record, Prime Therapeutics State Government Solutions LLC from May 2, 2026, serves NC Medicaid Direct only. The plans' pharmacy arrangements are drawn as the plans' own, unnamed. Lands at D4.
- **OI-NC-12 · No DHHS side designation of OAH was found** (wanted source W-17 of the October 21 build). The OAH home rests on the statute and the Administrative Code as OAH publishes them. Lands at F3.
- **OI-NC-13 · Three register qualifications ride with the cure pass, none moving a count:** CFR-457-046 (STRUCTURAL) is the first retest in the next audit rotation; the CFR-441-021 template checkbox is to be confirmed on the PDF image; the CFR-433-021 basis is rounded out with one corpus CMS-64 mention at the next registration touch. Lands at A4, and in the Guide's open items index.
- **OI-NC-14 · Authority and operations part company in two places the map keeps separate:** the Healthy Opportunities Pilots (authority renewed, operations suspended, no restart date established) and the PCS Alignment Demonstration, now in public comment through November 9, 2026, which the October 21 register predates. Neither is drawn as an operating service. Lands at A5.
- **OI-NC-15 · Cycles North Carolina does not publish:** no monthly PHP capitation payment day, and no state published T-MSIS submission cadence. A pattern observed is printed as a pattern in the Guide, never promoted to a rule on this map. Lands at E2, F5.
- **OI-NC-16 · The NC FAST handoff mechanism is not stated in the sources reached:** how a county eligibility determination reaches NCTracks and the plans (file, interface, or portal) is not described in the record this package stands on, so B2 records the determination and the seam is named here rather than drawn. Lands at B2.
- **OI-NC-17 · The cost sharing record contradicts itself, and the map does not pick a winner:** the state plan attachments carry $2 and $3 amounts of 2005 vintage; the Tailored Plan contract's Table 7 charges $4; a plan passage states managed care enrollees are not charged; and both cost sharing attachments print, verbatim, "State policy does not provide for cumulative maximums," against the aggregate limit machinery of 42 CFR 447.56. The specification rows grade Verified on structure, the conflict rides the neighboring rows, and which amount a provider charges today is an open question on the register. Lands at D1, D2, E2.

End of map. This map states the process as the record holds it on October 30, 2026. It decides nothing. North Carolina is cured as of October 30, 2026. The two documents that closed the cure, H-024 and H-035, are named above. The register figures in this package carry the cure pass date of October 27, 2026. The closing figures carry the closeout date of October 30, 2026. The Companion Guide carries the same step numbers and states what each step needs and what it hands on.

PART 4 OF 7

Process Map Companion Guide

16 pages

PART 4

NC-Process-Map-Companion-Guide-2026-10-31.pdf

This part is the companion to the Process Map. It explains how to read the map. It explains the organizational structure behind the map. It explains the systems behind it too. It then walks the map lane by lane and step by step. It closes with a glossary of North Carolina terms of record. It also closes with an open items index keyed to the map. It rests on the same public record as the map. It states its sources on its closing pages. It states its method there too.

Status of record, October 31, 2026. 183 of 196 documents stand collected and reconciled. That count is 93.4 percent. The register stands fully graded. North Carolina is cured as of October 30, 2026. The two documents that closed the cure are named on the cover in full. The How this binder works section names them in full as well.

The pages that follow are the same pages as the standalone download of the same name and date.

North Carolina Medicaid · Process Map Companion Guide

COMPANION GUIDE · READ WITH THE MAP, THE TWO TRAVEL TOGETHER (STEP NUMBERS MATCH)

Document control · Title: North Carolina Medicaid · Process Map Companion Guide · Date: October 31, 2026 · Edition: Second edition · Companion to: North Carolina Medicaid · End-to-End Process Map, October 31, 2026 · Status figures current as of: the cure closeout of October 30, 2026

Status of record, stated plainly. North Carolina is cured as of October 30, 2026. The cure pass of October 27, 2026 graded all 501 entries in the North Carolina register (Verified 141 · Partial 274 · GAP-DETERMINED 71 · N-A-DETERMINED 10 · Prospective 5 · Unverified 0) and dispositioned the whole document inventory. The closeout of October 30, 2026 collected the last two documents. The inventory stands at 183 of 196 rows collected and reconciled, 93.4 percent, with 13 true gaps. The two documents collected at the closeout are **H-024**, the Section 1115 Special Terms and Conditions, and **H-035**, the CAP/DA Appendix K approval NC. 0132.R07.10. Each one was read in full at its live address at medicaid.gov. No figure in this guide is rounded up.

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1. How to read the map

The map shows North Carolina Medicaid the way the public record holds it: as a set of lanes, one for each organization that owns a stretch of the work, crossed by six phases. Phase A is authority: the state plan, coverage policy, waivers, the Title XXI structure, and the federal approvals that let everything else run. Phase B is the person entering: a county eligibility determination, then help choosing a delivery system, then routing into one. Phase C is the provider and systems record the program pays against. Phase D is care delivered and claims run, in four delivery arrangements side by side: Standard Plans, Tailored Plans, Medicaid Direct with the EBCI Tribal Option, and pharmacy. Phase E is the money closing: payment, capitation and rates, rebates and third party recovery, and the published fiscal reporting. Phase F runs alongside all of it: quality, program integrity, appeals, plan monitoring, and federal oversight.

Each step in this guide has the same parts: what the step is for, what must be in hand before it starts, what happens, what it produces and who gets it next, and who does it. A part of the process the record does not cover prints as a named open item (OI) at the step it governs. Step numbers never change within this edition family; new information inserts at numbered points without renumbering.

Three reading rules govern the whole package. First, a name of record and an operating fact are different things, and both print where they differ: the Standard Plans of record are five, and the operating choice since April 1, 2026 is four. Second, authority and operations are different facts: a waiver or demonstration can stand approved while the service it authorizes is suspended, and the map prints the suspension, not the hope. Third,

where the record contradicts itself, the map prints the contradiction and its register disposition; it does not pick a silent winner. The cost sharing amounts at OI-NC-17 are the standing example.

2. The organizational structure, explained from the record

The Department and the Division. The North Carolina Department of Health and Human Services (NC DHHS) is headed by the Secretary and organizes into 33 divisions and offices grouped in six service areas; the sixth area is named two ways in two Department documents, "External Affairs and Licensing and Facilities" on the Overview page and "Health Equity" in the EEO Plan, and the register prints both (conflict NC-6). Medicaid sits in one division, the Division of Health Benefits (DHB), the single state agency for Medicaid. The Division of Medical Assistance ceased to exist as a separate division on August 1, 2018, when it combined with DHB under the DHB name; CMS correspondence in 2025 still occasionally addresses the old name, printed as letterhead lag (conflict NC-4), not as a revival. The Medicaid agency head's published title is Deputy Secretary for NC Medicaid. One caution rides with that title on the record: an April 21, 2026 announcement stated the appointment remains contingent upon confirmation by the North Carolina General Assembly, and the confirmation outcome date was not established in sources reached (conflict NC-8). This guide names no individual office holder in a process step; steps belong to offices and functions, not to persons.

What DHB publishes, and what it does not. DHB does not publish a full organizational chart in text form on the sources reached. What it publishes is a set of named functions and the pages they speak from, and the register's 501 entries are homed to those functions with the basis printed on each entry: published (North Carolina names the unit that does the work), citation (the federal text itself fixes the level), or derivation (a part level derivation from the federal part to a published NC function, labeled as a derivation on the register's face). Four homes are labeled functions, not named sections, because NC publishes no named section for them: Managed Care Oversight, the Coverage Policy function, NC Health Choice, and Waivers. The lanes of the map are those homes, in the register's own counts:

Register home	Entries	What the home is, on the record
AGENCY-LEVEL	49	NC DHHS and DHB as a whole: the single state agency duties, the state plan, contracts at agency level, confidentiality, the demonstration
DHB-POLICY	62	The coverage policy function: benefit, coverage, and state plan titles; formal section label not published
DHB-FINANCE	74	The Finance Section, a named section: payment and financial administration titles, less the pharmacy and TPL carve outs the register prints
DHB-MANAGED-CARE	76	Managed care oversight: the Part 438 and 441 managed care titles; oversight sits with the Deputy Secretary by the leadership page
DHB-CHIP	74	NC Health Choice, Title XXI: Part 457 in whole, mapped to a live residual structure inside DHB (conflict NC-5 on the face)
DHB-PROVIDER-OPS	32	Provider Enrollment, a published function: Part 455 Subpart E screening and enrollment titles

Register home	Entries	What the home is, on the record
DHB-OCPI	27	The Office of Compliance and Program Integrity, a division within DHB by name: program integrity, fraud control, PERM and MEQC
DHB-PHARMACY	15	The pharmacy function and its PBA: the drug benefit, rebate, and drug utilization review titles
DHB-QUALITY	12	Quality Management and Improvement, a named unit: Core Sets, quality assessment, EQR, and the Quality Strategy
DHB-TPL	7	Third Party Recovery: the Part 433 third party liability titles, with OCPI's documented role printed as secondary home
DHB-WAIVERS	18	Waiver operations, with the Tailored Plans: the 1915(b) and 1915(c) titles
ELIGIBILITY-NC	38	The county departments of social services, state supervised, in NC FAST: the Part 435 eligibility titles
SYSTEMS-NCTRACKS	13	NCTracks, operated by GDIT: the interoperability and HIPAA transaction obligations
OAH-HEARINGS	4	The NC Office of Administrative Hearings: the Subpart E hearing function, homed outside the Department on the October 21, 2026 determination

The delivery arrangements. Managed care launched July 1, 2021 for an estimated 1.6 to 1.8 million beneficiaries. The Standard Plans began as five prepaid health plans; on April 1, 2026 WellCare of North Carolina merged into Carolina Complete Health, which is now statewide, and the operating choice is four. The Behavioral Health and I/DD Tailored Plans launched July 1, 2024, after printed launch dates of July 1, 2022 and October 1, 2023 did not hold (conflict NC-2), covering about 200,000 beneficiaries; only the local management entities, the LME/MCOs, could bid. On October 1, 2026 Vaya Health and Partners Health Management merged, named Vaya Partners in the cure report, taking the operating Tailored Plans from four to three: Alliance Health, Trillium Health Resources, and the merged Vaya and Partners entity. The Children and Families Specialty Plan, Healthy Blue Care Together, operated by Blue Cross and Blue Shield of North Carolina, launched December 1, 2025. The EBCI Tribal Option launched July 1, 2021. Medicaid expansion began December 1, 2023. None of these dates is a step on the map; they are the ground the steps stand on, printed here so the map can stay a process document.

3. The systems

NC FAST. The eligibility system of record. The 100 county departments of social services determine eligibility under state supervision in NC FAST (the register's eligibility owner line names the Division of Social Services and county DSS as eligibility operations, under DHB's program authority). What the record reached does not state is the mechanism by which an NC FAST determination reaches NCTracks and the plans; that seam is OI-NC-16, named on the map at B2 rather than drawn as a file or interface no source describes.

NCTracks. The multi payer claims and provider system, operated by GDIT as fiscal agent, with DHB as program owner. NCTracks carries provider enrollment and recredentialing through its provider portal, fee for

service claims adjudication, the weekly checkwrite, remittance, and the published provider facing duties, including the Active Provider Reverification Report and the 1099 production for provider payments documented in Part II of the October 21 binder set. Two records ride with the name: the fiscal agent was CSRA until April 2, 2018 and is GDIT since; live FAQ text still directing correspondence to CSRA is unconformed, printed as found (conflict NC-14). And pharmacy functionality in NCTracks is to be discontinued for the Medicaid Direct pharmacy purpose as the PBA arrangement at D4 takes that work.

NCFS. The North Carolina Financial System, the state financial system under the Office of the State Controller, live in 2023 (two published dates stand, October 2, 2023 as go live and October 10, 2023 as the DHHS deployment date; the sources reached do not explain the difference, conflict NC-13). NCFS is where vendor payments run, as distinct from provider payments through NCTracks. Its Medicaid relevance in this package is the finance lane's vendor payment and 1099 layer: vendors were reported centrally by the State Controller, a design that ends with tax year 2025, and from January 2027 each state agency files its own 1099 information, with the governing memo (NCFS 26-1, October 13, 2025) and the older Controller policy text unreconciled on who files to the North Carolina Department of Revenue (conflicts NC-11 and NC-12). NCFS carries no Medicaid claim and no eligibility record in anything this package prints; it is drawn only where the finance lane touches it, at E4.

4. Lane by lane notes: the steps

PHASE A · Authority, policy, and the federal interface

A1 · Hold and maintain the State Plan; submit SPAs. Lane: NC DHHS and DHB, agency level. Purpose: keep one governing plan in force and move every change through CMS in the open. In hand: the Title XIX State Plan of record (register document H-001) and the State Plan Public Notices page (H-002). What happens: the plan is amended whenever federal statute or regulation, state law, organization, policy, or program operation materially changes (42 CFR 430.10 and 430.12, register entry CFR-430-001, graded Verified); SPAs post publicly for 10 days before submission under the NC entry NC-002, then list as sent to CMS. Produces: the amended plan and the SPA packets, several of which the cure pass holds as approved instruments. Next: A6. Open item: the state side procedure and clock for answering a CMS request for additional information on pending material is stated in no held document (CFR-430-002, Partial); it is carried in OI-NC-09.

A2 · Make coverage policy by the North Carolina procedure. Lane: DHB Coverage Policy function. Purpose: turn authority into the clinical coverage policies providers and plans actually work from. In hand: G.S. 108A-54.2 and entry NC-003. What happens: a coverage policy publishes for 45 days of comment, and a modified policy re-notices for 15 days. Produces: the clinical coverage policy texts. The cure pass acquired policy texts mid pass for five policies that had stood as titles only (hysterectomy, abortions, sterilization, psychiatric residential treatment, and home health), and 15 register rows were re-graded on the texts read; that history is why this lane's guide entry insists on text, not titles. Next: every delivery lane in Phase D.

A3 · Hold the waiver authorities. Lane: DHB Waivers, with the Tailored Plans. Purpose: keep each home and community based authority in force and inside its approved terms. In hand: the 1915(c) Innovations and TBI waivers, the Community Alternatives Program waivers including CAP/DA and CAP/C, and the Appendix K mechanism for emergency flexibilities. What happens: Innovations and TBI services run through the Tailored Plans; CAP services run through Medicaid Direct; an Appendix K operates only as CMS approves it. Produces: the waiver programs at D2 and D3. Open item: **OI-NC-02**, document H-035, the CAP/DA Appendix K approval NC.0132.R07.10, closed at the closeout of October 30, 2026, when the approval was read in full at its live address; the state posts R07.09, and this guide does not treat R07.09 as the approval of record for R07.10.

A4 · Hold the Title XXI structure. Lane: DHB NC Health Choice. Purpose: administer what remains of NC Health Choice as a Title XXI program inside DHB, on its own terms. In hand: Session Law 2022-74's direction to combine the programs, the April 1, 2023 move of about 55,000 children to NC Medicaid, and the still listed separate NC Health Choice State Plan on the Public Notices page. What happens: Part 457 obligations are graded against the residual structure, with conflict NC-5 on the face of the rows it touches. Produces: the CHIP reporting and audit record. Open item: **OI-NC-13**, whose heaviest member is CFR-457-046, a STRUCTURAL not applicable determination the second seat flagged as the register's first retest, because the retained plan text describes the former separate CHIP regime in substantive terms and the determination stands on the later CMS approved conversion record.

A5 · Hold the Section 1115 demonstration authority. Lane: NC DHHS and DHB, agency level. Purpose: keep the Reform Demonstration (11-W-00313/4) in force as the authority under which managed care and the Healthy Opportunities Pilots operate. In hand: the CMS renewal approval of December 10, 2024, running to December 9, 2029; the application had requested November 1, 2024 to October 31, 2029, and the approved dates govern (conflict NC-3). What happens: quarterly and annual monitoring reporting runs at F5 (entry NC-011). The Healthy Opportunities Pilots stand in this step as authority only: the General Assembly did not fund the pilots after July 1, 2025 and operations suspended; $9 million in SFY27 restart funding and continuing renewal negotiations stand on the same agency page, and no restart service date was established (conflict NC-10). Open item: **OI-NC-01**, document H-024, the Special Terms and Conditions that state the demonstration's operative terms, closed at the closeout of October 30, 2026. The document was read in full at its live address at medicaid.gov. Its cover records the Whole Family Transition to Care conforming change under section 71109, adding STC 4.3.b(iii), running from October 1, 2026 through December 9, 2029. The approval record and the CMS demonstration page held as H-027 corroborate the document.

A6 · CMS receives, approves, defers, or disallows. Lane: CMS, federal interface. Purpose: the federal half of every authority act in this phase. In hand: SPA packets, waiver applications and renewals, and demonstration material as submitted at A1, A3, and A5. What happens: CMS approves, requests more information, defers, or disallows, on the Part 430 machinery. Produces: approvals that return to A1, A3, and A5 as the authority of

record. Open item: none on collection. The two documents that stood open at the cure pass, H-024 and H-035, were both collected at the closeout of October 30, 2026.

PHASE B · Eligibility and choice

B1 · The county determines eligibility. Lane: county departments of social services, in NC FAST. Purpose: decide, at the county counter, who is eligible and in which category, under state supervision. In hand: the application, the Part 435 eligibility titles, and the state eligibility manuals. What happens: the county DSS determines and redetermines eligibility in NC FAST. Produces: the eligibility determination that B5 routes and Phase D pays against. Open items on this lane's register rows: the choice of category rule and the SSI loss redetermination rule are each asked, as manual statements, on the faces of CFR-435-006 and CFR-435-033 (both GAP-DETERMINED); the unwinding reporting submissions are asked to be filed with the record at CFR-435-029. See OI-NC-09 and OI-NC-16.

B2 · NC FAST records the determination. Lane: county DSS and NC FAST (system). Purpose: make the determination a system record the rest of the program can stand on. In hand: the B1 determination. What happens: the determination stands in NC FAST, the eligibility system of record. Produces: the record B3, B5, and the delivery lanes rely on. Open item: **OI-NC-16**. The handoff mechanism out of NC FAST is not stated in the sources reached; this guide names the seam and invents no interface.

B3 · The Enrollment Broker helps the beneficiary choose. Lane: NC Medicaid Enrollment Broker. Purpose: choice counseling: help beneficiaries choose or change a health plan, so B5's routing is the beneficiary's choice where choice exists. In hand: the enrollment of record from B2 and the plan choices open to the beneficiary's population. Published access: 833-870-5500. What happens: the broker assists selection and change. Produces: the plan selection B5 effectuates. Open item: **OI-NC-07**. The broker contract is not held, and the current contractor identity beyond the 2018 award to MAXIMUS was not established in sources reached; this guide prints the function and the award, and no current company name as fact.

B4 · The Ombudsman assists the beneficiary. Lane: NC Medicaid Ombudsman. Purpose: a beneficiary facing assistance channel outside the plan and outside the county. Published access: 877-201-3750. What happens: the Ombudsman assists with problems and routes what it cannot resolve. Produces: assistance and referral. Two limits print with this step: neither the Ombudsman nor the Broker is the Subpart E hearing authority (that is OAH, at F3), and the Ombudsman annual report is one of the instruments the record does not hold (**OI-NC-08**).

B5 · Route the beneficiary to their delivery system. Lane: DHB Managed Care Oversight. Purpose: turn an eligibility record and, where it applies, a beneficiary choice into an enrollment in exactly one delivery arrangement: Standard Plan, Tailored Plan, Medicaid Direct, or the EBCI Tribal Option. In hand: B2's record, B3's selection, and the population rules (Tailored Plan populations are defined by diagnosis and waiver enrollment; Medicaid Direct holds those outside managed care; the Tribal Option is an election for eligible

members). Produces: the enrollment Phase D delivers against. Open item: none drawn at this step; the routing rules themselves rest on the contract and policy record graded in the register, whose executed contract gap is OI-NC-03.

PHASE C · Provider enrollment and systems readiness

C1 · Provider Enrollment holds the function. Lane: DHB Provider Operations. Purpose: own enrollment as a program function: the named contact for provider enrollment issues and the process NCTracks executes. In hand: 42 CFR Part 455 Subpart E and Part 424 conditions as the register homes them to this lane. What happens: screening policy, enrollment standards, and provider questions land here; execution lands at C2. Produces: the enrollment framework C2 runs. Open item: the NCTracks affiliation disclosure question set carrying 42 CFR 455.107 is asked on CFR-455-009 (GAP-DETERMINED); see OI-NC-09.

C2 · NCTracks enrolls and reverifies the provider. Lane: NCTracks, operated by GDIT. Purpose: create and keep current the enrolled provider record every claim edit and payment stands on. In hand: the provider's application through the NCTracks provider portal. What happens: GDIT, as fiscal agent, executes enrollment and recredentialing under DHB as program owner. Actively enrolled providers finish reverification at least every five years (42 CFR 455.414); notifications begin 70 days before the due date, and the provider has the notification window the state publishes to finish; the application fee, the federal amount plus $100 under G.S. 108C-2.1, is charged again at each five year recredentialing (entries NC-004 and NC-005). Produces: the enrolled provider record, next holder every lane in Phase D. Name note: correspondence addresses in older and some live texts still say CSRA; GDIT is the operator of record since April 2, 2018 (conflict NC-14).

C3 · Publish the reverification horizon. Lane: NCTracks, operated by GDIT. Purpose: make the coming year's reverification due dates visible before they bite. What happens: the Active Provider Reverification Report refreshes monthly with twelve months of due dates. North Carolina publishes no single statewide resumption date, and none is printed in this package. Produces: the report providers and plans plan against. Next: C2, provider by provider.

C4 · Carry the interoperability duties. Lane: Systems, NCTracks, under DHB. Purpose: the access APIs and standard transactions the federal interoperability titles require. In hand: 42 CFR 431.70 and the related Part 431 and Part 457 API titles, and 45 CFR Part 162. Federal date of record for the access APIs: January 1, 2027. What happens on the record: the register grades the documentation rows GAP-DETERMINED (Patient Access API, CFR-431-013; Provider Access API and payer to payer exchange, CFR-431-014; provider directory API, CFR-431-015; CHIP Patient Access API, CFR-457-054; and the Part 162 companion guide rows), each with the action "publish the documentation" on its face. Produces, when it lands: the published API documentation that closes **OI-NC-10**. This guide draws no endpoint, because no endpoint is in the record.

PHASE D · Care delivery and claims

D1 · The Standard Plans deliver and report encounters. Lane: Standard Plan prepaid health plans. Purpose: deliver the Standard Plan benefit to enrolled members and account for it in encounter data. Plans of record: AmeriHealth Caritas North Carolina, Carolina Complete Health, Healthy Blue, UnitedHealthcare Community Plan, and WellCare of North Carolina. Operating fact, printed with the names wherever this guide lists them: WellCare of North Carolina merged into Carolina Complete Health on April 1, 2026, Carolina Complete Health is statewide (conflict NC-1's governing position, after the April 1, 2026 merger), and the operating choice is four plans. In hand: the enrollment from B5 and the model contract record; the executed Standard Plan contract instance is not public (**OI-NC-03**), and every register row that rests on the model form says so on its face. Produces: care, encounters (validated in the EQR lane at F1), and the plan reporting E2 and F6 consume. Cost sharing in this lane is OI-NC-17: the record contradicts itself on amounts, and this guide does not state a member's copay as fact.

D2 · The Tailored Plans deliver integrated care and the waiver services routed to them. Lane: Tailored Plans, with DHB Waivers. Purpose: one plan for physical health, behavioral health, and long term services for the Tailored populations, including Innovations and TBI waiver enrollees. Plans of record: Alliance Health, Partners Health Management, Trillium Health Resources, and Vaya Health. Operating fact: three operating plans since the October 1, 2026 merger of Vaya Health and Partners Health Management (Vaya Partners in the cure report's naming). Launched July 1, 2024 (conflict NC-2). In hand: B5 routing, the A3 waiver authorities, and the Tailored Plan contract record, whose executed instance is likewise not public (OI-NC-03); its Table 7 is the source of the $4 figure in the cost sharing conflict (OI-NC-17). Produces: integrated care and waiver services, encounters, and plan reporting. Also in this product family: the Children and Families Specialty Plan, Healthy Blue Care Together (Blue Cross and Blue Shield of North Carolina), for children and youth in the child welfare system, launched December 1, 2025. Open item on geography: the TBI Waiver does not operate in all areas, and no single current DHB page states operator and counties together (conflict NC-9).

D3 · Medicaid Direct and the EBCI Tribal Option deliver the rest. Lane: NC Medicaid Direct, with the EBCI Tribal Option. Purpose: the fee for service remainder, whole and unembarrassed: beneficiaries outside managed care, the Community Alternatives Program waivers, and care management through Community Care of North Carolina for much of this population. The EBCI Tribal Option, the primary care case management entity created by the Cherokee Indian Hospital Authority, stands in this lane as the tribal election inside the same remainder. In hand: B5 routing and NCTracks enrollment and claims (C2, D5). Produces: fee for service care paid on the D5 checkwrite. Open items: the Medicaid Direct PIHP executed contract is the third of the three missing contract families (OI-NC-03), and no NEMT broker is named in the sources reached for the transportation benefit in this lane (OI-NC-08).

D4 · Pharmacy, in two arrangements. Lane: DHB Pharmacy, with the PBA. Purpose: the drug benefit, with its two arrangements kept separate because the record keeps them separate. For NC Medicaid Direct, from May

2, 2026, Prime Therapeutics State Government Solutions LLC supports pharmacy benefit operations as the Pharmacy Benefit Administrator: formulary, drug rebate administration, point of sale claims, drug utilization review, prior authorization, PHP Lock-In oversight, and reporting. NC Medicaid Direct continues to manage all clinical policies and reimbursement methodologies for point of sale pharmacy, and NCTracks pharmacy functionality is to be discontinued for this purpose. Inside the prepaid health plans, pharmacy runs through the plans' own arrangements; no plan pharmacy benefit manager is named in the sources reached, and none is named here (**OI-NC-11**). Produces: dispensed drugs, rebate administration feeding E3's finance record in part, and DUR feeding F1 and F2.

D5 · NCTracks adjudicates and pays fee for service claims on the weekly checkwrite. Lane: NCTracks, operated by GDIT. Purpose: the payment heartbeat of the fee for service program. Cycle of record (entry NC-006): claims cutoff Thursday, portal claims to 11:59 p.m. and batch by 6:00 p.m.; checkwrite normally the following Tuesday, the date the state approves and releases funds and the date on the Remittance Advice; electronic funds transfer effective Wednesday; the cycle shifts on the published holiday and quarter and year end rule. Annual schedules publish as PDFs for 2025, 2026, and 2027. In hand: the enrolled provider record (C2) and the eligibility record (B2, by the seam named at OI-NC-16). Produces: paid claims, remittance, and the payment record F2 and E1 read. No monthly PHP capitation payment day is published in any source reached; capitation timing is not drawn into this cycle (OI-NC-15).

PHASE E · Payment, finance, and recovery

E1 · Finance answers for the money to CMS. Lane: DHB Finance Section, with agency level. Purpose: claim the federal share correctly and keep the procedures that govern refunds, crediting, and disallowance in the open. In hand: the Part 433 financial administration titles and the Part 447 payment titles as homed to this lane (74 entries, the register's joint largest finance block, at Verified 11, Partial 50, GAP-DETERMINED 12). Open items of record on this step: the CMS-64 crediting procedure for the federal share of provider overpayments (CFR-433-021, GAP-DETERMINED, with the basis completion noted at OI-NC-13), the quarterly voided check refund and disallowance interest procedures (CFR-433-005), the quarterly 433.74 donation and tax summary reports (CFR-433-007), the MMIS reapproval record (CFR-433-011), and any current replacement advance planning document (CFR-433-012). Produces: the claiming record CMS oversees at F5.

E2 · Rates and capitation stand on certifications the public record does not hold. Lane: DHB Finance, with DHB Managed Care. Purpose: set and certify the rates the plans are paid. What the record shows: the certifications are referenced in state and association letters and posted nowhere; the register's actions are to publish them (CFR-438-003, CFR-438-005, CFR-447-020). The NC specific directed payment preprints, including the HASP preprint, are CMS downloads only (**OI-NC-06**). The statutory floor that is public: the 88 percent medical loss ratio minimum at G.S. 108D-65 (entry NC-009), with plan MLR calculated and reported annually. Produces, when the certifications post: the rate record that closes OI-NC-05. Until then, every rate statement in this package carries the gap with it.

E3 · Third party recovery, and estate recovery. Lane: DHB Third Party Recovery (TPL). Purpose: where another payer or an estate owes, Medicaid is not the first dollar, and the federal share of what is recovered goes back correctly. In hand: the Part 433 third party titles homed to this lane (7 entries), the TPL manual MA-2400, acquired in the cure pass with its currency flagged (the text was last reissued January 1, 2011), and the estate recovery manual MA-2285, also acquired in the cure pass. Recoveries run through the state's vendor arrangement; no vendor name is carried in the sources reached for this lane, and none is printed. OCPI's TPL role on an EBCI facing document is printed in the register as the secondary home; both homes stand. Open items: the federal share repayment procedure (CFR-433-015) and the incentive payment and distribution procedure (CFR-433-018), both GAP-DETERMINED.

E4 · Vendor payments run through NCFS. Lane: DHB Finance, on the state NCFS system. Purpose: the agency's own vendor money, as distinct from provider money at D5. What happens: vendors are paid through NCFS under the State Controller, and the tax reporting design for those payments changes at tax year 2026, from central filing by the Controller to agency filing, with the governing documents unreconciled as printed in section 3 of this guide (conflicts NC-11 to NC-13). Produces: vendor payment and the agency's 1099 record, documented in full in Part II of the October 21 binder set. This step is a touchpoint, not a Medicaid payment channel: no claim pays here.

E5 · Publish the fiscal reporting of record. Lane: DHB Finance Section. Purpose: the recurring public account of the program's money. Instruments: the Medicaid Annual Report and Tables, by state fiscal year, SFY 2025 the latest as reached, with the Finance Section as published contact and no publication month or day printed on the index page (its anchor stands UNRESOLVED in the register, entry NC-007); medical loss ratio reporting, state published in both CMS defined and Department defined forms; and the PHP Performance Metrics report to the General Assembly under Session Law 2023-134, section 9E.20, the SFY 2025 report dated April 6, 2026 (entry NC-008). Produces: the published fiscal record F5 and the public read.

PHASE F · Quality, integrity, appeals, and oversight

F1 · Quality Management and Improvement holds the quality record. Lane: DHB Quality (QMI). Purpose: state the quality strategy, measure against it, and publish the measurement. Instruments of record: the Managed Care Quality Strategy (the record holds the 2023 document; the 2025 strategy is **OI-NC-04**, approved July 1, 2025 by a DHB bulletin's account, published by the same account on this unit's page, and not on that page when the cure pass read it in full; federal rules call for a current strategy at 42 CFR 438.340, and its triennial review fell due in this window); the Annual Quality Report (the held report covers 2021 to 2023, published June 2025; register document H-123, whose citation class the second seat corrected in the cure pass, a chart value misread as a citation, printed in the cure report as a finding); the program wide EQR Technical Report, annual, EQRO Health Services Advisory Group (HSAG), the current 2024 to 2025 report acquired in the cure pass, with Encounter Data Validation reports alongside; and Core Set reporting, whose submission rows stand GAP-DETERMINED (CFR-437-001 to CFR-437-004). Produces: the quality record F5 and the public read.

This lane's register line is the thinnest in the book, 12 entries at Verified 1, and this guide prints that as the finding it is.

F2 · OCPI holds program integrity. Lane: DHB Office of Compliance and Program Integrity. Purpose: fraud control, error measurement, and the audit side of utilization control. In hand: the Part 455 program integrity titles and the Part 456 control and audit titles the register splits to this lane (the same Part's quality assessment and drug use review duties sit with Quality and Pharmacy, on the CFR's own line). Cycles of record: Payment Error Rate Measurement and Medicaid Eligibility Quality Control. Open items: any professional review agreement (CFR-456-003), any remote facility variance (CFR-456-017), and the quarterly satisfactory showing record (CFR-456-019), each GAP-DETERMINED with "produce it or state that none exists" on its face.

F3 · OAH conducts the fair hearing. Lane: North Carolina Office of Administrative Hearings. Purpose: the hearing itself, outside the agency that acted. Authority: G.S. 108A-70.9A and 108A-70.9B for contested Medicaid recipient appeals involving DHHS, G.S. Chapter 108D for appeals involving an MCO, procedure at 26 NCAC 03 .0401 to .0402. What happens: on the DHHS track the beneficiary returns the hearing request to OAH within 30 days of the adverse decision; on the MCO track the instrument is the State Fair Hearing Request; an Administrative Law Judge conducts the hearing. County DSS handles eligibility appeals at the first level, and the agency side duties that are not the hearing (notice, aid pending) sit at F4. Basis of the home: the determination of October 21, 2026, resting on the statute and the Administrative Code as OAH publishes them; a DHHS side designation of OAH was not found and the determination does not rest on it (**OI-NC-12**). The lane's four register entries (CFR-431-022, CFR-431-023, CFR-431-025, CFR-431-027) all grade Partial.

F4 · The agency side of the appeal: notice, aid pending, corrective action. Lane: agency level, DHHS and DHB and the determining county DSS. Purpose: the duties that belong to whoever took the adverse action, paired with F3's hearing. In hand: 42 CFR 431.206, 431.210, and 431.211 (notice content and advance notice, CFR-431-024) and 431.230 and 431.231 (maintain and reinstate services pending hearing, CFR-431-026), both homed agency side on the same October 21, 2026 determination that homed the hearing to OAH. Produces: the notice the beneficiary appeals from, services maintained while the appeal runs, and corrective action executed on the F3 decision.

F5 · Federal oversight of the running program. Lane: CMS, with agency level reporting. Purpose: the standing account the state renders upward. Instruments: Section 1115 quarterly monitoring reports and the annual monitoring report by demonstration year (entry NC-011); SPA and waiver monitoring from Phase A; EQR and quality reporting from F1; and T-MSIS, for which CMS lists North Carolina as updated for the July 2026 reporting period, while North Carolina's own published submission cadence was not established in sources reached (**OI-NC-15**). Produces: the federal oversight record. Nothing in this step publishes anything itself; publication of North Carolina's own figures waits on the Founder's word, as the cure report records.

F6 · Managed Care Oversight holds the plans to the record. Lane: DHB Managed Care Oversight. Purpose: monitor the plans against the contract and the federal managed care titles, and remedy shortfalls in the open. In

hand: the Part 438 titles homed to this lane (76 entries, Verified 12, Partial 58, GAP-DETERMINED 6, the register's largest Partial block), the monitoring system the register asks to be published as a single description mapped to the 438.66(c) domains (CFR-438-021), and network adequacy remedy plans, asked starting with the shortfalls on the record (CFR-438-033). Standing limit, printed with the step: executed contracts are not public for any of the three contract families (**OI-NC-03**), and the CMS approval of the EQRO contract and the FFP rate claimed for EQRO activities are asked at CFR-438-047. A monitoring lane whose base contracts are model forms is monitoring against a published template; the register says so on every affected row, and so does this guide.

5. Glossary: North Carolina terms of record

- **Appendix K.** The emergency amendment mechanism for a 1915(c) waiver. In this package, the term matters for one document: the CAP/DA Appendix K approval NC.0132.R07.10, document H-035, collected at the closeout of October 30, 2026.
- **CAP, CAP/C, CAP/DA.** Community Alternatives Program waivers, run through NC Medicaid Direct. CAP/DA serves adults with disabilities; CAP/C serves children.
- **Checkwrite.** The NCTracks weekly payment cycle: Thursday claims cutoff, Tuesday checkwrite, Wednesday electronic funds transfer (entry NC-006).
- **Children and Families Specialty Plan (CFSP).** The managed care product for children and youth in the child welfare system: Healthy Blue Care Together, operated by Blue Cross and Blue Shield of North Carolina, launched December 1, 2025.
- **County DSS.** The 100 county departments of social services, which determine Medicaid eligibility under state supervision, in NC FAST.
- **DHB.** The Division of Health Benefits, inside NC DHHS, the single state Medicaid agency since the August 1, 2018 combination that ended the Division of Medical Assistance (DMA) as a separate division.
- **EBCI Tribal Option.** The primary care case management entity created by the Cherokee Indian Hospital Authority for eligible members of the Eastern Band of Cherokee Indians, launched July 1, 2021.
- **Enrollment Broker.** The contracted choice counseling function (833-870-5500). Contract awarded to MAXIMUS in 2018; current contractor identity beyond that award not established in sources reached.
- **EQRO, EQR.** External Quality Review Organization, and the review it performs. North Carolina's EQRO of record is the Health Services Advisory Group (HSAG).
- **GDIT.** The operator of NCTracks and the state's fiscal agent, under that name since April 2, 2018 (formerly CSRA).
- **HASP.** The directed payment arrangement whose preprint is among the CMS download only instruments at OI-NC-06. The record of this package names the preprint, not its terms, and this glossary does not expand it beyond the record.

- **Healthy Opportunities Pilots (HOP).** The Section 1115 test of non medical interventions (housing, food, transportation, interpersonal safety). Authority renewed; operations suspended after July 1, 2025 for lack of funding; no restart service date established.
- **Innovations Waiver.** The 1915(c) waiver for individuals with intellectual and developmental disabilities, served through the Tailored Plans.
- **LME/MCO.** Local management entity, managed care organization: the entities from which the Tailored Plans were procured.
- **MA-2285, MA-2400.** The state manual numbers of record for Estate Recovery and for Third Party Liability. MA-2400's text was last reissued January 1, 2011; its currency is flagged wherever this package cites it.
- **Medicaid Direct.** NC Medicaid Direct, the fee for service remainder for beneficiaries outside managed care.
- **MLR.** Medical loss ratio. North Carolina's statutory minimum is 88 percent, G.S. 108D-65.
- **NC FAST.** The eligibility system of record used by the county departments of social services.
- **NCFS.** The North Carolina Financial System, the state financial system under the State Controller, where vendor payments run.
- **NC Health Choice.** The Title XXI (CHIP) program. About 55,000 children moved from it to NC Medicaid on April 1, 2023 under Session Law 2022-74; a separate Health Choice State Plan still lists on the Public Notices page (conflict NC-5).
- **NCTracks.** The multi payer claims, provider enrollment, and payment system, operated by GDIT as fiscal agent, DHB as program owner.
- **OAH.** The North Carolina Office of Administrative Hearings, which conducts Medicaid state fair hearings and recipient appeals through its Administrative Law Judges.
- **OCPI.** The Office of Compliance and Program Integrity, a division within DHB.
- **Ombudsman.** The NC Medicaid Ombudsman (877-201-3750), a beneficiary assistance channel. Not the hearing authority.
- **PBA.** Pharmacy Benefit Administrator, for NC Medicaid Direct only: Prime Therapeutics State Government Solutions LLC, from May 2, 2026.
- **PHP.** Prepaid health plan, the managed care plan form of the Standard Plan, Tailored Plan, and PIHP contract families.
- **PIHP.** Prepaid inpatient health plan, the contract form of the Medicaid Direct behavioral health arrangement in the register's contract family naming.
- **QMI.** Quality Management and Improvement, the DHB unit that publishes the Quality Strategy, the Annual Quality Report, EQR reports, and MLR material.

- **Reverification.** North Carolina's term for the five year provider revalidation cycle in NCTracks (42 CFR 455.414), with 70 day advance notifications and the monthly Active Provider Reverification Report.
- **SPA.** State Plan Amendment, posted publicly for 10 days before submission to CMS (entry NC-002).
- **Standard Plan.** The prepaid health plan product for most managed care beneficiaries, launched July 1, 2021. Five plans of record; four in operating choice since April 1, 2026.
- **STCs.** Special Terms and Conditions, the operative terms of a Section 1115 demonstration approval. For the current period, document H-024, collected at the closeout of October 30, 2026.
- **Tailored Plan.** The Behavioral Health and I/DD Tailored Plan product, launched July 1, 2024. Four plans of record; three operating since October 1, 2026.
- **TBI Waiver.** The Traumatic Brain Injury 1915(c) waiver, served through a Tailored Plan and not operating in all geographic areas.
- **TPL, Third Party Recovery.** Third party liability: the function that identifies other coverage, pursues recovery, and repays the federal share, under manual MA-2400.

6. Open items index, keyed to the map

Owner is stated as the register and cure report state it: a level of the state's structure, or the house desk that owns a capture remainder. "What closes it" is the act that would let the next grading pass re-grade the rows behind the item.

Open item	Lands at (map steps)	Owner of record	What closes it
OI-NC-01 · H-024, Section 1115 Special Terms and Conditions, collected at the closeout of October 30, 2026	A5, A6	Closed	The document was read in full at its live address at medicaid.gov and classed MAPPED-TEXT; its rows stand reconciled and the state stands cured as of October 30, 2026
OI-NC-02 · H-035, CAP/DA Appendix K approval NC.0132.R07.10, collected at the closeout of October 30, 2026	A3, D2	Closed	The same collection event as OI-NC-01; the document was read in full at its live address and classed REVIEWED-NO-CFR-CITATION-FOUND
OI-NC-03 · Executed contracts not public, all three managed care families	D1, D2, D3, F6	Division of Health Benefits (DHB)	Post the signed executed base contract for the Standard Plan, Tailored Plan, and Medicaid Direct PIHP families
OI-NC-04 · 2025 Quality Strategy not posted where the bulletin named (true gap NL-06)	F1	DHB, Quality Management and Improvement	Post the CMS approved 2025 Quality Strategy on the Quality Management and Improvement

Open item	Lands at (map steps)	Owner of record	What closes it
			page (register action at CFR-438-043 and entry NC-012)
OI-NC-05 · Capitation rate certifications referenced, posted nowhere	E2, D1	DHB	Publish the rate certifications for the current rating period (CFR-438-003, CFR-438-005, CFR-447-020)
OI-NC-06 · Directed payment preprints, including HASP; DSH audit or settlement document; standalone 1915(b) approval letter	E2, A3, E1	DHB; CMS is the host for the preprints	Post or file each instrument with the state record
OI-NC-07 · Enrollment Broker contract not held; current contractor identity not established beyond the 2018 award	B3	DHB, Managed Care Oversight	Produce the broker contract, which also settles the current contractor identity
OI-NC-08 · NEMT broker contract and Ombudsman annual report not held	B4, D3	DHB	Produce each instrument
OI-NC-09 · The standing acquisition list: 13 true gaps and the instruments behind the 71 GAP-DETERMINED rows, including the 10A NCAC 22 rulemaking notices	Across A1, C1, C4, E1, E3, F1, F2	Each row's owning level, on the register's face (section 5D owner, action, and question on all 345 Partial and GAP-DETERMINED rows)	Each acquisition upgrades its rows at the next grading pass
OI-NC-10 · Interoperability API documentation GAP-DETERMINED, against the January 1, 2027 federal date	C4	DHB, Systems (NCTracks)	Publish the Patient Access, Provider Access, and directory API documentation and the Part 162 companion guides
OI-NC-11 · No plan pharmacy benefit manager named in the record	D4	The plans, under DHB Pharmacy's policy record	A plan or state source of record naming the arrangements; until then the map draws them unnamed
OI-NC-12 · No DHHS side designation of OAH found (wanted source W-17)	F3	DHHS and DHB, agency level	Produce the designation instrument; the OAH home does not wait on it, resting on statute and the Administrative Code
OI-NC-13 · Three cure qualifications: CFR-457-046 first retest; CFR-441-021 checkbox confirmation; CFR-433-021 basis completion	A4, A2, E1	The audit rotation (retest); the registrar (the two record completions)	The next audit rotation and the next registration touch, respectively
OI-NC-14 · Authority and operations apart: Healthy Opportunities Pilots suspended; PCS Alignment Demonstration in public comment through November 9, 2026, postdating the register	A5	NC DHHS and DHB; the General Assembly on pilot funding	A restart service date established on the record; the demonstration entering the register at its next build

Open item	Lands at (map steps)	Owner of record	What closes it
OI-NC-15 · Unpublished cycles: no monthly PHP capitation payment day; no state published T-MSIS cadence	E2, D5, F5	DHB Finance; DHB, agency level	Publish the cycle, or leave the absence on the record as this package leaves it
OI-NC-16 · NC FAST handoff mechanism not stated in sources reached	B2	Eligibility operations (Division of Social Services and county DSS), under DHB	A source of record describing how a determination reaches NCTracks and the plans
OI-NC-17 · Cost sharing record in conflict: $2 and $3 plan amounts of 2005 vintage; $4 at Tailored Plan Table 7; a no charge passage for managed care enrollees; "no cumulative maximums" against 42 CFR 447.56	D1, D2, E2	DHB, agency level and Finance	Conform the state plan attachments to the operative amounts and state the aggregate limit machinery, as the register's open questions ask

7. Sources, method, and the closing note

This package stands on four records, and on nothing else. The North Carolina register of record, 501 entries with their NC homes and determinations of October 27, 2026, confirmed at the closeout of October 30, 2026. The NC Cure Report of October 27, 2026, for the document axis, the findings, and the verification, and the drill down closeout of October 30, 2026, for the collection of the last two documents and the closing of the cure. The determinations file of record for October 27, 2026, for every row level action and question this guide summarizes. And the October 21, 2026 North Carolina binder set, Part I in particular, for the program structure, the published organization, the cycles, and the 16 register conflicts (NC-1 to NC-16) this guide prints where they land. Where those records are silent, this guide names the silence as an open item; it does not fill it from general knowledge of how Medicaid usually works, and it names no person, vendor, or procedure the records do not name.

The closing note is the status note, repeated because it is the package's honesty: North Carolina is cured as of October 30, 2026. The register is graded in full and the inventory is dispositioned in full, as of the cure pass of October 27, 2026. The last two documents, H-024, the Section 1115 Special Terms and Conditions, and H-035, the CAP/DA Appendix K approval NC.0132.R07.10, were collected at the closeout of October 30, 2026. Each one was read in full at its live address at medicaid.gov. This map and this guide are the process as the record holds it, gaps named, and nothing rounded up.

End of guide. Companion to the North Carolina Medicaid End-to-End Process Map, October 31, 2026. The step numbers match on both. Built from public information and the house record. Agentic Armor LLC.

PART 5 OF 7

1099 Deep Dive (Atlas Part II)

13 pages

PART 5

NC-Atlas-Part-II-1099-Deep-Dive-2026-10-31.pdf

This part is Part II of the North Carolina Atlas work. It covers the 1099 reporting line in depth. It follows NCTracks and the provider line. It follows NCFS and the vendor line. It follows Form NC-3 and the state filing layer. It runs from the federal requirement to the state machinery that carries it. It rests on the federal regulation text. It also rests on the state's published systems and filing record, in the edition of October 31, 2026.

Status of record, October 31, 2026. 183 of 196 documents stand collected and reconciled. That count is 93.4 percent. The register stands fully graded. North Carolina is cured as of October 30, 2026. The two documents that closed the cure are named on the cover in full. The How this binder works section names them in full as well.

The pages that follow are the same pages as the standalone download of the same name and date.

The North Carolina 1099 Deep Dive

NCTracks and the provider line, NCFS and the vendor line, Form NC-3 and the state filing layer: Part II of the North Carolina Master Binder

Federal Atlas Program, North Carolina

Reissued edition of October 31, 2026. This edition reissues the refreshed edition of October 27, 2026 on the cured record of October 30, 2026. The refreshed edition refreshed the October 21, 2026 edition of Part II. It keeps the October 21 structure (sections 4.1 to 4.10). It carries the North Carolina public record retrieved October 21, 2026. It applies the October 27, 2026 cure pass where the cure record supersedes the October 21 text. It applies the cure pass where the lane notes supersede that text as well. The cure pass is the October 27, 2026 review that graded every register entry against public evidence. Figures touched by the cure carry the cure pass date, October 27, 2026, on their face.

Status, printed honestly. North Carolina is cured as of October 30, 2026. The cure pass of October 27, 2026 stands finished and verified. The closeout of October 30, 2026 collected the last two open documents and closed the cure. The register of 501 entries is fully graded. The grades are Verified 141, Partial 274, GAP-DETERMINED 71, N-A-DETERMINED 10, Prospective 5, and Unverified 0. The document reconciliation stands at 183 of 196 rows, 93.4 percent, at October 30, 2026. The inventory holds 13 true gaps. The two documents collected at the closeout are H-024, the 1115 Special Terms and Conditions, WFTC overlay version, and H-035, the CAP/DA Appendix K approval NC.0132.R07.10. Both documents sit at medicaid.gov. Direct download was refused for each one. Each one was read in full at its live address through the house browser lane.

Boundary of this part. This part covers the 1099 reporting line for North Carolina only. It covers the provider line through NCTracks. It covers the vendor line through NCFS. It covers the state filing layer through Form NC-3. It does not cover the full North Carolina register. That register sits in the Atlas Register volume. It does not cover any other state. It does not restate federal figures that the refresh sources do not carry. Section 4.6 flags those figures instead. This part speaks as of October 30, 2026. This edition is dated October 31, 2026.

What the refresh changed. The refresh made four cures. It also made one plain naming. First, the NC Health Choice coverage note in section 4.2 now carries the cure posture for conflict NC-5. That posture is stated here in plain words. The conversion to a Medicaid expansion CHIP was approved September 11, 2023, under Session Law 2022-74 (cure record, October 27, 2026). Second, the NCDOR format position in section 4.5 now matches the systems lane record, called Lane B in the files. XML filing in eNC3 is a stated plan for January 2027. It is not a present acceptance. Two details come out because the lane record does not carry them. One detail is a specifications revision number. The other is a live-testing claim. Third, section 4.5 gains the Form NC-1099M paragraph the October 21 edition omitted. That paragraph is sourced to the 1099 Addition and to Lane B. Fourth, section 4.6 no longer restates federal figures that the refresh sources do not carry. It flags those figures on its face. It keeps only what a North Carolina source confirms. Fifth, the managed care 1099 gap is named plainly. It is named in section 4.1. It is named in its own headed passage in section 4.2. It is named at gap G-05. The Refresh Record at the end of this part gives the full change list with sources.

Contents. Section 4.1 gives the systems map, in five lines. Section 4.2 covers the provider line, NCTracks. Section 4.3 covers the vendor line, NCFS and the State Controller. Section 4.4 covers DHHS own position. Section 4.5 covers the state filing layer, NCDOR and Form NC-3. Section 4.6 covers the federal floor, as far as the refresh sources carry it. Section 4.7 covers correction and mismatch machinery on North Carolina lines. Section 4.8 gives the NC year-end calendar. Section 4.9 gives the NC gap register, with 11 gaps. Section 4.10 covers conflicts inside the 1099 record. The Refresh Record of October 27, 2026 follows. The Sources list closes the part.

4.1 The systems map, in five lines

1. The provider line. NCTracks is the multi-payer MMIS. GDIT operates it as fiscal agent for the Department of Health and Human Services. NCTracks sends provider 1099s. It sends one form per Tax ID per payer. DHB and DPH are the payers named. A form is due when payments to the NPIs under a Tax ID reach $600. The 1099s on this line are issued through the NCTracks fiscal agent operation. No NCTracks source names a separate accountable issuer. The State Controller is not named on this line at all.

2. The vendor line, through tax year 2025. NCFS is the North Carolina Financial System. It went live in October 2023. It is the state central financial system of record where it carries payment reporting. It holds the State supplier payment data as flagged invoice data. The Office of the State Controller transmitted one electronic file to the IRS for all NCFS agencies. Each agency printed and mailed its own forms. Each agency also filed its own 1099 information with the NC Department of Revenue.

3. The vendor line, from tax year 2026. The IRS retired FIRE. OSC no longer files for agencies. Each agency files its own 1099s through the IRS IRIS portal. It files from an NCFS-supplied file by form type (NEC, MISC, G). It files under its own Transmitter Control Code. NCFS remains the system of record for the underlying payment data. The filing act moves to the agencies.

4. The state layer. Form NC-3 is the Annual Withholding Reconciliation. It is due electronically through eNC3 by January 31. The state copies of W-2 and 1099 statements go with it. The federal and state combined filing program does not satisfy North Carolina. Required statements are filed directly with NCDOR.

5. TIN data. The vendor line runs on the OSC Substitute W-9. It also runs on IRS TIN Matching under OSC Policy 1200.02. The provider line runs on the NCTracks provider record. That record holds the TIN, the legal name, and a TIN-standardized 1099 address. No published TIN-matching owner sits on that line. No published B-notice owner sits on it either. Between the two lines sits the gap this part names plainly. For care the health plans pay, no North Carolina source reached states who issues the 1099. Payment routing for managed care is established. 1099 reporting for plan-paid amounts is not (section 4.2, gap G-05).

How to read this part. Every fact below is North Carolina own published record, retrieved October 21, 2026. A sentence can carry the October 27, 2026 cure pass date instead. A sentence can also sit in section 4.6, which is labeled for what it is. Where the NC record does not establish a point, this part prints NOT ESTABLISHED. It also names the sources searched (section 4.9). Nothing is filled by analogy to another state. Nothing is filled from federal practice. Nothing is filled from a commercial filing vendor. The lane note of record for this part is Lane B, North Carolina 1099, The Systems Portion End to End. Lane B is the systems research file behind this part. The retrieval date is October 21, 2026 for every source in that file.

4.2 The provider line: NCTracks

Who sends. NC publishes no single sentence naming an issuer of provider 1099s. What it publishes is an operational chain, and the refresh prints it as the Founder directed, through the fiscal agent operation. NCTracks sends the form. "NCTracks will send a 1099 if all payments to NPI(s) listed under a given tax ID add up to $600.00 or more. If you have multiple NPIs you will only receive one 1099 per Tax ID per payer (DHB/DPH)." GDIT operates NCTracks as "the State contractor for NCTracks, the multipayer Medicaid Management Information System (MMIS)," under contract to DHHS. GDIT is the fiscal agent for DHHS and for the NCTracks claims payment system, and GDIT succeeded CSRA as fiscal agent on April 2, 2018, with its published role unchanged. Live FAQ text still directs correspondence to "CSRA" at the same Raleigh post office box (Conflict NC-14). The State Controller is not named anywhere in the provider line. Any OSC role in provider 1099s is NOT ESTABLISHED. A named accountable owner of the production is likewise not published (Gap G-01).

Form and box. The current NCTracks FAQs and announcements say "1099" throughout and never name the form number or box. The only NC statement naming the form is a 1999 DMA bulletin ("correct issuance of 1099 MISC forms"), which predates NCTracks, the DMA to DHB combination of August 1, 2018, and the federal 1099-NEC split. The current production form and box are NOT ESTABLISHED (Gap G-06). The federal medical-payments convention is not imported into NC record.

Threshold, aggregation, and the record. The trigger is $600.00 in aggregate payments to the NPIs under one Tax ID, one form per Tax ID per payer. A provider paid over $600 by both DHB and DPH receives two forms. Income is reported to the Tax ID on the provider record that received payment, in Lane B words. "The income received during the calendar year is reported to the Tax ID number listed on the providers record that received payment." And: "The name on the 1099 matches the name on the enrolled NPI." Since August 2015, all NPIs sharing a TIN carry the same "1099 Reporting/Pay-To Address" and the same Organization Name, the legal name for the TIN, standardized by the system from the most recent record. One Manage Change Request for one NPI replicates to every NPI on the TIN. Where NCTracks and the IRS disagree, the IRS record controls. The provider is directed to establish what the IRS holds (CP575 or a verification letter. The FAQ prints the IRS toll-free business line as 1-800-829-4933) and conform the other record to it. NC FAQ warns of "28% withheld" while a mismatch is unresolved. That figure is NCTracks published wording on that page, quoted as NC wording only. The October 21 edition compared it to a federal backup withholding rate carried from program federal research. That comparison figure does not appear in the refresh sources and is not restated as verified in this refresh (see section 4.6 and the Refresh Record).

Mailing and reprints. There is no standing published mailing date. Each cycle is announced. For the 2025 cycle, the announcement (December 30, 2025) set mailing on Tuesday, January 20, 2026, Monday being the Martin Luther King Jr. holiday, to the 1099 Reporting/Pay-To Address on file, with seven to ten business days allowed for delivery. Reprints, including prior years back to 2013, run through one channel. That channel is the portal Contact Us form with subject "1099 Not Received" and the mailing address in the message field; allow ten business days. The same page states the fiscal agent limit in predecessor name. CSRA was not the fiscal agent during the earlier period and cannot produce those forms; the FAQ does not name the period or the predecessor who could. The published phone contact for an incorrect EIN is the general Call Center, 800-688-6696; no 1099-specific number is published. The standing FAQs disagree with each other on the non-receipt trigger (ten business days by Contact Us; "second Friday of February"; February 10 in the 2013 and 2014 announcements): Conflict NC-15. Other published handling rules stand as Lane B carries them: a deceased provider form is best sent to the provider estate or administrator under IRS guidelines, and a wrong address does not block IRS submission ("The IRS has but does not use the address to process returns, so the 1099 can still be submitted to the IRS"), a sentence that confirms submission happens without naming the transmission route (Gap G-03).

Corrections: a posture of limits. NC published correction posture for provider 1099s is mostly what cannot be done. A 1099 "cannot be regenerated due to a name change" (a legal name change updates the record prospectively, on documentation, namely a letter on company letterhead signed by the authorized individual and an IRS letter verifying provider name and TIN, sent by fax, email, or mail to the enrollment address the FAQ prints). Payments made to a record listed as an individual rather than the organization are fixed by the recipient filing a nominee or middleman return, a new Form 1099 and Form 1096 naming itself as payer and the true owner as recipient, not by a corrected NCTracks form. A closed year "is not a correctable item." And no published process for correcting a 1099 amount, or for NCTracks issuing a corrected form, was found in the FAQs or announcements reached. The point stands as NOT ESTABLISHED (Gap G-07).

Coverage, with the cure posture for NC Health Choice. NCTracks supports DHB, the Division of Mental Health, Developmental Disabilities and Substance Use Services, the Division of Public Health, and the Office of Rural Health, and its recipient side lists Medicaid, Health Choice, Public Health, and Rural Health and Community Care services. But only DHB and DPH are named as 1099 payers. Whether the other divisions payments generate 1099s under their own payer identities is NOT ESTABLISHED (Gap G-11). No separate NC Health Choice 1099 production is named anywhere. The beneficiary fact stands as the October 21 edition printed it: as of April 1, 2023, all NC Health Choice beneficiaries with active eligibility moved to Medicaid. The program posture around that fact is now stated in its cure form (cure record, October 27, 2026). Conflict NC-5 is graded through on the position that the conversion to a Medicaid expansion CHIP was approved September 11, 2023, under Session Law 2022-74, while the State Plan Public Notices page still lists a separate NC Health Choice State Plan. Nothing in either posture names a Health Choice 1099, payer, or production, and the sources reached are consistent with Health Choice payments having sat inside the DHB payer count while the separate beneficiary program existed. This part does not upgrade consistency into a finding. One exclusion is published: "Since LME's are local government agencies,

neither they nor their rendering providers would receive a 1099."

The managed care 1099 gap, named plainly

What the record shows. Payment routing is established, in NC Medicaid own words as Lane B carries them. Claims for beneficiaries enrolled in NC Medicaid Direct continue to be submitted to NCTracks, and claims for members enrolled in Medicaid Managed Care are submitted to the assigned health plan. Most NC Medicaid spending now runs through managed care (1099 Addition, plan-paid line passage). The NCTracks 1099 operation described above is the fee-for-service operation. It describes forms for payments on the NCTracks line, counted per DHB and DPH payer. What the record does not show. No North Carolina publication reached states that a Prepaid Health Plan (PHP) issues its own 1099s to its network providers for plan-paid amounts. No North Carolina publication reached states that NCTracks or DHB issues 1099s covering managed care payments. No North Carolina publication reached allocates 1099 responsibility between NCTracks and the PHPs by program, claim type, or payment channel. The NCTracks 1099 FAQs and announcements never mention PHPs, Standard Plans, Tailored Plans, or managed care. The NC Medicaid pages reached never mention provider 1099s at all. The cure record adds one fact that closes the most obvious place the answer could have sat (cure record, October 27, 2026, finding 4). No signed executed base contract is posted for any of the three managed care contract families (Standard Plan, Tailored Plan, and Medicaid Direct PIHP). The state posts the model instrument, the RFP or RFA form, and the amendment series only. So the allocation cannot be read from a signed PHP contract in the public record either. Where plan-paid provider income reporting sits, then, on the public record reached. The record names it nowhere. The duty is unpublished at the state level for the majority line of NC Medicaid spend, and this part does not infer plan issuance from the fact that plans pay the claims. A filer whose providers are paid by the plans holds the question open on its own contracts until the State publishes the allocation. Operating context at the cure-pass date follows, so the gap is not read against a stale plan count. The operating Tailored Plans stand at three at October 27, 2026, after the Vaya Health and Partners Health Management merger effective October 1, 2026, as Vaya Partners (cure record, October 27, 2026, finding 5). The October 21 set printed four. This gap is carried as Gap G-05 in section 4.9, with its sources searched and its closing instrument named.

4.3 The vendor line: NCFS and the State Controller

The system. The North Carolina Financial System (NCFS), built on Oracle Financials Cloud Solutions, replaced the existing solutions for general accounting functions, including Accounts Payable and payments, serving agencies, universities, and other government units and entities, and the more than 3,000 employees managing accounting and financial operations. In the terms this refresh was directed to use, NCFS is the state central financial system of record where it carries payment reporting. Supplier registration enters vendor TIN data there. Agencies flag invoices for 1099 reporting there. The flagged data is validated there on the maintenance report named below. NC publishes two go-live dates, October 2, 2023 in OSC 2023 Key Information ("NCFS Go Live," in a transition calendar otherwise framed around NCAS), and October 10, 2023 ("deploy") on DHHS NCFS page, and the difference is flagged, not resolved (Conflict NC-13). Vendors enter through supplier registration and the OSC Substitute W-9. DHHS own NCFS page directs that sub-W-9 and electronic payment forms be submitted through division contacts and contract administrators before invoices are submitted, to avoid payment delays.

The central process, through tax year 2025. OSC Official Memorandum NCFS 26-1 (October 13, 2025) is the controlling operational document. Annual processing begins in early December. OSC words govern: "OSC will transmit one file for the NCFS agencies' 1099 data to the IRS. Each agency will be reported under its own Federal ID number and is responsible for its data but is not responsible for transmitting the original electronic file. There should be no direct reporting of original NCFS 1099 data by the agencies to the IRS. As in the past, any 1099 information that is not maintained within NCFS will be the responsibility of the agency." The memo states the deadline for submitting the 2025 1099 electronic file to the IRS as January 31, 2026, and the filing act itself on Friday, January 30, 2026. Agencies procured their own supplies, printed from NCFS, and mailed forms to recipients by January 31, 2026. "OSC will not supply envelopes for printed 1099s or blank 1099/1096 forms for 1099 changes." Forms are made available for printing inside NCFS (printing guides AP-39 for original forms and AP-42 for

correction forms. The AP-42 worked example displays the "NC 1099 MISC Report"). Agencies, not OSC, filed their own 1099 information to NCDOR (Memo 26-1, in its own words, "Individual state agencies are responsible for filing their own 1099 information to the North Carolina Department of Revenue (NCDOR)"), and state withholding from NCFS payments "will not be reflected on the IRS 1099 forms that are printed from NCFS." Because reporting is centralized, the memo imposes a monthly duty, namely to review the NCFS AP-022 1099 Maintenance Report for accuracy each month to validate and update 1099 information. Foreign nationals are not 1099 recipients. "Non-resident Aliens (Foreign Nationals) are not eligible to receive IRS Form 1099. These transactions receive a 1042-S form which will be provided by OSC to each reporting agency," issued out of Sprintax Calculus, and agencies are told not to flag foreign vendors for 1099 reporting. P-Card payments are kept out of NCFS: "To avoid duplicate reporting of these transactions, 1099 eligible payments made with a P-Card should not be recorded in NCFS," a within-NCFS guard for payment-card transactions reportable on Form 1099-K, not a provider and vendor de-duplication rule (Gap G-04). Corrections recorded in NCFS from February 2, 2026 (zero-dollar invoices) were filed centrally on March 30, 2026. After that date, corrections travel as agency-built 1099 correction text files to OSC, prepared under IRS Publication 1220 specifications. Memo 26-1 does not enumerate the form types in the tax year 2025 central file in the text reached. A published OSC enumeration for that year is NOT ESTABLISHED (Gap G-10).

The policy layer, and its two open tensions. OSC Statewide Policy 1200.02 (Tax Compliance Policy, directory last updated January 21, 2025) assigns agencies compliance with IRS rules on information reporting, "B" notices, and backup withholding; describes TIN Matching, the IRS pre-filing e-service that compares the name and TIN on the OSC Substitute W-9, IRS Form W-9, or W-8 forms against IRS records; and states in its directory summary that OSC, as central processor, "will submit the electronic 1099-MISC file to the IRS and the NC Department of Revenue in a timely manner." Companion Policy 1200.01 requires each agency to comply with federal information return and Form W-2 reporting, including procedures for accumulating calendar year data and preparing returns in IRS acceptable media. Two tensions stand inside OSC own publications. First, the policy names only a 1099-MISC central file, while the production it governs is broader, by tax year 2026 published as NEC, MISC, and G, with no conforming policy text reached (Conflict NC-12). Second, the policy has OSC submitting to NCDOR, while Memo 26-1, the later operational document, makes each agency responsible for its own NCDOR filing (Conflict NC-11). Both statements stand in OSC publications as retrieved; the memo governs operations as the later, operational instrument, and this part prints the conflict rather than choosing silently.

The tax year 2026 break. OSC July 29, 2026 memo, "1099 Process Changes for Tax Year 2026," changes the architecture. "The IRS has retired the FIRE (Filing Information Returns Electronically) system currently used by OSC to file 1099s electronically on behalf of NCFS agencies. Starting tax year 2026, the IRS is requiring that 1099s be submitted to their new IRIS (Information Returns Intake System) portal." OSC determined central filing is "no longer reasonable". IRIS offers only application-to-application (A2A) filing, rejected as not feasible given the complexity and volume of statewide reporting and corrections across more than 40 legal entities, or template upload, and central filing would require OSC access to each agency IRIS portal, increasing risk and liability for error. From January 2027, each NCFS agency files its own 1099s in IRIS, uploading an NCFS-supplied csv by form type (NEC, MISC, G) that NCFS supports through the IRIS template process. Corrections are made manually in the portal and, in OSC words, can be filed immediately within the portal rather than waiting for an OSC-determined correction filing date. The portal itself prints IRS-approved forms in real time once a file is submitted. OSC continuing role is support. The support items are the csv, work with Oracle to keep the csv working with the IRIS template, the NCFS 1099 Invoice Maintenance Report, information sessions, and the TCC process. Under OSC Agency Steps memo (August 25, 2026), each agency names a minimum of two Responsible Officials, up to two Authorized Delegates, and a minimum of two Contacts. Each user obtains an individual ID.me account. A Responsible Official applies for the agency IRIS Transmitter Control Code with the agency EIN, selecting "Issuer" as role, "Portal" as transmission method, and "No" to "Will you participate in the Combined Federal/State Filing (CF/SF) program?". Both the TCC application and a new Delegation of Disbursement Authority were due by September 30, 2026, with an OSC Contact Center ticket (ncfs@ncosc.gov) by October 1, 2026, carrying Responsible Official and Authorized Delegate names and emails and the TCC application tracking number. The IRS may take up to 45 calendar days to approve a TCC, issued as a 5-digit alphanumeric code by mail. OSC October 2026 newsletter confirms agency CFOs should have

completed the TCC application by September 30 and carries the same transition as a standing update.

TIN data in NCFS. The collection instrument is the OSC Substitute W-9 (not the IRS form). It covers taxpayer identification type; the 9-digit TIN (EIN, SSN, or ITIN, without dashes); DUNS if applicable; legal name as registered with the IRS or Social Security Administration, the name shown on the income tax return; business or DBA name separately; legal and remittance addresses; contact data; entity type and classification. Supplier registration is a joint agency and OSC effort whose first agency-facing step is "TIN matching and initial approval," followed by spend authorization approval, then site setup, with formatting rules published in OSC October 2026 newsletter (no punctuation in supplier names or Tax ID numbers; supplier names in all capitals; supplier type undesignated unless the supplier is an individual). Ongoing accuracy is invoice-level: agencies flag invoices for 1099 reporting and validate on report RPT-AP-022 throughout the year. NCFS is the system of record for that flagged invoice data. Beyond the above, the internal NCFS supplier-master schema, matching cadence, and who at OSC runs TIN Matching for which agencies are NOT ESTABLISHED in sources reached. Policy 1200.02 describes TIN Matching as a service available to authorized payers and assigns its accuracy benefits to the vendor master database without naming an operator per agency.

4.4 DHHS own position

DHHS sits on both lines at once. Its program payments flow through NCTracks, where DHB and DPH are named payers. DHHS is itself an NCFS agency, one of the more than 40 legal entities reported under its own Federal ID, which for tax year 2026 must hold its own IRIS TCC and file its own vendor 1099s. OSC memos are addressed to all NCFS agency CFOs and publish no DHHS carve-out, and no DHHS-specific exception is published in the sources reached. What DHHS does not publish, in the sources reached, is a 1099 instruction set of its own. No departmental procedure distinct from OSC statewide memos and the NCTracks provider material (Gap G-08). Its published NCFS material is the deployment notice and the hosted Substitute W-9 instructions. Whether DHHS reconciles a payee who appears on both of its sides, an NCTracks provider who is also an NCFS vendor, is the de-duplication question, and it is open (Gap G-04).

4.5 The state filing layer: NCDOR and Form NC-3

This section is the NC Department of Revenue layer, printed as its own layer as the refresh directed. It covers the duty. It covers the statements. It covers the direct-filing rule. It covers the penalties. It covers the state-only forms. It covers the format position. Each item rests on NCDOR own published text as Lane B carries it.

The reconciliation. Under G.S. 105-163.7, every employer annually files an informational return with the Secretary of Revenue that reconciles the total North Carolina income tax withheld as listed on W-2 and 1099 statements with the amount of tax reported to the Department as withheld for the year. That return is Form NC-3, Annual Withholding Reconciliation, filed in the Secretary prescribed format. One NC-3 is filed per withholding account ID, with the state copy of each required W-2 and 1099 statement, electronically through the eNC3 and Information Reporting Application, due on or before January 31 of the succeeding year. Filing NC-3 requires a North Carolina withholding account ID number (register online for immediate issuance, or file Form NC-BR. Paper registration takes about four weeks). NC-3 and the statements may be submitted in separate uploads provided both are in by the due date. Corrections that change NC withholding previously reported go on Form NC-3X through a "New Amended Submission" in eNC3, with corrected W-2c, 1099, or 1042-S statements. Corrections that change no withholding figures (SSN, name, and the like) may be filed as corrected statements alone. A terminating business files by the last day of the month following the end of the calendar quarter of closure, with any statements not yet available filed when available but no later than the following January 31.

Who owes what. A filer must file NC-3 if required to withhold, or if it voluntarily withheld, NC income tax ("You must file Form NC-3 if you are required to withhold or you voluntarily withheld North Carolina income taxes," eNC3 FAQ). The statements that must accompany it turn on withholding, as the eNC3 FAQ table carries them. W-2 is required with or without NC withholding (with withholding: yes; without: yes, if issued to an NC resident or to a non-resident for services performed in NC). W-2G is required with withholding, and without withholding is not required if reported

to the IRS. Forms 1099-MISC, 1099-NEC, 1099-B, 1099-DIV, 1099-DA, 1099-INT, 1099-OID, and 1099-G are each required with withholding, and without withholding are not required (for 1099-MISC and 1099-NEC, not required; for the others, not required if reported to the IRS; for tax year 2025, Form 1099-DA cannot be filed electronically through eNC3 and is mailed to NCDOR, PO Box 25000, Raleigh, NC 27640-0001). Form 1099-R is required with withholding, and without withholding is required if the recipient address is in North Carolina. Form 1042-S is required with withholding, and without withholding is required if it includes North Carolina source income. Form NC-1099M is required with withholding, and without withholding is not required if reported to the IRS on a federal Form 1099-NEC or 1099-MISC. Under a standing Secretary waiver in the Important Notice ("This waiver will continue until further notice"), federal 1099-MISC and 1099-NEC statements that report no NC withholding need not be submitted with NC-3, while any statement reporting NC withholding must be filed as part of the NC-3 filing. Filers with no NC-3 duty may still owe statements directly: anyone who "directly or indirectly pays or controls the payment of any income to any taxpayer in North Carolina" must file certain W-2 and 1099 statements with the Department, a duty NCDOR ties to G.S. 105-154(b) in the same FAQ. Statements without NC withholding can be filed through eNC3 (upload, manual entry, or a combination) or on paper to the Department Raleigh post office box, without an NC-3, without any other cover page, without a withholding account ID, and, in that non-NC-3 lane, without exposure to the informational return penalties (see Penalties below). The eNC3 FAQ also carries a December edge case: a new withholding number issued in December may not be eNC3-eligible, and a paper NC-3 with statements attached by the due date is directed, with waiver available via Form NC-5501.

CF/SF does not satisfy North Carolina. NCDOR current FAQ answers the substitution question directly. "No. The required W-2 and 1099 statements must be filed directly with the Department." The 2018 specifications frame the same rule from the other side. "Although North Carolina participates in the IRS Combined Federal/State Filing Program," original, void, or corrected versions of the listed forms must be filed directly with NCDOR. The forms that page lists for mandatory direct filing are 1099-K; 1099-R where state tax withheld is populated and NC tax has been withheld or the recipient address is in NC; 1099-MISC where state tax withheld is populated and NC tax has been withheld, or specified income boxes are populated, and the recipient address is in NC (box numbers and form names as the 2018 specifications print them, including nonemployee compensation on 1099-MISC, which predates the federal 1099-NEC split in that document text); and the NC-specific forms NC-1099NRS, NC-1099PS, and NC-1099ITIN (the PS and ITIN forms filed in 1099-MISC format per Publication 1220; NRS in 1099-S format). The same page lists, for recipients with an NC address, 1099-B, 1099-DIV, 1099-INT, 1099-OID, 1099-G, and W-2G as also to be filed directly in electronic format if the information was not filed with the IRS via CF/SF or NC tax was withheld. The operative rule is one rule; the framing differs by document age (Conflict NC-16). OSC instruction that state agencies answer "No" to CF/SF participation on their IRIS TCC applications is an OSC instruction for the state-agency IRIS application, consistent with the direct-filing rule, and is quoted in section 4.3 only as such.

Penalties. In the NC-3 lane, G.S. 105-236(a)(10) carries, in NCDOR penalty page words. "A taxpayer will be assessed a penalty of $50 per day, up to a maximum of $1,000, for failure to file the informational return by the date the return is due," and "A taxpayer will be assessed the $200 penalty for failure to file Form NC-3 in the format prescribed by the Secretary." Late and wrong-format penalties can both apply. The automatic waiver of the $200 format penalty that had applied since 2020 no longer applies to returns due on or after January 1, 2022 ("will not automatically waive," Important Notice). Waiver is by Form NC-5501, Request for Waiver of an Informational Return Penalty (also requestable by phone, 1-877-252-3052, or by letter, per the FAQ). Filers not required to file NC-3 are not subject to the informational-return penalties, including when they file statements on paper in the non-NC-3 lane. Form 1099-K sits on a separate NC track: payment settlement entities file a duplicate of their federal Form 1099-K information with NCDOR by March 31 for the preceding calendar year under G.S. 105-251.2 (Session Law 2017-204), electronically, with, in the 2018 specifications words, no provision in North Carolina law permitting waiver of that electronic filing requirement. The same specifications state a $1,000.00 penalty for a report not timely filed, and no later NCDOR page reached restates that amount. Both 1099-K statements are the 2018 specifications wording, dated as such.

State-only forms. North Carolina keeps forms of its own beside the federal set. Form NC-1099M, Compensation Paid to a Payee, reports non-wage compensation paid for services performed in North Carolina and the North

Carolina tax withheld from it, for compensation paid on or after January 1, 2020. It is owed only where North Carolina tax is withheld, and it does not have to be filed where a federal Form 1099-MISC or Form 1099-NEC is required for the same compensation. It is never used to report wages (1099 Addition, Determination 5. Lane B, section 3.2 table). The NC-1099NRS, NC-1099PS, and NC-1099ITIN forms are carried in the CF/SF passage above, on the 2018 specifications text.

Furnishing. NCDOR eNC3 material reached governs filing with the Department. No NC-specific rule on furnishing 1099 copies to payees (timing, format, consent for electronic furnishing) was found in the NCDOR sources reached. The point stands as NOT ESTABLISHED (Gap G-09). OSC January 31 postmark instruction in section 4.3 binds state agencies as an OSC instruction in Memo 26-1, not as an NCDOR furnishing rule of general application.

The format position, as Lane B carries it (refresh cure). NCDOR plans to make XML filing available in January 2027, aligning with the IRS retirement of the FIRE system. NCDOR will support the IRS IRIS XML format. Publication 1220 format will no longer be supported by NCDOR beginning January 2027. CSV will not be supported. Manual entry in eNC3 continues. XML-supported forms are as the FAQ lists them. The forms are 1099-B, 1099-DIV, 1099-G, 1099-INT, 1099-K, 1099-MISC, 1099-NEC, 1099-OID, 1099-R, and W-2G (tax years 2024 to 2026) and 1042-S (tax years 2025 to 2026). Form NC-3 and Form W-2 continue in text format (W-2 per SSA specifications). NCDOR requires the TIN Type field (TINSubmittedTypeCd) as Individual_TIN or Business_TIN. "we do not accept Unknown." XML questions go to enc3@ncdor.gov. These are stated as NCDOR plans in that FAQ. The file specifications location was blank in the page text Lane B reached. The October 21 edition printed this passage in present tense (already accepts now), with a specifications revision number and a testing claim the lane record does not carry. The refresh prints the lane position and removes those two details. See the Refresh Record. NC-3 January 31 date, note, is North Carolina own. It coincides with a federal recipient-copy date, but it binds in NC by NC statute and is administered by NCDOR through eNC3, a state duty, not a federal echo.

4.6 The federal floor, as far as the refresh sources carry it

Label. This section is the federal layer. In the October 21 edition it printed federal figures carried from program federal research rather than from North Carolina sources. The refresh rule for this edition is that nothing rides unverified. A claim that cannot be re-verified from the refresh sources (the October 21 edition itself, Lane B, the 1099 Addition, and the cure record) comes out or stands flagged. The federal figures listed in the next paragraph could not be re-verified from those sources, and this refresh does not restate them as verified figures. Lane B by its terms does not restate federal dates as NC facts, and neither the Addition nor the cure record carries them.

Flagged, not restated. The October 21 section 4.6 printed the items that follow. A general threshold rising to $2,000 for payments in 2026 under the One Big Beautiful Bill Act (P.L. 119-21, section 70433), with attorney, royalty, and medical-payment threshold notes; federal late and incorrect information-return penalty tiers stated per form by lateness tier; CP2100 notice, B notice, and backup withholding timelines with a stated withholding rate and Form 945 reporting; and an electronic filing threshold stated as a count of information returns. Each of those figures is flagged here as carried federal research, unverified in this refresh, and none is relied on for any North Carolina statement in this part. A reader who needs the federal floor works it from the Generic Edition and the federal record, not from this part.

What the refresh sources do confirm. Two federal-route points are confirmed by a North Carolina source and stand as NC-established as well as federal. The IRS retired FIRE. From tax year 2026, 1099s go through the IRIS portal (OSC July 29, 2026 memo, quoted in section 4.3). One operative date for the 2026 cycle is carried from the 1099 Addition derived dates table, derived there from the published federal date under the federal weekend and holiday rule. Form 1099-NEC recipient copies and federal filing carry a published date of January 31. The operative date is Monday, February 1, 2027, because January 31, 2027 is a Sunday. The NCTracks $600 trigger in section 4.2 is NCTracks published trigger, stated as NC publishes it. No NC source reached restates the trigger for any later federal threshold era, and this part prints no restatement.

4.7 Correction and mismatch machinery on North Carolina lines

The two lines could hardly differ more. On the vendor line, corrections are a designed process with dates. Record them in NCFS from February 2, 2026, with zero-dollar invoices (report AP-41), in paid and accounted status by midnight March 29. OSC files the central correction file March 30 and correction forms print the same day (AP-42). Later corrections go as agency-built Publication 1220 text files through OSC. From tax year 2026 the design changes with the architecture. Corrections are made manually in the IRIS portal and, in OSC words, "can be filed immediately within the IRIS portal rather than waiting for the OSC determined correction filing date." TIN Matching is policy-assigned (Policy 1200.02), and supplier registration first gate is a TIN-matching approval. On the provider line, corrections are a set of published limits (section 4.2). No form is regenerated for name changes. Nominee returns cover wrong-record payments. Closed years are uncorrectable. No amount-correction process is published at all. No NCTracks or NC Medicaid source reached names a TIN-matching operator for providers, states whether provider TINs are run through IRS TIN Matching, or assigns B-notice receipt or handling to GDIT, DHB, or anyone else. The only published mismatch handling is the provider own: get the IRS record, conform NCTracks to it, call the Call Center. Extending OSC vendor-line policy across to NCTracks providers would be analogy. This part does not do it, and the point stands as Gap G-02. The federal mismatch machinery behind those terms is part of the flagged federal layer at section 4.6 and is not restated here as verified figures.

4.8 The NC year-end calendar

Every dated step below is stated by an NC source as a step in NC process. Federal dates are not restated here. Where an NC date coincides with a federal one, the NC source is the citation for that step.

Date	Step	Line
Monthly, all year	Review the NCFS AP-022 1099 Maintenance Report; validate and update 1099 information	Vendor
Early December	Annual 1099 processing in NCFS begins (Memo 26-1 wording)	Vendor
December 31	Calendar-year reporting period ends; "Deadline To Pay 1099 Invoices For CY2026" (NCFS Important Dates)	Vendor
January (announced per cycle)	Provider 1099s mailed to the 1099 Reporting/Pay-To Address: 2025 cycle, January 20, 2026; allow 7 to 10 business days	Provider
January 1 to 31	1099 forms available for printing in NCFS (AP-39); forms postmarked to suppliers by January 31	Vendor
January 29, 2026, midnight	Last changes to 1099 data in NCFS before OSC generates the original IRS file (tax year 2025 cycle)	Vendor
January 30, 2026	OSC transmits the original electronic 1099 file to the IRS for all NCFS agencies (tax year 2025 cycle)	Vendor
January 31	Form NC-3 plus required W-2 and 1099 statements due to NCDOR, electronically via eNC3	State layer
February 2, 2026	Agencies may begin recording 1099 corrections in NCFS (zero-dollar invoices)	Vendor
Second Friday of February (FAQ wording)	Provider non-receipt trigger in the current Wrong Address FAQ: one of three triggers in print (Conflict NC-15)	Provider
10 business days after request	Provider 1099 reprint delivery allowance (Contact Us, "1099 Not Received")	Provider
March 29, 2026, midnight	Last corrections entered in NCFS for the central correction file	Vendor
March 30, 2026	OSC submits the electronic corrections file; correction forms available for printing (AP-42); later corrections by agency text file per Publication 1220	Vendor
March 31	Payment settlement entities file duplicate 1099-K information with NCDOR (G.S. 105-251.2)	State layer

Date	Step	Line
September 30, 2026	Each NCFS agency IRIS TCC application and new Delegation of Disbursement Authority due (tax year 2026 transition)	Vendor
October 1, 2026	OSC Contact Center ticket due with Responsible Official and Authorized Delegate names and TCC tracking number	Vendor
January 2027	First agency-filed 1099s via IRIS (tax year 2026); NCDOR planned start for IRIS XML acceptance in eNC3, with Publication 1220 support ending at NCDOR as planned	Both

The items that follow are not published as dated steps. They print here so the absence is visible. The items are a provider-side correction cutoff before mailing, a provider corrected-1099 window, and a provider-line IRS transmission date. The items also include a tax year 2026 NCFS coding cutoff equivalent to the January 29, 2026 cutoff. The IRIS design removes the OSC-set correction date by OSC stated design, not by omission (Lane B, section 4.4).

4.9 The NC gap register: 11 gaps

On the pattern this program uses everywhere: what the record does not name is a gap, printed with the sources searched and what would close it. Eleven gaps stand in NC 1099 record. None is filled by inference. The cure record (October 27, 2026) does not renumber or close any of them; it adds the executed-contract fact that sharpens G-05, as that entry states.

G-01. Named accountable owner of provider 1099 production. What is missing is stated here. NCTracks sends the forms and GDIT operates the system as fiscal agent, but no NC source names a person, office, or division accountable for the production. The sources searched were NCTracks 1099 FAQ index and all four sub-pages; announcements 2013 to 2026, including the January 20, 2026 mailing; Contact Information (2025); NC Medicaid site search for "1099." The risk if it stays open is this. When a production fails (a late mailing, a wrong payer count), no published desk owns the answer. What closes it is an NC-published assignment of the production to a named DHB office or a fiscal-agent contract clause.

G-02. TIN matching and B-notice handling for Medicaid providers. What is missing is stated here. no source names a TIN-matching operator for NCTracks, states whether provider TINs are matched, or assigns B-notice handling to any party. The sources searched were all G-01 sources plus OSC Policies 1200.01 and 1200.02, read for any NCTracks application (none stated). The risk if it stays open is this. The federal mismatch machinery has no published NC operator on the provider line; mismatches surface as provider-initiated fixes after the fact. What closes it is an NCTracks or DHB publication assigning TIN matching and B-notice handling.

G-03. IRS transmission route for provider 1099s. What is missing is stated here. submission to the IRS is confirmed ("the 1099 can still be submitted to the IRS"); no source names FIRE, IRIS, paper and Form 1096, or who transmits. The sources searched were all G-01 sources. The risk if it stays open is this. The provider line filing route, and its readiness for the IRIS era, cannot be verified from the public record. What closes it is an NCTracks publication naming the route and transmitter. One note prevents conflation (Lane B, section 5(c)). NCDOR eNC3 and IRIS-XML material is the state filing route for payers generally. It is not evidence of the route NCTracks or OSC uses to file to the IRS.

G-04. De-duplication across the two systems. What is missing is stated here. no NC source addresses a payee who is both an NCTracks provider and an NCFS vendor, apportions reporting, or cross-checks the two productions. The published rules are each internal to one system (TIN aggregation in NCTracks; per-agency Federal IDs in NCFS; the P-Card guard in Memo 26-1). DHHS sits on both sides and publishes no reconciliation. The sources searched were all G-01 and vendor-line sources (Policy Directory, Memo 26-1, Process Changes memo, Agency Steps memo, NCFS Newsletter, 2023 Key Information), plus the DHHS NCFS page. The risk if it stays open is this. A dually-paid payee can be reported twice, split wrongly, or missed, with no published rule deciding which. What closes it is a published cross-system rule, or a DHHS reconciliation procedure.

G-05. The fee-for-service and managed care split (the managed care 1099 gap). What is missing is stated here. payment routing is established (Medicaid Direct claims to NCTracks; managed care claims to the health plan). No NC source states whether PHPs issue their own 1099s, whether NCTracks or DHB covers managed care payments, or how responsibility is allocated. NCTracks 1099 material never mentions managed care. NC Medicaid pages never mention provider 1099s. The sources searched were NCTracks 1099 material; medicaid.ncdhhs.gov site search and managed care claims fact sheet; DHHS pages. PHP contracts and plan manuals are outside the state-published record for this lane and were not treated as NC publications. The cure record (October 27, 2026, finding 4) confirms that no signed executed base contract for any managed care family is posted, so the signed-contract route does not close the gap on the public record. The risk if it stays open is this. The majority of NC Medicaid spend now runs through managed care; the 1099 responsibility for those payments is unpublished at the state level. What closes it is a statement in a PHP contract as published, or a DHB publication, allocating 1099 responsibility.

G-06. Provider 1099 form and box. What is missing is stated here. current NCTracks material says "1099" without naming the form or box; the only form named in NC record is a 1999 bulletin (1099-MISC), predating NCTracks and the NEC split. The sources searched were all G-01 sources. The risk if it stays open is this. Providers and researchers cannot confirm from NC own pages what they will receive. What closes it is one sentence in the NCTracks FAQs naming the current form and box.

G-07. Provider amount-correction process. What is missing is stated here. published limits cover name changes, wrong-record payments, and closed years; no process for correcting an amount, and no corrected-form issuance procedure, was found in the FAQs or announcements reached. The sources searched were all G-01 sources. The risk if it stays open is this. A wrong amount on a provider 1099 has no published remedy short of the Contact Us channel. What closes it is an NCTracks correction procedure for amounts.

G-08. A DHHS-specific 1099 procedure. What is missing is stated here. no DHHS-published instruction set of its own, distinct from OSC statewide memos and the NCTracks FAQs, was found. DHHS publishes the NCFS deployment notice and hosts the Substitute W-9 instructions. The sources searched were DHHS pages reached in Lane B, section 2.6, plus sections 4.3 and 4.4 sources. The risk if it stays open is this. The State largest department runs two 1099 lines with no departmental procedure in its own name. What closes it is a DHHS controller publication, if one exists, or confirmation that OSC memos are the whole procedure.

G-09. NC-specific furnishing rules. What is missing is stated here. NCDOR eNC3 material governs filing with the Department; no NC rule on furnishing copies to payees (timing, format, electronic-furnishing consent) was found in NCDOR sources reached. OSC January 31 postmark instruction binds state agencies as an OSC instruction, not as a general NCDOR rule. The sources searched were NCDOR eNC3 FAQ, penalty page, Important Notice, and 2018 specifications, as listed in Sources. The risk if it stays open is this. Payees NC furnishing rights rest entirely on the federal layer. What closes it is an NCDOR furnishing publication.

G-10. Form-type enumeration for the tax year 2025 central file. What is missing is stated here. Memo 26-1 does not enumerate form types in the text reached; the policy names only 1099-MISC; the NEC, MISC, G enumeration is published for tax year 2026 only. The sources searched were Memo 26-1, Policy Directory, Process Changes memo, AP-42 guide, as listed in Sources. The risk if it stays open is this. The scope of the last central filing cannot be fully reconstructed from OSC publications. What closes it is an OSC enumeration, or the AP-39 and AP-42 report set read as the enumeration.

G-11. 1099 payer identities beyond DHB and DPH. What is missing is stated here. NCTracks supports DMH/DD/SAS and ORH, but only DHB and DPH are named as 1099 payers; whether the other divisions payments generate forms under their own payer identities is not established. The sources searched were all G-01 sources plus the NCTracks Contact Information document and Recipients page. The risk if it stays open is this. Providers paid by the unnamed divisions cannot tell from NC pages whose payer name their form will carry. What closes it is an NCTracks statement of the payer list.

4.10 Conflicts inside the 1099 record

Six inconsistencies in NC own 1099 publications, collected and not resolved. NC-11 and NC-12 (OSC NCDOR-filing allocation and form scope) and NC-13 (the NCFS go-live dates) are stated in sections 4.2 and 4.3 respectively. All six print here as the register carries them.

Number	Subject	Disposition
NC-11	Who files NCFS 1099 data to NCDOR: OSC (Policy 1200.02) or each agency (Memo 26-1, the later operational document)	Memo governs operations; policy text unreconciled
NC-12	Policy form scope (1099-MISC only) against the published production (tax year 2026: NEC, MISC, G)	Production documents govern; policy conformance open
NC-13	NCFS go-live: October 2, 2023 (OSC) or October 10, 2023 deployment (DHHS)	Both stand as published; difference unexplained in sources reached
NC-14	Live FAQ text directs correspondence to "CSRA" years after the published CSRA to GDIT succession (April 2, 2018)	GDIT is operator of record; FAQ text unconformed
NC-15	FAQ vintage: a 2020-cycle mailing example and three different non-receipt triggers in print	Per-cycle announcements govern; no single current trigger published
NC-16	CF/SF framing: "participates" (2018 specifications) or "must file directly" (current FAQ), same operative rule	Direct filing governs; framing differs by document age

One further item belongs in this section because a reader will trip on it. The NCTracks Name and ID FAQ "28% withheld" warning (section 4.2) is quoted in this part as NC published wording, flagged, and never restated as a current federal rate. The October 21 edition printed a federal comparison rate beside it. That rate is part of the flagged federal layer at section 4.6 in this refresh and is not restated as verified.

Refresh Record, October 27, 2026

This record states what the refresh did, so no change rides silently. The base text is Part II, October 21, 2026 edition (12 pages). The lane of record is Lane B. Its retrieval date is October 21, 2026. The addition of record is the 1099 Addition, North Carolina, October 21, 2026. The cure record is the NC Cure Report, October 27, 2026. It includes the register as updated by the cure pass (nc-register.json, determinations at October 27, 2026).

1. Health Choice posture updated (section 4.2, Coverage). Added the cure position for conflict NC-5 (conversion to a Medicaid expansion CHIP approved September 11, 2023, under Session Law 2022-74). Source: Cure Report, section 4, finding 5, and section 3. The April 1, 2023 beneficiary move, the absence of any named Health Choice 1099 production, and the LME exclusion stand as Lane B carries them.

2. Tailored Plan operating count updated where the count appears (section 4.2, managed care passage). October 21 set: four operating Tailored Plans. Cure record: three operating at October 27, 2026, after the Vaya Health and Partners Health Management merger effective October 1, 2026, as Vaya Partners. Source: Cure Report, section 4, finding 5. No other plan count in this part changes. The Standard Plan choice set of four (after the April 1, 2026 merger the October 21 set already carried) is not restated in this part and is not affected.

3. Managed care gap sharpened, status unchanged (sections 4.1, 4.2, and 4.9, G-05). Added the cure fact that no signed executed base contract is posted for any managed care family, so the allocation cannot be read from a signed contract in the public record. Source: Cure Report, section 4, finding 4. G-05 stays open.

4. NCDOR format passage conformed to the lane (section 4.5). Present-tense acceptance language replaced with the planned January 2027 position. The specifications revision number and the live-testing claim printed October 21

come out, because Lane B records the specifications location as blank and neither the Addition nor the cure record carries those details. Sources: Lane B, section 3.6; defect first recorded as Pre-Live P-3 in the October 21 build folder.

5. Form NC-1099M added (section 4.5). The October 21 Part II omitted it. Sources: 1099 Addition, Determination 5; Lane B, section 3.2 table.

6. Federal floor flagged and cut to what the refresh sources carry (sections 4.2, 4.6, 4.7, 4.10). The threshold, penalty-tier, notice-timeline, and rate figures printed October 21 as program federal research are flagged at section 4.6 and not restated as verified anywhere in this refresh. No North Carolina statement in this part depends on them.

7. Everything else stands. NCTracks thresholds, mailing, reprint, and correction text; NCFS central filing, policy tensions, IRIS transition dates and duties; NCDOR NC-3, statement table, CF/SF rule, and penalties; the calendar; gaps G-01 to G-11; and conflicts NC-11 to NC-16 were each re-read against Lane B for this refresh and stand as Lane B carries them. The cure record supersedes no figure in those passages, and none was altered except for dash punctuation, which this edition prints without em or en dash characters throughout.

Sources

North Carolina sources, each retrieved October 21, 2026, as Lane B lists them: NCTracks provider portal, 1099 FAQs (index and four sub-pages), 1099 provider announcements (2013, 2014, 2015, and the January 20, 2026 mailing announcement dated December 30, 2025), CSRA to GDIT announcement (April 2, 2018), DMA is Now DHB notice, 1099 Reporting/Pay-To Address announcement (July 17, 2015), NCTracks Contact Information (updated April 4, 2025), and Recipients page. NC Medicaid: site search for "1099," Managed Care Claims and Prior Authorization Submissions fact sheet, and the October 1999 Tax Identification Information bulletin. Office of the State Controller: Statewide Policy Directory (Policies 1200.01 and 1200.02, last updated January 21, 2025), Memorandum NCFS 26-1 (October 13, 2025), Process Changes memo for tax year 2026 (July 29, 2026), Agency Steps for 1099 TCC Application (August 25, 2026), 1099 Information Session page, NCFS Newsletter (October 2026), 2023 1099 Reporting Key Information, Printing 1099 Correction Forms guide AP-42, and the OSC Substitute W-9 instructions as hosted by DHHS. DHHS: NCFS page and hosted Substitute W-9. NC Department of Revenue: eNC3 Frequently Asked Questions, eNC3 Penalty and Waiver Information, eNC3 Specifications for 1099 Reporting (issued January 30, 2018), Important Notice: Updates to North Carolina Withholding Tax, and the Form NC-1099M page as cited in the 1099 Addition. Program records for the refresh: Lane B, North Carolina 1099: The Systems Portion End to End; 1099 Addition, North Carolina (October 21, 2026), including its derived dates table and Determination 5; NC Cure Report (October 27, 2026), findings 4 and 5 and sections 3 and 8 as cited; and the North Carolina register as updated by the cure pass (nc-register.json) for conflict NC-5 grading posture. Commercial filing vendor summaries encountered in searching were not relied on for any fact in this part.

PART 6 OF 7

Cure Report, Publication Edition

3 pages

PART 6

NC-Cure-Report-2026-10-31.pdf

This part is the publication edition of the Cure Report. The Cure Report is the record of the October 27, 2026 review that graded every register entry against public evidence. The closeout of October 30, 2026 completed the cure. This part prints the verdict. It prints the counts over the whole 196 row inventory. It prints the counts over all 501 register entries. It names the two documents that closed the cure. It prints the findings of substance. It prints in this binder from the same file as its standalone download. Its verdict stands on its face. The review is complete. North Carolina is cured as of October 30, 2026.

Status of record, October 31, 2026. 183 of 196 documents stand collected and reconciled. That count is 93.4 percent. The register stands fully graded. North Carolina is cured as of October 30, 2026. The two documents that closed the cure are named on the cover in full. The How this binder works section names them in full as well.

The pages that follow are the same pages as the standalone download of the same name and date.

AGENTIC ARMOR LLC

North Carolina Cure Report: Publication Edition

Date: October 31, 2026 **Publisher:** Agentic Armor LLC

Verdict: North Carolina is cured as of October 30, 2026. The document inventory has been fully reviewed and reconciled, and the register has been fully graded. The first publication edition of this report, dated October 27, 2026, printed the state not yet cured, on exactly two documents. The closeout of October 30, 2026 collected both documents and closed the cure. This edition carries that result.

Publication edition, October 31, 2026. An independent product of Agentic Armor LLC, built from public information: the state's own published record and the federal regulation text. Agentic Armor LLC is not affiliated with, endorsed by, or authorized by CMS or HHS.

The counts

Whole inventory	**196 rows**
Collected and reconciled	**183 rows**
Share of the whole inventory	**93.4 percent**
True gaps	**13**
Located but not collected	**0**

The register carries **501 determinations, fully graded**: Verified 141, Partial 274, GAP-DETERMINED 71, N-A 10, Prospective 5, and Unverified 0. The closeout did not move the tallies. They stand exactly as the cure pass of October 27, 2026 left them.

The two documents that closed the cure

Two documents held the state open at the cure pass. Both were collected at the closeout of October 30, 2026.

1. **The 1115 Special Terms and Conditions (H-024).** The current approval terms for North Carolina's Section 1115 demonstration. The document carries the CMS approval letter of September 25, 2026 to Melanie Bush. It names demonstration project 11-W-00313/4. Its cover records the Whole Family Transition to Care conforming change under section 71109, adding STC 4.3.b(iii). The change runs from October 1, 2026 through December 9, 2029. The full text was searched for every citation to Title 42 and Title 45 of the Code of Federal Regulations. Every match was read in place. The row is classed MAPPED-TEXT.

2. **The CAP/DA Appendix K approval NC.0132.R07.10 (H-035).** The current Appendix K approval for the Community Alternatives Program for Disabled Adults waiver. The document covers the Hurricane Helene response. Jay Ludlam signed it on June 20, 2025. It runs from September 25, 2024

to June 30, 2025. The full text was read end to end. A search for Code of Federal Regulations citations returns zero matches. The row is classed REVIEWED-NO-CFR-CITATION-FOUND.

Four routes were worked for each document, in order. Direct download from medicaid.gov was refused. No Internet Archive snapshot exists for either address. No state agency copy exists to take. The State posts the R07.09 Appendix K for CAP/DA, not the R07.10 amendment. Both documents were then read in full at their live addresses through the house browser lane. That lane is the remedy of record this house used during the cure pass itself. One limit rides with both classes. The browser lane returns text without a file, so no source file is held for either document. Each row's hash is the hash of its saved read evidence note, and the row says so.

One sensitivity is printed, as it was in October. Five rows of the inventory rest on the browser lane instead of a held file. Held to the file standard on those five rows, the count would print 178 of 196. The lane is the house's own remedy of record, and its limit is stated on every row it carries.

The flag count and the qualifications

The NC-5 conflict flag count is closed at 14 rows. The determinations file of record carries the flag on exactly 14 rows. The built register carries it on the same 14 rows. All 14 sit in Part 457. The count of 11 in the October 27, 2026 edition of this report was an undercount. The register governs.

Three qualifications stood open at the second seat. All three are dispositioned. CFR-433-021 is closed. Its basis now carries the H-131 OIG report mention it had omitted, and the GAP-DETERMINED grade stands. CFR-457-046 rides as a named qualification. Its basis was re-read and verified complete and pinpointed, and it is the first retest in the next audit rotation. CFR-441-021 is confirmed and closed. The page image was read directly, and the Verified grade rests on the methods text exactly as the flag said at the cure.

Findings of substance

1. **The 2025 Quality Strategy is not where the public record says it is.** A Division of Health Benefits bulletin records that the 2025 NC Medicaid Managed Care Quality Strategy was approved on July 1, 2025 and published on the Quality Management and Improvement page. That page, read in full, carries no Quality Strategy document. The strategy the record holds is the 2023 document. Federal rules call for a current quality strategy (42 CFR 438.340), and its regular review fell due in this period. The document is recorded as a true gap. The remedy is in the state's hands: post the approved strategy where the bulletin says it lives.

2. **The governing record contradicts itself on cost sharing amounts.** The state plan attachments carry a complete specification structure at older amounts of $2 and $3; a Tailored Plan contract table charges $4; and a plan passage states that managed care enrollees are not charged. Which amount a provider charges today remains an open question on the face of the register.

3. **The plan states no cumulative maximum where the federal rule requires one.** Both cost sharing attachments print, verbatim, "State policy does not provide for cumulative maximums," against the aggregate limit in 42 CFR 447.56, which caps cost sharing at 5 percent. The affected determination grades Partial, with the conflict stated on its face.

4. **Executed contracts are not public for any of North Carolina's three managed care contract families.** For the Standard Plan, the Tailored Plan, and the Medicaid Direct PIHP contracts alike, the state posts the model instrument, the request form, and the amendment series; no signed executed

base contract is posted for any of the three. They are three of the 13 true gaps, and every managed care determination that rests on a model form says so on its face.

5. **The register was stale against the record it describes, and has been corrected on the current record.** It carried no mention of the Vaya Health and Partners Health Management merger effective October 1, 2026, which took the operating Tailored Plans from four to three. It still described NC Health Choice in an earlier form, although its conversion was approved on September 11, 2023. It also predates the PCS Alignment Demonstration now in public comment through November 9, 2026. Grading was done on the current public record throughout.

6. **Earlier collection notes did not match the documents' own text.** Seven records had been carried on summary notes alone. Read against their own text, the claimed citations were absent in those records. One of them, the NC Medicaid Annual Quality Report 2021-2023, had been credited with a citation that proved on reading to be a chart value, a rate of 441.25 per 100,000 beneficiaries, not a regulation reference. The record was corrected, and the overall count did not change.

7. **Instruments the record does not hold.** Each of the following is a closed, recorded gap, not an open search: the managed care capitation rate certifications; the North Carolina directed payment preprints, including the HASP preprint; the current DSH audit or settlement document; the standalone CMS 1915(b) approval letter; the Enrollment Broker contract; the NEMT broker contract; the Ombudsman annual report; and the NC Register rulemaking notices for 10A NCAC 22. Together with the items above, these make the 13 document gaps, with 71 gap determined register rows behind them.

PART 7 OF 7

The Atlas Register

416 pages

PART 7

NC-Atlas-Register-2026-10-31.pdf

This part holds the register in full. It carries all 501 entries of the North Carolina CFR and compliance calendar register. Each entry carries its determination of October 27, 2026. Each entry also carries the dated set and the conflicts on the register's face. The register rests on the register of record as graded on October 27, 2026. It is the evidence volume behind every count printed in this binder's front matter.

Status of record, October 31, 2026. 183 of 196 documents stand collected and reconciled. That count is 93.4 percent. The register stands fully graded. North Carolina is cured as of October 30, 2026. The two documents that closed the cure are named on the cover in full. The How this binder works section names them in full as well.

The pages that follow are the same pages as the standalone download of the same name and date.

FEDERAL ATLAS PROGRAM: NORTH CAROLINA

The North Carolina Register

All 501 entries of the CFR and compliance calendar register. Each entry carries its cure determination of October 27, 2026. The volume also carries the dated set and the conflicts. It is the companion volume to the North Carolina Master Binder. Reissued October 31, 2026 on the cured record of October 30, 2026.

Federal Atlas Program / October 31, 2026

Contents

1. The Register: North Carolina, in Full 3

The Register: North Carolina, in Full

This volume is the North Carolina register of the Federal Atlas Program. The cure pass of October 27, 2026 refreshed it from the register of record. It holds **501 entries**. Of those entries, 489 come from the federal CFR text. Another 4 come from North Carolina statute and session law. Another 8 come from North Carolina agency-published process. The evidence classes are **500 GOVERNING, 1 DERIVED, and 0 EXTRAPOLATED**. A total of 269 recurring entries carry no calendar anchor in their source. They keep the anchor state UNRESOLVED. No anchor was invented in this build.

> **Status statement.** The cure pass is the review of October 27, 2026 that graded every entry in this register against public evidence. This register is fully graded under that review. All 501 entries carry a cure determination from the cure pass. The count of unverified entries is zero. That count prints as Unverified 0. North Carolina is cured as of October 30, 2026. The closeout of October 30, 2026 collected the last two open documents. They are H-024, the 1115 Special Terms and Conditions, WFTC overlay version, and H-035, the CAP/DA Appendix K approval NC.0132.R07.10. Both documents were read in full at their live addresses at medicaid.gov. The document inventory stands at 183 of 196 documents collected and reconciled. That count is 93.4 percent. The inventory holds 13 true gaps. The determination tallies did not move in the closeout. They stand at Verified 141, Partial 274, GAP-DETERMINED 71, N-A-DETERMINED 10, Prospective 5, and Unverified 0.

What this volume covers. This volume covers the North Carolina register in full. It covers all 501 entries. It covers each entry's determination of October 27, 2026. What this volume does not cover. This volume does not cover any other state. It does not cover the documents behind the determinations. Those documents sit in the held corpus, and the Public Record Gaps volume names the ones the public record does not hold. This volume does not restate a determination. Each determination prints as recorded. The date this volume speaks as of. This volume speaks as of October 30, 2026. This edition is dated October 31, 2026. A later grading pass can change a determination after that date.

Cure pass counts (October 27, 2026)

Cure determination	Entries
Verified	141
Partial	274
GAP-DETERMINED	71
N-A-DETERMINED	10
Prospective	5
Unverified	0

Total	**501**

Homes

NC home	Entries
Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)	76
Division of Health Benefits — NC Health Choice (Title XXI)	74
Division of Health Benefits — Finance Section	74
Division of Health Benefits — Coverage Policy Function (formal section label not published)	62
NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)	49
Eligibility — county departments of social services (state-supervised), NC FAST	38
Division of Health Benefits — Provider Enrollment (NCTracks provider portal)	32
Division of Health Benefits — Office of Compliance and Program Integrity (OCPI)	27
Division of Health Benefits — Waiver Operations, with the Tailored Plans (LME/MCOs)	18
Division of Health Benefits — Pharmacy (Pharmacy Benefit Administrator for NC Medicaid Direct)	15
Systems — NCTracks (GDIT, fiscal agent) under the Division of Health Benefits	13
Division of Health Benefits — Quality Management and Improvement	12
Division of Health Benefits — Third Party Recovery / Third Party Liability	7
North Carolina Office of Administrative Hearings (OAH) — Medicaid State Fair Hearings	4
UNASSIGNED (no sourced NC home)	0

How to read the register

Entries print in register order. Register order is the order of the register of record. It is also the row order of the determinations file of record. Each entry prints its citation and its topic. It prints its obligated level, its cadence, its evidence class, and its anchor state. It prints its North Carolina home. It prints the basis that home assignment rests on. It then prints its cure determination of October 27, 2026.

The cure determination line gives the verdict. It also gives the determiner. The determiner is the grading seat that made the determination. The basis states what the held record carries for the entry. It states that point in the determiner's words. The record location states where that evidence sits in the held corpus. Both lines print exactly as recorded. This volume does not paraphrase either line.

A Verified entry means one thing. The basis shows the held record carrying the requirement at the record location. A Partial entry means part of the requirement is carried. The rest of the requirement is not carried. Each Partial entry carries a section 5D face. That face names the

uncovered element in plain terms. It names the owner level. It names the action that level owns. It states the open question. A GAP-DETERMINED entry means no North Carolina evidence for the requirement was found on the searches recorded. Each such entry carries the same section 5D face. An N-A-DETERMINED entry rests on the section 3A closed list. That list is the closed set of reasons a requirement can be found not applicable. Each such entry carries a section 3A footing. The footing gives the closed list reason. It gives the determiner. It gives the basis and the record location the entry rests on. A Prospective entry means the duty is not yet due. Each such entry carries its federal applicability date from the determinations file. It also carries the future dates the register carries.

Applicability prints from the determinations file of record for every entry. The determinations file citation or topic can differ from the register of record. Where it differs, both lines print. The determinations file line carries a label that says so. Nothing is silently conformed. Searches recorded print where the determinations file carries them. Guidance readings print where the determinations file carries them. Flags print where the row carries them.

One discipline carries over from the October 21 build. An obligation's evidence class grades the obligation and its date. A mapping's basis grades the assignment. The basis prints with the entry. Its kind is one of three kinds. The kind can be published, citation, or derivation. Derived dates carry the label DERIVED. They are counted separately. Extrapolated items never enter the governing counts. Anchorless recurring obligations keep the anchor state UNRESOLVED. No anchor was invented. South Carolina-dictated entries from the pattern build do not transfer. This volume does not carry them. The authority order runs in one direction. The Code of Federal Regulations comes first. North Carolina statute comes next. North Carolina agency-published process comes last.

Sources of record

Sources of record. The register of record is the North Carolina register of the Federal Atlas Program, State 1, North Carolina. The cure pass graded it on October 27, 2026. Each of its 501 entries carries its determination of October 27, 2026. The determinations file of record is the determinations file for October 27, 2026. It holds 501 rows. The cure narrative is the NC Cure Report of October 27, 2026. The October 21, 2026 register volume predates grading entirely. Every entry in that volume stood not assessed. This volume supersedes it as the printed register. This volume keeps its form. The closeout of October 30, 2026 completed two items in this file. It completed the basis of CFR-433-021. It confirmed the flag on CFR-441-021. Both changes print in the entries below exactly as recorded.

The dated set

Events in this set state a date in their own text. This set is the register's only calendared set.

Entry	Obligation	Date(s)	Class
CFR-431-002	Medicaid Advisory Committee (MAC) and Beneficiary Advisory Council (BAC)	2027-07-10	DERIVED
CFR-431-013	Patient Access API (beneficiary data access)	2027-01-01	GOVERNING

CFR-431-014	Provider Access API and Payer-to-Payer data exchange	2027-01-01	GOVERNING
CFR-431-016	Prior authorization — denial reasons and prior auth API	2027-01-01	GOVERNING
CFR-437-001	Annual Child, Adult, and Health Home Core Set reporting	Dec 31	GOVERNING
CFR-437-003	Exemption request for Core Set population reporting	Sep 1	GOVERNING
CFR-438-007	Pass-through payment phase-out	2027-07-01	GOVERNING
CFR-438-045	EQR annual technical report — finalization, posting, CMS notice	Apr 30	GOVERNING
CFR-438-048	Medicaid managed care quality rating system (MAC QRS)	2028-09-01, 2028-12-31	GOVERNING
CFR-440-005	Annual prior authorization metrics reporting	2027-03-31	GOVERNING
CFR-441-046	1915(c) waiver — incident management system and 90% performance levels	2027-07-09, 2029-07-09	GOVERNING
CFR-441-050	1915(c) waiver — payment adequacy: 80% direct-care compensation	2030-07-09	GOVERNING
CFR-441-061	HCBS website transparency	2027-07-09	GOVERNING
CFR-447-012	Maximum allowable cost sharing + annual CPI-U indexing	Oct 1	GOVERNING
CFR-447-028	Comparative payment rate analysis + disclosure every 2 years	Jul 1 (biennial)	GOVERNING
CFR-447-045	Annual DSH data submission to CMS	Jun 30	GOVERNING
CFR-457-055	Provider Access API, payer-to-payer exchange, privacy resources	2027-01-01	GOVERNING
CFR-457-057	Annual report to CMS (due January 1)	Jan 1	GOVERNING
CFR-457-060	Prior authorization: denial reasons, PA API, public metrics	2027-01-01	GOVERNING
NC-006	NCTracks weekly checkwrite cycle	Weekly — Thu cutoff → Tue checkwrite → Wed EFT	GOVERNING
CFR-438-026	Appointment wait time standards	2027-07-09	GOVERNING
CFR-438-027	Annual secret shopper surveys (provider directories and wait times)	2028-07-09	GOVERNING

Conflicts carried on the register's face

#	Subject	Governing position	Conflicting position	Disposition
NC-1	Carolina Complete Health regions (2021 era)	Current state governs the footprint: after the April 1, 2026 merger, Carolina Complete Health is statewide and Standard Plan choices are four (Lane A §2.2).	2021-era sources state the plan's regions two ways: 'regions 3, 4, and 5' (NCDHHS/Cherokee release summary) vs 'Regions 3 & 5 only' (HRSA narrative).	Historical conflict kept visible; the register and calendar use the current statewide footprint.
NC-2	Tailored Plan launch date in NC documents	Tailored Plans launched July 1, 2024 (NCTracks launch notice; DHB fact sheets).	Earlier NC documents print October 1, 2023 (EVV Q&A) and an original July 1, 2022 scheduled date (DY5 monitoring report).	The 2024 date governs; the earlier printed dates are carried as the delay history, not as operative dates.
NC-3	1115 renewal period — requested vs approved	Approved: December 10, 2024 – December 9, 2029 (CMS approval; NC 1115 page).	The renewal application as submitted requested November 1, 2024 – October 31, 2029.	Approved dates govern authority; requested dates are application history.
NC-4	Division name in federal correspondence	DMA and DHB combined into the Division of Health Benefits effective August 1, 2018 (NCTracks notice).	CMS SPA approvals in 2025 still address the 'Division of Medical Assistance.'	DHB is the governing name; the CMS addressing is flagged as letterhead lag, not a revival of DMA.
NC-5	NC Health Choice — combined vs still listed	Approximately 55,000 NC Health Choice children moved to NC Medicaid on April 1, 2023, under Session Law 2022-74's direction to combine the programs (NCDHHS, Jan. 30, 2023).	The State Plan Public Notices page still lists a separate 'NC Health Choice State Plan — Child Health Plan under Title XXI.'	Both print. Part 457 obligations are mapped to DHB's NC Health Choice home with this conflict on the face; the binder does not print 'CHIP eliminated in NC.'
NC-6	NCDHHS service areas — the sixth area's name	The Overview page lists six service areas ending 'External Affairs and Licensing and Facilities.'	The EEO Plan lists the sixth area as 'Health Equity.' Both claim 33 divisions and offices.	Kept visible; the binder's structure chapter prints both namings. No register count turns on it.
NC-7	Tailored Plan name — Vaya	NC-published sources (NCTracks launch table; DHB eligibility	NC Justice FAQ and some secondary listings use 'Vaya Total Care.'	The binder uses 'Vaya Health' and notes the variant.

	Health vs Vaya Total Care	page) use 'Vaya Health.'		
NC-8	Deputy Secretary title and status timing (Bush)	October 2026 listings and a September 25, 2026 CMS letter use 'Deputy Secretary for NC Medicaid' without 'Interim.'	A March 19, 2026 DHB letter is signed 'Interim Deputy Secretary'; the April 21, 2026 announcement states the appointment 'remains contingent upon confirmation by the North Carolina General Assembly.' The confirmation outcome date was NOT ESTABLISHED in sources reached.	The binder uses the current published title and prints the contingency and the unestablished confirmation date.
NC-9	TBI Waiver geography and operator framing	The TBI Waiver is served through a Tailored Plan and does not operate in all geographic areas (Trillium handbook).	NC Justice FAQ frames it as 'Alliance Health is the only Tailored Plan that currently offers TBI Waiver services'; the handbook frames it by county list. No single current DHB page states operator and counties together.	Both framings print; the waiver chapter carries the gap as a named research item.
NC-10	Healthy Opportunities Pilots — authorized vs operating	The General Assembly did not fund HOP after July 1, 2025, 'causing the program to suspend operations at this time' (NCDHHS HOP page).	The same page records the 1115 extension, renewal negotiations, and $9 million in SFY27 restart funding; no restart service date was established in sources reached.	Authority and operations are printed as separate facts; HOP is never listed as an operating service for the suspension period without the funding qualifier.
NC-11	Who files NCFS 1099 data to NCDOR — OSC or the agencies	Memo NCFS 26-1 (Oct. 13, 2025), the later operational document: 'Individual state agencies are responsible for filing their own 1099 information to the North Carolina Department of Revenue (NCDOR).'	OSC Policy 1200.02 summary (directory, last updated Jan. 21, 2025): OSC 'will submit the electronic 1099-MISC file to the IRS and the NC Department of Revenue.'	Both print in Part II §4.3. The memo governs operations as the later, operational instrument; the policy text is unreconciled on the record reached.
NC-12				

	OSC policy form scope vs. the production it governs	OSC's tax-year-2026 production is published by form type: NEC, MISC, G (Process Changes memo, Jul. 29, 2026).	Policy 1200.02 names only an 'electronic 1099-MISC file' as centrally submitted; no conforming policy text was reached.	The production documents govern; the policy's narrower scope prints as an open conformance item.
NC-13	NCFS go-live date	OSC's 2023 Key Information sheet: 'October 2, 2023 — NCFS Go Live.'	DHHS's NCFS page: 'on October 10, 2023, North Carolina will deploy its new financial system.'	Both dates stand as published; the sources reached do not explain the difference (go-live vs. deployment milestone).
NC-14	Fiscal-agent name in live NCTracks FAQ text	CSRA became GDIT on April 2, 2018 (NCTracks announcement); the current Contact Information document gives GDIT at P.O. Box 300009, Raleigh.	Live 1099 FAQ text still directs returns and enrollment correspondence to 'CSRA' at the same box.	GDIT is the operator of record; the FAQ text is unconformed, printed as found.
NC-15	NCTracks 1099 FAQ vintage — mailing example and non-receipt triggers	Each cycle's mailing date is announced per cycle (2025 cycle: mailed Jan. 20, 2026, announced Dec. 30, 2025).	The standing FAQs carry a 2020-cycle example ('mailed on or before Jan. 15, 2021') and two different non-receipt triggers (10 business days via Contact Us; 'second Friday of February'); the 2013/2014 announcements used February 10.	No single current trigger date is published; the binder prints the per-cycle announcements as governing and the FAQ texts as standing, unreconciled guidance.
NC-16	CF/SF framing across NCDOR document vintages	Current eNC3 FAQ: CF/SF may not be used 'instead of filing these forms directly with the Department'; required statements must be filed directly with NCDOR.	2018 Specifications: 'Although North Carolina participates in the IRS Combined Federal/State Filing Program,' listed forms 'must be filed directly.'	The operative rule is the same (direct filing); the participation framing differs by document age. Both print.

Entries (501, in register order)

CFR-430-001: State plan maintenance and amendment submittal

CITATION: 42 CFR 430.10, 430.12

TOPIC: State plan maintenance and amendment submittal

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - upon any material change in Federal/State law, regulation, policy, organization, or program operation

EVIDENCE CLASS: GOVERNING

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as single state agency under Title XIX

BASIS: State plan p.17-18 carries the 430.10 submission: DHHS as single state agency submits the plan and agrees to administer the program in accordance with the plan, Titles XI and XIX, and all applicable federal regulations. Section 7.1 at plan pp.181-182 (42 CFR 430.12(c)) states the plan will be amended whenever necessary to reflect new or revised federal statutes or regulations or material change in state law, organization, policy or agency operation. Approved SPAs in the held corpus (for example SPA NC-26-0001 and NC-26-0003 packets) show the amendment machinery in use.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan pp.17-18 and pp.181-182; SPA packets H-003 and H-004

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 430.10 and 430.12 text as carried in the register requirement of record

CFR-430-002: Respond to CMS requests on pending plan material

CITATION: 42 CFR 430.16

TOPIC: Respond to CMS requests on pending plan material

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - within CMS's 90-day review window for each pending plan submission

EVIDENCE CLASS: GOVERNING

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as state agency with pending plan material before CMS

BASIS: The held record shows NC plan material moving through CMS submission in practice: the State Plan Public Notices page (H-002) lists dated ten-day postings for SPA 26-0001 (Jan. 14, 2026), SPA 26-0002 (Feb. 13, 2026) and SPA 26-0003, with archives for 2021-2025, and approved SPA

packets are held. No held document states how NC responds to a CMS request for additional information on pending material, or within what time.

RECORD LOCATION: H-002 (H-002__6f49fb86.html), Medicaid State Plan Public Notices page, ten-day posting list; H-001 (H-001), NC Title XIX State Plan

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The state-side procedure and timeframe for responding to CMS requests on pending plan material (42 CFR 430.16) is not stated in any held document.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce or publish the SPA correspondence procedure showing how DHB answers CMS requests for additional information on pending plan material and the clock it works to.
>
> **QUESTION:** Where is NC's procedure for answering CMS requests on pending State plan material documented?

SEARCHES RECORDED: Full document-axis map searched for Part 430 provisions beyond 430.10 and 430.12 (only H-001 carries Part 430 text); held corpus text searched for CMS request and additional information language on pending plan material (no state procedure found).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 430.16 text as carried in the register requirement of record

CFR-430-003: State plan waiver requests and renewals (1915(b), 1915(c), 1916)

CITATION: 42 CFR 430.25

TOPIC: State plan waiver requests and renewals (1915(b), 1915(c), 1916)

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - renewal request 90–120 days before each waiver expiration (2-, 3-, or 5-year cycles)

EVIDENCE CLASS: GOVERNING

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC, which operates 1915(b) and 1915(c) waivers

BASIS: The plan's waiver pages (plan pp.14-15) record NC's waiver types under 1915(b)(1) through (4), 1915(c) home and community based services (model and non-model format) and 1916, and H-002 posts current waiver business including the draft 1915(b) waiver NC.042.06.06 (Sept. 1, 2025) and 1915(c) TBI, Innovations and CAP/DA applications and renewals. No held document states the 430.25 request and renewal submission procedure or renewal timing NC works to.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan pp.14-15; H-002 (H-002__6f49fb86.html), waiver postings

SECTION 5D FACE

UNCOVERED ELEMENT: The waiver request and renewal procedure and renewal lead times required by 42 CFR 430.25 are not stated in held evidence; only the existence of the waivers and current applications is carried.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Produce the waiver request and renewal calendar or procedure NC uses for 1915(b), 1915(c) and 1916 authorities.

QUESTION: What procedure and lead times govern NC's waiver renewal requests to CMS?

SEARCHES RECORDED: Full map searched for Part 430 provisions (only 430.10, 430.12 and 430.130 in H-001); corpus searched for waiver renewal request language (waiver applications found, no 430.25 procedure).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 430.25 text as carried in the register requirement of record

CFR-430-004: Quarterly grant reporting (CMS-37 estimates, CMS-64 expenditures)

CITATION: 42 CFR 430.30

TOPIC: Quarterly grant reporting (CMS-37 estimates, CMS-64 expenditures)

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - quarterly: CMS-37 45 days before quarter start; CMS-64 30 days after quarter end

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (quarterly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as Title XIX grantee filing quarterly budget and expenditure reports

BASIS: Two held documents carry the reporting forms in operation. The Section 1115 approval package (H-025) requires quarterly expenditure reporting through MBES/CBES on Form CMS-64, state estimates of matchable expenditures on Form CMS-37 for medical assistance and administration, and submission of the CMS-64 within 30 days after the end of each quarter. The HHS OIG report (H-131) shows MFCU-determined overpayments being reported and the federal share returned on the Form CMS-64, with three recommendations closed as implemented in February and March 2026. Both are program-specific; no held document states the general quarterly CMS-37 and CMS-64 grant reporting duty for the whole Title XIX program.

RECORD LOCATION: H-025 (H-025), 1115 extension approval package, section 17.2 standard funding process; H-131 (H-131__bec1f17c.html), OIG report A-06-23-04004

SECTION 5D FACE

UNCOVERED ELEMENT: A general state-side statement of the quarterly CMS-37 estimate and CMS-64 expenditure reporting cycle for the Title XIX grant as a whole (42 CFR 430.30) is not in the held evidence; coverage is demonstration-specific (H-025) and case-specific (H-131).

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Produce the quarterly grant reporting procedure or a filed CMS-37 and CMS-64 pair showing the standing quarterly cycle.

QUESTION: Where is the standing quarterly CMS-37 and CMS-64 reporting cycle for the whole program documented?

SEARCHES RECORDED: Corpus searched for CMS-64 and CMS-37: hits are the 1115 STCs (H-025), cost-report return language in plan attachments (H-001), and the OIG MFCU report (H-131); no general grant reporting procedure found. Full map Part 430 check as above.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 430.30 text as carried in the register requirement of record

FLAGS: Conflict in operation: H-131 found NC failed to report and return the federal share for seven MFCU cases ($30.4 million) in the audit period; recommendations later closed as implemented. Grade rests on the reporting machinery as documented in H-025 and H-131, not on clean performance.

CFR-430-005: Quality control program and correction of practice

CITATION: 42 CFR 430.32

TOPIC: Quality control program and correction of practice

OBLIGATED LEVEL: agency

CADENCE: RECURRING - continuing; corrective action when review findings reveal serious compliance problems

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC, which operates a Medicaid quality control system

BASIS: Plan section 4.4 at p.82 carries the quality control element in part: a system of quality control is implemented in accordance with 42 CFR Part 431 Subpart P, the state operates a Medicaid quality control claims processing assessment system meeting 431.830-431.836, and the state uses the PERM-based substitution for traditional MEQC review in its PERM cycle years (effective FFY 2013, 2016 and 2019). The correction-of-practice side of the provision, how identified errors change agency practice, is not described in any held passage.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan p.82 (section 4.4, Medicaid Eligibility Quality Control)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The corrective element: how NC analyzes quality control findings and corrects practice or policy in response is not carried in held evidence.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce a MEQC or PERM corrective action record showing findings carried into changed practice.
>
> **QUESTION:** How do NC's quality control findings change eligibility practice, and where is that recorded?

SEARCHES RECORDED: Corpus searched for MEQC, Medicaid Eligibility Quality Control and corrective practice language; only the plan section 4.4 passage and PERM references found.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 430.32 text as carried in the register requirement of record

CFR-430-006: Respond to OIG audit findings

CITATION: 42 CFR 430.33

TOPIC: Respond to OIG audit findings

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - upon release of each OIG audit report

EVIDENCE CLASS: GOVERNING

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC when HHS OIG audits NC Medicaid

BASIS: One complete instance is carried. H-131 (OIG report A-06-23-04004, issued June 20, 2024) records that NC concurred with all three OIG recommendations on MFCU-determined overpayments, stated it would refund the federal share for the unreported cases on the Form CMS-64 and described procedural steps, and the recommendation tracker in the same text shows all three recommendations closed as implemented on February 27 and March 4, 2026. No held document states a general NC procedure for responding to OIG audit findings across audits.

RECORD LOCATION: H-131 (H-131__bec1f17c.html), OIG report A-06-23-04004, findings, state comments and recommendation tracker

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** A general state-side procedure for responding to OIG audit findings is not in held evidence; only this single audit response is documented.
>
> **OWNER LEVEL:** NCDHHS Secretary

ACTION: Produce the department-level procedure for receiving, answering and closing OIG audit findings, or the response file for a second audit.

QUESTION: What is NC's standing procedure for responding to HHS OIG audit findings?

SEARCHES RECORDED: Full map and corpus searched for OIG audit response material: H-131 and H-132 are the only OIG reports acquired in this cure; H-132 is an MFCU inspection, not a state audit response procedure.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 430.33 text as carried in the register requirement of record

CFR-430-007: Deferred FFP claims — furnish documentation

CITATION: 42 CFR 430.40

TOPIC: Deferred FFP claims — furnish documentation

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - 60 days (120 with extension) from each deferral notice; 15 days to cure non-reviewable submissions

EVIDENCE CLASS: GOVERNING

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC when CMS defers an FFP claim

BASIS: No NC evidence for the deferral documentation duty was found. Corpus searches for deferral language returned only provider-level disallowance and cost disallowance passages in plan attachments and provider appeal rules, nothing about CMS deferral of a state FFP claim or the documentation a state furnishes in response.

RECORD LOCATION:

SECTION 5D FACE

UNCOVERED ELEMENT: The entire provision: no held document addresses furnishing documentation on a deferred FFP claim (42 CFR 430.40).

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Produce any deferral correspondence file or the finance procedure for answering a CMS deferral with documentation.

QUESTION: Has NC had an FFP claim deferred, and where is its documentation response recorded?

SEARCHES RECORDED: Full document-axis map: no document carries a 430.40 pinpoint. Held corpus and cure texts searched for deferral of claims, deferred claim and deferral documentation (provider cost disallowances only). REGISTER-COVERAGE lists only H-001 at part level for this row, and H-001 carries no 430.40 text.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 430.40 text as carried in the register requirement of record

CFR-430-008: Disallowance reconsideration process

CITATION: 42 CFR 430.42

TOPIC: Disallowance reconsideration process

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - within 60 days of each disallowance letter

EVIDENCE CLASS: GOVERNING

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC when CMS issues a disallowance

BASIS: No NC evidence for the disallowance reconsideration process was found. Searches for disallowance reconsideration and Departmental Appeals Board language returned nothing state-side; the disallowance hits in the corpus are provider payment disallowances under 10A NCAC 22J, a different process.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The entire provision: no held document addresses requesting reconsideration of a CMS disallowance (42 CFR 430.42).
>
> **OWNER LEVEL:** NCDHHS Secretary
>
> **ACTION:** Produce any disallowance reconsideration filing or the procedure NC would follow on receipt of a disallowance notice.
>
> **QUESTION:** Where would NC's request for reconsideration of a federal disallowance be documented?

SEARCHES RECORDED: Full map: no 430.42 pinpoint in any document. Corpus searched for disallowance reconsideration and Departmental Appeals Board (no hits); provider disallowance appeals in H-001/H-099 read and excluded as provider-level.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 430.42 text as carried in the register requirement of record

CFR-430-009: Repay unallowable Federal payments (installment schedules)

CITATION: 42 CFR 430.48

TOPIC: Repay unallowable Federal payments (installment schedules)

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - quarterly installments once a repayment schedule is established

EVIDENCE CLASS: GOVERNING

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC when federal payments are found unallowable

BASIS: No NC evidence for repayment of unallowable federal payments on an installment schedule was found. The one repayment instance in the corpus, return of the MFCU overpayment federal share on the Form CMS-64 (H-131), is a case recovery mechanism, not repayment of unallowable FFP under 430.48 with an installment schedule, and no held document states the 430.48 duty or a schedule.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The entire provision: no held document addresses repayment of unallowable federal payments or installment schedules under 42 CFR 430.48.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce any repayment agreement or schedule with CMS for unallowable FFP, or the finance procedure governing one.
>
> **QUESTION:** How would NC schedule repayment of unallowable federal payments, and where is that recorded?

SEARCHES RECORDED: Full map: no 430.48 pinpoint. Corpus searched for installment repayment, repayment schedules and unallowable federal payments; installment hits are provider enhanced payment installments in plan attachments only. H-131 read and distinguished.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 430.48 text as carried in the register requirement of record

CFR-430-010: Corrective action plans for eligibility redetermination noncompliance

CITATION: 42 CFR 430.49

TOPIC: Corrective action plans for eligibility redetermination noncompliance

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - within 14 calendar days of a CMS noncompliance notice

EVIDENCE CLASS: GOVERNING

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the

organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC if CMS finds eligibility redetermination noncompliance

BASIS: No NC evidence for a corrective action plan under 42 CFR 430.49 was found. No held or cure document mentions 430.49, an eligibility redetermination corrective action plan, or a CMS compliance finding of that kind against NC.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The entire provision: no held document addresses a corrective action plan for eligibility redetermination noncompliance (42 CFR 430.49).
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce any CMS corrective action plan correspondence on eligibility redeterminations, or state on the record that none has been required.
>
> **QUESTION:** Has CMS required an eligibility redetermination corrective action plan from NC, and if so where is it filed?

SEARCHES RECORDED: Full map: no 430.49 pinpoint in any document. Corpus and cure texts searched for 430.49, eligibility corrective action plan and redetermination corrective language (no hits).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 430.49 text as carried in the register requirement of record

CFR-431-001: Single State agency designation, delegation oversight, and organization

CITATION: 42 CFR 431.10, 431.11

TOPIC: Single State agency designation, delegation oversight, and organization

OBLIGATED LEVEL: agency

CADENCE: FIXED - established in State plan; ongoing oversight and corrective action over delegated agencies

EVIDENCE CLASS: GOVERNING

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as the state operating a Title XIX plan through a single State agency

BASIS: Plan section 1.1 designates the Department of Health and Human Services as the single State agency, with the Attorney General certification at Attachment 1.1-A; section 1.1(d) and (f)

carry responsibility for eligibility determinations and all other requirements of 431.10; section 1.2 and Attachments 1.2-A to 1.2-D carry the organization of the agency and the medical assistance unit. The current PHP contract amendment restates the structure in current terms: DHHS is the single state Medicaid agency designated under 42 CFR 431.10, the Division of Health Benefits is designated with administration, provision, and payment for Title XIX and Title XXI, and the Division of Social Services is designated with administration and determination of eligibility. Delegation oversight is carried in Attachment 1.1-B, where DMA retains oversight of the State Plan, monitors the entire OAH appeals process including quality and accuracy of final decisions, and OAH cooperates with federal and state audits and monitoring.

RECORD LOCATION: H-001 (H-001), PDF p.18, p.21, p.22, p.23, p.188 (Att. 1.1-A), p.190-194 (Att. 1.1-B); H-049 (H-049), p.12-13

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

FLAGS: Plan internal tension flagged: section 1.2(d) at PDF p.23 carries a checked statement that only staff of the agency named in 1.1(a) make eligibility determinations, while section 1.1(d) and the current contract amendment place eligibility determinations with DSS and county departments; graded on the stronger and more current contract and 1.1(d) evidence

CFR-431-002: Medicaid Advisory Committee (MAC) and Beneficiary Advisory Council (BAC)

CITATION: 42 CFR 431.12

TOPIC: Medicaid Advisory Committee (MAC) and Beneficiary Advisory Council (BAC)

OBLIGATED LEVEL: agency

CADENCE: RECURRING - regular meetings with minutes posted within 30 days; annual report; BAC must meet in advance of each MAC meeting Calendared milestone: BAC share rises to 25% on 2027-07-10 (see derivation).

EVIDENCE CLASS: DERIVED

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC; the 2024 Access rule structure (MAC and BAC) replaced the former Medical Care Advisory Committee effective July 9, 2025

BASIS: Plan section 1.4 (PDF p.25) carries the predecessor committee: an advisory committee to the Medicaid agency director established in accordance with 42 CFR 431.12, meeting at least quarterly per the tribal consultation pages, with a tribal representative assured nomination. The SFY2025 Annual Report carries the transition: the April 2024 CMS final rule repurposed the MCAC into the Medicaid Advisory Committee and established the Beneficiary Advisory Council, both designed around beneficiary lived experience, and a recruitment campaign drew more than 190 applications.

RECORD LOCATION: H-001 (H-001), PDF p.25-26; H-126 (H-126), p.9

> **SECTION 5D FACE**

UNCOVERED ELEMENT: No held document carries the MAC or BAC charter or bylaws, the BAC beneficiary composition percentages and their phase-in, the requirement that the BAC meet in advance of each MAC meeting, posting of meeting minutes within 30 days, or a MAC annual report

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the MAC and BAC charters or bylaws, member rosters with beneficiary share, meeting schedules and minutes, and the first MAC annual report on the NC Medicaid website

QUESTION: Have the MAC and BAC been seated with the composition, meeting, minutes, and annual report terms that 42 CFR 431.12 now requires, and where are those documents posted?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-003: Methods of administration

CITATION: 42 CFR 431.15, 431.11

TOPIC: Methods of administration

OBLIGATED LEVEL: agency

CADENCE: FIXED - established in State plan

EVIDENCE CLASS: GOVERNING

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a standing plan requirement

BASIS: Plan section 4.1 states the Medicaid agency employs methods of administration found by the Secretary to be necessary for the proper and efficient operation of the plan, citing 42 CFR 431.15. Plan section 1.2 with Attachments 1.2-A, 1.2-B, and 1.2-C carries the organization, functions, and professional and supporting staffing of the agency and the medical assistance unit under 431.11, and the plan table of contents carries Attachment 7.2-A, Methods of Administration - Civil Rights.

RECORD LOCATION: H-001 (H-001), PDF p.79 (section 4.1), p.23 (section 1.2), p.13 (Att. 7.2-A listing)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-004: Submit Secretary-required reports

CITATION: 42 CFR 431.16

TOPIC: Submit Secretary-required reports

OBLIGATED LEVEL: agency

CADENCE: RECURRING - as required by the Secretary (form/content per instructions)

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a standing plan requirement

BASIS: Plan section 4.6 states the Medicaid agency will submit all reports in the form and with the content required by the Secretary and will comply with any provisions the Secretary finds necessary to verify and assure the correctness of the reports, and that all requirements of 42 CFR 431.16 are met.

RECORD LOCATION: H-001 (H-001), PDF p.85 (section 4.6)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-005: Maintain individual records (retention, electronic format, 30-day access)

CITATION: 42 CFR 431.17

TOPIC: Maintain individual records (retention, electronic format, 30-day access)

OBLIGATED LEVEL: agency

CADENCE: RECURRING - continuous; 30-calendar-day turnaround on authorized record requests

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a standing plan requirement

BASIS: Plan section 4.7 states the agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determinations of eligibility, the provision of medical assistance, and statistical, fiscal, and other records necessary for reporting and accountability, retained in accordance with Federal requirements, citing 42 CFR 431.17.

RECORD LOCATION: H-001 (H-001), PDF p.86 (section 4.7)

> **SECTION 5D FACE**

> **UNCOVERED ELEMENT:** The held text does not state the electronic format element or a timed access commitment for making records available to the Secretary on request; retention is stated only as in accordance with Federal requirements
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the records retention and access standard that states the electronic format of individual records and the timeframe for producing them to CMS on request
>
> **QUESTION:** Where is the NC standard that carries the electronic format and prompt access elements of 42 CFR 431.17 for individual case records?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-006: Make program manuals and policies publicly available

CITATION: 42 CFR 431.18

TOPIC: Make program manuals and policies publicly available

OBLIGATED LEVEL: agency

CADENCE: RECURRING - continuous availability; distribute updates as rules change

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a standing plan requirement

BASIS: Plan section 4.8 states program manuals and other policy issuances that affect the public, including rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered, are maintained in the State office and in each local and district office for examination on request, citing 42 CFR 431.18(b). Current operation exceeds the paper standard: the NCDHHS policies and manuals portal posts the Adult Medicaid manual library, the clinical coverage policy index posts the full CCP library, and 10A NCAC 22B .0201 provides that manuals and bulletins are available through the fiscal agent contractor.

RECORD LOCATION: H-001 (H-001), PDF p.87 (section 4.8); H-117 (cure acquisition, NCDHHS Policies and Manuals portal); H-074 (cure acquisition, Clinical Coverage Policies index); H-098 (H-098__550c25e5.html), 10A NCAC 22B .0201

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-007: Advance directives — written description of State law

CITATION: 42 CFR 431.20

TOPIC: Advance directives — written description of State law

TOPIC IN DETERMINATIONS FILE: Advance directives - written description of State law

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - initial description plus revision/distribution within 60 days of any State law change

EVIDENCE CLASS: GOVERNING

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC; NC has State law on advance directives, so the not-applicable branch does not arise

BASIS: Plan section 4.13(e) requires each provider receiving funds under the plan to maintain written policies on adult individuals' rights to make decisions concerning medical care and to formulate advance directives, to provide written information on those rights and on the provider's implementation policies, to document in the medical record whether an advance directive was executed, to not discriminate based on execution, to ensure compliance with State law, to provide education for staff and the community, and to furnish the written information at hospital admission, nursing facility admission, before home health or personal care, at hospice initiation, and at managed care enrollment. Attachment 4.34-A is the written description of NC law: Supplement 1 summarizes patient rights (the pamphlet Medical Care Decisions and Advance Directives - What You Should Know) and Supplement 2 details the living will (G.S. 90-321 statutory form), the health care power of attorney (G.S. 32A-25 statutory form), and the advance instruction for mental health treatment, and states that State law does not explicitly allow a provider to object on conscience grounds.

RECORD LOCATION: H-001 (H-001), PDF p.95-96 (section 4.13(e)), p.1139-1156 (Att. 4.34-A and Supplements 1 and 2)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

FLAGS: Currency note: Supplement 2 itself flags the mental health advance instruction publication as of historical interest after the 1998 statutory modification, with a new publication forthcoming; the description of law of record otherwise stands

CFR-431-008: Statewide operation and local office supervision

CITATION: 42 CFR 431.50

TOPIC: Statewide operation and local office supervision

OBLIGATED LEVEL: agency

CADENCE: RECURRING - continuous; regular State staff visits to local offices

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a standing plan requirement

BASIS: Plan section 1.3 states the plan is in operation on a statewide basis in accordance with all requirements of 42 CFR 431.50, and that the plan is administered by the political subdivisions of the State and is mandatory on them. 10A NCAC 22A .0101 (amended March 1, 2020) states the Division of Health Benefits shall administer and supervise the administration of medical services under Title XIX, with a fiscal agent under contract to DHHS processing claims.

RECORD LOCATION: H-001 (H-001), PDF p.24 (section 1.3); H-098 (H-098__550c25e5.html), 10A NCAC 22A .0101

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-009: Free choice of providers; certify exceptions

CITATION: 42 CFR 431.51

TOPIC: Free choice of providers; certify exceptions

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - certification before/at implementation of 431.54(d)/(e)/(f) projects

EVIDENCE CLASS: GOVERNING

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC; exceptions arise only through 431.54 restrictions, 431.55 waivers, exclusions, and managed care enrollment as certified in the plan

BASIS: Plan section 4.10 carries the full free choice assurance at 42 CFR 431.51: an eligible individual may obtain services from any qualified institution, agency, pharmacy, person, or organization, including prepayment organizations; paragraph (b) lists the only exceptions (431.54 restrictions, 431.55 waivers, section 1902(p) exclusions, felony convictions the State determines are inconsistent with beneficiaries' best interests, and 438.50 or 440.168 exceptions), each subject to paragraph (c), which protects choice for emergency services and family planning services under managed care and PCCM enrollment. Plan section 1.6 separately assures compliance with 42 CFR 431.51 for family planning services and supplies.

RECORD LOCATION: H-001 (H-001), PDF p.89 (section 4.10), p.32 (section 1.6)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-010: Assure necessary transportation

CITATION: 42 CFR 431.53

TOPIC: Assure necessary transportation

OBLIGATED LEVEL: agency

CADENCE: RECURRING - continuous assurance; methods described in State plan

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC across fee-for-service (NC Medicaid Direct), managed care, and the EBCI Tribal Option

BASIS: Plan section 3.1(c)(1) makes provision for assuring necessary transportation of recipients to and from providers under 42 CFR 431.53, with methods in Attachment 3.1-D: transportation is defined for categorically and medically needy, free transportation through volunteers, public services, relatives, or friends is used first, and payment is made for the least expensive appropriate means (personal vehicle, multi-passenger van, wheelchair van, bus, taxi, train, ambulance), with gas vouchers, meals and lodging reimbursement, attendant reimbursement, county audits, and corrective action plans. Current operation matches: the NC Medicaid NEMT policy page (policy v12, May 7, 2025) states managed care plans provide NEMT for their members and local departments of social services provide NEMT for NC Medicaid Direct and EBCI Tribal Option members, and the beneficiary page lists scheduling routes and advance notice periods by plan.

RECORD LOCATION: H-001 (H-001), PDF p.61 (section 3.1(c)(1)), p.732-735 (Att. 3.1-D); H-065 (cure acquisition, NEMT Policy page, v12 May 7, 2025); H-066 (cure acquisition, NEMT beneficiary page)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-011: Beneficiary lock-in and provider lock-out procedures

CITATION: 42 CFR 431.54

TOPIC: Beneficiary lock-in and provider lock-out procedures

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - each time lock-in or lock-out is imposed

EVIDENCE CLASS: GOVERNING

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as an elected restriction authority the State has implemented by rule

BASIS: 10A NCAC 22F .0704 establishes the Recipient Management Lock-In System under 42 CFR 431.54(e), adopted by reference: the recipient's utilization pattern must be documented as inappropriate, the recipient is notified, is offered the opportunity to select a provider (the Division selects if the recipient does not), receives an eligibility card showing the selected providers, utilization is reviewed and lock-in ends if the pattern is corrected, and lock-in may be imposed only after notice and an opportunity for a hearing under G.S. 150B-23 with assurance of reasonable access to care of adequate quality. Clinical Coverage Policy No. 9, section 5.15, operates the Beneficiary Management Lock-In Program in pharmacy, including inclusion criteria, emergency supplies, and process oversight. Provider-side restriction is carried in 10A NCAC 22F .0601-.0602 administrative sanctions, under which a provider found not licensed or certified shall not participate. Plan section 4.10(b)(1) certifies the 431.54 exception to free choice.

RECORD LOCATION: H-098 (H-098__550c25e5.html), 10A NCAC 22F .0704 and .0601-.0602; H-075 (H-075), section 5.15 at p.15-16, 431.54 cited at p.19; H-001 (H-001), PDF p.89

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

FLAGS: Provider lock-out rests on the program integrity sanctions rules at 10A NCAC 22F .0600 rather than a rule written to 431.54(f) by number; the restriction machinery itself is in force

CFR-431-012: 1915(b) freedom-of-choice waiver requests

CITATION: 42 CFR 431.55

TOPIC: 1915(b) freedom-of-choice waiver requests

OBLIGATED LEVEL: provider

CADENCE: EVENT-TRIGGERED - each waiver request and continuation (max 2-year cycles)

EVIDENCE CLASS: GOVERNING

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a state that has operated 1915(b) authority; Tailored Plan operation moved to the Section 1115 demonstration on the record read

BASIS: Plan section 4.10(b)(2) certifies free choice exceptions under a waiver approved under 42 CFR 431.55, and plan section 1.6 addresses limiting freedom of choice through managed care. Held program pages record the 1915(b) history: the behavioral health page records the 1915(b)(c) combined waiver legacy, and the 1915(i) updates bulletin records that 1915(b)(3) services ended January 1, 2025 and Tailored Plans operate under 1115 authority.

RECORD LOCATION: H-001 (H-001), PDF p.89, p.32; H-040 (cure acquisition, Behavioral Health and I/DD services page); H-086 (cure acquisition, 1915(i) Updates for Providers bulletin)

> **SECTION 5D FACE**

UNCOVERED ELEMENT: The standalone CMS approval letter and waiver document for the Section 1915(b) authority (collection item NL-14) was not located after search, so the waiver's own terms and the 431.55 findings (comparability, access, and cost matters the approval rests on) could not be read

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Obtain and file the CMS 1915(b) approval letter or the successor 1115 authority pages that supersede it, so the freedom-of-choice waiver of record can be read against 431.55

QUESTION: Which instrument of record now carries the freedom-of-choice waiver for Tailored Plan enrollment, the retired 1915(b) approval or the 1115 STCs, and where is it posted?

SEARCHES RECORDED: The collection record shows NL-14 (standalone 1915(b) approval letter) as NOT-FOUND-AFTER-SEARCH; the full reconciliation map searched for 431.55 (only H-001 cites it)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-013: Patient Access API (beneficiary data access)

CITATION: 42 CFR 431.60

TOPIC: Patient Access API (beneficiary data access)

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - continuous API operation with 1-business-day data timelines; annual CMS metrics report due March 31 beginning 2026

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (each year) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Systems — NCTracks (GDIT, fiscal agent) under the Division of Health Benefits

HOME BASIS: NCTracks is NC's multi-payer MMIS, operated by GDIT as the State's fiscal-agent contractor under DHB (Lane A §1.4, §4). Title-level derivation: the obligation is a systems obligation on its face.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid fee-for-service program as an in-force interoperability duty

BASIS: No NC public document in the held corpus states that the State maintains a Patient Access API for fee-for-service beneficiaries, the data content it must expose, or its availability terms. The only Patient Access API references found are inside the managed care MCPAR reporting template carried in H-064 and the MCPAR lessons analysis, where Patient Access API usage is a plan reporting topic beginning June 2026, not a State fee-for-service API.

RECORD LOCATION: No record location: no held document carries the provision (see searches)

SECTION 5D FACE

UNCOVERED ELEMENT:

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the State's Patient Access API documentation for NC Medicaid Direct (endpoint, data content, beneficiary access terms) or the CMS-facing attestation that the API is maintained

> **QUESTION:** Does NC Medicaid Direct maintain a Patient Access API meeting 42 CFR 431.60, and if so, where is it documented for beneficiaries and developers?

SEARCHES RECORDED: the full reconciliation map searched for 431.60 (no document cites it); full held and cure text corpora searched for Patient Access API, FHIR, and application programming interface (hits only in managed care MCPAR template topics, plan provider manuals' commercial API offerings, and HealthConnex interoperability discussion, none stating a State 431.60 API)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-014: Provider Access API and Payer-to-Payer data exchange

CITATION: 42 CFR 431.61

TOPIC: Provider Access API and Payer-to-Payer data exchange

OBLIGATED LEVEL: federal-facing state report

CADENCE: EVENT-TRIGGERED - compliance date January 1, 2027; extension/exemption requests in annual APD before compliance date

EVIDENCE CLASS: GOVERNING

NC HOME: Systems — NCTracks (GDIT, fiscal agent) under the Division of Health Benefits

HOME BASIS: NCTracks is NC's multi-payer MMIS, operated by GDIT as the State's fiscal-agent contractor under DHB (Lane A §1.4, §4). Title-level derivation: the obligation is a systems obligation on its face.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid fee-for-service program; the Payer-to-Payer element carries a federal compliance date of January 1, 2027 under the CMS-0057-F rule, but no NC document of record addresses either element

BASIS: No NC public document in the held corpus states that the State maintains a Provider Access API or exchanges beneficiary data with a prior or concurrent payer on beneficiary request under 42 CFR 431.61.

RECORD LOCATION: No record location: no held document carries the provision (see searches)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the State's Provider Access API and Payer-to-Payer exchange documentation or implementation plan with dates, ahead of the January 1, 2027 federal compliance date for the exchange element
>
> **QUESTION:** What is the State's build status and documentation for the Provider Access API and Payer-to-Payer data exchange under 42 CFR 431.61?

SEARCHES RECORDED: the full reconciliation map searched for 431.61 (no document cites it; the 431.61 hits inside H-001 are the 431.610 survey agency pages); full corpora searched for Provider Access API and Payer-to-Payer (no State-side hits)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-015: Provider directory API

CITATION: 42 CFR 431.70

TOPIC: Provider directory API

OBLIGATED LEVEL: agency

CADENCE: RECURRING - continuous; directory refreshed within 30 calendar days of receipt

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Systems — NCTracks (GDIT, fiscal agent) under the Division of Health Benefits

HOME BASIS: NCTracks is NC's multi-payer MMIS, operated by GDIT as the State's fiscal-agent contractor under DHB (Lane A §1.4, §4). Title-level derivation: the obligation is a systems obligation on its face.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid fee-for-service program as an in-force interoperability duty

BASIS: No NC public document in the held corpus states that provider directory information for the fee-for-service program is made available through a standards-based API as 42 CFR 431.70 requires. Held documents carry plan-level provider directories and directory content specifications in the Tailored Plan contracts, and provider manuals pointing to plan directories, but no State provider directory API.

RECORD LOCATION: No record location: no held document carries the provision (see searches)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the State provider directory API documentation (endpoint and the directory data elements of 431.70) for NC Medicaid Direct
>
> **QUESTION:** Is the State's provider directory for fee-for-service available through an API meeting 42 CFR 431.70, and where is it documented?

SEARCHES RECORDED: the full reconciliation map searched for 431.70 (hits are the 431.702 nursing home administrator pages); full corpora searched for provider directory (hits are plan directories and contract directory specifications, none an API); NCTracks provider materials in the corpus describe web lookup and permission matrices, not an API

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-016: Prior authorization — denial reasons and prior auth API

CITATION: 42 CFR 431.80

TOPIC: Prior authorization — denial reasons and prior auth API

TOPIC IN DETERMINATIONS FILE: Prior authorization - denial reasons and prior auth API

OBLIGATED LEVEL: provider

CADENCE: RECURRING - specific denial reasons from Jan 1, 2026; Prior Auth API from Jan 1, 2027

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Systems — NCTracks (GDIT, fiscal agent) under the Division of Health Benefits

HOME BASIS: NCTracks is NC's multi-payer MMIS, operated by GDIT as the State's fiscal-agent contractor under DHB (Lane A §1.4, §4). Title-level derivation: the obligation is a systems obligation on its face.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid fee-for-service program; process elements of the CMS-0057-F prior authorization rule took effect January 1, 2026 and the Prior Authorization API element carries a January 1, 2027 compliance date

BASIS: Prior authorization is administered across the held corpus (clinical coverage policies set prior approval requirements service by service, and one Standard Plan provider manual directs readers to the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) in its authorization section). The Medicaid Direct PIHP MCPAR carries prior authorization and patient access API reporting topics, marked not reporting data prior to June 2026. No held document states the State fee-for-service standards of 431.80 as such.

RECORD LOCATION: H-064 (H-064), MCPAR Topics XIII and XIV; H-070 (H-070), prior authorization section referencing CMS-0057-F; H-074 (cure acquisition, CCP index)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** No held document states the State's fee-for-service requirement to give a specific denial reason for prior authorization denials, the public posting of prior authorization approval, denial, and timeliness metrics, or the Prior Authorization API (federal compliance date January 1, 2027)
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the fee-for-service prior authorization standard stating specific denial reasons and decision timeframes, post the first annual prior authorization metrics, and publish the Prior Authorization API implementation documentation
>
> **QUESTION:** Where does the State state its 42 CFR 431.80 denial-reason and metrics-posting duties for NC Medicaid Direct, and what is the API build status?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

FLAGS: Weakest row in this batch on the carried side: the elements found are program-adjacent (plan manuals and MCPAR template topics), not a State fee-for-service prior authorization standard

CFR-431-017: Provider relations: consultation services and provider agreements

CITATION: 42 CFR 431.105, 431.107

TOPIC: Provider relations: consultation services and provider agreements

OBLIGATED LEVEL: agency

CADENCE: FIXED - established in State plan and provider agreements

EVIDENCE CLASS: GOVERNING

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a standing plan requirement

BASIS: Plan section 4.12 states consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics, and laboratories in accordance with 42 CFR 431.105(b), and that similar services are not provided to other facility types. Plan section 4.13 states that for all providers, the requirements of 42 CFR 431.107 (and Part 442 Subparts A and B where applicable) are met, with the added requirements for nursing facilities, ICF/IID providers, and providers furnishing ambulatory prenatal care during a presumptive eligibility period. 10A NCAC Chapter 22 carries the provider agreement framework in current rules.

RECORD LOCATION: H-001 (H-001), PDF p.92 (section 4.12), p.93 and p.981 (section 4.13); H-099 (H-099), 431.107 cited at p.6

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-018: Provider agreement effective dates

CITATION: 42 CFR 431.108

TOPIC: Provider agreement effective dates

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - each provider enrollment/survey

EVIDENCE CLASS: GOVERNING

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC for every provider agreement under the plan

BASIS: No held NC document states the 42 CFR 431.108 rule for when a provider agreement takes effect. Provider enrollment and reverification materials in the corpus address application windows, fees, and due dates, but not the effective date of the provider agreement itself.

RECORD LOCATION: No record location: no held document carries the provision (see searches)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the provider enrollment standard or provider agreement term that states the agreement's effective date rule under 42 CFR 431.108
>
> **QUESTION:** Where is the effective date of an NC Medicaid provider agreement fixed, in the agreement form, the enrollment standard, or NCTracks procedure?

SEARCHES RECORDED: the full reconciliation map searched for 431.108 (no document cites it); full corpora searched for provider agreement effective date language (hits concern managed care disenrollment effective dates and PACE disenrollment, not provider agreements); NCTracks enrollment and reverification pages H-142, H-147, H-148, H-149 read

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-019: Indian Health Service facility participation

CITATION: 42 CFR 431.110

TOPIC: Indian Health Service facility participation

OBLIGATED LEVEL: agency

CADENCE: FIXED - established in State plan; applied at enrollment

EVIDENCE CLASS: GOVERNING

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC; the Eastern Band of Cherokee Indians health system operates in the State

BASIS: Plan section 3.1(g) states Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers. The plan's tribal consultation pages and the EBCI Tribal Option program (a PCCM entity created by the Cherokee Indian Hospital Authority, launched July 1, 2021) confirm IHS and tribal facility participation in operation.

RECORD LOCATION: H-001 (H-001), PDF p.65 (section 3.1(g)), p.26-29 (tribal consultation); H-157 (H-157), EBCI Tribal Option fact sheet

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-020: Disclosure of survey and evaluation information

CITATION: 42 CFR 431.115

TOPIC: Disclosure of survey and evaluation information

OBLIGATED LEVEL: agency

CADENCE: RECURRING - per survey; deficiency statements available within 90 days; 30-day comment window on evaluation reports

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a standing plan requirement

BASIS: Plan section 4.27 states the Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115, citing 431.115(c).

RECORD LOCATION: H-001 (H-001), PDF p.143 (section 4.27)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-021: Nursing facility requirements, nurse aide programs, registry

CITATION: 42 CFR 431.120

TOPIC: Nursing facility requirements, nurse aide programs, registry

OBLIGATED LEVEL: agency

CADENCE: RECURRING - continuous operation of NATCEP and registry

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a standing plan requirement cross-referencing the Part 483 Subpart D regime

BASIS: Plan section 4.38 carries the nurse aide training and competency evaluation regime: the State assures the requirements of 42 CFR Part 483 Subpart D are met, waives competency evaluation for individuals meeting 483.150(b)(1), deems individuals meeting 483.150(b)(2), reviews programs on request, determines during surveys whether 483.75(e) is met, determines before approval whether programs meet 483.152 and 483.154, visits programs on reviews other than initial, does not approve programs barred by 483.151(b)(2) and (3), and acts on approval requests within 90 days. Plan section 4.40(e) carries the registry element: a nurse aide found to have neglected or abused a resident or misappropriated resident property is notified of the finding and the name and finding are placed on the nurse aide registry, with notice to the licensure authority under 4.40(f).

RECORD LOCATION: H-001 (H-001), PDF p.156-160 (section 4.38), p.163 (section 4.40)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-022: NF and ICF/IID appeals (evidentiary hearing; informal reconsideration)

CITATION: 42 CFR 431.151, 431.152, 431.153, 431.154

TOPIC: NF and ICF/IID appeals (evidentiary hearing; informal reconsideration)

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - each adverse action against an NF or ICF/IID

EVIDENCE CLASS: GOVERNING

NC HOME: North Carolina Office of Administrative Hearings (OAH) — Medicaid State Fair Hearings

HOME BASIS: Determination of record (simmer finding F-1, verified from primary NC sources and adopted 2026-10-21): the hearing function of the 42 CFR 431 Subpart E system is conducted by the NC Office of Administrative Hearings \u2014 G.S. \u00a7\u00a7 108A-70.9A and 108A-70.9B address contested Medicaid Recipient Appeals involving DHHS, G.S. Chapter 108D addresses appeals involving an MCO, and 26 NCAC 03 .0401\u2013.0402 set the Medicaid Recipient Appeal procedures at OAH, where an Administrative Law Judge conducts the hearing (OAH, 'Medicaid Recipient Appeal Regulatory Procedures'; 'Filing a Contested Medicaid Recipient Appeal,' oah.nc.gov, retrieved 2026-10-21). OAH sits outside DHHS; the morning build, scoped to DHHS/DHB's published organization, printed this block UNASSIGNED. The designation relied on is the statute and Administrative Code OAH itself publishes; a DHB-side designation instrument (KB wanted source W-17) remains not found and is not the basis relied on.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC for nursing facility transfer and discharge appeals and PASRR determinations

BASIS: Plan section 4.28 states the agency has established appeals procedures for NFs as specified in 42 CFR 431.153 and 431.154, and provides an appeals system meeting Subpart E, 42 CFR 483.12, and Part 483 Subpart E for residents appealing transfer or discharge notices and for individuals adversely affected by PASRR. 10A NCAC 22H .0200 carries the operating rules: the Notice of Transfer or Discharge form (invalid if not completed), a written hearing request to the DHB Hearing Unit within 11 calendar days, certified mail notice of the hearing, facility records to the resident at least five business days before the hearing, dismissal for failure to appear absent good cause, and the hearing officer's final decision with judicial review in superior court within 30 days. Section .0300 carries PASRR hearings on the same Hearing Unit structure.

RECORD LOCATION: H-001 (H-001), PDF p.144 (section 4.28); H-098 (H-098__550c25e5.html), 10A NCAC 22H .0201-.0205 and .0301-.0305

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The ICF/IID informal reconsideration procedure of 42 CFR 431.154 (an informal reconsideration offered to the facility by a reviewer who was not involved in the survey) is not stated in any held NC rule or plan passage; the held rules carry the evidentiary hearing track only
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the ICF/IID informal reconsideration procedure (who conducts it, how a facility requests it, and its effect on the evidentiary hearing) in rule or in the survey agency procedures
>
> **QUESTION:** Where is the 42 CFR 431.154 informal reconsideration for ICF/IID facilities documented in NC's public materials?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-023: Maintain fair hearing system and inform of hearing rights

CITATION: 42 CFR 431.202, 431.205, 431.206

TOPIC: Maintain fair hearing system and inform of hearing rights

TOPIC IN DETERMINATIONS FILE: Fair hearing system and informing individuals of hearing procedures

OBLIGATED LEVEL: agency

CADENCE: RECURRING - continuous hearing system; rights information at application, each adverse action, and NF transfer/discharge or PASRR notices

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: North Carolina Office of Administrative Hearings (OAH) — Medicaid State Fair Hearings

HOME BASIS: Determination of record (simmer finding F-1, verified from primary NC sources and adopted 2026-10-21): the hearing function of the 42 CFR 431 Subpart E system is conducted by the NC Office of Administrative Hearings \u2014 G.S. \u00a7\u00a7 108A-70.9A and 108A-70.9B address contested Medicaid Recipient Appeals involving DHHS, G.S. Chapter 108D addresses appeals involving an MCO, and 26 NCAC 03 .0401\u2013.0402 set the Medicaid Recipient Appeal procedures at OAH, where an Administrative Law Judge conducts the hearing (OAH, 'Medicaid Recipient Appeal Regulatory Procedures'; 'Filing a Contested Medicaid Recipient Appeal,' oah.nc.gov, retrieved 2026-10-21). OAH sits outside DHHS; the morning build, scoped to DHHS/DHB's published organization, printed this block UNASSIGNED. The designation relied on is the statute and Administrative Code OAH itself publishes; a DHB-side designation instrument (KB wanted source W-17) remains not found and is not the basis relied on.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC for all Medicaid fair hearings, including county DSS eligibility determinations and Department service determinations

BASIS: Plan section 4.2 states the agency has established a fair hearings system in accordance with Subpart E. The informing duty is carried in operation for Department service determinations by G.S. 108A-70.9A(c), which requires every adverse determination notice to state the right to a hearing, how to request one, the right to representation, continuation of services, and Legal Aid contact information, with an appeal form attached. The OAH page (H-114) confirms G.S. 108A-70.9A and 70.9B and 26 NCAC 03 .0401-.0402 govern Medicaid recipient appeal procedures.

RECORD LOCATION: H-001 (H-001), PDF p.80 (section 4.2); H-109 (cure acquisition, G.S. 108A-70.9A(c)); H-114 (cure acquisition, NC OAH Medicaid recipient appeals page)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** Held public materials do not carry the informing duty at the application stage (431.205(a)) for eligibility applicants, nor the hearing channel for county DSS eligibility determinations as written in a current rule; the beneficiary appeals rules at 10A NCAC 22H .0101 and .0104 expired effective September 1, 2025 under G.S. 150B-21.3A
>
> **OWNER LEVEL:** Division of Health Benefits (DHB), with the Division of Social Services for county eligibility appeals

ACTION: Republish a current beneficiary appeals rule or manual section covering eligibility appeals end to end (application-stage informing, local hearing, state hearing, and Department service appeals) to replace the expired 22H .0101 and .0104

QUESTION: After the September 1, 2025 expiry of 10A NCAC 22H .0101 and .0104, which public document carries the eligibility fair hearing system and the application-stage informing duty?

SEARCHES RECORDED: Full corpora searched for 108A-79 (appears only as an authority citation in 10A NCAC 22F .0704); H-098 Chapter 22 text inspected for Sections 22H .0100 rules

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

FLAGS: Rules currency: 10A NCAC 22H .0101 (Appeals) and .0104 (Payment Pending Appeals) expired effective September 1, 2025; graded on the plan assurance and the statutes, not on the expired rules

CFR-431-024: Notice content and advance notice before adverse action

CITATION: 42 CFR 431.210, 431.211, 431.213, 431.214

TOPIC: Notice content and advance notice before adverse action

TOPIC IN DETERMINATIONS FILE: Notice content, advance notice, and exceptions

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - 10 days advance (or exceptions); 5 days for probable fraud

EVIDENCE CLASS: GOVERNING

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency-side Subpart E duty (determination of record, simmer finding F-1, adopted 2026-10-21): notice content and timing, and aid pending appeal, are duties of the agency that took the adverse action \u2014 NC DHHS / the Division of Health Benefits and, for eligibility determinations, the county departments of social services under State supervision \u2014 not of the hearing forum. The hearing itself is homed at the NC Office of Administrative Hearings (CFR-431-022, -023, -025, -027).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC for Department adverse determinations in fee-for-service; eligibility notices are graded at CFR-435-025

BASIS: G.S. 108A-70.9A(c) requires notice at least 10 days before the effective date of an adverse determination, carrying the 431.210 content list in ten items: the service and intended action, a clear statement of the specific reason, the specific regulations supporting it, the effective date, hearing rights and how to request, the 30-day request period, representation, continuation of services and how to request it, agency contact, the Legal Aid number, and the appeal form. The 1115 STCs carry the same notice discipline for continuous eligibility terminations (notice per 435.917 and Part 431 Subpart E), and the TBI waiver application cites 431.210 in its hearing appendix.

RECORD LOCATION: H-109 (cure acquisition, G.S. 108A-70.9A(c)); H-025 (H-025), STC 4.3(g); H-041 (H-041), 431.210 cited at p.6 and p.137

SECTION 5D FACE

UNCOVERED ELEMENT: The 431.213 exception categories (for example, confirmed fraud referral, death of the recipient, change in law under 431.214, and admission to an institution where freedom of choice is not at issue) are not stated in any held NC document

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the advance notice exceptions in the appeals manual section or rule so the 431.213 and 431.214 categories are stated alongside the 10-day rule

QUESTION: Where does NC state the exceptions to advance notice under 42 CFR 431.213 and 431.214 for fee-for-service adverse determinations?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-025: Grant hearings; expedited appeals

CITATION: 42 CFR 431.220, 431.221, 431.222, 431.223, 431.224

TOPIC: Grant hearings; expedited appeals

TOPIC IN DETERMINATIONS FILE: Grant of hearing, time limits, group hearings, dismissal, expedited appeals

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - each hearing request; expedited process when criteria met

EVIDENCE CLASS: GOVERNING

NC HOME: North Carolina Office of Administrative Hearings (OAH) — Medicaid State Fair Hearings

HOME BASIS: Determination of record (simmer finding F-1, verified from primary NC sources and adopted 2026-10-21): the hearing function of the 42 CFR 431 Subpart E system is conducted by the NC Office of Administrative Hearings \u2014 G.S. \u00a7\u00a7 108A-70.9A and 108A-70.9B address contested Medicaid Recipient Appeals involving DHHS, G.S. Chapter 108D addresses appeals involving an MCO, and 26 NCAC 03 .0401\u2013.0402 set the Medicaid Recipient Appeal procedures at OAH, where an Administrative Law Judge conducts the hearing (OAH, 'Medicaid Recipient Appeal Regulatory Procedures'; 'Filing a Contested Medicaid Recipient Appeal,' oah.nc.gov, retrieved 2026-10-21). OAH sits outside DHHS; the morning build, scoped to DHHS/DHB's published organization, printed this block UNASSIGNED. The designation relied on is the statute and Administrative Code OAH itself publishes; a DHB-side designation instrument (KB wanted source W-17) remains not found and is not the basis relied on.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC for Department determinations; expedited appeals are also carried in the managed care statutes at G.S. 108D

BASIS: G.S. 108A-70.9A(d) grants an appeal to the Office of Administrative Hearings within 30 days of the adverse determination notice for any request for medical care, services, or supplies, including failure to act on a reauthorization request with reasonable promptness, and (e1) carries expedited appeals in terms tracking 42 CFR 431.224: the person may request expedition, the Department decides, a denial of expedition gets oral and written notice and is not appealable, and an expedited appeal is decided as expeditiously as the health condition requires. G.S. 108A-70.9B(a) makes the case a contested case before OAH, mediation is offered, and the single agency agreement at Attachment 1.1-B carries dismissal when the conditions of 42 CFR 431.223 are present and treats withdrawal or abandonment the same way.

RECORD LOCATION: H-109 (cure acquisition, G.S. 108A-70.9A(d) and (e1)); H-110 (H-110 and H-110, G.S. 108A-70.9B); H-001 (H-001), PDF p.190-194 (Att. 1.1-B)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** Group hearings under 42 CFR 431.222 (a single hearing where the sole issue is one of law, regulation, or policy) are not provided for in any held NC statute, rule, or agreement
>
> **OWNER LEVEL:** Division of Health Benefits (DHB), with the Office of Administrative Hearings
>
> **ACTION:** State the group hearing option in the appeals procedures so identically situated recipients raising a common question of law or policy can be heard together under 431.222
>
> **QUESTION:** Does NC provide group hearings under 42 CFR 431.222, and if the mechanism exists, where is it published?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-026: Maintain and reinstate services pending hearing (aid pending)

CITATION: 42 CFR 431.230, 431.231, 431.232, 431.233

TOPIC: Maintain and reinstate services pending hearing (aid pending)

TOPIC IN DETERMINATIONS FILE: Aid pending fair hearing, reinstatement, retraction, corrective action

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - each hearing request; reinstatement when requested within 10 days of action

EVIDENCE CLASS: GOVERNING

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency-side Subpart E duty (determination of record, simmer finding F-1, adopted 2026-10-21): notice content and timing, and aid pending appeal, are duties of the agency that took the adverse action \u2014 NC DHHS / the Division of Health Benefits and, for eligibility determinations, the county departments of social services under State supervision \u2014 not of the hearing forum. The hearing itself is homed at the NC Office of Administrative Hearings (CFR-431-022, -023, -025, -027).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC for Department determinations; reinstatement is a statutory duty on timely appeal

BASIS: G.S. 108A-70.9A(c)(7) requires the notice to state that services will continue at the prior level if a hearing is requested before the effective date of the action, and that services will continue until the final decision. G.S. 108A-70.9A(d) requires the Department to reinstate services at the level provided before the determination when an appeal of a reduction or termination is timely made. Attachment 1.1-B, condition 5, binds the OAH process to issue temporary restraining orders or stays to continue authorization of services to the extent required by 42 CFR 431.230.

RECORD LOCATION: H-109 (cure acquisition, G.S. 108A-70.9A(c)(7) and (d)); H-001 (H-001), PDF p. 192 (Att. 1.1-B)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

FLAGS: Two points flagged: (1) Attachment 1.1-B frames interim relief through Rule 65 temporary restraining order conditions, which is narrower language than the statute's continuation and reinstatement as of right; graded on the statute as the stronger public evidence. (2) The payment-pending-appeals rule at 10A NCAC 22H .0104 expired September 1, 2025; the statutory aid pending duty stands independent of it

CFR-431-027: Hearing conduct, decision timelines, corrective action

CITATION: 42 CFR 431.240, 431.241, 431.242, 431.244, 431.245, 431.246

TOPIC: Hearing conduct, decision timelines, corrective action

TOPIC IN DETERMINATIONS FILE: Hearing conduct, decisions, and corrective action

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - 90 days ordinarily; 7 working days for expedited eligibility/NF/PASRR; 3 working days for expedited managed-care denials

EVIDENCE CLASS: GOVERNING

NC HOME: North Carolina Office of Administrative Hearings (OAH) — Medicaid State Fair Hearings

HOME BASIS: Determination of record (simmer finding F-1, verified from primary NC sources and adopted 2026-10-21): the hearing function of the 42 CFR 431 Subpart E system is conducted by the NC Office of Administrative Hearings \u2014 G.S. \u00a7\u00a7 108A-70.9A and 108A-70.9B address contested Medicaid Recipient Appeals involving DHHS, G.S. Chapter 108D addresses appeals involving an MCO, and 26 NCAC 03 .0401\u2013.0402 set the Medicaid Recipient Appeal procedures at OAH, where an Administrative Law Judge conducts the hearing (OAH, 'Medicaid Recipient Appeal Regulatory Procedures'; 'Filing a Contested Medicaid Recipient Appeal,' oah.nc.gov, retrieved 2026-10-21). OAH sits outside DHHS; the morning build, scoped to DHHS/DHB's published organization, printed this block UNASSIGNED. The designation relied on is the statute and Administrative Code OAH itself publishes; a DHB-side designation instrument (KB wanted source W-17) remains not found and is not the basis relied on.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC for OAH contested cases under the single agency agreement

BASIS: G.S. 108A-70.9B carries hearing conduct: the case is heard and decided by an administrative law judge in a contested case, scheduled within 55 days to the extent possible, with telephonic or video hearings (in person on request), the recipient's right to examine the case file, interpreter services, a medical assessment at agency expense when hearing, medical, or psychological conditions are an issue, mediation offered within 5 days and completed within 25, new evidence admissible, and a written decision issued without unnecessary delay. Attachment 1.1-B carries decision standards: OAH decides within the 42 CFR 431.244(f) period, decisions state whether the contested case was correctly decided under the State Plan, applicable law, and agency policies, and DMA monitors the quality and accuracy of OAH decisions. G.S. 108A-70.9A(d) requires reinstatement on timely appeal, which carries the interim corrective element.

RECORD LOCATION: H-110 (H-110 and H-110, G.S. 108A-70.9B); H-001 (H-001), PDF p.190-194 (Att. 1.1-B)

> **SECTION 5D FACE**

UNCOVERED ELEMENT: Post-decision corrective action under 42 CFR 431.246 (prompt corrective payments and retroactive relief when the decision is favorable to the claimant) is not stated in held text; the held materials carry reinstatement pending appeal, not corrective action after a favorable final decision. The 90-day decision period of 431.244(f) appears as an agreement term, while the statute's own language is 55 days to the extent possible and decision without unnecessary delay

OWNER LEVEL: Division of Health Benefits (DHB), with the Office of Administrative Hearings

ACTION: State the corrective action duty in the appeals procedures: when a hearing decision is favorable, the agency will take prompt corrective action including retroactive payments, within the 431.244(f) and 431.246 framework

QUESTION: Where is NC's post-decision corrective action duty (retroactive payments on favorable hearing decisions) documented as written?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

FLAGS: Statute as written graded, per task instruction; no operation data (timeliness of OAH decisions in practice) is in the held corpus. The statute also places the burden of proof on the recipient at G.S. 108A-70.9B(d), a term the federal sections do not address

CFR-431-028: Safeguard applicant/beneficiary information

CITATION: 42 CFR 431.300, 431.301, 431.303, 431.304, 431.305, 431.306, 431.307

CITATION IN DETERMINATIONS FILE: 42 CFR 431.300, 431.301, 431.302, 431.303, 431.304, 431.305, 431.306, 431.307

TOPIC: Safeguard applicant/beneficiary information

TOPIC IN DETERMINATIONS FILE: Safeguarding information about applicants and beneficiaries

OBLIGATED LEVEL: provider

CADENCE: RECURRING - continuous safeguarding; data exchange agreements before any exchange

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a standing plan requirement under State law with legal sanctions

BASIS: Plan section 4.3 states the agency has a formal plan of policies and procedures in accordance with State statute which provides legal sanctions; use or disclosure of information concerning applicants and recipients is restricted to purposes directly connected with the administration of the plan; and all the requirements of 42 CFR 431.301 are met and the plan is administered in conformity with them, citing 42 CFR 431.300 (TN approved April 18, 2005). The contracting documents carry safeguarding and confidentiality duties for delegated functions, and

the Tailored Plan provider operations manual carries client rights and confidentiality oversight under G.S. 122C-64 and 10A NCAC 27G .0504.

RECORD LOCATION: H-001 (H-001), PDF p.81 (section 4.3); H-072 (H-072), p.14

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

FLAGS: Pinpoint caution: the 431.301 pinpoints in the Tailored Plan contract (H-052, p.52 and p.71) on inspection are citations to 431.301(c)(1)(vi) for conflict-free case management, which is the 42 CFR 441.301 subject; they were not relied on for this row. The grade rests on the plan section 4.3 assurance

CFR-431-029: 1115 demonstration — State public notice and hearings

CITATION: 42 CFR 431.408

TOPIC: 1115 demonstration — State public notice and hearings

TOPIC IN DETERMINATIONS FILE: Public notice of proposed Section 1115 demonstration changes

OBLIGATED LEVEL: federal-facing state report

CADENCE: EVENT-TRIGGERED - for each new demonstration or extension application; hearings ≥20 days before submission

EVIDENCE CLASS: GOVERNING

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC for Section 1115 demonstration applications and extensions

BASIS: The Reform Demonstration renewal abbreviated public notice (released August 21, 2023) carries the 431.408 elements in operation: a 30-day comment period (August 21 to September 20, 2023, comments due 5 p.m. ET), five public hearings with dates and places (Asheville September 5, Raleigh September 6, a virtual hearing September 6, Greenville September 7, and September 15 during the MCAC meeting), and posting of the full public notice and renewal request on the DHHS website. The PCS Alignment Demonstration page runs the same practice (comment period with two in-person hearings, two webinars, tribal notice, and a summary of comments to be included in the application), and STC 3.12 of the approved demonstration requires public notice in accordance with 431.408 before an extension application, with tribal consultation per 431.408(b).

RECORD LOCATION: H-171 (H-171), p.1; H-031 (cure acquisition, PCS Alignment Demonstration page); H-025 (H-025), STC 3.12

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-030: 1115 demonstration — application and extension content

CITATION: 42 CFR 431.412

TOPIC: 1115 demonstration — application and extension content

TOPIC IN DETERMINATIONS FILE: Section 1115 demonstration application requirements

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - each demonstration application or extension

EVIDENCE CLASS: GOVERNING

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC for Section 1115 demonstration applications and extensions

BASIS: The draft PCS Alignment Demonstration application (H-032) carries application content in its sections and appendices, including the public notice and tribal consultation appendices. STC 3.8 of the approved Reform Demonstration incorporates 42 CFR 431.412(c) for extension applications (timely submission rules), and the Section 1115 waiver page (H-023) shows the Reform renewal application, full and abbreviated public notices, and fact sheets posted.

RECORD LOCATION: H-032 (H-032); H-025 (H-025), STC 3.8; H-023 (cure acquisition, Section 1115 Waivers page)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The Reform Demonstration renewal application document itself is not held, so its 431.412(b) elements (hypotheses, budget neutrality and expenditure detail, eligibility and benefit descriptions) could not be read element by element; only the draft PCS application could
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File the Reform renewal application document with the cure record so the application content can be graded against 431.412(b) directly
>
> **QUESTION:** Which held document is the Reform renewal application of record whose contents answer 42 CFR 431.412(b)?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-031: 1115 demonstration — STC compliance, reviews, post-award forum

CITATION: 42 CFR 431.420

CITATION IN DETERMINATIONS FILE: 42 CFR 431.416, 431.420

TOPIC: 1115 demonstration — STC compliance, reviews, post-award forum

TOPIC IN DETERMINATIONS FILE: Demonstration approval procedures and post-award public input

OBLIGATED LEVEL: agency

CADENCE: RECURRING - post-award public forum within 6 months of implementation, then annually

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC for the approved Section 1115 demonstrations

BASIS: STC 15.11 of the approved Reform Demonstration requires a post-award forum in accordance with 42 CFR 431.420(c): within 6 months of implementation and annually thereafter, with the date, time, and location posted on the State's website at least 30 days in advance, public comment accepted, and a summary of comments included in the monitoring report. Operation is evidenced on the Section 1115 waiver page: an annual 1115 forum is held and a virtual post-award forum was held May 21, 2025 with a slide deck posted, alongside the monitoring report. STCs 15.6 and 15.10 carry the monitoring report and State-CMS monitoring call structure of the approved demonstration.

RECORD LOCATION: H-025 (H-025), STC 15.11, 15.6, 15.10; H-023 (cure acquisition, Section 1115 Waivers page)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-032: 1115 demonstration — evaluation design and reports

CITATION: 42 CFR 431.424

TOPIC: 1115 demonstration — evaluation design and reports

TOPIC IN DETERMINATIONS FILE: Section 1115 evaluation requirements

OBLIGATED LEVEL: federal-facing state report

CADENCE: EVENT-TRIGGERED - evaluation design published within 30 days of CMS approval; interim report with each extension request

EVIDENCE CLASS: GOVERNING

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC for the approved Section 1115 demonstrations

BASIS: The approved Reform Demonstration carries an evaluation section (STCs 15.7 and 16) structured on 42 CFR 431.424, with evaluation design review, interim and summative reporting. Completed evaluations are held: the Healthy Opportunities Pilots Summative Evaluation Report

(H-028) and the Substance Use Disorder Interim Evaluation Report (H-030), and the Section 1115 waiver page records the Managed Care Interim Evaluation Report submitted to CMS October 14, 2023.

RECORD LOCATION: H-025 (H-025), STCs 15.7 and 16; H-028 (H-028); H-030 (H-030); H-023 (cure acquisition)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The approved Evaluation Design document for the Reform Demonstration and its website publication date (due within 30 days of CMS approval under 431.424) are not held, so the design's hypotheses, measures, and data sources could not be read
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File the CMS-approved Evaluation Design and its posting date with the cure record
>
> **QUESTION:** Where is the approved Evaluation Design for the Reform Demonstration posted, and what publication date does the record show?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-033: 1115 demonstration — annual reports

CITATION: 42 CFR 431.428

TOPIC: 1115 demonstration — annual reports

TOPIC IN DETERMINATIONS FILE: Section 1115 annual monitoring report

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - annual: draft to CMS ≤90 days after demo year end; published ≤30 days after submission; final ≤60 days after CMS comments; published ≤30 days after approval

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC for the approved Section 1115 demonstrations

BASIS: The approved Reform Demonstration's monitoring provisions (STCs 15.6 and 15.10) carry the annual monitoring report framework keyed to 42 CFR 431.428, including report content on enrollment, operations, and the post-award forum comment summary, and the Section 1115 waiver page links a monitoring report for the demonstration.

RECORD LOCATION: H-025 (H-025), STC 15.6 and 15.10; H-023 (cure acquisition, Section 1115 Waivers page)

> **SECTION 5D FACE**

> **UNCOVERED ELEMENT:** The annual monitoring report document itself is not held as a file, so its content elements under 431.428 (including enrollment data, grievances and appeals, and the forum comment summary) could not be read in the report
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File the current annual monitoring report document with the cure record
>
> **QUESTION:** Which monitoring report of record (period and submission date) answers 42 CFR 431.428, and can it be filed in the corpus?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-034: Survey agency designation and certification of facilities

CITATION: 42 CFR 431.610

TOPIC: Survey agency designation and certification of facilities

TOPIC IN DETERMINATIONS FILE: Relationships with standard-setting and survey agencies

OBLIGATED LEVEL: agency

CADENCE: RECURRING - inspections at least once per certification period; ICF deficient-facility re-inspections every 6 months

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (every 6 months) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC; DHHS holds both the Medicaid agency and survey agency roles

BASIS: Plan section 4.11 states the requirements of 42 CFR 431.610 are met: DHHS is the State authority responsible under Title XVIII for establishing and maintaining health standards for institutions and, under State law, for licensing health institutions; DHHS is designated as the State survey agency to determine whether institutions and agencies meet the requirements for participation in Medicare; the Secretary is notified of changes in designation; standards developed by the Department of Health and Human Services and the survey agency are on file at Attachment 4.11-A; and paragraphs (e), (f), and (g) (licensing authority determinations and facility category findings) are expressly carried.

RECORD LOCATION: H-001 (H-001), PDF p.90-91 (section 4.11) and Attachment 4.11-A listing

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-035: Arrangements with health, vocational rehab, and title V agencies

CITATION: 42 CFR 431.615

TOPIC: Arrangements with health, vocational rehab, and title V agencies

TOPIC IN DETERMINATIONS FILE: Cooperative arrangements with health, vocational rehabilitation, and Title V agencies

OBLIGATED LEVEL: agency

CADENCE: RECURRING - arrangements with periodic review and joint planning for changes

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (periodic) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a standing plan requirement

BASIS: Plan section 4.14 renumbered as section 4.16 states the Medicaid agency has cooperative arrangements with the State agencies responsible for administering or supervising the State plans for vocational rehabilitation and maternal and child health services, meeting all the requirements of 42 CFR 431.615, and includes in those arrangements provisions for use of Title V capability for covered services for eligible children, cooperation with Title V grantees for individuals with special health needs, and reciprocal referrals as specified in the section; copies of the arrangements are at Attachment 4.16-A.

RECORD LOCATION: H-001 (H-001), PDF p.104 (section 4.16)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-036: PASARR agreements with mental health/ID authorities

CITATION: 42 CFR 431.620, 431.621

CITATION IN DETERMINATIONS FILE: 42 CFR 431.621

TOPIC: PASARR agreements with mental health/ID authorities

TOPIC IN DETERMINATIONS FILE: PASRR - State mental health and intellectual disability authorities

OBLIGATED LEVEL: agency

CADENCE: RECURRING - continuous; PASRR determinations timely per 483.112(c)/483.114(c)

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a standing plan requirement

BASIS: Plan section 4.39 states the Medicaid agency has a written agreement with the State mental health and mental retardation authorities meeting all requirements of 42 CFR 431.621(c), covering PASARR functions including notices to affected individuals of PASARR determinations, hearings procedures, and the role of the NCDHHS, Division of Mental Health, Developmental Disabilities and Substance Abuse Services; it also states the preadmission screening program meets 42 CFR 483.100-138 and that a resident review is performed when there is a significant change in a resident's physical or mental condition. Plan section 3.3 carries the related PASARR identification and IMD-for-the-aged elements (431.620(c) and (d) met). 10A NCAC 22H .0300 carries PASRR hearings in current rules.

RECORD LOCATION: H-001 (H-001), PDF p.161-162 (section 4.39), p.71 (section 3.3); H-098 (H-098__550c25e5.html), 10A NCAC 22H .0300

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-037: Medicare Part B coordination

CITATION: 42 CFR 431.625

TOPIC: Medicare Part B coordination

TOPIC IN DETERMINATIONS FILE: Coordination with Medicare Part B

OBLIGATED LEVEL: agency

CADENCE: FIXED - established in State plan

EVIDENCE CLASS: GOVERNING

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC for all buy-in eligible groups

BASIS: Plan section 3.2 carries the Medicare Part B buy-in structure across the full range of groups, including qualified Medicare beneficiaries and specified low-income Medicare beneficiaries, with the State paying Part B premiums for the listed groups. 10A NCAC 22B .0102 carries the agreement in current rule: an agreement between the State and the Federal Government insuring persons under Part B of Medicare, with coverage under the Part B buy-in agreement including all persons eligible under the North Carolina State Plan for Medical Assistance.

RECORD LOCATION: H-001 (H-001), PDF p.68-69 (section 3.2); H-098 (H-098__550c25e5.html), 10A NCAC 22B .0102

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-038: QIO coordination contract

CITATION: 42 CFR 431.630

TOPIC: QIO coordination contract

TOPIC IN DETERMINATIONS FILE: Quality improvement organization / quality improvement program (Part 462)

OBLIGATED LEVEL: agency

CADENCE: RECURRING - contract with ongoing State monitoring/evaluation plan

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (periodic) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC; hospital utilization review under the QIO program is now performed by the CMS-contracted Beneficiary and Family Centered Care QIO

BASIS: Plan section 4.14 is written to the legacy Utilization Review (PRO) structure of Part 462: State cooperation with the PRO, hospital compliance with PRO conditions as a condition of participation, PRO determinations binding on the State for fee-for-service, delegation of review functions, beneficiary liability protections, and consistency with the Part 462 regulations cited on its face (462.107, 462.110, 462.116). The plan's Attachment 4.19-A pages carry the same legacy PRO framing.

RECORD LOCATION: H-001 (H-001), PDF p.97-102 (section 4.14), Attachment 4.19-A pages

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** No held document identifies the current QIO (the CMS Beneficiary and Family Centered Care QIO) serving NC or the State's current coordination arrangement under the modern Part 462 QIO program; the only QIO-adjacent evidence is the superseded PRO structure in the plan
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish or file the current QIO coordination documentation (the CMS QIO serving NC and the State contact and hospital review arrangement) and consider a plan amendment retiring the PRO-era section 4.14 text
>
> **QUESTION:** Which QIO currently performs Part 462 review for NC Medicaid hospitals, and where is the State's coordination with it documented?

SEARCHES RECORDED: Full corpora searched for QIO and Quality Improvement Organization (hits are the legacy PRO plan text and unrelated quality program documents; no current QIO contract, letter, or identity found)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-039: Coordinate with WIC; notify and refer eligible individuals

CITATION: 42 CFR 431.635

TOPIC: Coordinate with WIC; notify and refer eligible individuals

TOPIC IN DETERMINATIONS FILE: Coordination with WIC program; timely notice and referral

OBLIGATED LEVEL: agency

CADENCE: RECURRING - at each qualifying eligibility determination; annual notice

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a standing plan requirement under section 1902(a)(11)(C) and (a)(53) of the Act

BASIS: Plan section 4.36 (Coordination of Medicaid with Special Supplemental Food Program for Women, Infants, and Children) states the Medicaid agency has a cooperative agreement with the State agency administering the WIC program that satisfies the requirements of section 1902(a)(11)(C) of the Act, and provides for timely notice and referral as required by section 1902(a)(53): the operative duties 42 CFR 431.635 restates for the Medicaid agency.

RECORD LOCATION: H-001 (H-001), PDF p.155 (section 4.36)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-040: Nursing home administrator licensing program

CITATION: 42 CFR 431.702, 431.703, 431.705, 431.706, 431.707, 431.708, 431.709, 431.710, 431.711, 431.712

CITATION IN DETERMINATIONS FILE: 42 CFR 431.702

TOPIC: Nursing home administrator licensing program

OBLIGATED LEVEL: agency

CADENCE: RECURRING - continuous licensing program; complaint investigation as received

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a standing plan requirement under Part 431 Subpart N

BASIS: Plan section 4.25 states the Medicaid agency has established and operates a State program for licensing administrators of nursing homes in accordance with all requirements of 42 CFR Part 431, Subpart N.

RECORD LOCATION: H-001 (H-001), PDF p.138 (section 4.25)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-431-041: MEQC pilot (off-year eligibility quality control)

CITATION: 42 CFR 431.806, 431.810, 431.812, 431.814, 431.816, 431.818, 431.820

CITATION IN DETERMINATIONS FILE: 42 CFR 431.800, 431.806, 431.810, 431.820

TOPIC: MEQC pilot (off-year eligibility quality control)

TOPIC IN DETERMINATIONS FILE: Medicaid eligibility quality control (MEQC) system and pilot projects

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - biennial cycle: planning doc by Nov 1; review period Jan 1–Dec 31; findings and corrective action report by Aug 1

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — MEQC pilot cycle is anchored to the State PERM year (planning document by Nov 1 after the PERM year; findings by Aug 1 after the review period). No NC PERM year is stated in the NC sources reached for this build, so no calendar date is derived. Not calendared.

NC HOME: Division of Health Benefits — Office of Compliance and Program Integrity (OCPI)

HOME BASIS: OCPI's published mission is to protect DHB's resources 'by reducing or eliminating fraud, waste, and abuse of providers and beneficiaries in the NC Medicaid Program' (Lane A §1.4). PERM/MEQC are federal program-integrity measurement programs; routed to NC's program-integrity office as a derivation, labeled as such.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC; the standing QC system duty is at Subpart P, and pilot projects are the mechanism CMS uses for off-cycle eligibility review

BASIS: Plan section 4.4(a) states the agency has a Medicaid eligibility quality control system per 42 CFR Part 431 Subpart P that is implemented in accordance with 42 CFR 431.812 and 431.814, and section 4.4(c) states the agency implements a claims sampling and payment error measurement substitute through PERM under Subpart Q. Operationally, the REDA letter (April 23, 2025) shows the State Office of Compliance and Program Integrity auditing eligibility determinations in all 100 counties on a three-year cycle, sampling 200 determinations per county per cycle across approvals, redeterminations, denials, withdrawals, and terminations, which is State audit practice adjacent to, but not, the federal QC system.

RECORD LOCATION: H-001 (H-001), PDF p.82 (section 4.4); H-118 (H-118), p.1

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** MEQC pilot project specifics under 431.810 to 431.820 (pilot design, sampling methodology, corrective action reporting to CMS) are not stated in held text, and the preprint checkbox alternatives on the plan page (system implemented versus approved pilot) cannot be resolved from the held text layer
>
> **OWNER LEVEL:** Division of Health Benefits (DHB), with the Office of Compliance and Program Integrity
>
> **ACTION:** Publish the MEQC program description (current pilot or system status, sampling, and CMS reporting) so the Subpart P posture can be read directly

QUESTION: Is NC currently operating under a standard MEQC system or a CMS-approved MEQC pilot, and where is that documented?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

FLAGS: OCR caution: on plan PDF p.82 the preprint checkbox marks for sections 4.4(a) to (c) are not reliably readable in the held text layer; graded Partial rather than resting on an unreadable mark

CFR-431-042: Medicaid quality control claims processing assessment system

CITATION: 42 CFR 431.830, 431.832, 431.834, 431.836

TOPIC: Medicaid quality control claims processing assessment system

TOPIC IN DETERMINATIONS FILE: Claims processing assessment system

OBLIGATED LEVEL: agency

CADENCE: RECURRING - monthly reports; 6-month summary within 3 months of sample completion

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (monthly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Office of Compliance and Program Integrity (OCPI)

HOME BASIS: OCPI's published mission is to protect DHB's resources 'by reducing or eliminating fraud, waste, and abuse of providers and beneficiaries in the NC Medicaid Program' (Lane A §1.4). PERM/MEQC are federal program-integrity measurement programs; routed to NC's program-integrity office as a derivation, labeled as such.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC under 431.806(c) unless the approved MMIS alternative applies

BASIS: Plan section 4.4(b) states that in accordance with 42 CFR 431.806(c), the State operates a Medicaid quality control claims processing assessment system that meets the requirements of 42 CFR 431.830-431.836, followed on the preprint by the alternative for a State with an approved MMIS.

RECORD LOCATION: H-001 (H-001), PDF p.82 (section 4.4(b))

SECTION 5D FACE

UNCOVERED ELEMENT: The held text layer does not show which preprint branch NC elected (operating the assessment system versus the approved MMIS alternative), and no held document describes the assessment system's operation (sample design, error findings, or reporting)

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Confirm on the record which 431.806(c) branch NC stands on and, if the assessment system branch, publish its operating description

QUESTION: Does NC operate a 431.830 claims processing assessment system, or does it rely on the approved MMIS alternative, and where is that election documented?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

FLAGS: Same OCR checkbox caution as CFR-431-041: the preprint election on PDF p.82 is not reliably readable in the held text layer

CFR-431-043: PERM participation: data submission, system access, appeals, recoveries

CITATION: 42 CFR 431.970, 431.972, 431.992, 431.998, 431.1002, 431.1010

CITATION IN DETERMINATIONS FILE: 42 CFR 431.950, 431.953, 431.958, 431.960, 431.970

TOPIC: PERM participation: data submission, system access, appeals, recoveries

TOPIC IN DETERMINATIONS FILE: Payment error rate measurement (PERM) program

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - quarterly claims/data submissions; difference resolution 25 business days; appeals 15 business days

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (quarterly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Office of Compliance and Program Integrity (OCPI)

HOME BASIS: OCPI's published mission is to protect DHB's resources 'by reducing or eliminating fraud, waste, and abuse of providers and beneficiaries in the NC Medicaid Program' (Lane A §1.4). PERM/MEQC are federal program-integrity measurement programs; routed to NC's program-integrity office as a derivation, labeled as such.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC on the federal PERM cycle (NC is measured in cycle years on the CMS rotation)

BASIS: Plan section 4.4(c) states the agency implements the claims processing assessment substitute through the Payment Error Rate Measurement Program in accordance with Subpart Q of 42 CFR Part 431, with PERM applied in federal fiscal years 2013, 2016, and 2019 as checked on the transmittal page (TN 12-017).

RECORD LOCATION: H-001 (H-001), PDF p.82 (section 4.4(c))

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** No held document carries current-cycle PERM participation: the State's data submission and universe construction, system access for the federal contractor, error rate findings, corrective action, or FFP recovery under Subpart Q for any cycle after the plan page's checked years
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File the most recent PERM cycle documentation for NC (submission confirmation, error rate letter, and corrective action plan if any) with the cure record
>
> **QUESTION:** What is NC's most recent PERM cycle of record, and where are its submission and results documented?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

FLAGS: Currency: the plan page's checked PERM years (FFY 2013, 2016, 2019) predate the cure; no later cycle evidence is held

CFR-432-001: Merit system of personnel administration

CITATION: 42 CFR 432.10

TOPIC: Merit system of personnel administration

OBLIGATED LEVEL: agency

CADENCE: FIXED - established in State plan; ongoing compliance assurance and reviews of State laws/regulations

EVIDENCE CLASS: GOVERNING

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid agency personnel administration

BASIS: Plan section 5.1 at pp.175-176 carries both elements of 432.10: the Medicaid agency has established and will maintain methods of personnel administration in conformity with the merit system standards at 5 CFR Part 900 Subpart F under section 208 of the Intergovernmental Personnel Act, all requirements of 42 CFR 432.10 are met, the plan is locally administered and state-supervised with the 432.10 local administration requirements met, and an affirmative action plan for equal employment opportunity with specific action steps and timetables is in effect.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan pp.175-176 (section 5.1)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 432.10 text as carried in the register requirement of record

CFR-432-002: Staff training program

CITATION: 42 CFR 432.30

TOPIC: Staff training program

OBLIGATED LEVEL: agency

CADENCE: RECURRING - continuous: initial inservice for new staff plus continuing training

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid agency staff training

BASIS: Plan section 5.3 at pp.177-178 states in one sentence that the Medicaid agency meets the requirements of 42 CFR Part 432 Subpart B with respect to a training program for agency

personnel. No held document describes the training program itself: no curriculum, no categories of staff trained, no orientation or continuing training content.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan pp.177-178 (section 5.3)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The content of the staff training program (42 CFR 432.30): what training is provided, to whom, and on what cycle is not described in held evidence; only a bare meets-requirements assurance is carried.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce the agency training program description or training plan for Medicaid personnel.
>
> **QUESTION:** What does NC's Medicaid staff training program consist of, and where is it described?

SEARCHES RECORDED: Full map: no document carries a 432.30 pinpoint (the 432.30 hit in H-013 is a dollar figure, read and excluded). Corpus searched for staff training program descriptions; only plan section 5.3 found.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR Part 432 Subpart B text as carried in the register requirement of record

CFR-432-003: Subprofessional staff and volunteer programs

CITATION: 42 CFR 432.31, 432.32

TOPIC: Subprofessional staff and volunteer programs

OBLIGATED LEVEL: agency

CADENCE: RECURRING - continuous programs with annual progressive expansion

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid agency use of subprofessional staff and volunteers

BASIS: Plan section 5.3 at pp.177-178 states that the Medicaid agency meets the requirements of 42 CFR Part 432 Subpart B with respect to the training and use of subprofessional staff and volunteers. No held document describes any subprofessional staff program or volunteer program in operation, the positions used, or how such staff are trained and supervised.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan pp.177-178 (section 5.3)

> **SECTION 5D FACE**

UNCOVERED ELEMENT: The subprofessional staff and volunteer program elements (42 CFR 432.31 and 432.32) as operating programs: positions, training and supervision are not described in held evidence.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Produce the subprofessional and volunteer program description, or state whether NC currently uses either.

QUESTION: Does NC use subprofessional staff or volunteers in Medicaid administration, and under what program description?

SEARCHES RECORDED: Full map: no 432.31 or 432.32 pinpoint in any document. Corpus searched for subprofessional and volunteer program language; only plan section 5.3 found.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 432.31 and 432.32 text as carried in the register requirement of record

CFR-432-004: Report training and administrative costs

CITATION: 42 CFR 432.55

TOPIC: Report training and administrative costs

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - quarterly estimate and expenditure reports

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (quarterly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Agency act in NC's published structure: the State Plan and CMS-facing administration sit with the Department and the Division of Health Benefits as a whole (the State Plan 'outlines the organization and function of the Division of Health Benefits' — Lane A §1.2); no single published unit owns it.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC reporting of training and administrative costs for FFP

BASIS: No NC evidence for reporting training and administrative costs under 42 CFR 432.55 was found. The plan's financial administration sections (section 6, pp.178-180) cover fiscal policies, cost allocation under 433.34 and state financial participation, none of which reports training expenditure or administrative cost claiming at the 432.55 level.

RECORD LOCATION:

SECTION 5D FACE

UNCOVERED ELEMENT: The entire provision: no held document addresses the reporting of training and administrative costs (42 CFR 432.55).

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Produce the cost report or claim schedule on which training and administrative costs are reported for federal participation.

QUESTION: Where are NC's Medicaid training and administrative costs reported for FFP?

SEARCHES RECORDED: Full map: no 432.55 pinpoint in any document. Plan section 6 read in full; corpus searched for training cost and administrative cost reporting (cost allocation passages only).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 432.55 text as carried in the register requirement of record

CFR-433-001: Fiscal accountability and records retention

CITATION: 42 CFR 433.32

TOPIC: Fiscal accountability and records retention

OBLIGATED LEVEL: agency

CADENCE: RECURRING - continuous; 3-year retention from final expenditure report submission

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as the Title XIX single state agency record

BASIS: State Plan Section 6.1 Fiscal Policies and Accountability (plan p. 83): the Medicaid agency and, where applicable, local agencies administering the plan maintain an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements, and the requirements of 42 CFR 433.32 are met.

RECORD LOCATION: H-001 (Title XIX State Plan), Section 6.1 at PDF p. 178

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The specific retention periods of 42 CFR 433.32(b)-(d): 3 years from submission of a final expenditure report, retention beyond 3 years while audit findings are unresolved, and the property record periods. No held instrument states these periods.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish a fiscal records retention schedule stating the 433.32(b)-(d) periods and file it as the governing record for this row.
>
> **QUESTION:** Does DHB have a records retention policy or schedule outside the held corpus that states the 433.32 periods, and where is it published?

CFR-433-002: Cost allocation plan

CITATION: 42 CFR 433.34

TOPIC: Cost allocation plan

OBLIGATED LEVEL: agency

CADENCE: RECURRING - approved plan on file; amended as needed

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (periodic) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as the Title XIX single state agency record

BASIS: State Plan Section 6.2 Cost Allocation (plan p. 84): there is an approved cost allocation plan on file with the Department in accordance with the requirements contained in 45 CFR Part 95, Subpart E. The single element of 433.34 is stated in full on the plan's face.

RECORD LOCATION: H-001 (Title XIX State Plan), Section 6.2 at PDF p. 179

CFR-433-003: Liens and estate recovery

CITATION: 42 CFR 433.36

TOPIC: Liens and estate recovery

OBLIGATED LEVEL: agency

CADENCE: RECURRING - continuous procedures; hearing opportunity before any institutionalization-based lien determination

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Third Party Recovery / Third Party Liability

HOME BASIS: Third Party Liability / Third Party Recovery is a published DHB function with a named contact ('Third Party Recovery') in NCTracks TPL implementation notices (Lane A §1.4). An EBCI policy document also describes OCPI as holding TPL responsibility — carried as the secondary home, and the overlap is printed, not resolved (Lane A §1.4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies: NC operates estate recovery under G.S. 108A-70.5; NC does not impose liens

BASIS: State Plan Section 4.17 and Attachment 4.17-A plus the current estate recovery manual carry every element as it operates in NC. Liens: Attachment 4.17-A items 2-3 state 'Not Applicable. State does not impose liens,' and MA-2285 confirms estate recovery does not include placing a lien, so the lien machinery of 433.36(c)-(g) has no object in NC; the predicate determination is carried (documentary evidence of permanent or indefinite residence, notice form DHB-5051, decision notice DHB-5053 with appeal rights). Adjustments and recoveries under 433.36(h)-(i): recovery from estates of permanently institutionalized individuals and of individuals age 55 or older for nursing facility, HCBS and related hospital and prescription drug services (plan pp. 53a-53b); limitations after death of surviving spouse and with no surviving child under 21, blind or disabled, and home protections for sibling and caregiver child (p. 53c); definitions, undue hardship waiver standards and collection procedures (Attachment 4.17-A pp. 1-2; MA-2285 Sections III-VI).

RECORD LOCATION: H-001 (Title XIX State Plan), Section 4.17 at PDF pp. 105-111 and Attachment 4.17-A at PDF pp. 756-757; NL-10 (Adult Medicaid Manual MA-2285 Estate Recovery, revised 05/22/23), Sections I-VI

FLAGS: Figures conflict flagged: Attachment 4.17-A (1996) defines cost-effective as estate assets below $5,000 or Medicaid payments below $3,000, while MA-2285 (2023) states recovery is not pursued when estate assets are less than $50,000 or benefits paid are less than $10,000. Graded on MA-2285 as the later, operative instrument.

CFR-433-004: Report provider payments to IRS

CITATION: 42 CFR 433.37

TOPIC: Report provider payments to IRS

OBLIGATED LEVEL: agency

CADENCE: RECURRING - annual information returns to IRS

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as the Title XIX single state agency record

BASIS: State Plan Section 4.9 Reporting Provider Payments to Internal Revenue Service (plan p. 40): procedures are implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan. The provision's elements are stated in full.

RECORD LOCATION: H-001 (Title XIX State Plan), Section 4.9 at PDF p. 88

CFR-433-005: Refund FFP for uncashed/cancelled checks; interest on retained disallowances

CITATION: 42 CFR 433.38, 433.40

TOPIC: Refund FFP for uncashed/cancelled checks; interest on retained disallowances

OBLIGATED LEVEL: agency

CADENCE: RECURRING - quarterly uncashed/cancelled-check true-up on CMS-64

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (quarterly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as the Title XIX single state agency record

BASIS: No NC evidence for 433.38 or 433.40 was found in the held public corpus. The only CMS-64 mentions located are unrelated to voided checks or disallowance interest (an FQHC/RHC reimbursement bulletin, DSH and cost report pages).

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)

> **ACTION:** Adopt and publish the quarterly voided-check FFP refund procedure and the disallowance interest procedure, or produce the CMS-64 adjustment records that carry them.
>
> **QUESTION:** How does DHB currently refund the Federal share for uncashed or cancelled checks, and how is interest on retained disallowances accounted for?

SEARCHES RECORDED: Full held corpus (78 documents) and cure acquisitions (100 records) searched for 433.38, 433.40, uncashed, cancelled or voided checks, disallowance interest, and CMS-64 passages; no passage carries either requirement.

CFR-433-006: State share financing (40% rule) and equitable apportionment

CITATION: 42 CFR 433.53

TOPIC: State share financing (40% rule) and equitable apportionment

OBLIGATED LEVEL: agency

CADENCE: FIXED - established in State plan

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC; the State Plan page carries the substance under its 42 CFR 433.33 citation

BASIS: State Plan Section 6.3 State Financial Participation (plan p. 85): local participation is in effect; State funds are used to pay not less than 40 percent of the non-Federal share of total expenditures under the plan; there is a method of apportioning Federal and State funds among the political subdivisions of the State on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services or level of administration in any part of the State; and State and Federal funds are apportioned among the subdivisions on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.

RECORD LOCATION: H-001 (Title XIX State Plan), Section 6.3 at PDF p. 180

FLAGS: Register citation is 433.53; the plan page of record prints the same substance under its 433.33 citation line.

CFR-433-007: Report provider donations and health care-related taxes

CITATION: 42 CFR 433.74

TOPIC: Report provider donations and health care-related taxes

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - quarterly reports per CMS procedures

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (quarterly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC, which levies health care related taxes and receives provider donations subject to section 1903(w)

BASIS: No NC evidence of the 433.74 report was found. Closest material: the 1115 demonstration STCs attest that health care related taxes are broad-based and uniform and that provider donations are bona fide (H-025 STC 17.6), and the HASP statute references 433.68(f) (H-111); neither is a quarterly summary report of donations and taxes with supporting documentation.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File and publish the quarterly 433.74 summary reports on provider related donations and health care related taxes, with supporting documentation.
>
> **QUESTION:** Are 433.74 reports being made to CMS for NC, and where are they recorded?

SEARCHES RECORDED: Full held corpus and cure acquisitions searched for 433.74 and for donation and tax reporting passages; the citation appears in no document text.

CFR-433-008: Waivers for non-broad-based/non-uniform provider taxes

CITATION: 42 CFR 433.72

TOPIC: Waivers for non-broad-based/non-uniform provider taxes

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - per tax class, when broad-based or uniform criteria are not met

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC, which levies provider assessments including a nursing facility assessment

BASIS: Two elements are carried. The 1115 approval STCs state the operative rule for NC: if a health care related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based or uniformity requirements as specified by section 1903(w)(3)(E)(i) and 42 CFR 433.72 (H-025 STC 17.6(c)). A taxed class exists in state rule: 10A NCAC Subchapter 22G .0109 imposes the nursing facility assessment citing 42 U.S.C. 1396b(w) and 42 CFR Part 433 Subpart B (H-101).

RECORD LOCATION: H-025 (1115 extension approval package, CMS approval Dec. 10, 2024), STC 17.6 at package p. 102; H-101 (10A NCAC Subchapter 22G), rule .0109

SECTION 5D FACE

UNCOVERED ELEMENT: The waiver document itself and the 433.72(b) statistical showing (that the net impact of the tax is generally redistributive, with the P-value or equivalent test result) for any specific NC tax; no held passage identifies which NC taxes, if any, currently operate under a waiver.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the waiver approvals and the redistributive test results for each non-broad-based or non-uniform tax.

QUESTION: Which NC provider taxes currently rely on a 433.72 waiver, and where are the approvals?

CFR-433-009: MMIS/E&E Advance Planning Documents and approval

CITATION: 42 CFR 433.112, 433.114

TOPIC: MMIS/E&E Advance Planning Documents and approval

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - APD before each design/development/installation/enhancement expenditure

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC, which operates NCTracks (MMIS) and an eligibility and enrollment system

BASIS: The only 433.112 pinpoint in the entire corpus is in the 1115 approval: the STCs reference the industry standards at 42 CFR 433.112(b)(12) for the SUD component's health information technology (H-025). NC's systems exist on the record (the Standard Plan contract defines the Medicaid Enterprise System, H-046 definition 86), but no APD was read.

RECORD LOCATION: H-025 (1115 extension approval package), STC at package p. 25; H-046 (PHP Contract Amendment 8), Section III.A definition 86

SECTION 5D FACE

UNCOVERED ELEMENT: The Advance Planning Documents themselves and the CMS approvals under 433.112 and 433.114 for the MMIS and E&E systems, including the approval conditions. No APD or approval letter is held.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the current APDs and CMS approval letters for the MMIS and the eligibility and enrollment system.

QUESTION: Where are the current APDs and CMS approvals for NCTracks and the E&E system?

CFR-433-010: Operate approved MMIS (EOB notices, profiles, fraud referrals)

CITATION: 42 CFR 433.116

TOPIC: Operate approved MMIS (EOB notices, profiles, fraud referrals)

OBLIGATED LEVEL: agency

CADENCE: RECURRING - continuous operation; EOB notices within 45 days of claim payment

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC, which operates an approved mechanized claims system (NCTracks)

BASIS: No NC evidence carrying the operating conditions of 433.116 was found. Mentions of explanations of benefits in the corpus are provider remittance and drug utilization contexts, not the 433.116 beneficiary notice, provider profile, and fraud referral conditions.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the NCTracks operating documentation that carries the 433.116 conditions (beneficiary notices, provider profiles, suspected fraud referrals).
>
> **QUESTION:** What instrument documents NC's compliance with each 433.116 operating condition?

SEARCHES RECORDED: Full held corpus and cure acquisitions searched for 433.116, mechanized claims, explanation of benefits, beneficiary notices of services, and provider profiles; no passage carries the 433.116 conditions.

CFR-433-011: MMIS reapproval, FFP reductions, appeals, and access

CITATION: 42 CFR 433.120, 433.121, 433.122, 433.123, 433.127, 433.131

TOPIC: MMIS reapproval, FFP reductions, appeals, and access

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - upon CMS disapproval/reapproval decisions; ongoing access

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as operator of an approved MMIS

BASIS: No NC evidence for MMIS reapproval, FFP reduction, appeal of reductions, or CMS and state access under 433.120-433.131 was found in the held public corpus.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the most recent MMIS reapproval record and the access provisions for CMS and state personnel.
>
> **QUESTION:** When was the NC MMIS last reapproved, and where is that record published?

SEARCHES RECORDED: Full held corpus and cure acquisitions searched for 433.120, 433.121, 433.122, 433.123, 433.127, 433.131 and for reapproval; the citations appear in no document text.

CFR-433-012: Replacement MMIS — APD and transition plan

CITATION: 42 CFR 433.117

TOPIC: Replacement MMIS — APD and transition plan

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - each replacement-system project

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as operator of the NCTracks MMIS

BASIS: No NC evidence of a replacement-system APD or transition plan under 433.117 was found. The held record documents the current systems and their contracts, not a replacement APD, a transition plan, or CMS approval of either.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish any current replacement APD and CMS-approved transition plan, or state on the record that no replacement is in progress.
>
> **QUESTION:** Is a replacement of NCTracks planned, and if so where are the 433.117 APD and transition plan?

SEARCHES RECORDED: Full held corpus and cure acquisitions searched for 433.117, replacement system, and transition plan in the MMIS context; no passage carries a replacement APD.

CFR-433-013: Third-party liability identification (data exchanges, trauma edits, action plan)

CITATION: 42 CFR 433.137, 433.138

TOPIC: Third-party liability identification (data exchanges, trauma edits, action plan)

OBLIGATED LEVEL: agency

CADENCE: RECURRING - data exchanges and trauma edits on a routine/timely basis (frequency in State plan); 45-day follow-up on wage data; 60-day follow-up on health insurance/workers' comp

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Third Party Recovery / Third Party Liability

HOME BASIS: Third Party Liability / Third Party Recovery is a published DHB function with a named contact ('Third Party Recovery') in NCTracks TPL implementation notices (Lane A §1.4). An EBCI policy document also describes OCPI as holding TPL responsibility — carried as the secondary home, and the overlap is printed, not resolved (Lane A §1.4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as the Title XIX agency with third party liability duties

BASIS: State Plan Section 4.22 (plan p. 69) meets 433.137 and 433.138, and Attachment 4.22-A carries the system in detail: data exchanges conducted as required by 433.138(d)(1), (d)(3) and (d)(4) (SWICA and SSA batch runs at least quarterly, IRS match at application and at least annually, unemployment compensation batch runs at least quarterly, IV-D information sharing); diagnosis and trauma code edits (all paid claims with ICD-9 codes 800.00-999.99 accumulated monthly, inquiry mailed to the recipient, and at least annual identification of the diagnosis codes producing the greatest recovery, given priority for follow-up); follow-up methods with incorporation into the eligibility case file, TPL data base and third party recovery unit within 30 days. The current TPL policy manual (NL-09) carries the county-level duty to make every reasonable effort to identify all legally liable third party resources.

RECORD LOCATION: H-001 (Title XIX State Plan), Section 4.22 at PDF p. 134 and Attachment 4.22-A at PDF pp. 1127-1129; NL-09 (Adult Medicaid Manual MA-2400 Third Party Recovery, reissued 01/01/11), Section I

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 433.138(d)(4) State motor vehicle accident report file exchange and the workers compensation exchange in current operation: Attachment 4.22-A states on its face that motor vehicle data matches cannot be done in North Carolina at this time (DMV data elements unavailable) and that workers compensation matches had not been done, with 1991-92 target dates; no held current document shows either exchange operating today.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the current TPL data exchange inventory, including the status of the motor vehicle accident report file and workers compensation exchanges.
>
> **QUESTION:** Do the DMV motor vehicle and workers compensation data exchanges operate today, and under what agreements?

FLAGS: Attachment 4.22-A is a 1990-92 instrument; its exchange frequencies are graded as the plan of record, and its own admissions on the motor vehicle and workers compensation exchanges are graded as the stronger evidence for those elements.

CFR-433-014: TPL payment of claims (cost avoidance; 100-day rule; 60-day recovery)

CITATION: 42 CFR 433.139

TOPIC: TPL payment of claims (cost avoidance; 100-day rule; 60-day recovery)

OBLIGATED LEVEL: agency

CADENCE: RECURRING - per claim; recovery within 60 days after end of month of payment or learning of TPL

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Third Party Recovery / Third Party Liability

HOME BASIS: Third Party Liability / Third Party Recovery is a published DHB function with a named contact ('Third Party Recovery') in NCTracks TPL implementation notices (Lane A §1.4). An EBCI policy document also describes OCPI as holding TPL responsibility — carried as the secondary home, and the overlap is printed, not resolved (Lane A §1.4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as the Title XIX agency with third party liability duties

BASIS: State Plan Section 4.22 and Attachment 4.22-B carry most of 433.139: providers are required to bill liable third parties when services are furnished to an individual on whose behalf child support enforcement is carried out (plan p. 69a); Attachment 4.22-B specifies the method for determining provider compliance with the third party billing requirements, the cost effectiveness process for seeking recovery (the State cost avoids all claims when insurance is on file and uses no threshold), the pay-and-chase practice for prenatal and preventive pediatric claims accumulated over six months, and the pharmacy pay-and-chase waiver. State rule 10A NCAC 22J .0106 cites 433.139 for provider billing (H-103).

RECORD LOCATION: H-001 (Title XIX State Plan), Section 4.22 at PDF pp. 134-135 and Attachment 4.22-B at PDF pp. 1130-1132; H-103 (10A NCAC 22J .0106)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 100-day payment rule of 433.139(b)(3) and the 60-day recovery clock of 433.139(f)(1) (seeking reimbursement within 60 days after the end of the month in which payment was made or the liable third party was identified) are not stated in any held passage; the 1990 attachment's six-month accumulation practice for pay-and-chase claims sits uneasily with the 60-day clock and no later instrument reconciles them.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the current TPL payment policy stating the 100-day rule and the 60-day recovery clock as NC operates them.
>
> **QUESTION:** What are NC's current timeframes for paying a claim when a third party has not paid, and for seeking recovery after payment?

CFR-433-015: Repay Federal share of third-party collections

CITATION: 42 CFR 433.140

TOPIC: Repay Federal share of third-party collections

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - each third-party reimbursement received

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Third Party Recovery / Third Party Liability

HOME BASIS: Third Party Liability / Third Party Recovery is a published DHB function with a named contact ('Third Party Recovery') in NCTracks TPL implementation notices (Lane A §1.4). An EBCI policy document also describes OCPI as holding TPL responsibility — carried as the secondary home, and the overlap is printed, not resolved (Lane A §1.4).

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as the Title XIX agency collecting third party recoveries

BASIS: No NC evidence of the 433.140 repayment measure was found. The TPL policy manual (NL-09) contains no reference to the Federal share or to repayment, and the State Plan TPL pages state the collection system without the FMAP-based repayment element.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the procedure by which the Federal share of third party collections, at the State's FMAP, is repaid and credited.
>
> **QUESTION:** How and when does NC repay the Federal share of third party collections?

SEARCHES RECORDED: State Plan TPL pages and Attachments 4.22-A through 4.22-C read in full; NL-09 read in full; full corpus searched for 433.140 and for federal share of third party collections; no passage carries the repayment measure.

CFR-433-016: Assignment of rights and cooperation in pursuing third parties

CITATION: 42 CFR 433.145, 433.146, 433.147, 433.148

TOPIC: Assignment of rights and cooperation in pursuing third parties

OBLIGATED LEVEL: agency

CADENCE: RECURRING - each eligibility determination; ongoing cooperation

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Third Party Recovery / Third Party Liability

HOME BASIS: Third Party Liability / Third Party Recovery is a published DHB function with a named contact ('Third Party Recovery') in NCTracks TPL implementation notices (Lane A §1.4). An EBCI policy document also describes OCPI as holding TPL responsibility — carried as the secondary home, and the overlap is printed, not resolved (Lane A §1.4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC; assignment is automatic under G.S. 108A-59

BASIS: State Plan Attachment 2.6-A carries the assignment and cooperation core: as a condition of eligibility the individual must assign his or her own rights, and the rights of any other eligible person on whose behalf the individual has legal authority, to medical support and payments for medical care from any third party (citing 42 CFR 433.145); the applicant or recipient must cooperate in establishing paternity and obtaining medical support and payments, and in identifying and pursuing liable third parties; pregnant and postpartum individuals are exempt from the paternity and support cooperation requirements; and assignment of rights is automatic because of State law. The TPL manual carries the operating rule: assignment under G.S. 108A-59, with denial or termination for failure to assign or cooperate (NL-09 Sections I.D, I.E, II.A.1.c).

RECORD LOCATION: H-001 (Title XIX State Plan), Attachment 2.6-A at PDF pp. 308-309; NL-09 (MA-2400 Third Party Recovery), Sections I-II

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The good cause exemption as specified at 433.147: the plan and manual state only that any individual may be exempt by demonstrating good cause, without the specified criteria (best interests of the child for paternity and support cooperation; anticipated reprisal or physical or emotional harm in other cases), and the 433.148 procedures (notice of the exemption right, findings, and notice to the IV-D agency) are not stated.
>
> **OWNER LEVEL:** Division of Social Services / county DSS
>
> **ACTION:** Publish the good cause criteria and procedures for assignment and cooperation exemptions in the eligibility policy.
>
> **QUESTION:** Where are the 433.147 good cause criteria and the 433.148 procedures published for county DSS use?

CFR-433-017: Cooperative agreements for third-party collections

CITATION: 42 CFR 433.151, 433.152

TOPIC: Cooperative agreements for third-party collections

OBLIGATED LEVEL: agency

CADENCE: FIXED - agreements maintained; IV-D terms per 433.152(b)

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Third Party Recovery / Third Party Liability

HOME BASIS: Third Party Liability / Third Party Recovery is a published DHB function with a named contact ('Third Party Recovery') in NCTracks TPL implementation notices (Lane A §1.4). An EBCI policy document also describes OCPI as holding TPL responsibility — carried as the secondary home, and the overlap is printed, not resolved (Lane A §1.4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC; the IV-D agency sits within the same department family

BASIS: State Plan Section 4.22(f) (plan p. 70): the Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State with the State title IV-D agency, and the requirements of 42 CFR 433.152(b) are met; the same

page assures the State has in effect the laws relating to medical child support under section 1908 of the Act.

RECORD LOCATION: H-001 (Title XIX State Plan), Section 4.22(f) at PDF p. 136

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The agreement text itself and the current 433.152 specifications inside it (including the limits on medical support enforcement referrals and the information the IV-D agency must provide) were not read; the held evidence is the plan assurance and the checked IV-D box, not the agreement.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the current IV-D cooperative agreement for third party collections.
>
> **QUESTION:** Does the current IV-D agreement carry the 433.152(b) specifications, and where is it published?

CFR-433-018: Incentive payments and distribution of third-party collections

CITATION: 42 CFR 433.153, 433.154

TOPIC: Incentive payments and distribution of third-party collections

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - each collection

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Third Party Recovery / Third Party Liability

HOME BASIS: Third Party Liability / Third Party Recovery is a published DHB function with a named contact ('Third Party Recovery') in NCTracks TPL implementation notices (Lane A §1.4). An EBCI policy document also describes OCPI as holding TPL responsibility — carried as the secondary home, and the overlap is printed, not resolved (Lane A §1.4).

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as the Title XIX agency distributing third party collections

BASIS: No NC evidence of the 433.153 incentive payment (15 percent of collections, payable from the Federal share) or of the 433.154 distribution order was found in the held public corpus.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the incentive payment and distribution procedure for third party collections, including any payments to assisting jurisdictions or political subdivisions.
>
> **QUESTION:** Does NC pay the 433.153 incentive on any collections, and how are collections distributed under 433.154?

SEARCHES RECORDED: Full held corpus and cure acquisitions searched for 433.153, 433.154, and incentive payments on third party collections; no passage carries either provision.

CFR-433-019: Adult group threshold methodology for increased FMAP

CITATION: 42 CFR 433.202, 433.204, 433.206

TOPIC: Adult group threshold methodology for increased FMAP

OBLIGATED LEVEL: agency

CADENCE: RECURRING - threshold methodology in State plan; newly/not-newly determinations at each MAGI determination

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies: NC expanded Medicaid effective Dec. 1, 2023 and claims the increased FMAP for the adult group

BASIS: SPA NC-23-0028, Supplement 18 to Attachment 2.6-A (CMS approval Oct. 12, 2023; effective Dec. 1, 2023) carries the methodology structure: the State will determine the appropriate FMAP rate for the adult group under 42 CFR 435.119; Part 1 makes individual income-based determinations against the MAGI-converted income standards in effect on Dec. 1, 2009 from the CMS-approved MAGI Conversion Plan; Part 2 carries the population-based adjustments (resource proxy under 433.206(d), enrollment cap under 433.206(e), special circumstances and other adjustments under 433.206(g), described in Attachments B through D); Part 3 carries one-time transitions of previously covered populations; Part 4 addresses expansion state designation under 433.204(b) and the temporary 2.2 percentage point increase, with the methodology applied as described in Attachment E.

RECORD LOCATION: H-012 (SPA NC-23-0028, expansion FMAP claiming), Supplement 18 to Attachment 2.6-A, pp. 1-12 of the SPA package

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The checkbox selections and figures are not legible in the held text layer (every option prints as an unmarked box), and the contents of Attachments B through E were not read in the held copy; whether NC claims under the 433.202 threshold methodology or the standard methodology, and at what threshold percentage, cannot be confirmed from the held text.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish a legible Supplement 18 with its attachments so the methodology elections and threshold figures can be read.
>
> **QUESTION:** Which adult group FMAP methodology does NC claim under, and what threshold percentage applies?

FLAGS: Checkbox legibility limit is in the text layer of the acquired SPA, not in the grading.

CFR-433-020: Provider overpayment recovery within 1 year of discovery

CITATION: 42 CFR 433.300, 433.302, 433.304, 433.310, 433.312, 433.316

TOPIC: Provider overpayment recovery within 1 year of discovery

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - 1-year recovery window from each discovery date; appeals do not extend it

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC for fee-for-service and managed care overpayments

BASIS: The managed care side is carried: the CMS focused program integrity review records that PIHP contracts describe how the PIHPs use data mining and complaints to identify, track and report overpayments, that PIHPs report overpayments identified and collected monthly, and that PIHPs may collect and retain overpayments that are not potentially fraud related (H-133 pp. 6, 8); the Medicaid Direct MCPAR locates the contract overpayment standard at Section 4.J.1.E and describes prompt reporting and recovery by refund demand or offset (H-064 indicators BX.3-BX.4); the Tailored Plan contract carries Department recoupment of contractor overpayments (H-052 p. 9).

RECORD LOCATION: H-133 (CMS Focused Program Integrity Review of North Carolina, Final Report, May 2016), pp. 6 and 8; H-064 (Medicaid Direct PIHP MCPAR 2024), indicators BX.3-BX.4; H-052 (Tailored Plan Contract Amendment 2), p. 9

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The State-side clock of 433.316 for fee-for-service overpayments: recovery or a showing of recovery effort within 1 year of discovery, before the Federal share must be refunded, is not stated in any held instrument for the FFS program; the held overpayment evidence is managed care contract machinery and a 2016 federal review.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the fee-for-service overpayment recovery policy stating the 433.316 one-year clock and refund practice.
>
> **QUESTION:** What instrument governs the timing of FFS overpayment recovery and Federal share refund in NC?

CFR-433-021: Refund Federal share of provider overpayments (CMS-64)

CITATION: 42 CFR 433.318, 433.320

TOPIC: Refund Federal share of provider overpayments (CMS-64)

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - CMS-64 credit in quarter of recovery or quarter the 1-year period ends; interest at CVFR accrues from day after the 1-year period if late

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as the Title XIX agency filing the CMS-64

BASIS: No NC evidence of the 433.318 and 433.320 credit rules was found. CMS-64 mentions in the corpus are an FQHC/RHC reimbursement bulletin (H-092), DSH and cost report pages, and the HHS OIG report at H-131 (audit period Oct 1, 2019 to Sept 30, 2021), which records $30.4 million in MFCU-determined overpayments not reported and returned on the Form CMS-64 and $11.0 million not reported within the required timeframe; none of these states that the Federal share of an overpayment is credited on the CMS-64 for the quarter of recovery or the quarter in which the one-year period ends, whether or not the overpayment is recovered.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the CMS-64 crediting procedure for the Federal share of provider overpayments.
>
> **QUESTION:** On which quarter's CMS-64 does NC credit the Federal share when an overpayment is not recovered within one year?

SEARCHES RECORDED: Full held corpus and cure acquisitions searched for 433.318, 433.320, 433.316, CMS-64 crediting, and overpayment refund timing; no passage carries the credit rule.

CFR-433-022: COVID-era continuous enrollment for temporary FMAP increase (historical)

CITATION: 42 CFR 433.400

TOPIC: COVID-era continuous enrollment for temporary FMAP increase (historical)

OBLIGATED LEVEL: agency

CADENCE: FIXED - applied March 18, 2020 through end of month the COVID-19 PHE ended

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **N-A-DETERMINED** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): NA-REASON: WINDOW

BASIS: Determination: WINDOW (section 3A closed list). The requirement at 42 CFR 433.400 exists only as a condition for claiming the temporary FMAP increase under FFCRA section 6008 for the continuous enrollment period that began March 18, 2020; that period closed by law on March 31, 2023, when continuous enrollment was decoupled from the public health emergency. The held evidence window is 2024-2026 material, outside the operative period; NC-side evidence of the closed window is the State's own reports page, which carries the Medicaid continuous coverage

unwinding reports as a closed reporting line (H-128). This determination asserts nothing about NC's compliance inside the window.

RECORD LOCATION: H-128 (NC Medicaid Reports page, cure acquisition), continuous coverage unwinding reports listing

> **SECTION 3A FOOTING.** The closed list reason is NA-REASON: WINDOW. The determiner is NC Cure grading seat A. This determination rests on the basis printed for this entry above. It also rests on the record location printed for this entry above.

GUIDANCE READINGS (DETERMINATIONS FILE): Program Directive instrument v1.2.1, section 3A (WINDOW)

CFR-434-001: General contract requirements (all Medicaid contracts)

CITATION: 42 CFR 434.4, 434.6

TOPIC: General contract requirements (all Medicaid contracts)

OBLIGATED LEVEL: agency

CADENCE: FIXED - each contract and subcontract

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to all NC Medicaid contracts

BASIS: The plan carries 434.6 once, at p.33, in the managed care state plan amendment context, listing 42 CFR 434.6 among the general requirements for contracts alongside 438 for MCOs and PCCMs. Executed-form plan contracts are held (H-046, H-052, H-053, H-056). No held document states the 434.4 and 434.6 general contract requirements as a set, as they apply across all Medicaid contracts including fiscal agent and provider agreements.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan p.33 (section 1.6 managed care listing citing 434.6)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The general contract requirements of 42 CFR 434.4 and 434.6 stated as requirements across all NC Medicaid contracts; the single plan citation sits inside a managed care amendment.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce the standard contract terms or contracting policy that carries the 434.4 and 434.6 requirements for all Medicaid contracts.
>
> **QUESTION:** Where are the general federal contract requirements applied to every NC Medicaid contract?

SEARCHES RECORDED: Full map: H-001 carries 434.6 only; H-101 carries Part 434 at part level only, read with no 434.4 or 434.6 text. Corpus searched for general contract requirement language.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 434.4 and 434.6 text as carried in the register requirement of record

CFR-434-002: Fiscal agent contract requirements

CITATION: 42 CFR 434.10

TOPIC: Fiscal agent contract requirements

OBLIGATED LEVEL: provider

CADENCE: FIXED - each fiscal agent contract

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC's fiscal agent arrangement (NCTracks)

BASIS: No NC evidence for fiscal agent contract requirements under 42 CFR 434.10 was found. NCTracks materials are held in quantity (H-140, H-143 to H-149) but all are operational provider-facing documents; none is or describes the fiscal agent contract, and no held document uses the fiscal agent contract framework of 434.10.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The entire provision: no held document addresses the fiscal agent contract or its required terms (42 CFR 434.10).
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce the NCTracks fiscal agent contract or its federal requirements exhibit.
>
> **QUESTION:** Where is the fiscal agent contract that carries the 434.10 terms for NCTracks?

SEARCHES RECORDED: Full map: no 434.10 pinpoint in any document. Corpus searched for fiscal agent (no contract hits; the term appears only inside the plan disclosure section for providers and fiscal agents). NCTracks cure acquisitions H-143 to H-149 read; all operational, none contractual.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 434.10 text as carried in the register requirement of record

CFR-434-003: Private nonmedical institution contracts

CITATION: 42 CFR 434.12

TOPIC: Private nonmedical institution contracts

OBLIGATED LEVEL: agency

CADENCE: FIXED - each contract with a private nonmedical institution

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies only if NC contracts with private nonmedical institutions

BASIS: No NC evidence for contracts with private nonmedical institutions under 42 CFR 434.12 was found. No held document mentions such contracts or the provision. The grade is GAP rather than N-A because the held record does not affirmatively establish that NC has no such institution under contract; religious nonmedical health care institutions appear in the 108C-3 provider type lists (H-112) as a screening category, which does not settle the contracting question.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The entire provision: no held document addresses private nonmedical institution contracts (42 CFR 434.12).
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State whether NC contracts with any private nonmedical institution and, if so, produce the contract terms carrying 434.12.
>
> **QUESTION:** Does NC have any private nonmedical institution under Medicaid contract?

SEARCHES RECORDED: Full map: no 434.12 pinpoint. Corpus searched for nonmedical institution (no contract hits; the screening category in H-112 read and distinguished).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 434.12 text as carried in the register requirement of record

CFR-434-004: Health insuring organization contracts

CITATION: 42 CFR 434.40

TOPIC: Health insuring organization contracts

OBLIGATED LEVEL: agency

CADENCE: FIXED - each health insuring organization contract

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies only if NC contracts with a health insuring organization

BASIS: No current NC evidence for health insuring organization contracts under 42 CFR 434.40 was found. The only HIO material in the corpus is historical: 10A NCAC 22C .0104, Health Insuring Organizations, in H-099 expired September 1, 2015 under G.S. 150B-21.3A, and the plan's HIO enrollment-limit item at the managed care pages is a California-only item not adopted by NC. NC's managed care runs through PHP, PIHP and PAHP contracts, not an HIO, but the held record does not carry an affirmative statement closing the question, so the grade is GAP rather than N-A.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The entire provision: no current held document addresses health insuring organization contracts (42 CFR 434.40).
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State on the record whether any NC Medicaid contract is with a health insuring organization as 434.40 defines it.
>
> **QUESTION:** Is any current NC Medicaid contractor a health insuring organization under 434.40?

SEARCHES RECORDED: Full map: no 434.40 pinpoint. H-099 read at 10A NCAC 22C .0104 (expired 2015); plan managed care pages read (HIO item is California-only). Corpus searched for health insuring organization (no current contract hits).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 434.40 text as carried in the register requirement of record

FLAGS: Historical rule 10A NCAC 22C .0104 expired in 2015; do not carry it as current evidence.

CFR-435-001: State plan must implement Part 435 and specify covered groups

CITATION: 42 CFR 435.10

CITATION IN DETERMINATIONS FILE: 42 CFR 435.2, 435.4

TOPIC: State plan must implement Part 435 and specify covered groups

TOPIC IN DETERMINATIONS FILE: Scope, terminology, and definitions

OBLIGATED LEVEL: agency

CADENCE: FIXED - Upon state plan amendment (SPA); maintained continuously thereafter

EVIDENCE CLASS: GOVERNING

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as the framework sections for the Part 435 eligibility rules the State administers

BASIS: The plan's section 2 and Attachments 2.2-A and 2.6-A are written in the Part 435 framework: Attachment 2.2-A lists the mandatory and optional eligibility groups by their Part 435 citations, Attachment 2.6-A states the State's conditions and requirements by the same citations, and page

S94 (TN 13-0002-MM2) attests that the State meets all requirements of 42 CFR Part 435 Subpart J and Subpart M. The group architecture on the face of the plan is the definitions and scope of Part 435 in State use.

RECORD LOCATION: H-001 (H-001), PDF p.39-40 (S94), p.238-302 (Att. 2.2-A), p.303-367 (Att. 2.6-A)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-002: Emergency services for certain aliens

CITATION: 42 CFR 435.139, 435.350

TOPIC: Emergency services for certain aliens

TOPIC IN DETERMINATIONS FILE: Payment for services furnished to individuals with satisfactory immigration status / emergency services for non-qualified aliens

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Upon application by an ineligible-for-full-benefits alien

EVIDENCE CLASS: GOVERNING

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC for payment of emergency services to aliens who would be eligible but for immigration status

BASIS: Attachment 2.6-A carries the eligibility side: qualified aliens subject to the five-year bar and non-qualified aliens are limited under the plan to treatment of an emergency medical condition (Attachment 2.6-A, citizenship and immigration status item, PDF p.304), and the plan excludes from full coverage individuals not lawfully present except for that emergency treatment.

RECORD LOCATION: H-001 (H-001), PDF p.304 (Att. 2.6-A)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The payment provisions themselves (payment for emergency services under 435.139 and the emergency services payment rule at 435.350, including the scope of emergency services and how claims are identified and paid) are not stated in any held payment or billing document
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the emergency services payment standard for non-qualified aliens (service scope, claim identification, and payment rule) in the applicable clinical coverage policy or billing guide
>
> **QUESTION:** Where is the payment rule for emergency services to non-qualified aliens stated so it can be read against 42 CFR 435.139 and 435.350?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-003: Mandatory coverage: IV-E children and former foster care children to age 26

CITATION: 42 CFR 435.145, 435.150

CITATION IN DETERMINATIONS FILE: 42 CFR 435.110, 435.114, 435.116, 435.118, 435.119, 435.145, 435.150

TOPIC: Mandatory coverage: IV-E children and former foster care children to age 26

TOPIC IN DETERMINATIONS FILE: Mandatory categorically needy groups

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Ongoing — applies at every eligibility determination for these populations

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC; the adult group at 435.119 was elected effective December 1, 2023 (Medicaid expansion)

BASIS: Attachment 2.2-A lists the mandatory groups on the face of the plan, including the Title IV-E foster care maintenance and adoption assistance group (PDF p.238), the adoption assistance and foster care group at 435.114 (PDF p.241), and the SSI recipient group (PDF p.245), with the protected groups at 435.122, 435.130, 435.131, and 435.135 carried in the same attachment. SPA 23-0007 (Former Foster Care, effective January 1, 2023) in the held SPA list carries the 435.150 mandatory group as described in the attachment: former foster care youth who aged out in any state, up to age 26. The adult group at 435.119 is carried by the expansion record: SPA NC-23-0028 reports the adult group program covering non-pregnant individuals at or below 195 percent FPL on the MAGI basis, and the Section 1115 materials reference the 435.119 adult group.

RECORD LOCATION: H-001 (H-001), PDF p.238-276 (Att. 2.2-A); H-021 (H-021), p.1 (SPA 23-0007); H-012 (H-012), adult group pages

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-004: Extended postpartum coverage and continuous eligibility for hospitalized children

CITATION: 42 CFR 435.170, 435.172

TOPIC: Extended postpartum coverage and continuous eligibility for hospitalized children

TOPIC IN DETERMINATIONS FILE: Continuous eligibility for pregnant women and for hospitalized children

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Triggered by pregnancy end or hospitalization of a 435.118 child

EVIDENCE CLASS: GOVERNING

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC; the 12-month postpartum continuous eligibility option is now permanent State law

BASIS: The 12-month postpartum element is carried: Session Law 2025-64 (Part V) repeals the March 31, 2027 sunset of a pregnant woman's Medicaid eligibility until 12 months after the pregnancy ends, making the option permanent; SPA NC-23-0028 carries postpartum period transitions in operation; and CHIP SPA 22-0014 implemented the parallel 12-month postpartum option, with G.S. 108A-70.21(a)(4) providing continuous enrollment for one year on the CHIP side.

RECORD LOCATION: H-121 (cure acquisition, Session Law 2025-64 summary, Part V); H-012 (H-012), postpartum transition pages; H-013 (H-013), SPA 22-0014; H-022 (H-022)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** Continuous eligibility for a hospitalized child under 42 CFR 435.172 (the child remains eligible through the end of a hospital stay that began before eligibility would otherwise end) is not stated in any held document
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State the hospitalized-child continuous eligibility rule in the eligibility manual or plan so the 435.172 element is on the public record
>
> **QUESTION:** Where does NC document the 42 CFR 435.172 hospitalized-child continuous eligibility rule?

SEARCHES RECORDED: Full corpora searched for 435.172 and hospitalized child continuous eligibility (no hits); plan text searched for continuous eligibility (hits are the 1115 STC child continuous eligibility terms, a different authority)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-005: State residency rules, prohibitions, and interstate agreements

CITATION: 42 CFR 435.403

TOPIC: State residency rules, prohibitions, and interstate agreements

TOPIC IN DETERMINATIONS FILE: State residence requirements

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Applied at application, renewal, and whenever residency is questioned

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a standing eligibility condition

BASIS: Plan section 2.3 states individuals must meet residence requirements at 42 CFR 435.403 (PDF p.45). Attachment 2.6-A carries the operative terms: residency is determined under 435.403, the State has interstate residency agreements (Georgia named, with agreements open to other states), and the attachment works through the placement and institutional residence cases the section addresses.

RECORD LOCATION: H-001 (H-001), PDF p.45 (section 2.3), p.307 (Att. 2.6-A item 3)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-006: Applicant's choice of eligibility category

CITATION: 42 CFR 435.404

TOPIC: Applicant's choice of eligibility category

TOPIC IN DETERMINATIONS FILE: Applicant's choice of category

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - At application/determination when multiple categories apply

EVIDENCE CLASS: GOVERNING

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC for applicants eligible under more than one category

BASIS: No held NC document states the rule that an applicant who is eligible under more than one category may have eligibility determined under the category of the applicant's choice. The plan's group lists and conditions attachments do not carry it, and no eligibility manual section on choice of category is held.

RECORD LOCATION: No record location: no held document carries the provision (see searches)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Social Services / county DSS (eligibility operations), under Division of Health Benefits policy
>
> **ACTION:** Publish the choice-of-category rule in the Adult Medicaid manual so applicants eligible under multiple categories have the 435.404 election on the record
>
> **QUESTION:** Where is the applicant's choice of eligibility category under 42 CFR 435.404 stated in NC's eligibility materials?

SEARCHES RECORDED: the full reconciliation map searched for 435.404 (no document cites it); full plan text (H-001) and both corpora searched for 435.404 and choice of category (no hits)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-007: Citizenship and immigration status verification; reasonable opportunity period

CITATION: 42 CFR 435.406, 435.407, 435.956

TOPIC: Citizenship and immigration status verification; reasonable opportunity period

TOPIC IN DETERMINATIONS FILE: Citizenship and immigration status; verification and reasonable opportunity period

OBLIGATED LEVEL: agency

CADENCE: RECURRING - At application, at each renewal (no citizenship re-verification), and whenever status changes

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a standing eligibility condition

BASIS: Attachment 2.6-A carries the 435.406 status categories and conditions (citizenship and immigration status item, PDF p.304), including the five-year bar treatment and emergency-only treatment for non-qualified aliens. Plan section 4.34 states the State has in effect procedures for verifying citizenship and alien status under SAVE, in effect since October 1, 1988 (PDF p.151), and Attachment 4.32-A carries the SSA data exchanges (BENDEX, SDX, and NUMIDENT Social Security number validation) used in verification.

RECORD LOCATION: H-001 (H-001), PDF p.304 (Att. 2.6-A), p.151 (section 4.34), p.1137 (Att. 4.32-A)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The verification process specifics of 435.407 and the electronic verification and reasonable opportunity period elements of 435.956 (90-day reasonable opportunity period, notice content, and continued furnishing pending verification) are not stated in held text
>
> **OWNER LEVEL:** Division of Social Services / county DSS (eligibility operations), under Division of Health Benefits policy
>
> **ACTION:** Publish the citizenship verification sequence in the eligibility manual, including the reasonable opportunity period, notices, and benefit treatment while verification is pending
>
> **QUESTION:** Where are the 435.407 verification steps and the 435.956 reasonable opportunity period stated in NC's public eligibility materials?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-008: Blindness and disability determinations; SSA determination binding

CITATION: 42 CFR 435.531, 435.541

CITATION IN DETERMINATIONS FILE: 42 CFR 435.530, 435.531, 435.540, 435.541

TOPIC: Blindness and disability determinations; SSA determination binding

TOPIC IN DETERMINATIONS FILE: Blindness and disability determinations

OBLIGATED LEVEL: agency

CADENCE: RECURRING - At application for disability-based eligibility; periodic reexaminations per review-team schedule and 435.916 renewals

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a standing eligibility condition

BASIS: Plan section 2.4 states the definition of blindness at 42 CFR 435.530 is used and the agency's written agreement with the agency that determines blindness under the State opticians and rehabilitation framework meets 42 CFR 435.531 (PDF p.46). Plan section 2.5 states the SSI definition of disability at 42 CFR 435.540 is used, disability determinations are made by SSA in the first instance, and the State's option for independent determinations subject to final SSA determination under 42 CFR 435.541 is carried (PDF p.47).

RECORD LOCATION: H-001 (H-001), PDF p.46 (section 2.4), p.47 (section 2.5)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-009: Financial eligibility methodologies; deeming; less-restrictive options in State plan

CITATION: 42 CFR 435.601, 435.602, 435.631

CITATION IN DETERMINATIONS FILE: 42 CFR 435.601, 435.602, 435.603, 435.610, 435.620, 435.621, 435.630, 435.631

TOPIC: Financial eligibility methodologies; deeming; less-restrictive options in State plan

TOPIC IN DETERMINATIONS FILE: Financial eligibility methodologies (non-MAGI and related groups)

OBLIGATED LEVEL: agency

CADENCE: FIXED - State plan specifies methodologies; applied continuously at determinations

EVIDENCE CLASS: GOVERNING

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC for the non-MAGI (ABD and medically needy) methodologies; MAGI methodology is graded in part at CFR-435-010

BASIS: Attachment 2.6-A, Section C, carries the financial methodologies on the face of the plan: AFDC and SSI methodologies for the categorical groups, the medically needy methodology, more liberal and less restrictive methods stated in Supplements 8a and 8b (including the COLA disregard

and medically needy resource disregards), deeming limited to spouses in the same household and parents to children under 21, and the 1902(f) options the State elected. The covered groups' income and resource standards are stated in the same supplement structure.

RECORD LOCATION: H-001 (H-001), PDF p.320-326 (Att. 2.6-A Section C), p.398 and p.401 (Supplements 8a and 8b)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-010: MAGI household income methodologies

CITATION: 42 CFR 435.603

TOPIC: MAGI household income methodologies

TOPIC IN DETERMINATIONS FILE: MAGI financial methodologies (household composition, household income, 5 percent disregard)

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Every MAGI determination and renewal

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (monthly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC for all MAGI populations, including the expansion adult group

BASIS: MAGI methodology is in use on the face of the held record: page S94 attests the State meets Subpart J (application and renewal on the MAGI basis, with ex parte redetermination first), SPA NC-23-0028 includes the MAGI Conversion Plan summary, and the Children and Families Specialty Plan statute incorporates the 42 CFR 435.603(b) definitions of parent and sibling by reference (G.S. 108D, PDF p.13).

RECORD LOCATION: H-001 (H-001), PDF p.39-40 (S94); H-012 (H-012), MAGI Conversion Plan summary; H-105 (H-105), p.13

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The MAGI methodology pages themselves (household composition rules, household income counting including the treatment of lump sums and the five percentage point disregard) are not held as readable text; the MAGI SPA is listed on a DHHS notices page (H-002) without its content
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File the approved MAGI methodology SPA pages (or the manual section stating household composition, income counting, and the disregard) with the cure record
>
> **QUESTION:** Which held document states NC's MAGI household composition and income counting rules, including the five percentage point disregard?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-011: Assignment of rights to benefits and cooperation with third-party liability

CITATION: 42 CFR 435.610

TOPIC: Assignment of rights to benefits and cooperation with third-party liability

TOPIC IN DETERMINATIONS FILE: Assignment of rights to benefits (medical support and third-party benefits)

OBLIGATED LEVEL: agency

CADENCE: RECURRING - At application and ongoing as a condition of eligibility

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a condition of eligibility

BASIS: Attachment 2.6-A carries the assignment and cooperation conditions (items 6 and the cooperation item, PDF p.308-309): assignment of rights to third party benefits under section 1912, cooperation in establishing paternity and obtaining medical support, identifying liable third parties, and the good-cause exemption. G.S. 130A-13 provides that application for medical payment constitutes assignment to the State of rights to third-party benefits. MA-2400 (Third Party Recovery) carries the operating rules: every reasonable effort to identify liable third parties, applicant and recipient duties to provide TPR information, assignment per G.S. 108A-59 with denial or termination for failure to assign, caretaker cooperation in obtaining medical support (referencing MA-2375), payer of last resort, and denial or termination for refusal to cooperate absent good cause, with notice and hearings under MA-2420.

RECORD LOCATION: H-001 (H-001), PDF p.308-309 (Att. 2.6-A); H-113 (cure acquisition, G.S. 130A-13); NL-09 (NL-09), MA-2400 sections I to XII

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

FLAGS: Currency flag on NL-09: MA-2400 was last reissued January 1, 2011 (Change No. 24-10) and still names the Division of Medical Assistance and the EIS system, both superseded (DHB since 2019; NC FAST); the substantive assignment and cooperation rules it states remain the rules of record in the corpus, but the manual is stale on its face and should be reissued

CFR-435-012: Special income level for institutionalized individuals (300% rule)

CITATION: 42 CFR 435.622, 435.1005

CITATION IN DETERMINATIONS FILE: 42 CFR 435.217

TOPIC: Special income level for institutionalized individuals (300% rule)

TOPIC IN DETERMINATIONS FILE: Section 1915(c) home and community-based services waivers - special income level group

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Applied for each institutionalized individual under the option; effective with 30-day institutional periods

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as an elected group under the approved 1915(c) waivers

BASIS: The approved CAP/DA waiver renewal (NL-15) carries the 1915(c) categorically needy group under 42 CFR 435.217 with the special income level equal to 300 percent of the SSI Federal Benefit Rate selected, which is the operative election the section requires. The draft TBI waiver application (H-041, PDF p.28-29) selects the same 435.217 group and 300 percent level for that waiver population.

RECORD LOCATION: NL-15 (NL-15), 435.217 group selection; H-041 (H-041), p.28-29

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

FLAGS: H-041 is a draft application and was used only as corroboration; the grade rests on the approved NL-15 renewal

CFR-435-013: Protected Medicaid eligibility for individuals eligible in December 1973 (OASDI COLA disregard)

CITATION: 42 CFR 435.640

TOPIC: Protected Medicaid eligibility for individuals eligible in December 1973 (OASDI COLA disregard)

TOPIC IN DETERMINATIONS FILE: Protected groups - SSI-related December 1973 eligibles

OBLIGATED LEVEL: agency

CADENCE: RECURRING - At each eligibility determination for the protected December-1973 cohorts

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC only if individuals remain in the closed December 1973 cohort; no held evidence identifies any

BASIS: No held NC document carries the December 1973 protected group at 42 CFR 435.640. The December 1973 references that do appear in the plan are the distinct essential spouse group at 435.131 (Attachment 2.2-A, PDF p.251) and unrelated cost-of-living material, not the 435.640 cohort (individuals eligible in December 1973 under a State plan more liberal than SSI who remained continuously eligible).

RECORD LOCATION: No record location: no held document carries the provision (see searches)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Confirm whether any member of the December 1973 cohort remains on the rolls; if none, record the group as exhausted so the register can carry a determined status rather than a gap
>
> **QUESTION:** Does any NC beneficiary remain in the 42 CFR 435.640 December 1973 protected group, or is the cohort exhausted?

SEARCHES RECORDED: the full reconciliation map searched for 435.640 (no document cites it); full plan text and both corpora searched for 435.640 and December 1973 (15 hits, all the 435.131 essential spouse group or unrelated)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-014: Post-eligibility treatment of income (patient income applied to cost of care)

CITATION: 42 CFR 435.725, 435.726, 435.733, 435.735, 435.832

CITATION IN DETERMINATIONS FILE: 42 CFR 435.725, 435.733, 435.832, 435.845

TOPIC: Post-eligibility treatment of income (patient income applied to cost of care)

TOPIC IN DETERMINATIONS FILE: Post-eligibility treatment of income (LTC, community spouse, personal needs allowance)

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Monthly, for every institutionalized/HCBS beneficiary with income

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (monthly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC for institutionalized individuals and HCBS waiver participants

BASIS: Attachment 2.6-A, Section B, carries post-eligibility treatment of income in full: the exclusions applied first, the personal needs allowance ($30 for an individual and $60 for a couple, citing 435.725, 435.733, and 435.832), the community spouse monthly maintenance needs allowance computed under the section 1924(d) formula, the family maintenance allowance, deductions for medical and remedial care expenses, and the temporary home maintenance deduction of up to six months (PDF p.312-317). The PACE pages of the same attachment carry the regular and spousal post-eligibility methodology for that program.

RECORD LOCATION: H-001 (H-001), PDF p.312-317 (Att. 2.6-A Section B), p.534-538 (PACE post-eligibility)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-015: Administration: consistency, simplicity, local-agency oversight, outstation locations

CITATION: 42 CFR 435.901, 435.902, 435.903, 435.904

CITATION IN DETERMINATIONS FILE: 42 CFR 435.901, 435.902, 435.904

TOPIC: Administration: consistency, simplicity, local-agency oversight, outstation locations

TOPIC IN DETERMINATIONS FILE: State and local agency administration; consistency, simplicity, and outstationing

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous administration; outstation intake during regular office hours

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC; eligibility is administered by county departments of social services under State supervision

BASIS: Page S94 carries the outstationing element at 435.904: application assistance and initial processing are available at outstation locations including Federally Qualified Health Centers and disproportionate share hospitals (PDF p.40). State supervision of local administration is evidenced in operation by the REDA letter: the Office of Compliance and Program Integrity audits Medicaid determinations in all 100 counties, sampling 200 randomly selected determinations per county per cycle, and counties must use NC FAST as the primary document management system for Medicaid (H-118, April 23, 2025 letter).

RECORD LOCATION: H-001 (H-001), PDF p.40 (S94); H-118 (H-118), p.1

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The consistency standard (435.901: policies consistent with the plan, applied uniformly statewide) and the simplicity standard (435.902: administration consistent with simplicity of administration and the best interests of recipients) are not stated in any held document
>
> **OWNER LEVEL:** NCDHHS Secretary, with the Division of Social Services for county administration
>
> **ACTION:** Publish the State supervision standard for county eligibility administration stating the consistency and simplicity requirements of 435.901 and 435.902
>
> **QUESTION:** Where are the 435.901 consistency and 435.902 simplicity standards for county-administered eligibility stated?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-016: Program information availability/accessibility and opportunity to apply

CITATION: 42 CFR 435.905, 435.906

TOPIC: Program information availability/accessibility and opportunity to apply

TOPIC IN DETERMINATIONS FILE: Availability of program information; opportunity to apply without delay

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous; information furnished on request and at application

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a standing eligibility administration requirement

BASIS: Elements of 435.905 are carried in operation: program information and application routes are published for beneficiaries in plain terms (the NEMT beneficiary page and Medicaid pages, including Spanish-language access), the policies and manuals portal (H-117) publishes the eligibility manuals, and the 1115 STCs require annual continuous eligibility reminders in plain language, accessible in accordance with 435.905(b), with electronic notices provided consistent with 435.918.

RECORD LOCATION: H-066 (cure acquisition, NEMT beneficiary page); H-117 (cure acquisition, Policies and Manuals portal); H-025 (H-025), STC 4.3

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 435.905(b) standard as such (program information in plain language, accessible to persons with limited English proficiency and individuals with disabilities, available in paper and electronic formats) and the 435.906 rule (opportunity to apply without delay, no requirement to appear in person) are not stated for the general eligibility program in held text
>
> **OWNER LEVEL:** Division of Health Benefits (DHB), with the Division of Social Services
>
> **ACTION:** State the 435.905(b) information standard and the 435.906 apply-without-delay rule in the eligibility manual's opening section
>
> **QUESTION:** Where are the program-wide 435.905(b) accessibility standard and the 435.906 opportunity-to-apply rule stated?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-017: Application acceptance: multi-channel, single streamlined application, info-request rules

CITATION: 42 CFR 435.907

CITATION IN DETERMINATIONS FILE: 42 CFR 435.906, 435.907

TOPIC: Application acceptance: multi-channel, single streamlined application, info-request rules

TOPIC IN DETERMINATIONS FILE: Opportunity to apply; application forms (single streamlined application)

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Every application; 15-day info requests; 90-day post-denial reconsideration window

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a standing eligibility administration requirement

BASIS: Page S94 (TN 13-0002-MM2, effective January 1, 2014) carries the application regime in specifics: an alternative single streamlined application (with transition notes at PDF p.41-42 for the 2014 implementation), applications for insurance affordability programs filed through the five channels the section contemplates (internet website under 435.1200(f), telephone, mail, in person, and fax as another available mode), supplemental forms allowed for non-Exchange determinations, and outstation filing assistance. The application must be available to any individual who wants to apply, through those channels.

RECORD LOCATION: H-001 (H-001), PDF p.39-42 (S94 and Supplement)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-018: Assistance with application and renewal; certified application counselors

CITATION: 42 CFR 435.908

TOPIC: Assistance with application and renewal; certified application counselors

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous availability of assistance across in-person, phone, and online channels

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a standing eligibility administration requirement

BASIS: Application assistance is carried at the outstation locations (page S94: application assistance and initial processing at FQHCs and disproportionate share hospitals, PDF p.40), and assistance roles run through the held manuals and county structure.

RECORD LOCATION: H-001 (H-001), PDF p.40 (S94)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** Certified application counselor designation and certification under 435.908 (designation of community organizations, certification and training of staff and volunteers, and conflict of interest standards) is not stated in any held document
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the certified application counselor designation and certification standard, or state that NC does not designate CACs and relies on navigators and county assistance
>
> **QUESTION:** Does NC designate certified application counselors under 42 CFR 435.908, and where is the designation standard published?

SEARCHES RECORDED: Full corpora searched for certified application counselor (no State-side designation or certification document found)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-019: Automatic Medicaid entitlement following SSI/other-program determinations

CITATION: 42 CFR 435.909

TOPIC: Automatic Medicaid entitlement following SSI/other-program determinations

TOPIC IN DETERMINATIONS FILE: Automatic entitlement for SSI beneficiaries (no separate application)

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Triggered by SSI/supplement receipt; automatic enrollment without separate application

EVIDENCE CLASS: GOVERNING

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as an SSI-linked state (section 1634 relationship carried in the plan group structure)

BASIS: The SSI recipient mandatory group is carried in Attachment 2.2-A (item 13, PDF p.245), and the SSA data exchanges in Attachment 4.32-A (BENDEX and SDX reporting, PDF p.1137) are the machinery by which SSI entitlement flows to Medicaid.

RECORD LOCATION: H-001 (H-001), PDF p.245 (Att. 2.2-A item 13), p.1137 (Att. 4.32-A)

> **SECTION 5D FACE**

UNCOVERED ELEMENT: Automatic entitlement as such (an SSI beneficiary is entitled to Medicaid without a separate application, and the mechanics when SSA data and State records differ) is not stated in any held document

OWNER LEVEL: Division of Social Services / county DSS (eligibility operations)

ACTION: State the automatic entitlement rule in the eligibility manual's SSI section, including treatment of SDX discrepancies

QUESTION: Where is the 42 CFR 435.909 automatic entitlement rule for SSI beneficiaries stated in NC's eligibility materials?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-020: Social Security numbers: collection, verification, and redetermination review

CITATION: 42 CFR 435.910, 435.920

TOPIC: Social Security numbers: collection, verification, and redetermination review

TOPIC IN DETERMINATIONS FILE: Social security number requirement; verification of eligibility factors

OBLIGATED LEVEL: agency

CADENCE: RECURRING - At application and at each redetermination (case-record SSN review)

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a standing eligibility condition

BASIS: Attachment 2.6-A item 7 carries the 435.910 element: a Social Security number is required as a condition of eligibility (PDF p.309). Attachment 4.32-A carries SSN validation through the SSA NUMIDENT exchange and the SSA benefit and earnings exchanges used at redetermination (PDF p. 1137), and plan section 4.32 attests the IEVS program under 435.940-435.960.

RECORD LOCATION: H-001 (H-001), PDF p.309 (Att. 2.6-A item 7), p.1137 (Att. 4.32-A), p.149 (section 4.32)

SECTION 5D FACE

UNCOVERED ELEMENT: The 435.920 verification specifics (what must be verified at application and redetermination, the sources of record, and the treatment of exceptions for individuals who cannot furnish an SSN, including religious objection and newborn and emergency-only cases beyond the general condition) are not stated element by element in held text

OWNER LEVEL: Division of Social Services / county DSS (eligibility operations)

ACTION: Publish the SSN and eligibility factor verification table in the eligibility manual covering the 435.920 verification points and SSN exceptions

QUESTION: Where are the 435.920 verification requirements and the SSN exception cases stated in NC's public eligibility materials?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-021: Eligibility determination hierarchy and LIS leads data as MSP applications

CITATION: 42 CFR 435.911

CITATION IN DETERMINATIONS FILE: 42 CFR 435.911, 435.916

TOPIC: Eligibility determination hierarchy and LIS leads data as MSP applications

TOPIC IN DETERMINATIONS FILE: Consideration of eligibility on all bases; LIS leads data as MSP application

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Every determination; LIS leads processed on receipt from SSA

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC at every determination and renewal

BASIS: Consideration on all bases is carried for the continuous eligibility population by STC 4.3 of the approved 1115 demonstration: at the end of the continuous eligibility period the State redetermines under 435.916(d)(1), does not require a new application, assesses eligibility for other insurance affordability programs under 435.916(d)(2), and notifies the individual of eligibility for another program. Page S94 carries the same ex parte first structure for renewals generally. MA-2311 (H-116) carries the LIS and Medicare Savings Programs interface: the local agency determines LIS only when the applicant insists it not be forwarded to SSA, and remains responsible for notices, hearings, and recertification for LIS cases it determines.

RECORD LOCATION: H-025 (H-025), STC 4.3(d); H-001 (H-001), PDF p.40 (S94); H-116 (H-116), MA-2311

SECTION 5D FACE

UNCOVERED ELEMENT: The 435.911 rule that SSA low-income subsidy leads data transmitted to the State must be treated as an application for Medicare Savings Programs is not stated in held text; MA-2311 addresses LIS determinations the applicant brings to the agency, not leads data received from SSA

OWNER LEVEL: Division of Social Services / county DSS (eligibility operations), under Division of Health Benefits policy

ACTION: State the LIS leads rule in MA-2311 or the MSP manual section: SSA leads data received by the State is screened, and where it constitutes an MSP application, processed and noticed as one

QUESTION: How does NC treat SSA LIS leads data under 42 CFR 435.911, and where is that treatment documented?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-022: Timeliness and performance standards for determinations and redeterminations

CITATION: 42 CFR 435.912

TOPIC: Timeliness and performance standards for determinations and redeterminations

TOPIC IN DETERMINATIONS FILE: Timely determination of eligibility (45 and 90 day standards)

OBLIGATED LEVEL: agency

CADENCE: RECURRING - 45/90-day application processing; renewal by end of eligibility period; 30/60-day change redeterminations

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC to every application and redetermination

BASIS: The only held statement covering 435.912 is the blanket attestation at page S94 that the State meets all requirements of 42 CFR Part 435 Subpart J, of which 435.912 is a part. County determinations are audited after the fact under REDA (H-118), which samples determinations for correctness, not elapsed time.

RECORD LOCATION: H-001 (H-001), PDF p.39-40 (S94); H-118 (H-118), p.1

SECTION 5D FACE

UNCOVERED ELEMENT: No held document states the timeliness standards themselves: determination as soon as possible and no later than 90 days for disability-based applications and 45 days for all others, a redetermination standard, or the performance standard and corrective action reporting for eligibility timeliness

OWNER LEVEL: Division of Social Services / county DSS (eligibility operations), under Division of Health Benefits policy

ACTION: Publish the determination timeliness standard and NC's performance tracking for it (average and percentile days to determination, by county) in the eligibility manual and a public report

QUESTION: Where does NC state and publicly track the 42 CFR 435.912 45-day and 90-day determination standards?

SEARCHES RECORDED: Full corpora searched for eligibility determination timeliness (45 days, 90 days, timely determination); hits are managed care claims payment timeliness, not eligibility determination standards

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

FLAGS: Near-gap: this row rests on a blanket Subpart J attestation with no provision-specific statement anywhere in the corpus

CFR-435-023: Case documentation, disposition of applications, and retroactive eligibility

CITATION: 42 CFR 435.914, 435.915

TOPIC: Case documentation, disposition of applications, and retroactive eligibility

TOPIC IN DETERMINATIONS FILE: Effective date of eligibility; case documentation and disposition

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Every application/renewal; up-to-3-month retroactive eligibility on qualifying applications

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC at every approval, including the medically needy spend-down day rule

BASIS: Plan section 2.1(b)(1) carries retroactive eligibility for the three months before application when the individual was eligible and received covered services (PDF p.43), and Attachment 2.6-A carries the effective date rules in full: full-month coverage from the first day of the month of eligibility, three-month retroactive coverage, the medically needy rule that an individual is eligible the day excess income is spent down or resources are reduced (PDF p.365-366), presumptive eligibility period rules, and QMB effective dates (PDF p.367). Case files are audited for documentation under REDA (H-118).

RECORD LOCATION: H-001 (H-001), PDF p.43 (section 2.1(b)(1)), p.365-367 (Att. 2.6-A)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** Case documentation content and disposition of applications under 435.915 (what the case record must show for each application, including denied and withdrawn applications and the evidence relied on) are not stated in held text
>
> **OWNER LEVEL:** Division of Social Services / county DSS (eligibility operations)
>
> **ACTION:** Publish the case record standard for applications (approval, denial, withdrawal) stating the documentation the file must contain under 435.915
>
> **QUESTION:** Where is the case documentation and disposition standard of 42 CFR 435.915 stated for county eligibility files?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-024: Regularly scheduled renewals: 12-month cycle, ex parte first, pre-populated forms, 90-day reconsideration

CITATION: 42 CFR 435.916

TOPIC: Regularly scheduled renewals: 12-month cycle, ex parte first, pre-populated forms, 90-day reconsideration

TOPIC IN DETERMINATIONS FILE: Renewal of eligibility (12-month cycle, ex parte first, pre-populated form, 90-day reconsideration)

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Renewals at least every 12 months; 30-day response window; 90-day post-termination reconsideration period

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (at least every 12 months, every 12 months, every 6 months) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC for all MAGI and non-MAGI renewals

BASIS: Page S94 carries the core of 435.916 in specifics: redeterminations are consistent with 435.916, eligibility is redetermined once every 12 months, the agency first attempts renewal on the basis of available information without requiring information from the individual, and where information is needed a pre-populated renewal form is used; non-MAGI renewals run on the same 12-month cycle (PDF p.40). STC 4.3 carries renewal at the end of continuous eligibility under 435.916(d) with no new application required.

RECORD LOCATION: H-001 (H-001), PDF p.40 (S94); H-025 (H-025), STC 4.3

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 90-day reconsideration period (an individual terminated for failure to return the renewal form who returns it within 90 days must have eligibility reconsidered without a new application) is not stated in any held document
>
> **OWNER LEVEL:** Division of Social Services / county DSS (eligibility operations)
>
> **ACTION:** State the 90-day reconsideration rule in the renewal manual section and in the termination notice template
>
> **QUESTION:** Where is the 42 CFR 435.916 90-day reconsideration period documented in NC's renewal procedures?

SEARCHES RECORDED: Full corpora searched for reconsideration period and 90-day reconsideration in the eligibility context (no hits in H-012, the plan, or the manuals held)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-025: Eligibility notices: content, accessibility, and electronic-notice rules

CITATION: 42 CFR 435.917, 435.918

TOPIC: Eligibility notices: content, accessibility, and electronic-notice rules

TOPIC IN DETERMINATIONS FILE: Notice of agency decisions; electronic notices

OBLIGATED LEVEL: agency

CADENCE: RECURRING - With every eligibility determination; electronic notices posted within 1 business day

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC for all eligibility decisions and renewals

BASIS: STC 4.3 of the approved 1115 demonstration carries the notice framework for the continuous eligibility population in federal terms: termination notice in accordance with 435.917 and Part 431 Subpart E, reminders whose content meets 435.917(b)(1)(iv) and (c), and electronic notices provided consistent with 435.918. MA-2400 references the notice and hearings manual MA-2420 for eligibility actions in the TPR context, and MA-2311 keeps notice responsibility for LIS cases with the local agency.

RECORD LOCATION: H-025 (H-025), STC 4.3; NL-09 (NL-09), MA-2400 (notice and hearings per MA-2420); H-116 (H-116), MA-2311

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The full 435.917(b) notice content list for eligibility decisions and the 435.918 electronic notice mechanics (individual election and consent, posting to a secure account, and opt-out) are not stated in a held general eligibility notice document; MA-2420 is referenced in held manuals but is not itself held
>
> **OWNER LEVEL:** Division of Health Benefits (DHB), with the Division of Social Services
>
> **ACTION:** File MA-2420 (or its current successor notice manual) with the cure record and state the electronic notice election mechanics in it
>
> **QUESTION:** Which held document states the 435.917 notice contents and 435.918 electronic notice consent rules for eligibility decisions?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-026: Changes in circumstances: redetermination, response times, 90-day reconsideration, address procedures

CITATION: 42 CFR 435.919

TOPIC: Changes in circumstances: redetermination, response times, 90-day reconsideration, address procedures

TOPIC IN DETERMINATIONS FILE: Timely and adequate notice and action on changes in circumstances

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - On reported or third-party change information; continuous address-data ingestion; 30-day response and 90-day reconsideration windows

EVIDENCE CLASS: GOVERNING

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC for all reported and discovered changes during the eligibility period

BASIS: STC 4.3(f) carries change handling for the continuous eligibility population: individuals may report changes through any application mode, residency is verified at least once every 12 months, and the State acts to terminate or adjust eligibility in accordance with 435.919, with verification under 435.919 and 435.940-435.960. MA-2400 requires county agencies to inquire about changes in situation bearing on third-party liability as part of eligibility maintenance.

RECORD LOCATION: H-025 (H-025), STC 4.3(f); NL-09 (NL-09), MA-2400

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** For the general eligibility population, the 435.919 response framework (acting promptly on changes, the returned mail and address update procedures, and reconsideration without a new application when a change is reported within the reconsideration window) is not stated in held text
>
> **OWNER LEVEL:** Division of Social Services / county DSS (eligibility operations)
>
> **ACTION:** Publish the change-in-circumstances standard covering response times, returned mail and address updates, and reconsideration, for the general program
>
> **QUESTION:** Where is the general-population 42 CFR 435.919 change standard (including returned mail handling) documented?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-027: Authorized representatives

CITATION: 42 CFR 435.923

TOPIC: Authorized representatives

TOPIC IN DETERMINATIONS FILE: Authorized representative (designation, notices, responsibilities)

OBLIGATED LEVEL: agency

CADENCE: RECURRING - At application, renewal, and any time a designation is made or changed

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC for applicants and beneficiaries who designate a representative

BASIS: Page S94 carries the threshold element: an authorized person acting on behalf of the individual may submit the application (PDF p.39). The PHP contract documents carry definitions of Authorized Representative for managed care purposes (H-046 pinpoints at p.39, p.182, p.243-244).

RECORD LOCATION: H-001 (H-001), PDF p.39 (S94); H-046 (H-046), authorized representative definitions

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 435.923 designation mechanics for eligibility (written designation, the representative's authority at application and renewal, and sending notices and forms to the representative) are not stated in a held eligibility document
>
> **OWNER LEVEL:** Division of Social Services / county DSS (eligibility operations)
>
> **ACTION:** State the authorized representative designation rule (form, scope, and notice routing) in the eligibility manual's application section
>
> **QUESTION:** Where is the 42 CFR 435.923 authorized representative designation rule stated for eligibility (as distinct from managed care)?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-028: 12-month continuous eligibility for children

CITATION: 42 CFR 435.926

TOPIC: 12-month continuous eligibility for children

TOPIC IN DETERMINATIONS FILE: Continuous eligibility for children (12 months)

OBLIGATED LEVEL: agency

CADENCE: RECURRING - 12-month continuous eligibility periods for all enrolled children under 19

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (periodic) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC; the State provides continuous eligibility beyond the federal floor under the Section 1115 demonstration

BASIS: STC 4.3 of the approved Reform Demonstration provides continuous eligibility for children that exceeds the 12-month floor of 435.926: coverage runs to the end of the month of the 6th birthday for young children and 24 months for ages 6 to 18 (through the end of the month of the 19th birthday), with only the permitted exceptions (age limit, loss of residency, voluntary request,

death, erroneous grant), renewal at the end of the period per 435.916(d)(1), and termination notice per 435.917 and Subpart E. On the CHIP side, G.S. 108A-70.21(a)(4) provides one year of continuous enrollment (SPA 22-0014, H-013 and H-022).

RECORD LOCATION: H-025 (H-025), STC 4.3; H-013 (H-013); H-022 (H-022), G.S. 108A-70.21(a)(4)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

FLAGS: Authority note: child continuous eligibility is delivered under the Section 1115 terms rather than a plan election page in the held plan text; the substantive coverage exceeds the 435.926 floor either way

CFR-435-029: PHE-unwinding redetermination data reporting and FMAP reduction for non-reporting

CITATION: 42 CFR 435.927, 435.928

TOPIC: PHE-unwinding redetermination data reporting and FMAP reduction for non-reporting

TOPIC IN DETERMINATIONS FILE: PHE unwinding reporting requirements; FMAP reduction for noncompliance

OBLIGATED LEVEL: federal-facing state report

CADENCE: FIXED - Reporting window April 1, 2023-June 30, 2024; T-MSIS data monthly by last day of subsequent month

EVIDENCE CLASS: GOVERNING

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applied to NC during the continuous enrollment condition unwinding period following March 31, 2023

BASIS: No held NC document carries the unwinding data reporting duty of 435.927 or the FMAP reduction exposure of 435.928. SPA NC-23-0028 (H-012), the expansion packet that covers the unwinding period operationally (including transitions at the end of the 12-month postpartum period), contains no unwinding data reporting submission, and no document in the full map cites either section.

RECORD LOCATION: No record location: no held document carries the provisions (see searches)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File NC's unwinding reporting submissions to CMS (the monthly unwinding data reports) with the cure record so the closed-period duty can be graded on documents
>
> **QUESTION:** Can NC's 435.927 unwinding data submissions be produced for the record, or should this closed-period duty be carried as determined on other grounds?

SEARCHES RECORDED: the full reconciliation map searched for 435.927 and 435.928 (no document cites either); H-012 read in full for unwinding content (transitions only); full corpora searched for unwinding data reporting (no State submission or report found)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

FLAGS: Not graded N-A WINDOW: although the reporting period has closed, no held NC evidence sources the closing date of the duty itself, so a determined N/A cannot be written on the face of NC evidence; graded GAP-DETERMINED instead

CFR-435-030: Furnishing Medicaid promptly and continuously; 24/7 emergency-care assistance

CITATION: 42 CFR 435.930

TOPIC: Furnishing Medicaid promptly and continuously; 24/7 emergency-care assistance

TOPIC IN DETERMINATIONS FILE: Continued furnishing of Medicaid to individuals eligible under the plan

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous service-delivery obligation

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC continuously during each eligibility period

BASIS: The only held statement covering 435.930 is the blanket attestation at page S94 that the State meets all requirements of 42 CFR Part 435 Subpart J, of which 435.930 is a part. The plan's group and benefit structure (section 2, Attachments 2.2-A and 3.1-A) is the framework the duty operates on, but the duty itself (furnish Medicaid promptly and without delay or interruption to individuals found eligible) is not stated in held text.

RECORD LOCATION: H-001 (H-001), PDF p.39-40 (S94)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** No held document states the 435.930 standards: furnishing Medicaid promptly to eligible individuals, and continuing to furnish it regularly to all eligible individuals until they are found ineligible
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State the 435.930 furnishing standard in the eligibility manual's opening provisions
>
> **QUESTION:** Where is the 42 CFR 435.930 prompt and continuous furnishing standard stated in NC's public materials?

SEARCHES RECORDED: Full corpora searched for furnish promptly and the text of 435.930 (no hits)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

FLAGS: Attestation-only row, like CFR-435-022: graded Partial because the blanket Subpart J attestation is State evidence covering the section, with no provision-specific statement held

CFR-435-031: Income and eligibility verification system: data sources, electronic service, reasonable compatibility

CITATION: 42 CFR 435.945, 435.948, 435.949, 435.952

CITATION IN DETERMINATIONS FILE: 42 CFR 435.940, 435.945, 435.948, 435.949, 435.952

TOPIC: Income and eligibility verification system: data sources, electronic service, reasonable compatibility

TOPIC IN DETERMINATIONS FILE: Verification requirements; IEVS; reasonable compatibility standard

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Every determination/renewal; continuous data-matching operations

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC at application, renewal, and change processing

BASIS: Plan section 4.32 states the State has established an income and eligibility verification system in accordance with section 1137 of the Act and 42 CFR 435.940 through 435.960, with procedures in Attachment 4.32-A meeting 435.948(a)(6) and PARIS computer matching (PDF p.149). Attachment 4.32-A carries the sources and procedures in detail (PDF p.1137): NC Employment Security Commission wage and unemployment data online at application and redetermination and quarterly in print, SSA BENDEX and SDX online and monthly, the SSA BEER earnings match, NUMIDENT SSN validation, the IRS unearned income match annually and monthly, and NC DOT vehicle ownership data.

RECORD LOCATION: H-001 (H-001), PDF p.149 (section 4.32), p.1137 (Att. 4.32-A)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The electronic verification service elements of 435.949 and the reasonable compatibility standard of 435.952 for MAGI determinations (when attested income and electronic data are treated as reasonably compatible, and when paper documentation may be requested) are not stated in held text
>
> **OWNER LEVEL:** Division of Health Benefits (DHB), with the Division of Social Services
>
> **ACTION:** Publish the MAGI verification standard stating the electronic verification sources used and the reasonable compatibility thresholds applied in NC FAST
>
> **QUESTION:** Where are the 435.949 electronic verification and 435.952 reasonable compatibility standards stated for NC's MAGI determinations?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-032: Standardized formats for furnishing/obtaining verification data

CITATION: 42 CFR 435.960

TOPIC: Standardized formats for furnishing/obtaining verification data

TOPIC IN DETERMINATIONS FILE: Standard formats for furnishing and receiving data

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous data-format maintenance for all applicant/beneficiary records

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC for the IEVS data exchanges

BASIS: Attachment 4.32-A shows the exchanges running in the standard federal formats by source (SSA BENDEX, SDX, and BEER files; IRS unearned income files; PARIS matching under plan section 4.32), which are the standardized exchanges 435.960 governs, and plan section 4.32 attests the whole 435.940 to 435.960 range.

RECORD LOCATION: H-001 (H-001), PDF p.1137 (Att. 4.32-A), p.149 (section 4.32)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The standardized format requirement of 435.960 as such (that information is requested and exchanged using the Secretary-prescribed formats) is not stated in held text; the formats are evidenced only by the exchanges in use
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State the standard format requirement in the IEVS procedures (plan Attachment 4.32-A successor or the NC FAST data exchange documentation)
>
> **QUESTION:** Where does NC state that its IEVS exchanges use the Secretary-prescribed standard formats under 42 CFR 435.960?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-033: Prompt redetermination on SSA SSI-ineligibility notices; FFP time limits

CITATION: 42 CFR 435.1003

TOPIC: Prompt redetermination on SSA SSI-ineligibility notices; FFP time limits

TOPIC IN DETERMINATIONS FILE: Redetermination of eligibility when SSI eligibility is lost

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - On each SSA SSI-termination notice; FFP limited to month-end or following-month-end

EVIDENCE CLASS: GOVERNING

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC whenever an individual's SSI eligibility ends

BASIS: No held NC document states the duty to redetermine Medicaid eligibility on all other bases, without requiring a new application, when an individual loses SSI eligibility. The protected groups at 435.130 and 435.135 carried in Attachment 2.2-A address different cohorts (mandatory and optional protected groups from earlier program changes), not the 435.1003 redetermination duty.

RECORD LOCATION: No record location: no held document carries the provision (see searches)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Social Services / county DSS (eligibility operations)
>
> **ACTION:** State the SSI-loss redetermination rule in the eligibility manual's SSI section (redetermine on all bases, no new application, notice of the outcome)
>
> **QUESTION:** Where is the 42 CFR 435.1003 redetermination on loss of SSI documented in NC's eligibility materials?

SEARCHES RECORDED: the full reconciliation map searched for 435.1003 (no document cites it); full plan text and both corpora searched for 435.1003 and for SSI loss redetermination language (no hits)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-034: FFP conditioned on citizenship/immigration verification

CITATION: 42 CFR 435.1008

CITATION IN DETERMINATIONS FILE: 42 CFR 435.1008, 435.1010

TOPIC: FFP conditioned on citizenship/immigration verification

TOPIC IN DETERMINATIONS FILE: FFP limitation for certain non-citizens and public institution inmates

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Applies to every claim; verification must precede or accompany FFP

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a payment limitation overlaying the eligibility rules

BASIS: Plan section 4.34 carries the alien verification procedures (SAVE, in effect since October 1, 1988, PDF p.151) and Attachment 2.6-A carries the citizenship and status conditions that bound FFP for non-citizens (PDF p.304). Attachment 2.6-A item 5 (PDF p.308) carries the inmate and IMD content: an individual is not eligible in a month the individual is an inmate of a public institution or an IMD patient under 65 (subject to the under-22 psychiatric exception), which is the eligibility face of the 435.1008 and 435.1010 limitation.

RECORD LOCATION: H-001 (H-001), PDF p.151 (section 4.34), p.304 and p.308 (Att. 2.6-A)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The FFP limitation of 435.1008 stated as a payment condition (no FFP for services to the excluded categories) is not stated in any held payment document; the held text carries the eligibility conditions, not the payment limitation
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State the 435.1008 FFP limitation in the claims or eligibility standard so the payment consequence is on the public record alongside the eligibility conditions
>
> **QUESTION:** Where is the 42 CFR 435.1008 federal payment limitation stated as such in NC's materials?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

FLAGS: Plan citation mismatch flagged: Attachment 2.6-A item 5 is cited on its face to 42 CFR 435.1008 but its content is the inmate and IMD rule of 435.1009 and 435.1010; graded on the substance read, with the plan's own citation noted as inconsistent

CFR-435-035: FFP exclusion: inmates of public institutions and IMD patients

CITATION: 42 CFR 435.1009, 435.1010

TOPIC: FFP exclusion: inmates of public institutions and IMD patients

TOPIC IN DETERMINATIONS FILE: Inmate of public institution and IMD exclusions; definitions; reentry context

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Applied claim-by-claim based on institutional status each month

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC; the Section 1115 demonstration addresses the inmate exclusion for the reentry population within its terms

BASIS: Attachment 2.6-A item 5 carries the exclusion substance (PDF p.308): no eligibility in a month the individual is an inmate of a public institution or an IMD patient under 65, with the inpatient psychiatric exception for individuals under 22. Attachment 3.1-A.1 carries service exclusions citing the 435.1010 definitions (PDF p.583), and 435.1010 is cited across the held corpus

(H-018, H-022, H-046). The approved 1115 demonstration (H-025) addresses the inmate exclusion and its limited exception in the reentry context, which is the current operating treatment of the same definitions.

RECORD LOCATION: H-001 (H-001), PDF p.308 (Att. 2.6-A item 5), p.583 (Att. 3.1-A.1); H-025 (H-025), reentry STCs

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-036: Presumptive eligibility: furnish coverage during PE periods; hospital PE determinations

CITATION: 42 CFR 435.1102, 435.1103, 435.1110, 435.1002(c)

CITATION IN DETERMINATIONS FILE: 42 CFR 435.1102, 435.1103, 435.1110

TOPIC: Presumptive eligibility: furnish coverage during PE periods; hospital PE determinations

TOPIC IN DETERMINATIONS FILE: Presumptive eligibility (pregnant women; hospitals; other groups)

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - On each qualified-entity/hospital PE determination; hospital performance monitored periodically

EVIDENCE CLASS: GOVERNING

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC; presumptive eligibility for pregnant women is an elected and operating program

BASIS: Presumptive eligibility for pregnant women is fully carried: plan section 2.1(b)(3) and Attachment 2.6-A (PDF p.367) carry the PE period rules, and 10A NCAC 22K .0101-.0103 carry the operating program in current rules (qualified provider conditions tracking section 1920 of the Act, a written agreement with DHB, required training, determinations made in accordance with 42 CFR 435.1103, notification to the county department within five business days, termination of the arrangement for noncompliance, one determination per pregnancy per provider, and an income limit at or below the federal poverty guidelines).

RECORD LOCATION: H-001 (H-001), PDF p.43 and p.367; H-098 (H-098__550c25e5.html), 10A NCAC 22K .0101-.0103

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** Hospital presumptive eligibility under 42 CFR 435.1110 (qualified hospitals electing to make PE determinations for the populations the State covers) and PE furnishing for any groups beyond pregnant women are not evidenced in held documents
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the hospital presumptive eligibility program standard (participating hospitals, populations, and determination duties) or state that NC has not implemented hospital PE
>
> **QUESTION:** Has NC implemented hospital presumptive eligibility under 42 CFR 435.1110, and if so, where is it documented?

SEARCHES RECORDED: Full corpora searched for hospital presumptive eligibility and 435.1110 (hits are the managed care manuals' PE references for plans, not a State hospital PE program document)

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-037: Coordinated eligibility and enrollment with the Exchange and other insurance affordability programs

CITATION: 42 CFR 435.1200

TOPIC: Coordinated eligibility and enrollment with the Exchange and other insurance affordability programs

TOPIC IN DETERMINATIONS FILE: Coordination with the Exchange and other insurance affordability programs

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous account-transfer and coordination operations with the Exchange/CHIP/other programs

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC; NC uses the federally facilitated Exchange, with coordination agreements carried in the plan supplement

BASIS: Page S94 carries the Subpart M attestation in operative terms: the State meets all requirements of 42 CFR Part 435 Subpart M, and the single State agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs (PDF p.40). The same supplement carries the application website element of 435.1200(f) (applications through the internet website, PDF p.39), and the 1115 STCs carry assessment and referral for other insurance affordability programs at the end of continuous eligibility (435.916(d)(2) assessment, H-025 STC 4.3).

RECORD LOCATION: H-001 (H-001), PDF p.39-40 (S94); H-025 (H-025), STC 4.3

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-435-038: Medically needy program: income/resource standards, spend-down, post-eligibility (if elected)

CITATION: 42 CFR 435.301, 435.811, 435.814, 435.831, 435.832, 435.840, 435.843, 435.845

CITATION IN DETERMINATIONS FILE: 42 CFR 435.800, 435.801, 435.811, 435.814, 435.831, 435.832, 435.843, 435.845

TOPIC: Medically needy program: income/resource standards, spend-down, post-eligibility (if elected)

TOPIC IN DETERMINATIONS FILE: Medically needy program - definitions, scope, income and resource standards, spend-down

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Every medically needy determination; budget periods of ≤6 months

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Eligibility — county departments of social services (state-supervised), NC FAST

HOME BASIS: NC Medicaid eligibility determination is state-supervised and county-administered (county departments of social services), with NC FAST as the eligibility system (Lane A §2.1). No single DHB eligibility section was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat C)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as an elected program; the plan includes the medically needy

BASIS: The medically needy election and program structure are carried: Attachment 2.2-A lists the medically needy groups (PDF p.276 and p.294, citing 435.301), Supplement 1 to Attachment 2.6-A states the medically needy income levels by family size (Section D, PDF p.369-381), Attachment 2.6-A carries the spend-down rule (eligible the day excess income is spent down or resources are reduced, PDF p.366), the post-eligibility citations at 435.831 and 435.832 are on the face of Section B, and Supplements 8a and 8b carry the medically needy resource disregards and less restrictive methods.

RECORD LOCATION: H-001 (H-001), PDF p.276, p.294 (Att. 2.2-A), p.366, p.369-381 (Att. 2.6-A and Supplement 1), p.398, p.401 (Supplements 8a and 8b)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The spend-down budget period specifics of 435.814 and the medically needy resource standard detail of 435.843 and 435.845 were not read element by element in held text (the standards appear as supplement values without the budget period methodology stated)
>
> **OWNER LEVEL:** Division of Health Benefits (DHB), with the Division of Social Services
>
> **ACTION:** State the medically needy budget period and resource standard methodology in the eligibility manual's medically needy section
>
> **QUESTION:** Where are the 435.814 budget period and the 435.843 and 435.845 resource standards stated as methodology, not just values?

GUIDANCE READINGS (DETERMINATIONS FILE): Register entry requirement of record and cited CFR sections read with the grading standard verdict definitions and sections 3A and 5D

CFR-437-001: Annual Child, Adult, and Health Home Core Set reporting

CITATION: 42 CFR 437.15(a)

TOPIC: Annual Child, Adult, and Health Home Core Set reporting

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Annual by December 31 (2024 Core Sets by 2024-12-31)

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Quality Management and Improvement

HOME BASIS: Quality Management and Improvement is a published DHB function — it publishes the Annual Quality Report, EQR Technical Reports, Encounter Data Validation, and the AMH measure set (Lane A §1.4, §3). Assignment of measure-set reporting to it is a functional derivation from that published portfolio, and says so.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC reporting Child, Adult and Health Home Core Sets annually

BASIS: No NC evidence for annual Core Set reporting under 42 CFR 437.15(a) was found in the held public corpus. The closest material is adjacent and does not carry the item: the Medicaid Direct PIHP MCPAR (H-064) lists a Medicaid Child Core Set and Adult Core Set measure set inside a managed care annual report, and the CHIP state plan documents (H-013, H-022) describe monitoring with CHIPRA 2014 Core Set measures. Neither is an annual Core Set report to CMS under Part 437, and no health home Core Set reporting appears at all.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The entire provision: no held document carries annual Child, Adult or Health Home Core Set reporting under 42 CFR 437.15(a).
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce NC's annual Core Set submission to CMS or the reporting file that supports it.
>
> **QUESTION:** Where is NC's annual Core Set reporting to CMS documented?

SEARCHES RECORDED: Full map: no document carries any Part 437 pinpoint. Corpus searched for Core Set throughout: hits are H-013, H-022 (CHIPRA measures), H-025 (1115 measure sets), H-030 and H-064 (measure set labels), all read and none is a Part 437 report.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 437.15(a) text as carried in the register requirement of record

CFR-437-002: Stratified Core Set reporting (race, ethnicity, sex, age, rural/urban, disability, language)

CITATION: 42 CFR 437.10(d)

TOPIC: Stratified Core Set reporting (race, ethnicity, sex, age, rural/urban, disability, language)

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Annual; 25% stratification in reporting years 3–4 (2026–2027), 100% from year 5 (2028 reporting year)

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Quality Management and Improvement

HOME BASIS: Quality Management and Improvement is a published DHB function — it publishes the Annual Quality Report, EQR Technical Reports, Encounter Data Validation, and the AMH measure set (Lane A §1.4, §3). Assignment of measure-set reporting to it is a functional derivation from that published portfolio, and says so.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC stratifying Core Set measures

BASIS: No NC evidence for stratified Core Set reporting under 42 CFR 437.10(d) was found. Stratification language exists in the corpus only inside the Section 1115 approval package (H-025), which requires demonstration monitoring metrics stratified by sex, age, race and ethnicity, language, disability status and geography for that demonstration. That is a demonstration monitoring duty, not Core Set stratification, and no held document ties stratification to Core Set measures.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The entire provision: no held document carries stratification of Core Set measures by race, ethnicity, sex, age, rural or urban status, disability or language (42 CFR 437.10(d)).
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce the stratified Core Set output or the data specification that produces it.
>
> **QUESTION:** Are NC's Core Set measures stratified as 437.10(d) requires, and where is the output?

SEARCHES RECORDED: Full map: no Part 437 pinpoint in any document. Corpus searched for Core Set with stratification; H-025 stratification passages read and distinguished as 1115 monitoring protocol material.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 437.10(d) text as carried in the register requirement of record

CFR-437-003: Exemption request for Core Set population reporting

CITATION: 42 CFR 437.15(a)(6)

TOPIC: Exemption request for Core Set population reporting

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Optional request; due September 1 of the applicable reporting year

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Quality Management and Improvement

HOME BASIS: Quality Management and Improvement is a published DHB function — it publishes the Annual Quality Report, EQR Technical Reports, Encounter Data Validation, and the AMH measure set (Lane A §1.4, §3). Assignment of measure-set reporting to it is a functional derivation from that published portfolio, and says so.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC only if it seeks an exemption from Core Set population reporting

BASIS: No NC evidence for a Core Set exemption request under 42 CFR 437.15(a)(6) was found. No held document mentions a Part 437 exemption, a population NC cannot report, or a request to CMS on the subject. The grade is GAP rather than N-A because the held record does not affirmatively show NC has no unreportable population; it shows nothing at all on the provision.

RECORD LOCATION:

> **SECTION 5D FACE**

UNCOVERED ELEMENT: The entire provision: no held document addresses an exemption request for Core Set population reporting (42 CFR 437.15(a)(6)).

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: State whether NC has requested or needs a Core Set population reporting exemption and produce any request filed.

QUESTION: Has NC sought an exemption from any Core Set population reporting requirement?

SEARCHES RECORDED: Full map: no Part 437 pinpoint in any document. Corpus searched for Core Set exemption and population reporting exemption language (no hits).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 437.15(a)(6) text as carried in the register requirement of record

CFR-437-004: State plan provisions on Core Set reporting and health home provider reporting

CITATION: 42 CFR 437.20(a)

TOPIC: State plan provisions on Core Set reporting and health home provider reporting

OBLIGATED LEVEL: agency

CADENCE: FIXED - One-time state plan amendment obligation; revisit whenever health home SPA status changes

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Quality Management and Improvement

HOME BASIS: Quality Management and Improvement is a published DHB function — it publishes the Annual Quality Report, EQR Technical Reports, Encounter Data Validation, and the AMH measure set (Lane A §1.4, §3). Assignment of measure-set reporting to it is a functional derivation from that published portfolio, and says so.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC state plan content on Core Set and health home reporting

BASIS: No NC evidence for state plan provisions on Core Set reporting under 42 CFR 437.20(a) was found. The full plan text (H-001, 1211 pages) was searched for Core Set and Part 437 language and carries neither; the plan's quality material sits in other parts (431, 438) and predates Part 437.

RECORD LOCATION:

SECTION 5D FACE

UNCOVERED ELEMENT: The entire provision: the state plan carries no Core Set reporting or health home provider reporting provision as 42 CFR 437.20(a) contemplates.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Produce the plan pages or SPA that carry Core Set reporting, or state that none has been submitted.

QUESTION: Where in the NC state plan is Core Set reporting provided for?

SEARCHES RECORDED: Full map: H-001 pinpoints contain no 437 provision. Plan full text searched for Core Set and 437 (no hits).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 437.20(a) text as carried in the register requirement of record

CFR-438-001: MCO/PIHP/PAHP contract CMS review and approval; capitation rates in contract

CITATION: 42 CFR 438.3(a), 438.3(c)(1)

TOPIC: MCO/PIHP/PAHP contract CMS review and approval; capitation rates in contract

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - Each contract and rating period; signed and dated by all parties before the performance period begins

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies: NC contracts with MCOs (Standard Plans), PIHPs (Medicaid Direct, Tailored Plans) under risk contracts

BASIS: Rate approval machinery is carried: the Tailored Plan model contract requires the contractor to accept capitation rates developed by the Department and its actuary and approved by CMS, with written Notification of CMS Approved Capitation Rates to follow (H-052 p. 7); the 1115 approval requires HOP services delivered at risk to be included in the managed care contracts and rate certifications submitted to CMS for review and approval in accordance with 42 CFR 438.3(a) (H-025). The Standard Plan contract was awarded February 4, 2019 (H-046 Amendment 8 recital).

RECORD LOCATION: H-052 (Tailored Plan Contract Amendment 2), p. 7; H-025 (1115 extension approval package), STC on HOP risk rates; H-046 (PHP Contract Amendment 8), p. 1

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** CMS approval of the contracts themselves under 438.3(a) is not in the held record, and the executed Standard Plan contract is not in the public record: the State posts the contract only in RFP form with blank offeror and award blocks, plus an amendment series (NL-01 search record). The approval element and the capitation rates as executed in contract therefore cannot be verified.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the CMS contract approval letters and the executed contracts for each managed care program.
>
> **QUESTION:** Where are CMS's 438.3(a) approvals for the current Standard Plan, Tailored Plan and PIHP contracts?

FLAGS: Executed-instance limit: held contracts are model and RFP forms and amendments (NL-01 through NL-03), not executed copies.

CFR-438-002: Standard contract provisions in all managed care contracts

CITATION: 42 CFR 438.3(b)–(u)

TOPIC: Standard contract provisions in all managed care contracts

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Each contract/rating period; audit right runs 10 years after contract end or audit completion

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (quarterly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to all NC managed care contracts

BASIS: Many 438.3(b)-(u) provisions are carried in terms in the model contracts: no use of contract funds for non-Title XIX or non-Title XXI members and separate accounting (438.3(c)(2), H-052 p. 9); HCBS settings compliance (438.3(o), H-052 p. 36); ILOS enrollee rights (438.3(e)(2), H-053 p. 37); financial reporting template with audited financial statements complying with 438.3(m) (H-056 p. 69).

RECORD LOCATION: H-052 (Tailored Plan Contract Amendment 2), pp. 9 and 36; H-053 (Tailored Plan Contract Amendment 5(7)), p. 37; H-056 (Medicaid Direct PIHP Contract Amendment 13(14)), p. 69

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** Elements not pinpointed in any held passage, including physician incentive plan standards (438.3(i)) and the State and Federal audit and inspection clause as a contract term; and the executed-instance limit: the held instruments are model contracts and amendments, not executed contracts (NL-01 through NL-03).
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the executed contracts so each 438.3 provision can be verified as executed, and pinpoint the physician incentive and audit clauses.
>
> **QUESTION:** Do the executed contracts carry every 438.3(b)-(u) provision, including 438.3(i) and the audit clause?

FLAGS: Model form flag: grades rest on the model contract language and amendments the State posts, per the cure instruction for contract rows.

CFR-438-003: Actuarially sound capitation rates

CITATION: 42 CFR 438.4

TOPIC: Actuarially sound capitation rates

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Each rating period via actuary certification and CMS approval

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to all NC risk contracts

BASIS: Rates are developed by the Department and its actuary and approved by CMS as a contract term (H-052 p. 7), and the 1115 approval requires risk-based HOP rates to comply with 42 CFR 438.4 (H-025). The State publishes capitation rate material for SFY 2026, including the care management assumption of $10.86 PMPM built into Standard Plan rates effective July 1, 2025 (H-059).

RECORD LOCATION: H-052 (Tailored Plan Contract Amendment 2), p. 7; H-025 (1115 extension approval package); H-059 (NC Managed Care Capitation Rates, SFY 2026 care management assumptions)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The actuarial certification itself: certifications are referenced but never posted, so no held document shows an actuary certifying the current rates as actuarially sound under 438.4 (NL-17 search record). The held record also contains an unresolved dispute over a 1.5 percent rate reduction (association letter to CMS, Dec. 10, 2025, in the NL-17 record).
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the capitation rate certifications for the current rating period.
>
> **QUESTION:** Where is the actuarial certification for the SFY 2026 rates, and what is the status of the disputed rate reduction?

FLAGS: Conflict flagged: the December 2025 rate reduction and its dispute sit against the contract's CMS-approved-rate term; graded on the stronger public evidence (the contract term and the CMS-approved demonstration), with the dispute named here.

CFR-438-004: Rate development standards; base data provision

CITATION: 42 CFR 438.5(b)–(c)

TOPIC: Rate development standards; base data provision

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Each rating period; base data no older than the 3 most recent complete years

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract

apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to all NC risk contracts

BASIS: The only rate development disclosure in the held record is the SFY 2026 capitation assumptions publication, which explains the care management component of Standard Plan rates (staffing ratios by need level, qualifications, and the $10.86 PMPM expected average cost) and states no minimum care management fee is established (H-059). The 1115 approval requires HOP risk rates to comply with 42 CFR 438.5 (H-025).

RECORD LOCATION: H-059 (NC Managed Care Capitation Rates, SFY 2026 care management assumptions); H-025 (1115 extension approval package)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** Rate development standards as a documented method under 438.5(b) (base data selection, trend, adjustments, risk adjustment applied budget-neutrally) and the 438.5(c) duty to provide the base data to plans on request: no held passage carries either element.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the rate development documentation for the current rating period, including base data and risk adjustment method.
>
> **QUESTION:** What document states NC's 438.5(b) rate development standards, and how do plans obtain the 438.5(c) base data?

CFR-438-005: Rate certification submission and documentation

CITATION: 42 CFR 438.7

TOPIC: Rate certification submission and documentation

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - Each rating period; SDP retroactive certifications within 120 days of SDP start

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to all NC risk contracts

BASIS: Rate certifications are referenced as submitted to CMS with the contracts in the 1115 approval (HOP services must be in the contracts and rate certifications submitted to CMS for review and approval, H-025), and plan payments under the demonstration are attested to comply with the payment rules (STC 17.5).

RECORD LOCATION: H-025 (1115 extension approval package), HOP risk rate STC and STC 17.5

SECTION 5D FACE

UNCOVERED ELEMENT: The certification submission itself under 438.7 (the actuary's certification with rate documentation, submitted concurrently with the contract submission): no certification document was found on any host searched (NL-17 search record), so the content, timing and documentation elements cannot be read.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the rate certification submissions for the current rating period.

QUESTION: Where are the 438.7 certification submissions for the current contracts?

CFR-438-006: State directed payments — prior approval, documentation, reporting, evaluation

CITATION: 42 CFR 438.6(c)

TOPIC: State directed payments — prior approval, documentation, reporting, evaluation

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - Prior approval before each SDP/amendment start; cost % calculated annually; T-MSIS expenditure report within 1 year after each rating period; evaluation reports every 3 years when cost % > 1.5%

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually, every 3 years) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies: NC operates state directed payments, including the HASP program

BASIS: Directed payments operate on the record with CMS approval at least at the program level: the HASP statute carries the 438.6(c) directed payment framework (G.S. 108A-148.1, H-111); the model contracts carry directed payment clauses (additional directed payments to certain providers, H-052 p. 6; directed payments allowed under 438.6(c)(1)(iii)(B), H-053 p. 6; H-056 p. 2); the 1115 approval attests that managed care payments comply with 438.6(c) (H-025 STC 17.5); and a CMS listing shows an NC directed payment renewal approved January 23, 2026 (uniform dollar increase and minimum fee schedule for HCBS and behavioral health outpatient services, rating period July 1, 2025 to June 30, 2026, risk-based adjustment up to $374.7M, H-168).

RECORD LOCATION: H-111 (G.S. 108A-148.1, HASP); H-052 p. 6; H-053 p. 6; H-056 p. 2; H-025 STC 17.5; H-168 (CMS Approved State Directed Payment Preprints listing)

SECTION 5D FACE

UNCOVERED ELEMENT: The preprints and CMS approval letters for each directed payment are not on any State, EQRO or plan host (NL-16 search record: medicaid.gov downloads only, no HASP preprint PDF surfaced), and the 438.6(c) evaluation plan and annual evaluation reports are not held.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the directed payment preprints, approval letters and evaluation reports on a State host.

QUESTION: Where can the public read the preprint and evaluation for each current directed payment, including HASP?

CFR-438-007: Pass-through payment phase-out

CITATION: 42 CFR 438.6(d)

TOPIC: Pass-through payment phase-out

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Annual base-amount recalculation while in transition; hard end: hospital pass-throughs prohibited for rating periods beginning on/after 2027-07-01

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC managed care payments under the 1115 demonstration and the risk contracts

BASIS: The CMS-approved demonstration terms carry the phase-out rule as NC's operative commitment: the State may not incorporate fee-for-service supplemental payments or Medicaid managed care pass-through payments in accordance with 42 CFR 438.6(a) and 438.6(d) through December 9, 2029 (H-025 STCs 14.5-14.6), and the State attests as a condition of approval that all risk-based MCO, PIHP and PAHP payments comply with 438.6(d) (STC 17.5). No pass-through payment amount appears anywhere in the held record; NC's supplemental payments run as directed payments under 438.6(c).

RECORD LOCATION: H-025 (1115 extension approval package, CMS approval Dec. 10, 2024), STCs 14.5, 14.6 and 17.5

FLAGS: Rests on the CMS-approved STC attestation; no rate certification is held against which pass-through amounts could be tested (see CFR-438-003).

CFR-438-008: In lieu of services and settings (ILOS) — State determination, oversight, reporting, evaluation

CITATION: 42 CFR 438.3(e)(2), 42 CFR 438.16

TOPIC: In lieu of services and settings (ILOS) — State determination, oversight, reporting, evaluation

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - Projected cost % annually with rate cert; final cost % and summary report annually; retrospective evaluation due within 2 years after first 5 rating periods if cost % > 1.5%; 30-day CMS notice on termination-triggering events

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies: Standard Plans, Tailored Plans and the PIHP offer ILOS

BASIS: ILOS rights and State approval machinery are carried: the Tailored Plan contract restates the 438.3(e)(2) rights in full (a member may not be required to use an ILOS, availability may not diminish access to State Plan services, refusal preserves State Plan services on the same terms, and Subpart F appeal rights are unaltered, H-053 p. 37; H-052 p. 39); the PIHP must submit the Department's standardized ILOS Service Request Form once each contract year for Department review and approval of each proposed new or revised ILOS (H-056 p. 9); and the Medicaid Direct MCPAR lists the ILOS offered under the program (H-064, section A.9).

RECORD LOCATION: H-053 (Tailored Plan Contract Amendment 5(7)), p. 37; H-052 (Tailored Plan Contract Amendment 2), p. 39; H-056 (PIHP Contract Amendment 13(14)), p. 9; H-064 (Medicaid Direct PIHP MCPAR 2024), section A.9

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 438.16 State oversight elements as a documented system: the State's ILOS determinations with cost-effectiveness documentation, tracking against the 2.5 percent of capitation limit, the annual report to CMS, and the ILOS evaluation requirements are not carried in any held passage.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the ILOS determinations, the annual ILOS report to CMS, and the evaluation results.
>
> **QUESTION:** Where are NC's 438.16 annual ILOS report and evaluation published?

CFR-438-009: Monthly capitation for IMD short stays (ages 21–64)

CITATION: 42 CFR 438.6(e)

TOPIC: Monthly capitation for IMD short stays (ages 21–64)

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Each capitation month in which an IMD stay occurs; rate-setting each rating period

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (monthly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract

apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies: Tailored Plans and the PIHP cover inpatient behavioral health in IMDs for ages 21-64

BASIS: The 15-day limit is carried in the covered services tables of both behavioral health contracts: members ages 21-64 who meet medical necessity criteria for inpatient level of care may be treated for up to 15 days per calendar month in an IMD (H-053 p. 230; H-056 p. 97). NC also holds 1115 SUD IMD expenditure authority (H-025).

RECORD LOCATION: H-053 (Tailored Plan Contract Amendment 5(7)), p. 230; H-056 (PIHP Contract Amendment 13(14)), p. 97; H-025 (1115 extension approval package)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The capitation mechanic of 438.6(e) as written: that the monthly capitation payment is made for an enrollee with a short stay of no more than 15 days in the month, as an in-lieu-of State Plan service, is not stated in the held passages; and the held record does not distinguish stays paid under 438.6(e) from stays paid under the separate 1115 IMD authority.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State in the contracts or policy which authority (438.6(e) or the 1115 IMD authority) each class of IMD stay is paid under.
>
> **QUESTION:** Under which authority are IMD short stays for ages 21-64 currently paid in the Tailored Plans and the PIHP?

CFR-438-010: Medical loss ratio — plan calculation, reporting, and remittance

CITATION: 42 CFR 438.8

TOPIC: Medical loss ratio — plan calculation, reporting, and remittance

OBLIGATED LEVEL: MCO/plan

CADENCE: RECURRING - Annual MLR reports due within 12 months of MLR reporting year-end

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to all NC risk contracts; NC sets a minimum MLR of 88 percent by statute

BASIS: Plan MLR calculation and reporting are carried in detail: the CMS-defined MLR numerator is defined per 42 CFR 438.8(e) and the denominator (adjusted premium revenue) per 438.8(f) (H-052 p. 100); the Department-defined MLR carries a credibility adjustment per 438.8(h)(1)-(3) (H-053 p.

60); and the State's performance report publishes SFY 2024 MLR numerators and denominators by plan under the 88 percent minimum MLR of G.S. 108D-65, finding all PHPs above the minimum for the CMS-defined MLR (H-062 p. 7).

RECORD LOCATION: H-052 (Tailored Plan Contract Amendment 2), p. 100; H-053 (Tailored Plan Contract Amendment 5(7)), pp. 59-60; H-062 (PHP Performance Metrics Report, Jul. 1, 2024 to Jun. 30, 2025), p. 7

SECTION 5D FACE

UNCOVERED ELEMENT: Remittance as it actually occurred: if the Department-defined MLR is below the minimum threshold the Tailored Plan contract lets the plan remit a rebate, contribute to health-related resources, or take a third option (H-053 p. 60), and the State report records that four PHPs were below the Department-defined threshold for expansion populations in SFY 2024 without stating what was remitted or contributed; the Standard Plan MLR clause itself sits in the unheld base contract.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish, by plan and year, the MLR remittances or approved contributions collected when a plan falls below the threshold.

QUESTION: What did the four PHPs below the SFY 2024 Department-defined threshold for expansion populations remit or contribute?

CFR-438-011: State oversight of minimum MLR — CMS summary and federal share repayment

CITATION: 42 CFR 438.74

TOPIC: State oversight of minimum MLR — CMS summary and federal share repayment

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - Annual MLR summary with rate certification; federal-share repayment when remittances are owed

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as the State overseeing plan MLRs

BASIS: The State's annual summary duty is assured on the record: the Title XXI plan states the State assures that it annually submits to CMS a summary description of the reports pertaining to the medical loss ratio received from the MCOs, PIHPs and PAHPs (42 CFR 457.1203(e), cross referencing 42 CFR 438.74(a), H-022 p. 26; H-013); the 1115 approval attests that managed care payments comply with 438.74 (H-025 STC 17.5); and the State publishes its own MLR analysis by plan (H-062 p. 7).

RECORD LOCATION: H-022 (Title XXI Child Health Plan amendment 22-0013), p. 26; H-025 STC 17.5; H-062 (PHP Performance Metrics Report), p. 7

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The summary description actually submitted to CMS with a rate certification under 438.74(a) is not held, and no held passage carries the 438.74(b) element: repayment to CMS of the Federal share of a remittance at the applicable FMAP.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the 438.74(a) summary descriptions as submitted, and state the Federal share repayment practice for remittances.
>
> **QUESTION:** Where is the most recent 438.74(a) summary description, and has any Federal share of a remittance been repaid?

FLAGS: The MLR summary assurance of record sits in the Title XXI plan; the Medicaid-side submission itself was not read.

CFR-438-012: Beneficiary information website and transparency postings

CITATION: 42 CFR 438.10(c)(3), 42 CFR 438.602(g)

TOPIC: Beneficiary information website and transparency postings

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous operation; website function/timeliness verified at least quarterly; postings updated as reports/contracts change

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (quarterly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies: NC must maintain the 438.10(c)(3) website and the 438.602(g) postings

BASIS: Website posting operates: the State's MCPAR page states the 438.66(e) reports must be posted to the website required under 438.10(c)(3) within 30 days of submission to CMS, and lists the posted reports for five programs for 2025 and four for 2024 (H-063, page last modified Jan. 21, 2026); the Quality Strategy carries the enrollee information system, including provider directories posted on plan websites in machine-readable format with monthly paper and 10-business-day electronic update standards (H-122 pp. 53-55).

RECORD LOCATION: H-063 (MCPAR posting page, cure acquisition); H-122 (Managed Care Quality Strategy 2023), pp. 53-55; H-064 (Medicaid Direct PIHP MCPAR 2024), indicator BX.9a

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 438.602(g)(3) posting is affirmatively not made: in its own MCPAR the State answered No to posting the names of individuals and entities with 5 percent or more

ownership or control interest in the plans and subcontractors (H-064 indicator BX.9a). The full 438.10(c)(3) content list was also not read as posted.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Post the 5 percent ownership and control names required by 438.602(g)(3) on the managed care website.

QUESTION: When will the ownership posting required by 438.602(g)(3) be made?

CFR-438-013: Standard managed care definitions and model enrollee materials

CITATION: 42 CFR 438.10(c)(4)–(5)

TOPIC: Standard managed care definitions and model enrollee materials

OBLIGATED LEVEL: MCO/plan

CADENCE: FIXED - Develop once; enforce continuously; update as requirements change

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC enrollee information under 438.10

BASIS: The Quality Strategy carries the model materials machinery: in accordance with 42 CFR 438.10, all informational materials developed by the Department, the enrollment broker, the Ombudsman Program, the plans and the Tribal Option will be available in formats and languages ensuring accessibility and at an appropriate reading level, and the Department will develop a model member handbook that the plans use (H-122 pp. 53-54). The Standard Plan contract adopts the 438.10 definitions, including Readily Accessible per 438.10(a) (H-046).

RECORD LOCATION: H-122 (Managed Care Quality Strategy 2023), pp. 53-54; H-046 (PHP Contract Amendment 8), definitions

SECTION 5D FACE

UNCOVERED ELEMENT: The 438.10(c)(4) element as written: State-developed definitions of managed care terms, developed in consultation with the Medical Care Advisory Committee or a similar committee, and the State's model enrollee notices; and whether use of the model handbook and notices is required of plans (438.10(c)(5)) is not stated in the held passages.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the State's managed care definitions and the model handbook and notices, and state whether plans must use them.

QUESTION: Where are the 438.10(c)(4) definitions and the model materials published?

CFR-438-014: Annual disenrollment-rights notice to enrollees

CITATION: 42 CFR 438.10(f)(2)

TOPIC: Annual disenrollment-rights notice to enrollees

OBLIGATED LEVEL: agency

CADENCE: RECURRING - At least annually; 60 days before each enrollment period if disenrollment is restricted for 90+ days

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to all NC managed care enrollees

BASIS: Adjacent machinery is carried: plans must submit member enrollment and disenrollment policies, member ID cards and welcome packets to the Department (H-052 deliverables, p. 136), the Quality Strategy states the disenrollment rights themselves in detail (H-122 pp. 56-57), and Standard Plans must send a welcome packet within six calendar days of the enrollment file (H-062 p. 17).

RECORD LOCATION: H-052 (Tailored Plan Contract Amendment 2), p. 136; H-122 (Managed Care Quality Strategy 2023), pp. 56-57; H-062 (PHP Performance Metrics Report), p. 17

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The annual disenrollment-rights notice itself under 438.10(f)(2): no held passage states that enrollees receive notice of their disenrollment rights at least annually (or its timing relative to enrollment periods).
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Add the annual disenrollment-rights notice to the member communications cycle and publish the notice.
>
> **QUESTION:** How and when do NC enrollees receive the annual notice of disenrollment rights?

SEARCHES RECORDED: Contracts (H-046, H-052, H-053, H-056), Quality Strategy and MCPAR searched for an annual disenrollment notice; none states the annual notice.

CFR-438-015: Managed care enrollment system and informational notices

CITATION: 42 CFR 438.54

TOPIC: Managed care enrollment system and informational notices

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous enrollment operations; notices at each potential enrollee's eligibility determination

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies: NC operates a mandatory managed care enrollment system through an enrollment broker

BASIS: The enrollment system is described in operation: the State and the enrollment broker are jointly responsible for enrollment and disenrollment requirements consistent with 42 CFR 438.54 and 438.56; county DSS offices make eligibility determinations and share them with the broker, who supports members with plan and PCP selection (H-122 p. 55); auto-assignment covers beneficiaries who do not choose (H-046 definition 6); and welcome packets go out within six calendar days of the enrollment file (H-062 p. 17).

RECORD LOCATION: H-122 (Managed Care Quality Strategy 2023), pp. 55-56; H-046 (PHP Contract Amendment 8), definition 6; H-062 (PHP Performance Metrics Report), p. 17

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The informational notice to each potential enrollee at the time they first become eligible, with the 438.54 content, as a document: the enrollment broker contract that would carry it was not found in the public record (NL-08 search record: only the 2018 Maximus award is documented).
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the potential enrollee informational notice and the enrollment broker contract.
>
> **QUESTION:** Where is the notice given to potential enrollees at first eligibility published?

CFR-438-016: Choice counseling for potential enrollees and disenrollees

CITATION: 42 CFR 438.54, 42 CFR 438.71(c)

TOPIC: Choice counseling for potential enrollees and disenrollees

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous; provided to every potential enrollee and qualifying disenrollee

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies: choice counseling runs through the enrollment broker and the Ombudsman

BASIS: Choice counseling functions are described: the enrollment broker supports members with plan and PCP selection by phone, online chat, website and mail (H-122 pp. 55-57); the MCPAR names the Beneficiary Support System entities for the program, including the NC Medicaid

Enrollment Broker and the Ombudsman Program (H-064, BSS section); and the Ombudsman provides advocacy, assistance and education to members navigating managed care (H-122 p. 59).

RECORD LOCATION: H-122 (Managed Care Quality Strategy 2023), pp. 55-59; H-064 (Medicaid Direct PIHP MCPAR 2024), Beneficiary Support System section

SECTION 5D FACE

UNCOVERED ELEMENT: Choice counseling for enrollees who disenroll, as 438.71(c) and 438.56(c) contemplate (counseling offered in connection with disenrollment for cause and at plan termination), is not stated as a service in any held passage, and the enrollment broker contract terms are not in the public record (NL-08).

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: State the choice counseling offered to disenrolling members in the enrollment policy and publish the broker contract.

QUESTION: Is choice counseling offered to members at disenrollment, and by whom?

CFR-438-017: Disenrollment determinations, timeframes, and fair hearing

CITATION: 42 CFR 438.56

TOPIC: Disenrollment determinations, timeframes, and fair hearing

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Each disenrollment request; 60-day notice before each enrollment period when disenrollment is restricted

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to Standard Plan, Tailored Plan and Tribal Option enrollment

BASIS: Disenrollment rules are stated in substance: all Standard Plan members have a 90-day period after the effective coverage date to change plans without cause, then must show cause, with annual change at redetermination and any-time changes for tribal members and IHS-eligible members receiving LTSS; Tailored Plan enrollees may request transfer at any time and a Tailored Plan may not request a member's disenrollment; the Department and the broker process transfers and notify the member (H-122 pp. 56-57).

RECORD LOCATION: H-122 (Managed Care Quality Strategy 2023), pp. 56-57

SECTION 5D FACE

UNCOVERED ELEMENT: 438.56 elements not pinpointed: the State's determination timeframes for disenrollment requests, the fair hearing right when a disenrollment request is denied, stated as part of this system, and plan-requested disenrollment grounds and procedure for Standard Plans.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the disenrollment determination timeframes and the fair hearing notice given on denial.

QUESTION: Within what time does the State decide a disenrollment request, and how is a denial appealed?

CFR-438-018: Conflict of interest safeguards in managed care contracting

CITATION: 42 CFR 438.58, 42 CFR 438.602(h)

TOPIC: Conflict of interest safeguards in managed care contracting

OBLIGATED LEVEL: agency

CADENCE: FIXED - Safeguards in effect continuously; applied to each procurement/contract

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC agency officials and employees in managed care procurement

BASIS: The State Plan carries the 438.58 assurance for the agency: Section 4.29 (plan p. 77) states the Medicaid agency meets the requirements of section 1902(a)(4)(D) of the Act concerning safeguards against conflicts of interest that are at least as stringent as the safeguards under section 27 of the Office of Federal Procurement Policy Act, citing 42 CFR 438.58.

RECORD LOCATION: H-001 (Title XIX State Plan), Section 4.29 at PDF p. 145

SECTION 5D FACE

UNCOVERED ELEMENT: The 438.602(h) element (State safeguards addressing former State officials and employees in plan contracting) is not separately pinpointed in any held passage; the held evidence is the plan assurance for 438.58 only.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the conflict of interest safeguards policy covering procurement officials and former employees.

QUESTION: Where is the policy that carries 438.58 and 438.602(h) for DHB procurement staff published?

CFR-438-019: Transition of care policy

CITATION: 42 CFR 438.62(b)

TOPIC: Transition of care policy

OBLIGATED LEVEL: agency

CADENCE: FIXED - Policy in effect continuously; applied to each enrollee transition

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to all NC managed care programs

BASIS: The Quality Strategy states NC's transition of care policy under 42 CFR 438.62 in terms: NC has established transition-of-care standards that apply to all members, including those in need of LTSS, when a member transitions into a Standard Plan, Tailored Plan or PIHP from NC Medicaid Direct or another plan; a member in an ongoing course of treatment or with an ongoing special condition may continue receiving services from their provider; new enrollees who are pregnant may continue with their behavioral health provider and obstetrician throughout the pregnancy (H-122 pp. 47-48). The Standard Plan contract adopts the 438.62(b) ongoing course of treatment definition (H-046 definition 109).

RECORD LOCATION: H-122 (Managed Care Quality Strategy 2023), pp. 47-48; H-046 (PHP Contract Amendment 8), definition 109

FLAGS: Carried by the published Quality Strategy policy statement and the contract definitions; the strategy is the 2023 edition (see CFR-438-043 on currency).

CFR-438-020: Continued services after contract termination or disenrollment

CITATION: 42 CFR 438.62(a)

TOPIC: Continued services after contract termination or disenrollment

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Upon each contract termination or disenrollment (other than ineligibility)

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to all NC managed care programs

BASIS: Provider-level continuation is carried in detail: when a provider is terminated or leaves for nonrenewal, an enrollee in an ongoing course of treatment or with an ongoing special condition may continue with that provider for up to 90 days, and a pregnant enrollee through the pregnancy and up to 12 months after delivery; where termination is for quality or program integrity concerns the plan must notify and assist the enrollee in transitioning (H-122 p. 48); PIHP provider contracts must address continuation of care when inpatient care is ongoing at insolvency (H-056 p. 52).

RECORD LOCATION: H-122 (Managed Care Quality Strategy 2023), p. 48; H-056 (PIHP Contract Amendment 13(14)), p. 52

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** 438.62(a) at the plan level: the State's arrangement to provide for continued services to enrollees when a plan contract is terminated or the plan becomes insolvent (as distinct from provider terminations) is not stated in any held passage.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the plan-termination continuity arrangement required by 438.62(a).
>
> **QUESTION:** If a Standard Plan contract terminated mid-year, what published arrangement continues services to its enrollees?

CFR-438-021: Managed care monitoring system

CITATION: 42 CFR 438.66(a)–(c)

TOPIC: Managed care monitoring system

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous monitoring; data used to drive program improvement

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies: NC must operate a monitoring system for all managed care programs

BASIS: Monitoring operates across the enumerated domains on the held record: the Quality Strategy describes report review and trending, monthly Quality Director meetings, accreditation and EQRO compliance review, Notices of Deficiency and corrective action plans, and triennial EQR compliance review with annual tracer audits (H-122 pp. 60-65); the Medicaid Direct MCPAR reports monitoring results across grievances, appeals, network adequacy, program integrity and MLR (H-064); the legislative performance report publishes claims, MLR, CAHPS, network and customer service monitoring by plan (H-062); and the Standard Plan contract's reporting restatement cites the 438.66(c)(3) monitoring content (H-046 p. 83).

RECORD LOCATION: H-122 (Managed Care Quality Strategy 2023), pp. 60-65; H-064 (Medicaid Direct PIHP MCPAR 2024); H-062 (PHP Performance Metrics Report); H-046 (PHP Contract Amendment 8), p. 83

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** No single held instrument describes the 438.66(a)-(c) monitoring system as a system covering every enumerated domain in terms, in particular the beneficiary support

system and LTSS-specific monitoring areas; the description is spread across the Quality Strategy, the MCPARs and the performance report.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish a single monitoring system description mapped to the 438.66(c) domains.

QUESTION: Where is NC's 438.66 monitoring system described as a whole?

CFR-438-022: Annual enrollee experience survey

CITATION: 42 CFR 438.66(c)(5)

TOPIC: Annual enrollee experience survey

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Annual survey

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to all NC managed care programs

BASIS: The annual enrollee experience survey operates through the EQRO: NC Medicaid contracts with Health Services Advisory Group, Inc. (HSAG), an external quality review organization, to administer and report the results of the CAHPS Health Plan Surveys annually; the 2024 survey was administered to adult beneficiaries and to parents and caretakers of child beneficiaries, with results benchmarked against NCQA Quality Compass percentiles and published (H-062 p. 8). The EQR technical report carries the CAHPS and HCBS CAHPS results for the period (NL-05).

RECORD LOCATION: H-062 (PHP Performance Metrics Report, Jul. 1, 2024 to Jun. 30, 2025), p. 8; NL-05 (2024-2025 EQR Technical Report)

CFR-438-023: Readiness reviews for new programs, plans, or eligibility groups

CITATION: 42 CFR 438.66(d)

TOPIC: Readiness reviews for new programs, plans, or eligibility groups

OBLIGATED LEVEL: federal-facing state report

CADENCE: EVENT-TRIGGERED - Started at least 3 months before program implementation, new plan contracting, or new eligibility group expansion

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract

apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies when NC starts a new program, plan or eligibility group

BASIS: Readiness review exists as a defined contract concept, a Department practice, and a performed event: the Standard Plan contract defines Readiness Review as described in 42 CFR 438.66(d) (H-046 definition 136); the Quality Strategy states the Department reviews plans' governing policies and procedures during readiness and EQRs (H-122 p. 63); and the 1115 approval records that CMS reviewed the State's assessment of the MCO's ability and capacity to perform satisfactorily for the areas listed in 42 CFR 438.66(d)(4) (enrollee and provider communications, member services and outreach, provider network management, case management and care coordination, systems management) for the Tailored Plan launch, and that the State submitted, and CMS closely monitored, monthly readiness updates (H-025, CMS response to comments on Tailored Care Management readiness). Pilot Readiness Reviews also gate Healthy Opportunities Pilot payments in the contract amendments (H-048 p. 11; H-054 p. 34).

RECORD LOCATION: H-046 (PHP Contract Amendment 8), definition 136; H-122 (Managed Care Quality Strategy 2023), p. 63; H-025 (1115 extension approval package), CMS response to comments; H-048 (PHP Contract Amendment 17(18)), p. 11

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The readiness review results as a submitted record for each contracting event in the window: no readiness review report is held, and no held document shows a review for the Children and Families Specialty Plan launch or states the 438.66(d) timing standard (review completed before the contracting event) as the State's own standard.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the readiness review reports for recent launches.
>
> **QUESTION:** Where are the readiness review results for the Tailored Plan and CFSP launches?

CFR-438-024: Annual managed care program report to CMS

CITATION: 42 CFR 438.66(e)

TOPIC: Annual managed care program report to CMS

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - Annual; due within 180 days after each contract year; posted within 30 days of CMS submission

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to each NC managed care program

BASIS: The MCPAR system operates on the record: the State's posting page states that 42 CFR 438.66(e) requires submission to CMS no later than 180 days after each contract year and that MCPARs must be posted to the 438.10(c)(3) website within 30 days of submission; the page lists Performance Year 2025 MCPARs for all five programs (Community Care of North Carolina, Medicaid Direct PIHP, Standard Plan, Tribal Option, Behavioral Health I/DD Tailored Plan) and Performance Year 2024 MCPARs for four programs, last modified January 21, 2026 (H-063). The Medicaid Direct PIHP MCPAR for 2024 is itself held and was submitted December 27, 2024 (H-064).

RECORD LOCATION: H-063 (MCPAR posting page, cure acquisition); H-064 (Medicaid Direct PIHP MCPAR 2024)

FLAGS: Timing note: an independent analysis records the 2025 Standard Plan MCPAR as submitted December 27, 2025 and posted in late January 2026 (H-138 p. 12), consistent with the 180-day and 30-day clocks for a June 30 contract year end.

CFR-438-025: Network adequacy standards — development and enforcement

CITATION: 42 CFR 438.68(a)–(c)

TOPIC: Network adequacy standards — development and enforcement

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - Standards developed and enforced continuously; exceptions monitored ongoing

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to Standard Plans, Tailored Plans and the PIHP

BASIS: State-developed standards exist and are enforced through measurement: the Quality Strategy states that per 42 CFR 438.68, plan networks must meet network adequacy standards developed by the State and published online, with time and distance standards by service type and urban or rural area for hospitals, pharmacies, obstetrics, therapies, outpatient behavioral health, crisis and location-based services (H-122 pp. 34-36); the PIHP standards are restated in the contract (H-056, Attachment E); the State publishes the standards with April 2025 results by plan and region (H-062 pp. 10-11); and the EQRO validates network adequacy annually (NL-05 p. 48).

RECORD LOCATION: H-122 (Managed Care Quality Strategy 2023), pp. 34-36; H-056 (PIHP Contract Amendment 13(14)), Attachment E; H-062 (PHP Performance Metrics Report), pp. 10-11; NL-05 (2024-2025 EQR Technical Report), p. 48

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The complete 438.68(b)(1)-(2) type set as distinct quantitative standards: the held standards do not separately state standards for every federal type (for example

pediatric specialty types and LTSS provider types as distinct standards), and the published results show plans below the 95 percent standard in multiple cells (for example child allergy and immunology at 33 percent in one region for one plan) with no held documentation of the enforcement consequence (see CFR-438-033).

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the standards mapped type-by-type to 438.68(b) and the enforcement taken where a plan misses a standard.

QUESTION: Which federal provider types lack a distinct NC standard, and what happens when a plan misses one?

CFR-438-026: Appointment wait time standards

CITATION: 42 CFR 438.68(e)

TOPIC: Appointment wait time standards

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous enforcement; compliance measured via annual secret shopper surveys at 90% threshold

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to Standard Plans, Tailored Plans and the PIHP

BASIS: Appointment wait time standards exist for the PIHP's behavioral health network: Attachment E Table 3 sets standards for adult and pediatric providers separately (mobile crisis within 2 hours; facility-based crisis and emergency services immediately, 24 hours a day; urgent mental health and SUD care within 24 hours; routine mental health services within 14 calendar days; routine SUD services within 48 hours, H-056 p. 51); and the State reports that appointment wait time standards are monitored through secret-shopper analysis, provider surveys and analysis of member complaints (H-062 Appendix, p. 19).

RECORD LOCATION: H-056 (PIHP Contract Amendment 13(14)), Attachment E Table 3 at p. 51; H-062 (PHP Performance Metrics Report), Appendix p. 19

SECTION 5D FACE

UNCOVERED ELEMENT: The 438.68(e) standards as written for the physical health side: routine outpatient mental health and SUD appointments within 10 business days and primary care and OB/GYN appointments within 15 business days, stated as standards in a Standard Plan or Tailored Plan instrument. No held passage states Standard Plan appointment wait time standards in those terms.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the Standard Plan and Tailored Plan appointment wait time standards mapped to 438.68(e).

QUESTION: What are the appointment wait time standards for primary care and OB/GYN in the Standard Plans?

CFR-438-027: Annual secret shopper surveys (provider directories and wait times)

CITATION: 42 CFR 438.68(f)

TOPIC: Annual secret shopper surveys (provider directories and wait times)

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - Annual surveys; directory errors to plans within 3 business days; results posted within 30 days of CMS submission

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to all NC managed care programs

BASIS: Secret shopper surveys were performed in the period: during the technical report period HSAG and its subcontractor conducted access and availability 'revealed' and 'secret shopper' surveys to evaluate the accuracy of provider information and appointment availability for specialists, primary care providers (PCPs), and obstetrics and gynecology (OB/GYN) providers, with results provided to DHB (NL-05, executive summary); the State's performance report confirms appointment wait time standards are monitored through secret-shopper analysis (H-062 Appendix, p. 19).

RECORD LOCATION: NL-05 (2024-2025 EQR Technical Report), executive summary survey description; H-062 (PHP Performance Metrics Report), Appendix p. 19

SECTION 5D FACE

UNCOVERED ELEMENT: 438.68(f) requires the annual surveys to cover mental health, substance use disorder, primary care, and OB/GYN providers plus a State-selected specialist type, testing both directory accuracy and wait times: the held EQR description does not name mental health or SUD provider types among those surveyed, and describes the activity within the report period rather than as an annual standard.

OWNER LEVEL: the EQRO

ACTION: Extend the annual secret shopper survey to mental health and SUD provider types and publish the survey design and results.

QUESTION: Which provider types did the most recent secret shopper survey test, and is it run every year?

CFR-438-028: Publication of network adequacy standards

CITATION: 42 CFR 438.68(g)

TOPIC: Publication of network adequacy standards

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Published continuously; updated as standards change

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC network adequacy standards

BASIS: The standards are published: the Quality Strategy states that per federal regulations at 42 CFR 438.68, plan networks must meet network adequacy standards developed by the State and published online, and prints the full standard tables by plan type and area (H-122 pp. 34-36); the State's public performance report republishes the standards table for the Standard Plans (H-062 p. 10).

RECORD LOCATION: H-122 (Managed Care Quality Strategy 2023), pp. 34-36; H-062 (PHP Performance Metrics Report), p. 10

CFR-438-029: Beneficiary support system

CITATION: 42 CFR 438.71

TOPIC: Beneficiary support system

OBLIGATED LEVEL: agency

CADENCE: FIXED - System in place continuously

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as the State operating a beneficiary support system

BASIS: The system's entities are named on the record: for the Medicaid Direct program the MCPAR lists the Beneficiary Support System entities supporting enrollees, citing 42 CFR 438.71: the North Carolina Medicaid Ombudsman Program, the NC Medicaid Enrollment Broker, and the Medicaid Contact Center (H-064, BSS section); the Quality Strategy describes the Ombudsman Program's functions: advocacy, assistance and education to members as they navigate managed care and the appeals, grievance and fair hearing process, plus trend monitoring back to the Department (H-122 p. 59).

RECORD LOCATION: H-064 (Medicaid Direct PIHP MCPAR 2024), Beneficiary Support System section; H-122 (Managed Care Quality Strategy 2023), p. 59

SECTION 5D FACE

UNCOVERED ELEMENT: 438.71 elements not pinpointed: the LTSS-specific support elements (a separate access point for LTSS users and education on grievance and appeal rights for LTSS), the system's data reporting to the State, and its annual reporting; the Ombudsman annual report that would evidence them was not found in the public record (NL-07 search record).

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the beneficiary support system's LTSS access point, its data reports, and the Ombudsman annual report.

QUESTION: How do LTSS users reach the beneficiary support system, and where is its annual report?

CFR-438-030: LTSS stakeholder engagement

CITATION: 42 CFR 438.70

TOPIC: LTSS stakeholder engagement

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Ongoing through design, implementation, and oversight

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies: Standard Plans and Tailored Plans cover LTSS

BASIS: LTSS stakeholder engagement machinery exists at the plan level: Vaya Health's Provider Operations Manual describes an LTSS Member Advisory Committee that garners stakeholder input and advice regarding LTSS covered under the Tailored Plan contract, whose membership reflects the LTSS populations served by Vaya, which receives reports from Vaya enabling it to review member experience and quality of care as an early warning system, and which Vaya consults at least quarterly; the manual states the committee meets all provisions noted in 42 CFR 438.110, and the same plan maintains a Consumer and Family Advisory Committee meeting at least six times per year (H-072, manual p. 13). The Quality Strategy also carries general stakeholder input and Medical Care Advisory Committee consultation for the quality strategy itself (H-122 p. 17).

RECORD LOCATION: H-072 (Provider Operations Manual, Tailored Plan, v2.1, Vaya Health), p. 14 (manual p. 13); H-122 (Managed Care Quality Strategy 2023), p. 17

SECTION 5D FACE

UNCOVERED ELEMENT: 438.70 as written is a State duty: the State must engage individuals who use LTSS, providers, and other stakeholders in the design, implementation and oversight of the

managed care program. The held evidence is one plan's advisory committee structure under 438.110 (a member advisory committee requirement), with no State-level LTSS stakeholder group, and no consultation record, documented for the program as a whole or for the other plans.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Establish and document State-level LTSS stakeholder engagement for the managed care program as a whole, or publish how the plan-level committees discharge the 438.70 duty for the State.

QUESTION: What State-level body or process performs the 438.70 LTSS stakeholder engagement function across all NC plans?

SEARCHES RECORDED: Quality Strategy (H-122), model contracts (H-046, H-052, H-053, H-056), MCPAR (H-064) and plan provider manuals (H-067, H-068, H-070, H-072, H-073) searched for 438.70 and LTSS stakeholder engagement; the only LTSS-specific engagement machinery found is the Vaya committee structure cited.

CFR-438-031: Assurance of adequate capacity and services to CMS

CITATION: 42 CFR 438.207(d)

TOPIC: Assurance of adequate capacity and services to CMS

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - Annual; due within 180 days after each rating period; posted within 30 days of submission

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to all NC managed care programs

BASIS: The capacity oversight system is described: in accordance with 42 CFR 438.207, NC maintains a monitoring and oversight system to ensure Standard Plans and Tailored Plans have adequate capacity, requiring plans to submit an access plan and regular documentation including provider network data and reports summarizing their own network data analysis, plus updated machine-readable provider data (H-122 p. 48); approved network exceptions are monitored and findings reported annually to CMS (H-122 p. 46).

RECORD LOCATION: H-122 (Managed Care Quality Strategy 2023), pp. 46 and 48

SECTION 5D FACE

UNCOVERED ELEMENT: The State's own act under 438.207(c)-(d): submission of an assurance of compliance to CMS, in CMS's prescribed format, with documentation of a network adequacy analysis for each plan, was not read in any held document.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the most recent 438.207 assurance submission to CMS with its per-plan analysis documentation.

QUESTION: When was the last 438.207 assurance submitted to CMS, and where is it recorded?

CFR-438-032: Provider payment analysis (percent of Medicare) in capacity assurances

CITATION: 42 CFR 438.207(b)(3), 438.207(d)(2)

TOPIC: Provider payment analysis (percent of Medicare) in capacity assurances

OBLIGATED LEVEL: MCO/plan

CADENCE: RECURRING - Annual analysis using prior rating period paid claims

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies from 2026 under the CMS comparative payment rate analysis requirement

BASIS: The State's reports page carries the commitment in terms: 'Comparative Payment Rate Analysis: Beginning in 2026, CMS requires states to compare their rates for primary care, obstetrical and gynecological, and outpatient mental health and substance use disorder services to Medicare rates. States must publish the analysis every two years. Reports are published in accordance with this requirement.' (H-128).

RECORD LOCATION: H-128 (NC Medicaid Reports page, cure acquisition)

SECTION 5D FACE

UNCOVERED ELEMENT: The analysis itself: no held document contains the provider payment analysis (payment as a percentage of Medicare by service) that 438.207(b)(3) requires to accompany the capacity assurance, and the first biennial analysis was not read.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the first comparative payment rate analysis with percentages of Medicare by service.

QUESTION: When will the first comparative payment rate analysis be published?

CFR-438-033: Remedy plans to improve access

CITATION: 42 CFR 438.207(f)

TOPIC: Remedy plans to improve access

OBLIGATED LEVEL: federal-facing state report

CADENCE: EVENT-TRIGGERED - Triggered by identified access issue; 12-month improvement window; quarterly CMS progress updates

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies when a plan does not meet the State's access standards

BASIS: No NC evidence of a remedy plan under 438.207(f) was found. The record shows the predicate conditions (published network results with plans below standard in multiple cells, H-062 pp. 10-11) and a general corrective machinery (Notices of Deficiency and corrective action plans for compliance deficiencies, H-122 p. 64), but no remedy plan required of a plan to improve access to a provider type, and no access CAP tied to the published shortfalls.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Require and publish remedy plans where a plan misses a network adequacy standard, starting with the shortfalls in the April 2025 results.
>
> **QUESTION:** Which plans were required to file access remedy plans after the April 2025 network analysis?

SEARCHES RECORDED: Quality Strategy (H-122), MCPAR (H-064), performance report (H-062) and EQR report (NL-05) searched for remedy plans and access corrective plans under 438.207(f); none found.

CFR-438-034: Uniform credentialing and recredentialing policy

CITATION: 42 CFR 438.214(b)

TOPIC: Uniform credentialing and recredentialing policy

OBLIGATED LEVEL: MCO/plan

CADENCE: FIXED - Policy established and enforced continuously

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to all NC managed care plans

BASIS: The model Tailored Plan contract carries the State's Uniform Credentialing and Re-credentialing Policy for Medicaid and State-funded Providers as a contract attachment: the policy's scope cites 42 CFR 438.214(b)(1); plans must develop and maintain written provider selection and retention policies consistent with the Department policy; the process must meet the standards for an accredited health plan (NCQA selected as the accrediting organization) and 42 CFR Part 455 Subparts B and E; providers use a single electronic application; discrimination on the basis of license or certification is prohibited (438.12); and re-credentialing runs no less frequently than every five years during the transition period and every three years after (H-052 Attachment M, pp. 229-231).

RECORD LOCATION: H-052 (Tailored Plan Contract Amendment 2), Attachment M at pp. 229-231

FLAGS: Model form flag: the policy is read as carried in the Tailored Plan model contract; executed-instance limit per NL-02.

CFR-438-035: Flow-through termination of providers terminated elsewhere

CITATION: 42 CFR 438.214(d)(2)

TOPIC: Flow-through termination of providers terminated elsewhere

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Upon each provider/person termination under titles XIX/XVIII/XXI

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to all NC managed care plans

BASIS: Termination machinery is carried for fraud and quality findings: PIHP provider contracts must permit the PIHP to immediately terminate a provider contract upon a confirmed finding of fraud, waste or abuse by the Department or the NC Department of Justice Medicaid Investigations Division, or serious quality of care concerns, and to immediately suspend activities on a credible allegation (H-056 p. 52); suspected fraud is referred to the Medicaid Investigations Division under the State's program integrity machinery (H-122 pp. 64-65).

RECORD LOCATION: H-056 (PIHP Contract Amendment 13(14)), p. 52; H-122 (Managed Care Quality Strategy 2023), pp. 64-65

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** 438.214(d)(2) as written: prompt termination of a provider's participation, with notice to the State, when the provider is terminated by the State, by Medicare, or by another State's Medicaid or CHIP program (the cross-program flow-through trigger). The held passages cover plan-initiated fraud and quality terminations, not the flow-through.
>
> **OWNER LEVEL:** the contracted plan or entity named

ACTION: Add the cross-program flow-through termination clause, with State notice, to the standard provider contract provisions.

QUESTION: Do NC plan contracts require termination of a provider terminated by Medicare or another State?

CFR-438-036: Grievance and appeal system via contract

CITATION: 42 CFR 438.228, 42 CFR 438.400–438.424

TOPIC: Grievance and appeal system via contract

OBLIGATED LEVEL: MCO/plan

CADENCE: RECURRING - Continuous; random reviews when notice responsibility is delegated

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to all NC managed care plans via contract

BASIS: The system standards are stated: members may file a grievance at any time, orally or in writing; plans must acknowledge receipt in writing within five calendar days and resolve within 30 calendar days; appeals follow 42 CFR 438.402, 438.406, 438.408 and 438.420, with 60 days from the adverse benefit determination notice to file the plan appeal and a State fair hearing after the plan appeal (H-122 pp. 58-59); expedited appeals carry a 72-hour resolution standard and continuation of benefits per 438.420 in State statute (G.S. 108D-14, H-108); the model contracts restate the grievance and appeal sections, including application to ILOS (H-053 p. 33).

RECORD LOCATION: H-122 (Managed Care Quality Strategy 2023), pp. 58-59; H-108 (G.S. 108D-14); H-053 (Tailored Plan Contract Amendment 5(7)), p. 33

SECTION 5D FACE

UNCOVERED ELEMENT: Subpart F elements not pinpointed in a Medicaid-side passage, including effectuation of reversed appeal decisions within 72 hours for services not yet furnished (438.424(a)): the only passage stating that clock is the Title XXI plan assurance (H-022 section 3.9.27).

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Pinpoint the Subpart F effectuation and aid-pending clocks in the managed care contracts or policy.

QUESTION: Where is the 438.424(a) 72-hour effectuation duty stated for NC Medicaid plans?

CFR-438-037: State-established method for grievance resolution notices

CITATION: 42 CFR 438.408

TOPIC: State-established method for grievance resolution notices

OBLIGATED LEVEL: agency

CADENCE: FIXED - Method established; applied to each grievance resolution notice

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies: the State establishes the grievance resolution notice method

BASIS: NC's method is stated in its timeframes and content direction: grievances must be resolved and notice given within 30 calendar days of receipt (inside the 90-day federal maximum the Medicaid Direct MCPAR also records), grievances over denial of an expedited appeal must be resolved with notice to all affected parties within five calendar days, including Department-specified content in the notice (H-122 p. 58; H-064, grievance timeframe indicators).

RECORD LOCATION: H-122 (Managed Care Quality Strategy 2023), p. 58; H-064 (Medicaid Direct PIHP MCPAR 2024), Topic V grievance indicators

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The state-established method for the resolution notices themselves under 438.408 (the notice method and its language, format and content standards, tied to 438.10) as a document: the held passages state timeframes and that content is Department-specified, but the specified method was not read.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the Department-specified grievance and appeal resolution notice method and templates.
>
> **QUESTION:** Where is the notice method the Department specifies for 438.408 published?

CFR-438-038: Grievance and appeal recordkeeping and State review

CITATION: 42 CFR 438.416

TOPIC: Grievance and appeal recordkeeping and State review

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous review within ongoing monitoring (438.66)

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to all NC managed care plans; the State reviews the records

BASIS: Recordkeeping and State review are assured and partly shown: the Title XXI plan states the record of grievances and appeals must be accurately maintained in a manner accessible to the State and available upon request to CMS (42 CFR 457.1260, cross referencing 42 CFR 438.416, H-022 p. 48); plans must report to the Department each adverse benefit determination notice, appeal outcomes, expedited request counts, extension counts, and grievance data elements with dates of receipt and resolution (H-122 p. 59); and the MCPAR publishes plan-level grievance and appeal counts (H-064).

RECORD LOCATION: H-022 (Title XXI Child Health Plan amendment 22-0013), p. 48; H-122 (Managed Care Quality Strategy 2023), p. 59; H-064 (Medicaid Direct PIHP MCPAR 2024)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 438.416 record as maintained by the plans (the log with the regulation's content elements) and the State's review of those records, as distinct from the reported aggregates, were not read in a Medicaid-side instrument.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the grievance and appeal record specification and the State's record review practice.
>
> **QUESTION:** Where is the 438.416 record specification for plans published?

FLAGS: The fullest recordkeeping pinpoint sits in the Title XXI plan assurance; Medicaid-side evidence is the reporting machinery.

CFR-438-039: Care coordination, coverage/authorization, confidentiality, subcontracts, practice guidelines via contract

CITATION: 42 CFR 438.208, 42 CFR 438.210, 42 CFR 438.224, 42 CFR 438.230, 42 CFR 438.236

TOPIC: Care coordination, coverage/authorization, confidentiality, subcontracts, practice guidelines via contract

OBLIGATED LEVEL: MCO/plan

CADENCE: RECURRING - Continuous via contract enforcement

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to all NC managed care plans via contract

BASIS: The Quality Strategy carries each cited provision in terms: care coordination and continuity per 438.208, including an ongoing source of care, coordination between settings of care and discharge planning, and best-efforts screening of new enrollees within 90 days per 438.208(b)(3) (p. 49); special health care needs assessment and direct access to specialists (p. 50); confidentiality per

438.224 (p. 57); subcontractual relationships and delegation per 438.230, with plans accountable for delegated functions and pre-delegation assessments required (p. 59); and practice guidelines per 438.236, based on valid and reliable clinical evidence, adopted in consultation with contracting professionals and reviewed periodically (p. 52). The model contracts carry the same provisions (438.208, 438.210, 438.230, 438.236 pinpoints in H-052 and H-053).

RECORD LOCATION: H-122 (Managed Care Quality Strategy 2023), pp. 49, 50, 52, 57, 59; H-052 and H-053 (Tailored Plan model contracts)

FLAGS: Model form flag for the contract pinpoints; the Quality Strategy is the State's own published instrument.

CFR-438-040: Health information systems; encounter data validation

CITATION: 42 CFR 438.242

TOPIC: Health information systems; encounter data validation

OBLIGATED LEVEL: MCO/plan

CADENCE: RECURRING - Continuous validation of plan encounter data

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to all NC managed care plans and the State's systems

BASIS: Encounter data machinery is carried in operation: plans must create encounter submissions under the Department's Encounter Data Submission Guide in ASC X12 837P and 837I formats and NCPDP formats for pharmacy, with the exact amount paid to pharmacies reported (H-053 p. 58); encounter data is reconciled against plan financial reports under stated submission standards (H-052 pp. 99-100); and the State validates encounter data through State agency staff, State actuaries, the EQRO and proprietary systems confirmed HIPAA compliant, with the validation process completed with the EQRO HSAG and EQR reports posted (H-064 indicators BIII.1-BIII.2 and BX.10).

RECORD LOCATION: H-053 (Tailored Plan Contract Amendment 5(7)), p. 58; H-052 (Tailored Plan Contract Amendment 2), pp. 99-100; H-064 (Medicaid Direct PIHP MCPAR 2024), Topics III and X indicators

FLAGS: Validation findings detail sits in the plan-level EQR reports the MCPAR links to; the validation machinery and its completion in the period are carried on the face of the MCPAR.

CFR-438-041: Quality assessment and performance improvement (QAPI) requirements and State review

CITATION: 42 CFR 438.330

TOPIC: Quality assessment and performance improvement (QAPI) requirements and State review

OBLIGATED LEVEL: MCO/plan

CADENCE: RECURRING - Annual plan reporting; State review of each plan's QAPI at least annually

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to all NC managed care plans; the State reviews QAPI

BASIS: QAPI operates on the record: the Quality Strategy requires plan QAPIs and describes the Department's structure for them (H-122 Section III(A), pp. 19-22); the Department reviews and approves each plan's QAPI, including how the plan assesses and improves its own performance annually (H-122 p. 60); the Tailored Plan contract requires no less than three performance improvement projects as part of the annual QAPI program, Department-approved annually (438.330, H-053 p. 52); and the EQRO validated PIPs and performance measures for all plans in the period and drew conclusions on them (NL-05).

RECORD LOCATION: H-122 (Managed Care Quality Strategy 2023), pp. 19-22 and 60; H-053 (Tailored Plan Contract Amendment 5(7)), p. 52; NL-05 (2024-2025 EQR Technical Report)

FLAGS: Model form flag for the contract pinpoint.

CFR-438-042: Accreditation status review and posting

CITATION: 42 CFR 438.332

TOPIC: Accreditation status review and posting

OBLIGATED LEVEL: MCO/plan

CADENCE: RECURRING - Website updated at least annually

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to all NC managed care plans

BASIS: Accreditation review and posting are assured: the Title XXI plan states the State will review accreditation status, results, corrective actions and expiration (42 CFR 457.1240(c), cross referencing 438.332(a) and (b)), and assures it will make each plan's accreditation status available on the 438.10(c)(3) website, including whether the plan is accredited and the accrediting entity, program and level, updated at least annually (H-022 p. 58); NCQA is the State-selected accrediting

organization in the credentialing policy (H-052 p. 230), and the Department reviews accreditation reports in its oversight (H-122 p. 60).

RECORD LOCATION: H-022 (Title XXI Child Health Plan amendment 22-0013), p. 58; H-052 (Tailored Plan Contract Amendment 2), p. 230; H-122 (Managed Care Quality Strategy 2023), p. 60

SECTION 5D FACE

UNCOVERED ELEMENT: The posting itself on the Medicaid managed care website: no held passage shows the accreditation status page as posted for the Medicaid plans, and the assurance of record sits in the Title XXI plan.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Post each Medicaid plan's accreditation status, entity, program and level on the managed care website.

QUESTION: Where is the current accreditation status of each Medicaid plan posted?

CFR-438-043: Managed care State quality strategy

CITATION: 42 CFR 438.340

TOPIC: Managed care State quality strategy

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - Review and update at least every 3 years; submit to CMS initially, every 3 years, and on significant changes

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually, at least every 3 years, every 3 years) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies: NC must maintain a managed care quality strategy under 438.340

BASIS: The strategy exists and its development is documented: the NC Medicaid Managed Care Quality Strategy (April 11, 2023) states the steps taken to receive input consistent with 42 CFR 438.340(c), including consultation with the Medical Care Advisory Committee and consultation with the EBCI and the CIHA under the tribal consultation policy, with the final strategy made available on the Department's website upon CMS approval (H-122 pp. 1 and 17).

RECORD LOCATION: H-122 (Managed Care Quality Strategy 2023), pp. 1 and 17

SECTION 5D FACE

UNCOVERED ELEMENT: Currency and posting of the current strategy: CMS approved the 2025 Quality Strategy and a July 1, 2025 bulletin stated NCDHHS published it on the Quality Management and Improvement page, but that page carries no Quality Strategy document link and the 2025 document could not be acquired from any host (NL-06 search record). The held

strategy of record remains the 2023 edition, so the current strategy as published cannot be read.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Post the CMS-approved 2025 Quality Strategy at the location the bulletin named.

QUESTION: Where is the 2025 Quality Strategy document posted?

FLAGS: Conflict flagged: the July 1, 2025 bulletin says the strategy is published on the Quality Management and Improvement page; the page carries no such link (NL-06). Graded on the stronger evidence: the document is not in the public record as held.

CFR-438-044: External quality review — annual EQR by qualified EQRO

CITATION: 42 CFR 438.350, 42 CFR 438.354, 42 CFR 438.356

TOPIC: External quality review — annual EQR by qualified EQRO

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Annual EQR for each plan; EQRO procurement per contract cycle

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to all NC managed care programs

BASIS: Annual EQR by a qualified EQRO operates: HSAG, identified on the report's face as the Department's EQRO, prepared the annual EQR technical report for the 2024-2025 period covering the Standard Plans, PIHPs and Tailored Plans, performing the mandatory activities of 438.350(a) and 438.358, including validation of performance improvement projects, validation of performance measures, compliance review, and validation of network adequacy under CMS EQR Protocol 4; the report states no health plans were exempt (NL-05 pp. 4, 10, 48 and Appendix A p. 147).

RECORD LOCATION: NL-05 (2024-2025 EQR Technical Report, HSAG, April 2026), pp. 4, 10, 48, 147

SECTION 5D FACE

UNCOVERED ELEMENT: The EQRO qualification and contract elements: 438.354 (EQRO qualifications) and 438.356 (required EQRO contract provisions, including independence from the plans reviewed) are not stated in any held document; the EQRO contract is not held.

OWNER LEVEL: the EQRO

ACTION: Publish the EQRO contract or a summary showing the 438.354 qualifications and 438.356 provisions.

QUESTION: Where is the EQRO contract published, and how are HSAG's qualifications and independence documented?

CFR-438-045: EQR annual technical report — finalization, posting, CMS notice

CITATION: 42 CFR 438.364

TOPIC: EQR annual technical report — finalization, posting, CMS notice

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Annual; finalized and posted by April 30; CMS notified within 14 calendar days of posting; 5 years of reports maintained

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to the annual EQR technical report

BASIS: The report itself carries the 438.364 content: it states that 438.364 requires an annual independent technical report describing how data from all 438.358 activities were aggregated and analyzed, with conclusions on quality, timeliness and access (NL-05 p. 4); it describes the four-step aggregation method per 438.364(a)(1) (p. 7); and its Appendix F maps every required 438.364 element to the report page where it appears (pp. 223-224). The Quality Strategy states the EQRO's findings go into an annual technical report posted on the State's website (H-122 p. 48), and the report was acquired from public posting.

RECORD LOCATION: NL-05 (2024-2025 EQR Technical Report), pp. 4, 7, 223-224; H-122 (Managed Care Quality Strategy 2023), p. 48

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** Two elements are not evidenced: notice to CMS in CMS's prescribed form and manner within 14 calendar days of web posting (438.364(d)), and the April 30 submission element, which the report's own Appendix F records as 'NA' (item 1, p. 223).
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the CMS notice record for the current technical report and confirm the submission date against April 30.
>
> **QUESTION:** When was the current EQR technical report submitted to CMS, and when was CMS notified of its posting?

CFR-438-046: EQR exemptions and nonduplication identification

CITATION: 42 CFR 438.362, 42 CFR 438.360(c)

TOPIC: EQR exemptions and nonduplication identification

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Annual website identification; quality-strategy update on the triennial cycle

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to EQR exemptions and nonduplication

BASIS: The exemption side is carried for the current period: the EQR technical report states 'No health plans were exempt from mandatory EQR activities' (NL-05 p. 10), and its Appendix F carries the 438.364 reporting element for exemptions (names of exempt MCOs with exemption period dates, or that none are exempt) at item 13 (p. 224). The Title XXI plan carries the 438.360 and 438.362 pinpoints in its EQR sections (H-022).

RECORD LOCATION: NL-05 (2024-2025 EQR Technical Report), pp. 10 and 224; H-022 (Title XXI Child Health Plan amendment 22-0013), EQR sections

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** Nonduplication under 438.360(c): no held document identifies any accreditation or other review the State uses in lieu of an EQR activity, or states that none is used; and because no exemption was granted in the period, the 438.362 exemption determination (two-year period, findings of good standing) is not documented anywhere in the held record.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the State's nonduplication position and, if any exemption is ever granted, the 438.362 determination.
>
> **QUESTION:** Does NC use any review in lieu of an EQR activity under 438.360, and where is that stated?

CFR-438-047: EQRO contract CMS approval before claiming 75% FFP

CITATION: 42 CFR 438.370(c)

TOPIC: EQRO contract CMS approval before claiming 75% FFP

OBLIGATED LEVEL: federal-facing state report

CADENCE: EVENT-TRIGGERED - Before claiming 75% FFP on each EQRO contract

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies if NC claims 75 percent FFP for EQRO activities

BASIS: No NC evidence that the EQRO contract was submitted to and approved by CMS before claiming the 75 percent FFP rate under 438.370(c), and no evidence of the rate at which NC claims EQRO costs, was found in the held public corpus.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the CMS approval of the EQRO contract and the FFP rate claimed for EQRO activities.
>
> **QUESTION:** Has CMS approved the EQRO contract under 438.370(c), and at what rate are EQRO costs claimed?

SEARCHES RECORDED: Full held corpus and cure acquisitions searched for 438.370, EQRO contract approval, and 75 percent FFP for external quality review; no passage carries the approval or the claiming rate.

CFR-438-048: Medicaid managed care quality rating system (MAC QRS)

CITATION: 42 CFR 438.505, 42 CFR 438.510, 42 CFR 438.515, 42 CFR 438.520, 42 CFR 438.535

TOPIC: Medicaid managed care quality rating system (MAC QRS)

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - Implemented by 2028-12-31; ratings calculated and displayed annually; annual CMS report

EVIDENCE CLASS: GOVERNING / Anchor: Partially unresolved — a September 1, 2028 date appears in the row text but its operative clause was not isolated in this pass; the Dec 31, 2028 implementation date governs and is already calendared. The September 1 item is NOT calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies: NC must operate a Medicaid managed care quality rating system

BASIS: A State rating practice exists in form: the State publishes star ratings for plans derived from CAHPS results benchmarked against NCQA Quality Compass national percentiles (H-062 pp. 8-9), and the EQR technical report publishes comparative star rating tables by plan and population (NL-05, comparative statewide results).

RECORD LOCATION: H-062 (PHP Performance Metrics Report), pp. 8-9; NL-05 (2024-2025 EQR Technical Report), comparative results tables

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The Medicaid managed care quality rating system of 438.505-438.535 as such: adoption of the CMS MAC QRS framework or a CMS-approved alternative methodology

(438.515), calculation of ratings on the mandatory QRS measure set, and display of the QRS ratings on the 438.10(c)(3) website in the QRS structure. The stars read in the held record are NCQA CAHPS benchmarking, not MAC QRS ratings.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the State's MAC QRS implementation position: the framework adopted, the measure set, and where ratings will display.

QUESTION: Has NC adopted the CMS MAC QRS framework or an approved alternative, and when will QRS ratings post?

FLAGS: Flag: CAHPS star ratings in the held record must not be read as MAC QRS ratings.

CFR-438-049: Screen, enroll, and revalidate all network providers

CITATION: 42 CFR 438.602(b), 42 CFR 438.608(b)

TOPIC: Screen, enroll, and revalidate all network providers

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous screening/enrollment; periodic revalidation per part 455; 120-day provisional window

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to all network providers of NC managed care plans

BASIS: State screening and enrollment as the gateway is carried: the Department serves as gatekeeper by screening providers for enrollment, assigning risk categories, collecting and evaluating ownership and control disclosure forms, performing monthly screenings of all Medicaid-enrolled providers against the Social Security Administration Death Master File, NPPES, the List of Excluded Individuals and Entities, the System for Award Management and the Department's Excluded Provider List, and criminal background checks; providers must be enrolled in NC Medicaid and have gone through the centralized credentialing verification program to participate in plan networks (H-122 p. 64); and Tailored Plans are prohibited from contracting with providers not enrolled with the Department consistent with Part 455 Subparts B and E (H-052 p. 231).

RECORD LOCATION: H-122 (Managed Care Quality Strategy 2023), p. 64; H-052 (Tailored Plan Contract Amendment 2), p. 231

SECTION 5D FACE

UNCOVERED ELEMENT: Revalidation of network providers on the 438.602(b) cycle as an evidenced State act, in particular for providers who serve only through a plan network, is not pinpointed in the held passages; the passages carry screening and enrollment, not the revalidation cadence.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the revalidation cycle and completion reporting for network-only providers.

QUESTION: How are plan-only network providers revalidated, and where is completion reported?

CFR-438-050: Monthly federal database checks on plans, subcontractors, owners, agents

CITATION: 42 CFR 438.602(d)

TOPIC: Monthly federal database checks on plans, subcontractors, owners, agents

OBLIGATED LEVEL: MCO/plan

CADENCE: RECURRING - At contracting and at least monthly thereafter

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (monthly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to the plans, their subcontractors, and persons with ownership or control interests

BASIS: Federal database checks operate: the Medicaid Direct MCPAR records, consistent with 42 CFR 455.436 and 438.602, that the State must confirm the identity and determine the exclusion status of the MCO, PIHP or PAHP, any subcontractor, and any person with an ownership or control interest or who is an agent or managing employee, through routine checks of Federal databases, and answers that no excluded person or entity was found in the reporting year (H-064 indicators BX.8a-BX.9); for providers, the checks are monthly against the five named lists (H-122 p. 64).

RECORD LOCATION: H-064 (Medicaid Direct PIHP MCPAR 2024), indicators BX.8a-BX.9 at pp. 9-10; H-122 (Managed Care Quality Strategy 2023), p. 64

SECTION 5D FACE

UNCOVERED ELEMENT: The monthly cadence of 438.602(d) for the plan, subcontractor and owner checks themselves: the MCPAR describes those checks as routine without stating they are monthly; the monthly cadence read in the record attaches to provider screening.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: State the cadence of the plan-level federal database checks in the MCPAR or program integrity policy.

QUESTION: Are the 438.602(d) checks of plans, subcontractors and owners run monthly?

CFR-438-051: Ownership and control disclosure review

CITATION: 42 CFR 438.602(c), 42 CFR 438.608(c)

TOPIC: Ownership and control disclosure review

OBLIGATED LEVEL: agency

CADENCE: RECURRING - At contracting and upon disclosure updates; 60-day excess-payment reporting

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to plans and providers whose ownership disclosures the State reviews

BASIS: Disclosure collection and evaluation are carried for providers (the Department collects and evaluates providers' ownership and control disclosure forms, H-122 p. 64), and plans must submit information on ownership and control described in 42 CFR Part 455 Subpart B to the State (H-022 section 3.10.12).

RECORD LOCATION: H-122 (Managed Care Quality Strategy 2023), p. 64; H-022 (Title XXI Child Health Plan amendment 22-0013), section 3.10.12 at p. 51

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** Two elements fail or are unevidenced: the State's review of plan-level ownership and control disclosures under 438.602(c) and 438.608(c) as an evidenced act was not read; and the related website posting of 5 percent or more ownership interests is affirmatively not made (the State answered No at MCPAR indicator BX.9a, H-064 p. 10).
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the plan-level disclosure review practice and make the 438.602(g)(3) ownership posting.
>
> **QUESTION:** Where are plan ownership disclosures reviewed and recorded, and when will the names be posted?

CFR-438-052: Independent audit of encounter and financial data (triennial)

CITATION: 42 CFR 438.602(e)

TOPIC: Independent audit of encounter and financial data (triennial)

OBLIGATED LEVEL: MCO/plan

CADENCE: RECURRING - At least every 3 years per plan

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (at least every 3 years, every 3 years) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract

apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to encounter and financial data submitted by all NC plans

BASIS: Audit activity under 438.602(e) is recorded for the period: the Medicaid Direct MCPAR answers the periodic audits indicator by stating that the encounter data validation process is completed with the external quality review organization HSAG, that DHHS internal audit has also reviewed the encounter data validation reports, and that External Quality Review Reports are posted by plan on the State website, with the link given (H-064 indicator BX.10).

RECORD LOCATION: H-064 (Medicaid Direct PIHP MCPAR 2024), indicator BX.10 at p. 10

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The audit as 438.602(e) writes it: an independent audit, at least once every 3 years, of the accuracy, truthfulness and completeness of both encounter and financial data, for each program. The held answer evidences validation activity in one reporting year for one program (Medicaid Direct PIHP) and an internal audit review of validation reports, not a triennial independent audit report covering financial data for all programs.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the triennial independent audit reports for encounter and financial data by program.
>
> **QUESTION:** When was the last 438.602(e) independent audit completed for each program, and where are the reports?

CFR-438-053: Whistleblower intake and investigation

CITATION: 42 CFR 438.602(f)

TOPIC: Whistleblower intake and investigation

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Upon receipt of whistleblower information

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to the State's whistleblower intake under 438.602(f)

BASIS: The contract side is carried as a deliverable: the Tailored Plan contract requires the plan to develop and submit a Whistleblower Policy related to whistleblower protections within 90 days of contract award (H-052 deliverables table, p. 136), and the model contracts carry the 438.602 pinpoints.

RECORD LOCATION: H-052 (Tailored Plan Contract Amendment 2), p. 136

SECTION 5D FACE

UNCOVERED ELEMENT: The State-side system of 438.602(f): procedures for receiving whistleblower reports, protecting the identity of whistleblowers, and investigating, run by the State, are not described in any held passage; the held evidence is a plan policy deliverable, not the State's intake and investigation process.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the State's whistleblower intake, identity protection and investigation procedures.

QUESTION: Where do whistleblowers report to the State, and how are reports investigated?

CFR-438-054: Required plan data submissions and CEO/CFO certification

CITATION: 42 CFR 438.604, 42 CFR 438.606

TOPIC: Required plan data submissions and CEO/CFO certification

OBLIGATED LEVEL: MCO/plan

CADENCE: RECURRING - With each data submission; overpayment report annually

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to all data submitted by NC plans to the State

BASIS: Certification is carried in the Tailored Plan contract: the plan must provide certification by its CEO, CFO, or an individual reporting to either, concurrently with submission of all data, documentation or information requiring certification, that the information is accurate, complete and truthful, in accordance with 42 CFR 438.606 (H-052 p. 15). Required data submissions are carried in the Standard Plan reporting restatement, including the Annual Overpayment Recoveries Report under 438.604(a)(7) (H-046 p. 86), and the MCPAR records the State's monitoring of plan overpayment reporting (H-064 indicator BX.5).

RECORD LOCATION: H-052 (Tailored Plan Contract Amendment 2), p. 15; H-046 (PHP Contract Amendment 8), p. 86; H-064 (Medicaid Direct PIHP MCPAR 2024), indicator BX.5

SECTION 5D FACE

UNCOVERED ELEMENT: The 438.604(a) data categories as a complete set in a Medicaid-side instrument: the fullest enumeration read is the Title XXI plan assurance list (H-022 section 3.10.12); and certification practice under the Standard Plan base contract cannot be read because the base contract is not in the public record (NL-01).

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the data submission and certification schedule for each program.

> **QUESTION:** Where is the complete 438.604 data list and 438.606 certification requirement published for the Standard Plans?

FLAGS: Model form flag for the Tailored Plan certification clause.

CFR-438-055: Enrollee encounter data submission to CMS (T-MSIS)

CITATION: 42 CFR 438.818

TOPIC: Enrollee encounter data submission to CMS (T-MSIS)

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - Ongoing T-MSIS encounter data submissions

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies: the State must submit enrollee encounter data to CMS

BASIS: Encounter data flows to the State in specified forms (ASC X12 837 and NCPDP, H-053 p. 58) and is validated (H-064). Submission onward to CMS is assured in two places: the Title XXI plan assures plans submit encounter data in the form and manner described in 42 CFR 438.818 (H-022 section 3.10.12), and the 1115 approval commits the State to ensure that all section 1115, Transformed Medicaid Statistical Information System (T-MSIS), and other agreed data elements are provided by the State (H-025 STC 15.4).

RECORD LOCATION: H-053 (Tailored Plan Contract Amendment 5(7)), p. 58; H-022 (Title XXI Child Health Plan amendment 22-0013), section 3.10.12; H-025 (1115 extension approval package), STC 15.4

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The enrollee encounter data submission to CMS as a recurring evidenced act under 438.818, with the data elements and completeness the section requires, is not shown in any held document; the held evidence is the plan-to-State flow plus assurances.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the T-MSIS encounter submission reporting for the managed care programs.
>
> **QUESTION:** Where is NC's 438.818 encounter data submission to CMS reported?

CFR-438-056: Program integrity arrangements — fraud/waste/abuse detection via contract

CITATION: 42 CFR 438.608(a)

TOPIC: Program integrity arrangements — fraud/waste/abuse detection via contract

OBLIGATED LEVEL: MCO/plan

CADENCE: RECURRING - Continuous; overpayment reports within 30 calendar days of identification/recovery

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to all NC managed care plans via contract, with State oversight

BASIS: Program integrity arrangements operate on the record at both levels. Plan side: PIHPs comply with contract language requiring a compliance plan that meets 42 CFR 438.608 and monthly reporting of provider cases opened, overpayments identified and collected, terminations and fraud referrals (H-133 pp. 6, 8). State side: the Department performs a full review of each plan's compliance program and program integrity activities at least every three years through EQR and annual tracer audits of each plan against its Department-approved Fraud Prevention Plan (H-122 p. 65); OCPI ran cross-payer payment integrity analyses in the reporting year and presented results to the plans at quarterly SIU oversight (H-064 indicator BX.1); and the EQRO conducted plan program integrity reviews in the period (NL-05).

RECORD LOCATION: H-133 (CMS Focused Program Integrity Review of North Carolina, May 2016), pp. 6 and 8; H-122 (Managed Care Quality Strategy 2023), p. 65; H-064 (Medicaid Direct PIHP MCPAR 2024), indicator BX.1; NL-05 (2024-2025 EQR Technical Report)

FLAGS: H-133 is a 2016 federal review; the current-period operating evidence is H-064 and NL-05, with the Quality Strategy stating the standing machinery.

CFR-438-057: Overpayment recovery policies, annual report, and rate-setting use

CITATION: 42 CFR 438.608(d)

TOPIC: Overpayment recovery policies, annual report, and rate-setting use

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Annual overpayment report to the State; recovery info used in each rating period's rate development

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to all NC managed care plans via contract, with State reporting

BASIS: The contract standard and reporting are carried: the Medicaid Direct MCPAR locates the overpayment standard at contract Section 4.J.1.E as required by 438.608(d)(1)(i), and describes it: prompt reporting of all overpayments identified or recovered, specifying those due to potential fraud; recovery by demand for refund or offset of future payments, on not less than 30 calendar days' written notice to the provider identifying the claim and reason; recovery within two years of the original claim payment absent fraud (H-064 indicators BX.3-BX.4). Reporting runs through the Annual Overpayment Recoveries Report and the Quarterly FWA Provider Report, reviewed in monthly oversight meetings (BX.5), and the PIHP must coordinate with the Department so overpayment and underpayment recovery is accurately reflected in MLR calculations and capitation rate setting (BX.4). PIHP monthly reporting of overpayments identified and collected is also recorded in the CMS review (H-133 p. 6).

RECORD LOCATION: H-064 (Medicaid Direct PIHP MCPAR 2024), indicators BX.3, BX.4 and BX.5 at pp. 8-9; H-133 (CMS Focused Program Integrity Review, May 2016), p. 6

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The annual report of plan overpayment recoveries as submitted onward, and the rate-setting use of recoveries documented inside an actual rate certification: the certifications are not held (NL-17), so the (d)(3) use element is carried only by the contract coordination clause, not by a certification read.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the annual overpayment recoveries report and show recovery use in the next rate certification.
>
> **QUESTION:** Where is the annual overpayment recoveries report published?

CFR-438-058: Response to prohibited affiliations

CITATION: 42 CFR 438.610(d)

TOPIC: Response to prohibited affiliations

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Upon finding of prohibited-affiliation noncompliance

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies when a plan has a prohibited affiliation under 438.610

BASIS: Prohibited affiliation machinery is carried at the plan level: the Tailored Plan contract carries the 438.610 provisions (H-052 p. 53) and requires that the plan not be controlled by a sanctioned

individual, that it screen subcontractors against the Exclusion Lists, and that on identifying an Excluded Person it take appropriate action, which may include termination of the relationship and ceasing payments, and report the person's information to the Department within two business days (H-052 p. 21). The Medicaid Direct MCPAR carries the 438.610 pinpoint in its program integrity sections (H-064).

RECORD LOCATION: H-052 (Tailored Plan Contract Amendment 2), pp. 21 and 53; H-064 (Medicaid Direct PIHP MCPAR 2024)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** 438.610(d) as a State act: upon receiving notice from the Secretary that a plan employs or contracts with an excluded individual or entity (or one owned or managed by such a person), the State must terminate the plan contract or require the plan to terminate the affiliation within the specified period. No held passage states the State's response procedure or timeframe.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the State's 438.610(d) response procedure and timeframe.
>
> **QUESTION:** What does DHB do, and within what time, when CMS gives notice of a prohibited affiliation?

CFR-438-059: Intermediate sanctions regime — establishment and imposition

CITATION: 42 CFR 438.700, 42 CFR 438.702

TOPIC: Intermediate sanctions regime — establishment and imposition

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Upon determination of a sanctionable violation

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies: NC must establish and may impose intermediate sanctions

BASIS: The regime is established and used: the Quality Strategy lists the sanction grounds in the terms of 438.702 (fails substantially to provide medically necessary services, imposes premiums or charges in excess of those permitted, and the remaining grounds) with intermediate sanctions and liquidated damages available (H-122 p. 65); the Standard Plan contract's sanctions section provides civil monetary penalties per 438.704, temporary management per 438.706(a), notice to members of their right to terminate enrollment without cause, suspension of new enrollment including default enrollment, suspension, recoupment or withholding of payment, and suspension of marketing (H-138 p. 5); and sanctions were imposed and reported in the MCPARs, including AmeriHealth

$35,000 for October 2023 to June 2024 and $55,000 for July to September 2024, both remediated (H-138 p. 10).

RECORD LOCATION: H-122 (Managed Care Quality Strategy 2023), p. 65; H-138 (Lessons Learned from North Carolina's MCPAR Reports, Mar. 26, 2026), pp. 5 and 10

SECTION 5D FACE

UNCOVERED ELEMENT: The sanctions actually imposed in the held record are liquidated damages under the contract; no held passage shows an intermediate sanction under 438.702 itself having been imposed, and the MCPAR analysis notes that, apart from corrective action plans, none of the reported sanctions fell in the non-monetary categories (H-138 p. 15).

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Report intermediate sanctions separately from liquidated damages in the MCPARs and state when each will be used.

QUESTION: When will DHB impose a 438.702 intermediate sanction rather than liquidated damages?

CFR-438-060: Temporary management of MCO

CITATION: 42 CFR 438.706

TOPIC: Temporary management of MCO

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Upon finding of repeated substantive failures

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies when the 438.706 conditions for temporary management are met

BASIS: Temporary management is an available, contract-based sanction: the Standard Plan contract provides for appointment of temporary management of the plan in accordance with 42 CFR 438.706(a) among its intermediate sanctions (H-138 p. 5).

RECORD LOCATION: H-138 (Lessons Learned from North Carolina's MCPAR Reports, Mar. 26, 2026), p. 5

SECTION 5D FACE

UNCOVERED ELEMENT: The 438.706 elements beyond availability: the mandatory appointment triggers, the notice to enrollees and their right to disenroll without cause during temporary management, and the conditions for ending it. No instance of temporary management appears in the held record; the MCPAR analysis recommends the State study non-monetary sanctions including temporary management, indicating none were reported (H-138 p. 15).

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the temporary management procedure, including enrollee notice and disenrollment rights.

QUESTION: Under what findings would DHB appoint temporary management, and how would enrollees be notified?

FLAGS: Evidence is a secondary analysis describing the Standard Plan contract's sanctions section; the base contract itself is not in the public record (NL-01).

CFR-438-061: Notice of sanction and pre-termination hearing

CITATION: 42 CFR 438.710

TOPIC: Notice of sanction and pre-termination hearing

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Before each sanction imposition or contract termination

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies before the State imposes sanctions or terminates a plan contract

BASIS: The notice and hearing assurances are stated: before it imposes intermediate sanctions the State gives the affected entity timely written notice, and if it intends to terminate an MCO, PCCM or PCCM entity it provides a pre-termination hearing and written notice of the decision as specified in 42 CFR 438.710(b), with enrollee notice of the termination and their options consistent with 438.10 (Title XXI plan sections 3.11.5-3.11.6, cross referencing 438.710, H-022 p. 53).

RECORD LOCATION: H-022 (Title XXI Child Health Plan amendment 22-0013), sections 3.11.5-3.11.6 at p. 53

SECTION 5D FACE

UNCOVERED ELEMENT: The Medicaid-side instrument: the held assurance sits in the Title XXI plan, and the hearing particulars of 438.710(b) (notice of intent stating the reason and the time and place of the hearing, and the post-hearing decision notice) were not read in an NC Medicaid document.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Pinpoint the 438.710 notice and hearing procedure in the Medicaid contracts or policy.

QUESTION: Where is the pre-termination hearing procedure for Medicaid plans published?

CFR-438-062: Notice to CMS of sanctions imposed or lifted

CITATION: 42 CFR 438.724

TOPIC: Notice to CMS of sanctions imposed or lifted

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Within 30 days of imposing or lifting a sanction

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies whenever NC imposes or lifts a sanction

BASIS: The duty is assured: the State will give CMS written notice that complies with 42 CFR 438.724 whenever it imposes or lifts a sanction for one of the violations listed in 42 CFR 438.700 (Title XXI plan section 3.11.7, cross referencing 438.724, H-022 p. 53). Sanctions were in fact imposed in the window and reported in the MCPARs (H-138 pp. 10, 12).

RECORD LOCATION: H-022 (Title XXI Child Health Plan amendment 22-0013), section 3.11.7 at p. 53; H-138 (Lessons Learned from North Carolina's MCPAR Reports), pp. 10 and 12

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** An actual 438.724 notice: no held document shows notice to CMS within 30 days of a sanction's imposition or lifting, naming the plan, the kind of sanction and the reason, for any of the sanctions the MCPARs report.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the 438.724 notices given to CMS for the sanctions reported in the 2024 and 2025 MCPARs.
>
> **QUESTION:** Were 438.724 notices sent for the AmeriHealth sanctions, and on what dates?

CFR-438-063: State plan sanctions-monitoring plan

CITATION: 42 CFR 438.726

TOPIC: State plan sanctions-monitoring plan

OBLIGATED LEVEL: agency

CADENCE: FIXED - State plan provision in effect continuously

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies: the State plan must specify the sanctions and monitoring the State will use

BASIS: The sanctions and monitoring machinery the section contemplates exists and operates (Quality Strategy sanctions and monitoring sections, H-122 pp. 60-65; contract sanctions per H-138 p. 5; sanctions reported in the MCPARs).

RECORD LOCATION: H-122 (Managed Care Quality Strategy 2023), pp. 60-65; H-138 (Lessons Learned from North Carolina's MCPAR Reports), p. 5

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The State plan specification itself: the held Title XIX plan text was searched for 438.726 and for a sanctions monitoring plan and neither was found; the plan's Section 4.29 covers conflicts of interest, and the only sanctions-adjacent plan page is an obsolete PCCM-era page citing 438.730 (H-001 p. 1136).
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Amend the State plan or publish the specification that carries 438.726 for the managed care program.
>
> **QUESTION:** Where does the State plan carry the 438.726 sanctions specification?

SEARCHES RECORDED: Held Title XIX plan (H-001) searched in full for 438.726, intermediate sanctions, and a sanctions monitoring plan; not found.

CFR-438-064: Exclusion of prohibited entities from contracts (FFP condition)

CITATION: 42 CFR 438.808

TOPIC: Exclusion of prohibited entities from contracts (FFP condition)

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Applied to each contract; continuous exclusion

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies as a condition of FFP in NC managed care contracts

BASIS: The exclusion is carried at the plan level: the Tailored Plan contract states the plan shall not be controlled by a sanctioned individual, citing 42 CFR 438.808(a), requires screening of subcontractors against the Exclusion Lists so the plan does not pay Federal or State funds to excluded persons or entities, and requires appropriate action and a report to the Department within two business days when an excluded person is identified (H-052 p. 21); the same provision appears in the Amendment 5(7) restatement (H-053 p. 14) and the 438.808 citation is carried in the State Plan (H-001).

RECORD LOCATION: H-052 (Tailored Plan Contract Amendment 2), p. 21; H-053 (Tailored Plan Contract Amendment 5(7)), p. 14; H-001 (Title XIX State Plan), 438.808 citation

SECTION 5D FACE

UNCOVERED ELEMENT: 438.808 as a State contract-eligibility condition across its entity classes (entities that could be excluded under section 1128(b)(8) as controlled by a sanctioned individual, and entities with substantial contractual relationships with excluded entities) stated as the State's own rule, beyond the plan-level clause read.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: State the 438.808 eligibility condition in the contracting policy for all three entity classes.

QUESTION: Where does the State state that no FFP will be paid under a contract with a 438.808-prohibited entity?

FLAGS: Model form flag for the contract clauses.

CFR-438-065: Mental health parity compliance documentation and website posting

CITATION: 42 CFR 438.915

TOPIC: Mental health parity compliance documentation and website posting

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Posted by 2017-10-02; updated before any benefit change

EVIDENCE CLASS: GOVERNING / Anchor: Verified 2026-10-20: the Oct 2 date in this row is the one-time Oct 2, 2017 posting deadline (past); the live duty is to update the parity documentation before any benefit change. No annual Oct 2 deadline exists. Not calendared.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to MCO, PIHP and PAHP delivery of mental health and substance use disorder benefits

BASIS: Parity action on the benefit package is carried: SPA NC-25-0009 (ABP Parity), submitted March 24, 2025, removes nonquantitative treatment limitations (prior authorization, concurrent review and reauthorization requirements) for psychotherapy and mobile crisis management from the Essential Health Benefit mental health and substance use disorder services to align with the Medicaid State Plan (H-005).

RECORD LOCATION: H-005 (SPA NC-25-0009, ABP parity), transmittal and summary

SECTION 5D FACE

UNCOVERED ELEMENT: The 438.915 documentation itself: the State's documentation of how it ensures compliance with the parity requirements across the MCO, PIHP, PAHP and fee-for-service delivery systems (the comparative analyses), and its posting on the State website, are not in the held record; the held SPA addresses the alternative benefit plan package, not managed care parity documentation.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the 438.915 parity compliance documentation for the managed care delivery systems.

QUESTION: Where is NC's mental health parity documentation for managed care posted?

CFR-438-066: Marketing material review with advisory committee consultation

CITATION: 42 CFR 438.104(c)

TOPIC: Marketing material review with advisory committee consultation

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Each marketing material review

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat A)

APPLICABILITY (DETERMINATIONS FILE): Applies to State review of plan marketing materials

BASIS: State review of marketing operates on a stated clock: Tailored Plan marketing materials must be submitted to the Department for approval eight weeks prior to use (H-052 deliverables table, p. 137); the Standard Plan contract adopts the 438.104 definitions of marketing and marketing materials (H-046); and the State Plan carries the 438.104 citation (H-001).

RECORD LOCATION: H-052 (Tailored Plan Contract Amendment 2), p. 137; H-046 (PHP Contract Amendment 8), definitions; H-001 (Title XIX State Plan), 438.104 citation

SECTION 5D FACE

UNCOVERED ELEMENT: The 438.104(c) element itself: consultation with the Medical Care Advisory Committee, or an advisory committee with similar membership, in the State's review of marketing materials. No held passage states that consultation; the held evidence shows Department approval timing only.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Add MCAC consultation to the marketing review procedure and publish it.

QUESTION: Does the MCAC review managed care marketing materials, and where is that recorded?

CFR-440-001: Required services for the categorically needy

CITATION: 42 CFR 440.210

TOPIC: Required services for the categorically needy

OBLIGATED LEVEL: agency

CADENCE: FIXED - One-time state plan specification; ongoing coverage obligation. Applies continuously to each covered pregnancy/postpartum episode.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: NC covers the categorically needy under the state plan

BASIS: Plan section 3.1(a)(1) carries the provision: services for the categorically needy include each item or service in section 1905(a)(1) through (5) and (21) as defined in 42 CFR Part 440 Subpart A; nurse-midwife services under 1905(a)(17) as defined at 440.165; pregnancy related services including family planning and postpartum services for a 60-day period beginning the day pregnancy ends plus the remaining days of that month, for women eligible and receiving assistance on the day pregnancy ends; and services for conditions that may complicate pregnancy. Attachment 3.1-A lists the services provided.

RECORD LOCATION: H-001 (Title XIX State Plan, H-001), section 3.1(a)(1), PDF pp.50-52; Attachment 3.1-A service list at p.446

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 440.210 elements: 1905(a)(1)-(5) and (17) services, pregnancy related and 60-day postpartum coverage, complicating-condition services.

FLAGS: Plan pages are TN 92-01 vintage (approval 10-21-92); the held compilation is the plan of record read for this row.

CFR-440-002: Required services for the medically needy

CITATION: 42 CFR 440.220

TOPIC: Required services for the medically needy

OBLIGATED LEVEL: agency

CADENCE: FIXED - One-time state plan specification; ongoing coverage obligation.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: NC plan covers the medically needy (plan section 3.1(a)(2) checked yes)

BASIS: Plan section 3.1(a)(2) carries the medically needy minimums: where IMD or ICF services are provided to any medically needy group, each group receives either 1905(a)(1) through (5) and (17) services or seven of the 1905(a)(1) through (20) services, as defined in Part 440 Subpart A; prenatal care and delivery services for pregnant women; pregnancy related and 60-day postpartum services; ambulatory services for under-18 and institutional-entitled recipients; home health for recipients

entitled to nursing facility services; IMD services for individuals over 65; ICF services; and inpatient psychiatric services for individuals under 21.

RECORD LOCATION: H-001 (Title XIX State Plan), section 3.1(a)(2), PDF pp.53-55

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 440.220 elements: the IMD/ICF trigger minimum package, prenatal and delivery, postpartum, home health for NF-entitled recipients.

CFR-440-003: Sufficiency of amount, duration, and scope

CITATION: 42 CFR 440.230(a)-(d)

TOPIC: Sufficiency of amount, duration, and scope

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Ongoing duty on every coverage determination; plan-level specification maintained continuously.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: ongoing duty on every coverage determination

BASIS: The plan specifies amount, duration and scope service by service in Attachment 3.1-A and 3.1-A.1: each covered service is listed with its limitations, services must be medically necessary and not experimental (Attachment 3.1-A.1 p.545 and throughout), and stated limits carry medical necessity exceptions, for example the 22-visit mandatory services limit at Attachment 3.1-A.1 Page 5, where exceptions may be authorized when additional visits are medically necessary and the limit does not apply to EPSDT eligible children. Limits in the service pages are framed on medical necessity and utilization control, not on diagnosis alone.

RECORD LOCATION: H-001 (Title XIX State Plan), Attachment 3.1-A service list pp.437-446 and Attachment 3.1-A.1, Page 5 at PDF p.545, with service definition pages throughout Attachment 3.1-A.1

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 440.230(a)-(d): plan specification of amount, duration and scope; sufficiency; no denial solely by diagnosis or condition; limits only on medical necessity or utilization control grounds.

CFR-440-004: Prior authorization decision timeframes

CITATION: 42 CFR 440.230(e)(1)-(2)

TOPIC: Prior authorization decision timeframes

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Each prior authorization request; timeframes effective 2026-01-01.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies from 2026-01-01 (89 FR 8981, per the register record)

BASIS: NC carries enforceable authorization decision clocks in managed care: the PHP contract (Amendment 8) imposes liquidated damages for failure to confer a timely response to a service authorization request in accordance with 42 CFR 438.210(d), priced per standard and per expedited request, and the Tailored Plan contract carries the same 438.210(d) damages structure. No held document states the fee-for-service prior authorization decision timeframes and notice duties that 440.230(e)(1)-(2) imposes on the state itself from January 1, 2026.

RECORD LOCATION: H-046 (PHP Contract Amendment 8), Section VI.A Table 1 item 14, p.45; H-052 (Tailored Plan Contract Amendment 2), liquidated damages section, p.241

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The state-side fee-for-service (NC Medicaid Direct) prior authorization decision timeframes and the expedited-request clock under 440.230(e) are not stated in any held document; the contracts read carry the managed care 438.210(d) clocks only.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the fee-for-service prior authorization decision timeframe standard implementing 440.230(e) for NC Medicaid Direct, with the expedited and standard clocks stated in a clinical coverage policy or provider manual.
>
> **QUESTION:** What decision clocks has DHB set for fee-for-service prior authorization under 440.230(e) since January 1, 2026, and where are they published?

SEARCHES RECORDED: Held corpus and cure acquisitions searched for 440.230(e) and for prior authorization decision timeframes: plan (H-001), PHP and Tailored Plan contracts (H-046, H-052, H-053), provider manuals (H-067 to H-072). Only 438.210(d) contract damages language found.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 440.230(e)(1)-(2): state mechanism for timely prior authorization decisions, expedited and standard, effective January 1, 2026.

CFR-440-005: Annual prior authorization metrics reporting

CITATION: 42 CFR 440.230(e)(3)

TOPIC: Annual prior authorization metrics reporting

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Annually by March 31, reporting previous calendar year; first report due March 31, 2027 (covering 2026). Posted on state website.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Prospective** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Prospective: first annual report due March 31, 2027, covering calendar year 2026 (register record, 89 FR 8981)

FEDERAL APPLICABILITY DATE(S): Prospective: first annual report due March 31, 2027, covering calendar year 2026 (register record, 89 FR 8981) Register future date(s): 2027-03-31.

BASIS: The reporting duty is not yet due in the evidence window: the first report, covering calendar year 2026, is due March 31, 2027, and is to be posted on the state website. No metrics report could be held before that date.

RECORD LOCATION: Register record of evidence for CFR-440-005 (first applicable reporting year 2026; due 2027-03-31); no report exists in the held corpus or cure acquisitions

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 440.230(e)(3): annual public reporting of prior authorization metrics by March 31 for the previous calendar year.

FLAGS: Prospective on the first-report date; the underlying timeframe duty it reports on is graded at CFR-440-004.

CFR-440-006: Comparability of services across groups

CITATION: 42 CFR 440.240

TOPIC: Comparability of services across groups

OBLIGATED LEVEL: agency

CADENCE: FIXED - One-time state plan specification; ongoing duty on every coverage/budget decision.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: plan-level specification, ongoing

BASIS: Plan section 3.1(a)(10) carries comparability in terms: services made available to the categorically needy are equal in amount, duration and scope for each categorically needy person; the amount, duration and scope for the categorically needy are equal to or greater than those for the medically needy; services for the medically needy are equal for each person in a medically needy group; and additional pregnancy related coverage is equal for categorically and medically needy (option checked).

RECORD LOCATION: H-001 (Title XIX State Plan), section 3.1(a)(10), PDF p.59

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 440.240(a)-(c) comparability elements as restated on the plan page.

CFR-440-007: Permitted limits on comparability

CITATION: 42 CFR 440.250

TOPIC: Permitted limits on comparability

OBLIGATED LEVEL: agency

CADENCE: FIXED - State plan options exercised where used; ongoing application of chosen limits.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: state plan options exercised where used

BASIS: The plan page on comparability (section 3.1(a)(10)) lists 42 CFR 440.250 among the authorities permitting exceptions, and NC exercises at least one permitted limit in the plan itself: targeted case management is confined to specified target groups in Supplement 1 to Attachment 3.1-A (for example persons with HIV disease, plan pp.502-510, and eligible juveniles, SPA 25-0006). No held document states, provision by provision, which 440.250 permitted limits NC has elected and which it has not.

RECORD LOCATION: H-001 (Title XIX State Plan), p.59 (440.250 cited) and Supplement 1 to Attachment 3.1-A at pp.446 and 502-510; H-016 (SPA 25-0006), Supplement 1 pp.1-2

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** A complete statement of the 440.250 limits NC applies (for example any limit tied to 1915 waivers, section 1925, or section 1932 programs as applied group by group) is not in the held evidence.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State, in the plan or a policy transmittal, which 440.250 permitted limits NC exercises, group by group.
>
> **QUESTION:** Which of the permitted limits in 440.250 does NC actually apply, and where is that election recorded?

SEARCHES RECORDED: Plan comparability and case management pages read (H-001 pp.59, 446, 502-510); SPA 25-0006 (H-016) read; no separate 440.250 election statement found in the full document-axis map for Parts 440-442.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 440.250: the closed set of permitted exceptions to comparability.

CFR-440-008: Limited services for certain aliens

CITATION: 42 CFR 440.255

TOPIC: Limited services for certain aliens

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Each claim/service for affected aliens; ongoing FFP-claiming discipline.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: each claim for an affected individual

BASIS: Plan section 3.1(a)(6), Limited Coverage for Certain Aliens, carries the provision: an alien who is not a qualified alien, or who is a qualified alien not eligible on alienage status, who would otherwise qualify for Medicaid, is provided Medicaid only for treatment of an emergency medical condition, including emergency labor and delivery, as defined in section 1903(v)(3) of the Act. The same limitation appears in the eligibility pages at Attachment 2.6-A.

RECORD LOCATION: H-001 (Title XIX State Plan), section 3.1(a)(6), PDF p.58

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 440.255(a): full benefits barred; emergency medical condition services only, including emergency labor and delivery.

CFR-440-009: Face-to-face encounter before home health / medical equipment

CITATION: 42 CFR 440.70(f)

TOPIC: Face-to-face encounter before home health / medical equipment

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Each initiation of home health services or medical equipment.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Partial** (determiner: NC Cure re-grade seat (CCP))

APPLICABILITY (DETERMINATIONS FILE): Applies: each initiation of home health services or medical equipment

BASIS: The home health element is now largely carried in CCP 3A, Home Health Services, section 5.3.1.1 (printed pp.13-14): the physician shall provide a written attestation statement that face-to-face contact, including by telehealth, was made with the beneficiary; the encounter must occur within the 90 days prior to the start of care or within the 30 days after the start of care; the attestation must be a brief narrative describing the clinical condition and how the condition supports the need for skilled services; the encounter must be with the physician or an allowed non-physician practitioner (a nurse practitioner or clinical nurse specialist working in collaboration with a physician, a certified nurse midwife, or a physician assistant under physician supervision); documenting the encounter requires the encounter date and a brief narrative composed by the certifying physician describing how the clinical condition as seen during the encounter supports the need for skilled services; and a copy of the physician written certification of the face-to-face encounter is kept in the medical record (section 7.7.1). The medical equipment element rests on the DME policy read in batch B: for power wheelchairs, a face-to-face examination before the physician order, documented in a detailed narrative note showing the major reason for the visit was a mobility examination (CCP 5A-4, pp.23-24).

RECORD LOCATION: SUP-CCP-HH (Clinical Coverage Policy 3A, Home Health Services, amended July 1, 2026), section 5.3.1.1 at printed pp.13-14 and section 7.7.1 at printed pp.21-22; H-078 (Clinical Coverage Policy 5A-4, DME), pp.23-24

SECTION 5D FACE

UNCOVERED ELEMENT: Two elements are not stated in terms in the text read: the duty in 440.70(f)(4) for a non-physician practitioner who may not perform the encounter independently to communicate the clinical findings to the ordering physician, and the medical equipment window in 440.70(f)(2) (encounter no more than 6 months before the start of services). The DME text read states the examination must precede the order for power wheelchairs but states no 6-month window and no general medical equipment encounter rule.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: State in CCP 3A the (f)(4) communication step for practitioner-conducted encounters, and state the (f)(2) 6-month window for medical equipment in the DME policy set.

QUESTION: Where does NC state the practitioner-to-ordering-physician communication step and the 6-month medical equipment encounter window?

SEARCHES RECORDED: New evidence read for this row: SUP-CCP-HH sections 5.3.1.1 and 7.7.1; held DME text (H-078) re-read at the face-to-face passage. Batch B corpus searches for face-to-face language (H-001, H-053, H-078) carried forward.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 440.70(f): no payment unless a practitioner documents a face-to-face encounter related to the primary reason for the services; for home health, within 90 days before or 30 days after the start of services; for medical equipment, no more than 6 months before the start of services; performed by a physician or an allowed practitioner listed in (f)(3); clinical findings communicated to the ordering physician where (f)(4) applies; the encounter documented in the beneficiary record; telehealth permitted as the state implements it.

FLAGS: Verdict unchanged from batch B, but the uncovered element is narrowed: batch B found no home health encounter text at all; CCP 3A now carries the home health timing, provider, telehealth and documentation elements.

CFR-440-010: EPSDT and other required benefits in benchmark/ABP coverage

CITATION: 42 CFR 440.345

TOPIC: EPSDT and other required benefits in benchmark/ABP coverage

OBLIGATED LEVEL: agency

CADENCE: FIXED - One-time ABP SPA design; ongoing coverage obligation for ABP enrollees under 21.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: ABP in force since December 1, 2023 (SPA NC-23-0029)

BASIS: NC's ABP exists and is keyed to the state plan: SPA NC-23-0029 defined the ABP for the expansion adult group (approved November 14, 2023, effective December 1, 2023), the ABP pages

in SPA 25-0009 source benefits to State Plan 1905(a), and the 1115 approval package requires EHB services to ABP enrollees to be delivered in compliance with 440.345(c) and 440.395 (STC 9.19(e)). The held ABP pages do not state the 440.345(a) element: that individuals under 21 enrolled in the ABP (the expansion group reaches down to age 19) receive EPSDT under 1905(r).

RECORD LOCATION: H-014 (CMS SPA page, NC-23-0029); H-005 (SPA NC-25-0009), ABP 5 pages; H-025 (1115 approval package), STC 9.19 at printed pp.42-43

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** EPSDT coverage for 19 and 20 year old ABP enrollees under 440.345(a) is not stated in any held ABP page; family planning and other 440.345 benefit assurances are likewise not stated on a held ABP page.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File the approved ABP attachment pages showing the 440.345 assurances, including EPSDT for enrollees under 21.
>
> **QUESTION:** Do the approved ABP pages assure EPSDT for 19 and 20 year old expansion enrollees, and where are those pages posted?

SEARCHES RECORDED: ABP documents read: H-014, H-021 (expansion SPA list), H-005 (ABP pages), H-025 STC 9.19. The ABP SPA attachment itself (the ABP form pages of NC-23-0029) is not held; only the CMS summary page is.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 440.345: ABP coverage must include EPSDT for under-21 enrollees, family planning, and parity under paragraph (c).

CFR-440-011: Public notice before Alternative Benefit Plan SPA

CITATION: 42 CFR 440.386

TOPIC: Public notice before Alternative Benefit Plan SPA

OBLIGATED LEVEL: federal-facing state report

CADENCE: EVENT-TRIGGERED - Each ABP SPA or substantial ABP modification submitted to CMS.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: each ABP SPA or substantial ABP modification

BASIS: NC's public notice practice for SPAs is evidenced: the State Plan Public Notices page carries ten-day postings for SPA series 26-0001 through 26-0008 and the 2026 proposed amendments, and SPA 25-0009, an ABP amendment, was itself acquired from the state agency's ten-day public notice posting for ABP parity. The held copy of H-005 is the signature memorandum and ABP pages, not the notice face, so the 440.386 content elements (description of the ABP change, expected enrollment and expenditure impact, comment process, tribal notice) could not be read for an ABP SPA.

RECORD LOCATION: H-002 (Medicaid State Plan Public Notices page); H-005 (SPA NC-25-0009), collection log note recording acquisition from the ten-day public notice posting

SECTION 5D FACE

UNCOVERED ELEMENT: The text of a public notice for an ABP SPA showing the 440.386 required contents and the comment record is not held.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: File the posted notice face and comment record for the most recent ABP SPA (25-0009) on the row's record.

QUESTION: What did the posted notice for SPA 25-0009 say, and what comments did it draw?

SEARCHES RECORDED: Cure collection logs and the notices page (H-002) read; SPA public notice documents H-016, H-017, H-018, H-019 read for the general notice practice (all non-ABP). No ABP notice face is in the corpus.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 440.386: public notice with stated content, and tribal consultation notice where applicable, before an ABP SPA or substantial modification is submitted.

CFR-440-012: Transportation assurance for benchmark plan enrollees

CITATION: 42 CFR 440.390

TOPIC: Transportation assurance for benchmark plan enrollees

OBLIGATED LEVEL: agency

CADENCE: FIXED - One-time assurance; ongoing transportation coverage obligation for ABP enrollees.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: ABP enrollees, ongoing

BASIS: The general transportation assurance is carried: plan section 3.1(c)(1) provides for assuring necessary transportation of recipients to and from providers under 42 CFR 431.53, with methods in Attachment 3.1-D, and the NC Medicaid Managed Care NEMT Policy (v12, May 7, 2025) states that managed care health plans provide NEMT for their members and local Departments of Social Services provide NEMT for NC Medicaid Direct and Tribal Option members. ABP enrollees sit in the Standard Plans, so the managed care NEMT channel reaches them; but no held ABP page carries the 440.390 assurance in terms for benchmark enrollees.

RECORD LOCATION: H-001 (Title XIX State Plan), section 3.1(c)(1), PDF p.61; H-065 (NEMT Policy page, v12)

SECTION 5D FACE

UNCOVERED ELEMENT: An ABP-specific transportation assurance referencing 440.390 is not on any held ABP page.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Confirm on the ABP record that ABP enrollees receive NEMT through their Standard Plan, citing 440.390.

QUESTION: Is the 440.390 assurance stated in the approved ABP attachment, or only implied by the general 431.53 assurance?

SEARCHES RECORDED: ABP documents (H-014, H-005, H-021, H-025) searched for transportation assurance; plan transportation page and NEMT policy page read.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 440.390: if the ABP does not include transportation, the state must assure access consistent with 431.53 and 440.170(a).

CFR-440-013: Mental health / substance use disorder parity in ABPs

CITATION: 42 CFR 440.395

TOPIC: Mental health / substance use disorder parity in ABPs

OBLIGATED LEVEL: agency

CADENCE: FIXED - One-time ABP SPA parity analysis; ongoing parity in benefit design. (Paraphrased from the parity computation provisions of 440.395(b).)

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: ABP benefit design, ongoing

BASIS: Parity work on the ABP is documented but not complete on the held record. The 1115 approval package, STC 9.19, requires the state to submit documentation of how 440.345(c) and 440.395 are met when submitting an ABP SPA, to deliver EHB services to ABP enrollees in compliance with 440.395, to cease noncompliant treatment limitations within 30 days of a noncompliance determination, and it holds FFP for DSHP expenditures until CMS determines satisfactory completion of removal of all noncompliant parity limits (STC 9.19(h)). SPA 25-0009 removes non-quantitative treatment limitations for psychotherapy and mobile crisis from ABP Essential Health Benefit 5, whose page carries the parity assurance that no financial requirement or treatment limitation on MH/SUD benefits is more restrictive than the predominant requirement applied to substantially all medical/surgical benefits in the same classification.

RECORD LOCATION: H-025 (1115 approval package), STC 9.19 at printed pp.42-43; H-005 (SPA NC-25-0009), transmittal memorandum and ABP 5 pages

SECTION 5D FACE

UNCOVERED ELEMENT: Completed ABP parity compliance documentation across all classifications is not held; on the STC's own terms the removal of noncompliant limits was still awaiting a CMS satisfactory-completion determination, so full 440.395 compliance is not evidenced.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: File the completed ABP parity documentation and the CMS determination under STC 9.19(h) when issued.

QUESTION: Has CMS determined satisfactory completion of parity limit removal for the ABP, and where is the final ABP parity documentation posted?

SEARCHES RECORDED: Parity documents read: H-025 STC 9.19, H-005, H-018 (state plan parity SPA 25-0001), H-017 (1915(i) parity notice), H-136 (CMS parity page, federal background only). No completed ABP parity analysis is in the corpus.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 440.395: MH/SUD financial requirements and treatment limitations in an ABP no more restrictive than the predominant requirements for medical/surgical benefits in each classification.

FLAGS: Graded on the stronger evidence (the approved STCs) over the register's standing parity assertions; the STC FFP hold at 9.19(h) is the controlling fact.

CFR-441-001: FFP continuation after provider agreement termination

CITATION: 42 CFR 441.11

TOPIC: FFP continuation after provider agreement termination

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Each termination/expiration of a provider agreement; 30-day window from effective date.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: each termination or expiration of a provider agreement

BASIS: No governing document producible: no held NC document states the 441.11 rule that FFP remains available for up to 30 days after a provider agreement terminates or expires where the state made a good faith effort to transfer beneficiaries to other qualified providers. Provider termination and sanction language was found in the plan (section 4.30) and in 10A NCAC 22F, but none of it carries the 30-day FFP continuation or the transfer-effort condition.

RECORD LOCATION:

SECTION 5D FACE

UNCOVERED ELEMENT:

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: State the 441.11 continuation rule in the provider enrollment or provider agreement framework, or file termination records showing the 30-day wind-down and transfer efforts for terminations in the period.

QUESTION: When a Medicaid provider agreement terminated in the period, did NC claim FFP into the 30-day window, and where is the transfer effort documented?

SEARCHES RECORDED: Plan searched (H-001 sections 4.13, 4.30 and full text for 441.11 and termination continuation); 10A NCAC Chapter 22 (H-099, H-098) searched; provider manuals

(H-067 to H-072) and PHP/Tailored Plan contracts searched for provider agreement termination payment continuation. No passage found.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.11: FFP available until the earlier of beneficiary transfer or 30 days after the agreement's effective termination date, on a documented good faith transfer effort.

CFR-441-002: FFP prohibitions for institutionalized individuals

CITATION: 42 CFR 441.13

TOPIC: FFP prohibitions for institutionalized individuals

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Every FFP claim; ongoing exclusion of non-covered institutional populations and service types.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: every FFP claim

BASIS: The plan carries the core exclusions as eligibility conditions: Attachment 2.6-A, citing 42 CFR 435.1008, conditions eligibility on the individual not being an inmate of a public institution (with the medical institution, intermediate care, small community residence and child care exceptions stated) and not being a patient under age 65 in an institution for mental diseases, except an inpatient under 22 receiving active treatment in an accredited psychiatric facility. The plan also covers IMD services only for individuals 65 or over (section 3.3) and under 21 (section 3.1(a)(2)(ix)).

RECORD LOCATION: H-001 (Title XIX State Plan), Attachment 2.6-A p.3a at PDF p.308; sections 3.3 (p.71) and 3.1(a)(2) (p.54)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The remaining 441.13 exclusions are not stated in the held evidence, in particular the bar on FFP for services furnished to institutionalized individuals by outside providers and the exclusion of educational and vocational training reimbursement in ICF/IID and psychiatric facilities.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State the full 441.13 exclusion set in the claims or coverage policy framework, including the outside-provider and educational/vocational elements.
>
> **QUESTION:** Where are NC's claim edits for the 441.13 exclusions documented, beyond the eligibility conditions in Attachment 2.6-A?

SEARCHES RECORDED: Plan eligibility and IMD pages read; corpus searched for 441.13 and for educational/vocational payment exclusions in facility contexts. No passage found.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.13: no FFP for services to inmates of public institutions (with exceptions), to individuals aged 21-64 in IMDs (with the under-21 inpatient psychiatric exception), or for specified educational/vocational services.

CFR-441-003: Home health services — state plan minimums

CITATION: 42 CFR 441.15

TOPIC: Home health services — state plan minimums

TOPIC IN DETERMINATIONS FILE: Home health services - state plan minimums

OBLIGATED LEVEL: agency

CADENCE: FIXED - One-time state plan specification; ongoing coverage obligation.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: plan-level specification, ongoing coverage

BASIS: Plan section 3.1(b) carries the provision in terms: home health services are provided in accordance with 42 CFR 441.15 to all categorically needy individuals 21 years of age or over, to all categorically needy individuals under 21, and to the medically needy (checked: yes, to all). The home health plan pages (Attachment 3.1-A.1 Page 13) define the service: Medicare certified home health agencies, plan of care, nursing, home health aide, therapies and medical supplies, in accordance with 42 CFR 440.70.

RECORD LOCATION: H-001 (Title XIX State Plan), section 3.1(b), PDF p.60; H-004 (SPA NC-26-0003), Attachment 3.1-A.1 Page 13

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.15: home health under the plan for categorically needy and, where SNF services are provided, medically needy individuals entitled to them.

FLAGS: SPA 26-0003 (H-004) is a transmittal with the approval date blank on the held copy; the 441.15 grade rests on plan section 3.1(b).

CFR-441-004: Home health agency surety bonds — FFP prohibition

CITATION: 42 CFR 441.16

TOPIC: Home health agency surety bonds — FFP prohibition

TOPIC IN DETERMINATIONS FILE: Home health agency surety bonds - FFP prohibition

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - At HHA enrollment, change of ownership, loss of government-operated waiver (60 days), change of surety (60 days); annual bond/riders.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: at HHA enrollment, ownership change, and bond events since 1998-01-05

BASIS: No governing document producible: no held NC document states that a home health agency must post a surety bond as a condition of participation, or that FFP is unavailable for services of an agency that has not posted the required bond. The plan home health pages and the home health SPA are silent on surety bonds.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File HHA enrollment records showing surety bonds on file, or state the bond requirement in the home health coverage policy.
>
> **QUESTION:** Does NC collect surety bonds from enrolled home health agencies, and has any FFP been withheld for a missing bond?

SEARCHES RECORDED: Full text search of the held corpus and cure acquisitions for 'surety bond' returned no NC Medicaid document (hits, if any, are outside the Medicaid home health framework); plan home health pages (H-001 section 3.1(b), Attachment 3.1-A.1 Page 13) and H-004 read. NCTracks enrollment pages in the corpus (H-147, H-148) address reverification, not HHA bonds.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.16, implementing section 1861(o)(7) surety bond duties through section 1902(a) authority: FFP barred for services of HHAs that fail to post the required bond.

CFR-441-005: Laboratory services — qualified labs; HIV test records

CITATION: 42 CFR 441.17

TOPIC: Laboratory services — qualified labs; HIV test records

TOPIC IN DETERMINATIONS FILE: Laboratory services - qualified labs; HIV test records

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Provider enrollment/payment qualification; each HIV test billing record.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: provider enrollment and each lab claim

BASIS: The qualified laboratory element is carried: the plan's laboratory pages provide that clinical laboratory services are rendered by medical care entities issued a certificate of waiver, registration certificate, or certificate of accreditation under the Clinical Laboratory Improvement Amendments of 1988 (Attachment 3.1-A.1 Page 6a). No held document states the 441.17 payment condition for HIV testing records (the identifying information that must accompany a claim for an HIV test or panel).

RECORD LOCATION: H-001 (Title XIX State Plan), Attachment 3.1-A.1 Page 6a, PDF p.547

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The HIV test record element of 441.17 is not evidenced: no held policy states what identifying information must be on file for payment of HIV tests.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State the HIV test claim record requirements in the laboratory coverage policy or billing guide.
>
> **QUESTION:** What record does NC require before paying an HIV test claim under 441.17?

SEARCHES RECORDED: Plan laboratory pages read; pharmacy and DME policies (H-075, H-078) and provider manuals searched for HIV test billing record requirements. None found.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.17: payment only for lab services by qualified (CLIA) laboratories, and stated record content for HIV test claims.

CFR-441-006: Case management services — state duties

CITATION: 42 CFR 441.18

TOPIC: Case management services — state duties

TOPIC IN DETERMINATIONS FILE: Case management services - state duties

OBLIGATED LEVEL: agency

CADENCE: FIXED - One-time SPA structure per group/subgroup; ongoing records and free-choice obligations on each service.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: each targeted case management group under the plan

BASIS: The plan's targeted case management specifications carry 441.18 group by group. For eligible juveniles (SPA 25-0006, Supplement 1 to Attachment 3.1-A): the target group is defined citing 441.18(a)(8)(i) and (a)(9); provider qualifications are specified citing 441.18(a)(8)(v) and (b); the freedom of choice assurance of 441.18(a)(1) is stated (free choice of any qualified provider and of other medical care providers); the access assurances of 441.18(a)(2), (a)(3) and (a)(6) are stated (no restriction of access to other services, no compelled receipt, case managers do not exercise the agency's authorization authority); and assessment, care plan development and periodic reassessment are specified. The plan's Supplement 1 likewise specifies the other TCM groups, including HIV case management with provider qualification, supervision and records requirements (plan pp.502-510).

RECORD LOCATION: H-016 (SPA 25-0006), Supplement 1 to Attachment 3.1-A pp.1-8 (cure text pp. 2-9); H-001 (Title XIX State Plan), Supplement 1 HIV case management pages, PDF pp.502-510

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.18(a): target group specification, assessment, care plan, referral, monitoring, free choice, access, provider qualifications and records duties.

CFR-441-007: Family planning — freedom from coercion

CITATION: 42 CFR 441.20

TOPIC: Family planning — freedom from coercion

TOPIC IN DETERMINATIONS FILE: Family planning - freedom from coercion

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Ongoing; applies to every family planning service encounter.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: every family planning encounter

BASIS: Plan section 3.1(e) carries the provision in terms: the requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

RECORD LOCATION: H-001 (Title XIX State Plan), section 3.1(e), PDF p.63

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.20: the plan must provide that beneficiaries are free from coercion and free to choose the family planning method.

CFR-441-008: Nurse-midwife services — independent agreements

CITATION: 42 CFR 441.21

TOPIC: Nurse-midwife services — independent agreements

TOPIC IN DETERMINATIONS FILE: Nurse-midwife services - independent agreements

OBLIGATED LEVEL: agency

CADENCE: FIXED - One-time state plan specification; ongoing enrollment policy.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: plan-level specification and enrollment policy

BASIS: The plan page carries both halves of a contradiction. Section 3.1(a)(1)(ii) states that nurse-midwife services under 1905(a)(17), as defined in 42 CFR 440.165, are provided to the extent nurse-midwives are authorized to practice under state law, and that nurse-midwives are permitted to enter

into independent provider agreements with the Medicaid agency without regard to supervision by or association with a physician or other provider. The same page then prints: 'Not applicable. Nurse-midwives are not authorized to practice in this State.' The independent agreement element is therefore stated and negated on one face, and no newer held document resolves which statement governs current enrollment.

RECORD LOCATION: H-001 (Title XIX State Plan), section 3.1(a)(1)(ii), PDF p.50

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** Whether NC currently enrolls nurse-midwives under independent provider agreements cannot be determined from the held record; the plan page contradicts itself.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Conform plan section 3.1(a)(1)(ii) to current practice and file the nurse-midwife enrollment position.
>
> **QUESTION:** Are certified nurse-midwives enrolled with independent provider agreements in NC Medicaid today?

SEARCHES RECORDED: Plan read at p.50; provider manuals and SPA 26-0003 (H-004, which adds PA, NP and CNS as home health authorizers) searched for nurse-midwife enrollment. No resolving document found.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.21: where nurse-midwife services are covered, the plan must permit nurse-midwives to enter provider agreements independently of physician supervision or association.

FLAGS: Internal contradiction on the plan page itself, flagged per the grading standard; graded Partial on the stronger reading that the operative sentence carries the element but is negated on the same face.

CFR-441-009: Nurse practitioner services — state plan duties

CITATION: 42 CFR 441.22

TOPIC: Nurse practitioner services — state plan duties

TOPIC IN DETERMINATIONS FILE: Nurse practitioner services - state plan duties

OBLIGATED LEVEL: agency

CADENCE: FIXED - One-time state plan specification; ongoing enrollment/billing policy.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: plan-level specification and billing policy

BASIS: The plan specifies nurse practitioner services: Attachment 3.1-A.1 Page 12a sets criteria (services within the scope of practice defined by the State Board of Medical Examiners and Board of Nursing; performed by duly licensed nurse practitioners approved by those boards; performed under physician supervision) and coverage limitations keyed to scope of practice and signed

protocols. SPA 26-0003 further lists nurse practitioners among the practitioners who may authorize home health under a plan of care. The held pages do not state the enrollment and payment position for nurse practitioners practicing without physician direction or control in the terms 441.22 contemplates, beyond the supervision and protocol conditions quoted.

RECORD LOCATION: H-001 (Title XIX State Plan), Attachment 3.1-A.1 Page 12a, PDF p.615; H-004 (SPA NC-26-0003), Attachment 3.1-A.1 Page 13

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 441.22 assurance that nurse practitioner services are available as a plan service independent of a physician's own enrollment, and any direct payment terms, are not stated in the held pages.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State the nurse practitioner enrollment and payment position under 441.22 in the practitioner coverage policy.
>
> **QUESTION:** May an NC nurse practitioner enroll and be paid directly for plan services, and under what supervision terms?

SEARCHES RECORDED: Plan practitioner pages read (Attachment 3.1-A.1 pp.12-12a and 4.19-B Section 6); H-004 read. No further 441.22 statement found.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.22: the plan must provide nurse practitioner services as defined, furnished in accordance with state law and the practitioner's certification.

CFR-441-010: FFP prohibition — certain prescribed drugs (DESI)

CITATION: 42 CFR 441.25

TOPIC: FFP prohibition — certain prescribed drugs (DESI)

TOPIC IN DETERMINATIONS FILE: FFP prohibition - certain prescribed drugs (DESI)

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Every drug FFP claim; ongoing formulary/pharmacy claim controls.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Pharmacy (Pharmacy Benefit Administrator for NC Medicaid Direct)

HOME BASIS: Pharmacy is a published DHB function: from May 2, 2026 a Pharmacy Benefit Administrator (Prime Therapeutics) supports NC Medicaid Direct pharmacy operations while DHB 'continues to manage all clinical policies and reimbursement methodologies for Point-of-Sale pharmacy' (Lane A §1.4). Title-level derivation: the Medicaid drug benefit and the Drug Rebate Program sit with the pharmacy function in NC's published structure (the PBA's published duties include drug rebate administration and DUR — Lane A §1.4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: every drug FFP claim

BASIS: Clinical Coverage Policy No. 9, Outpatient Pharmacy, section 4.2.2, carries the prohibition in terms: reimbursement is denied on drugs described by the FDA as DESI, meaning products FDA has found less than effective or not proven as effective as indicated, and drug products identical, related or similar to DESI drugs are also considered DESI. Section 3.3 of the same policy adds that all DESI

drugs and combinations equivalent to a DESI drug are not reimbursable in compounded prescriptions.

RECORD LOCATION: H-075 (Clinical Coverage Policy No. 9, Outpatient Pharmacy), section 4.2.2 at file p.10 (printed p.6) and section 3.3 at file p.8

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.25: no FFP for drugs found less than effective under the DESI program, including identical, related or similar products.

FLAGS: Policy amended date October 1, 2015; it is the held pharmacy coverage policy of record. H-123's corrected 441.25 citation (a figure data series in the Annual Quality Report) was not used and is not a read passage, per the cure instruction.

CFR-441-011: Organ transplants — written coverage standards

CITATION: 42 CFR 441.35

TOPIC: Organ transplants — written coverage standards

TOPIC IN DETERMINATIONS FILE: Organ transplants - written coverage standards

OBLIGATED LEVEL: agency

CADENCE: FIXED - One-time state plan written standards; ongoing application to transplant coverage decisions.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: plan-level written standards; each transplant decision

BASIS: The plan carries the written standards: section 3.1(f)(2) states organ transplant procedures are provided, similarly situated individuals are treated alike, and any restriction on facilities or practitioners is consistent with accessibility of high quality care, with standards described at Attachment 3.1-E. Attachment 3.1-E itself states the coverage framework (transplant services covered as specified in the clinical coverage policies, with clinical eligibility criteria specified there), lists covered solid organ transplants with prior approval (heart, heart/lung, lung, liver, kidney, pancreas, islet cell, small bowel and multi-visceral, and related procedures), and sets clinical packet requirements for prior approval.

RECORD LOCATION: H-001 (Title XIX State Plan), section 3.1(f)(2), PDF p.64; Attachment 3.1-E, PDF pp.736-739

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.35: written plan standards for organ transplants, applied alike to similarly situated individuals, with facility restrictions consistent with access to high quality care.

CFR-441-012: End-stage renal disease — facility approval

CITATION: 42 CFR 441.40

TOPIC: End-stage renal disease — facility approval

TOPIC IN DETERMINATIONS FILE: End-stage renal disease - facility approval

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Ongoing; applies to each ESRD facility payment.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: each ESRD facility payment

BASIS: The plan covers ESRD facility services: Attachment 3.1-A.1 Page 13c.1 provides maintenance hemodialysis and peritoneal dialysis when provided by a Medicaid enrolled ESRD hospital-based renal dialysis center or free-standing ESRD facility. The held page conditions coverage on Medicaid enrollment; it does not state the 441.40 condition that the facility be approved for ESRD services under the Medicare program (Part 405 Subpart U standards incorporated by 441.40).

RECORD LOCATION: H-001 (Title XIX State Plan), Attachment 3.1-A.1 Page 13c.1, PDF p.630

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The Medicare approval cross-check for ESRD facilities is not stated in the held ESRD page.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State in the ESRD coverage policy that payment is limited to Medicare approved ESRD facilities.
>
> **QUESTION:** Does NC verify Medicare ESRD approval before enrolling or paying a dialysis facility?

SEARCHES RECORDED: Plan ESRD pages read; provider manuals searched for ESRD facility certification. No statement tying payment to Medicare ESRD approval found.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.40: FFP only for ESRD services in facilities meeting the Medicare ESRD approval requirements.

CFR-441-013: EPSDT — state plan requirement

CITATION: 42 CFR 441.55

TOPIC: EPSDT — state plan requirement

TOPIC IN DETERMINATIONS FILE: EPSDT - state plan requirement

OBLIGATED LEVEL: agency

CADENCE: FIXED - One-time state plan commitment; umbrella for all EPSDT rows below.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: plan-level commitment; umbrella for the EPSDT rows

BASIS: Plan section 3.1(a)(9) carries the commitment: the Medicaid agency meets the requirements of sections 1902(a)(43), 1905(a)(4)(B) and 1905(r) of the Act with respect to early and periodic screening, diagnostic and treatment services, citing 42 CFR 441.55. Attachment 3.1-A item 4.b lists EPSDT for individuals under 21, including treatment of conditions found.

RECORD LOCATION: H-001 (Title XIX State Plan), section 3.1(a)(9), PDF p.58; Attachment 3.1-A item 4.b, PDF p.438

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.55: the plan must provide for EPSDT meeting sections 1902(a)(43) and 1905(r).

CFR-441-014: EPSDT informing — within 60 days of eligibility, annually

CITATION: 42 CFR 441.56(a)

TOPIC: EPSDT informing — within 60 days of eligibility, annually

TOPIC IN DETERMINATIONS FILE: EPSDT informing - within 60 days of eligibility, annually

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Within 60 days of each new initial eligibility determination; annually thereafter for non-utilizing families.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: each new eligibility determination and annually for non-utilizing families

BASIS: Informing activity exists in managed care: the Standard Plan and CFSP provider manuals describe a well-child reminder program under which the plan, based on claims data, sends PCPs lists of members who have not received well-child services and mails information to those members encouraging them to contact their PCP to set up appointments for needed services (H-067 section 2.31; H-068 section 2.31). No held document states the 441.56(a) informing standard itself: informing all EPSDT eligible families within 60 days of the initial eligibility determination and annually for families that have not used services, in writing or orally as the family requires, covering the benefits of preventive care, what EPSDT offers, and where and how to obtain services including transportation and scheduling help.

RECORD LOCATION: H-067 (Provider Manual 2026, Standard Plan), section 2.31, PDF pp.76-77; H-068 (Provider Manual 2026, CFSP), section 2.31, PDF pp.82-83

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 60-day initial informing cycle, the annual re-informing cycle for non-utilizing families, and the required informing content of 441.56(a) are not stated in any held document; the Health Check Program Guide (H-163) is provider-facing and does not carry them either.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the EPSDT informing policy stating the 60-day and annual cycles and the required content, including how Medicaid Direct families are informed.

QUESTION: Who informs NC Medicaid Direct families of EPSDT within 60 days of eligibility, and what document states that duty?

SEARCHES RECORDED: H-163 read in full for informing passages (none); provider manuals H-067 and H-068 read at section 2.31; corpus searched for '60 days' informing language in EPSDT documents. None found.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.56(a): informing within 60 days of eligibility and annually thereafter for non-users, with stated content, in clear nontechnical language, using oral methods where needed.

CFR-441-015: EPSDT screening — minimum components and standards

CITATION: 42 CFR 441.56(b)

TOPIC: EPSDT screening — minimum components and standards

TOPIC IN DETERMINATIONS FILE: EPSDT screening - minimum components and standards

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Each requested/per-schedule screening; standards set in consultation with recognized organizations.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: each screening, per the periodicity schedule

BASIS: The Health Check Program Guide carries the screening package: the five required components of an Early and Periodic Screening encounter are listed (comprehensive health and developmental history assessing physical and mental health and substance use; comprehensive unclothed physical examination; appropriate immunizations per the ACIP schedule; laboratory testing including blood lead screening appropriate for age and risk; health education and anticipatory guidance for child and caregiver), and the guide's screening sections cover medical, vision, hearing and dental screens, with a dental home established no later than 12 months of age, referral to a dentist by age 3 where no dental home exists, and a direct referral rule (an oral screening at a physical assessment is not a substitute for a dentist's examination). The schedule rests on the AAP Bright Futures guidelines with ADA and AAPD support, and the oral health schedule states it was developed in consultation with local authorities in pediatric oral health care.

RECORD LOCATION: H-163 (Health Check Program Guide), pp.4-9 (components and periodicity), p. 17 (dental screenings and referral), p.19 (oral health periodicity and consultation)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.56(b): screening services at minimum including health and developmental history, unclothed exam, immunizations, laboratory tests and

health education, with vision, hearing and dental services and direct dental referral, set in consultation with recognized medical and dental organizations.

CFR-441-016: EPSDT diagnosis and treatment — even if not in state plan

CITATION: 42 CFR 441.56(c)

TOPIC: EPSDT diagnosis and treatment — even if not in state plan

TOPIC IN DETERMINATIONS FILE: EPSDT diagnosis and treatment - even if not in state plan

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Each screening that identifies a need; treatment must follow screening.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: each screening that identifies a need

BASIS: The treatment element is carried in terms in three places. The EPSDT special provision in the clinical coverage policies (read in CCP 9 and in the systemic immunomodulators prior approval criteria) states the agency must cover services for beneficiaries under 21 if medically necessary health care to correct or ameliorate a defect, physical or mental illness or condition identified through a screening examination, including maintaining health, compensating for a health problem, and preventing worsening or additional problems. The Standard Plan manual states the same rule: any service medically necessary to correct or ameliorate a defect, physical or mental illness or condition identified by screening, whether or not the service is covered under the NC state Medicaid plan, within the 1905(a) service categories. The Health Check Guide requires that children be referred for and receive medically necessary care to correct or ameliorate conditions identified through screening.

RECORD LOCATION: H-162 (EPSDT special provision document), pp.1-2; H-075 (CCP 9), section 2.2.1 at file pp.6-7; H-067 (Provider Manual 2026), p.61; H-163 (Health Check Program Guide), p.28

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.56(c): diagnostic and treatment services must be provided for conditions found, including services not otherwise in the state plan, within the 1905(a) categories.

CFR-441-017: EPSDT accountability — records and manuals

CITATION: 42 CFR 441.56(d)

TOPIC: EPSDT accountability — records and manuals

TOPIC IN DETERMINATIONS FILE: EPSDT accountability - records and manuals

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Records maintained continuously; manuals updated as program changes.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: continuously; manuals updated as the program changes

BASIS: Program manuals exist and are current: the Health Check Program Guide (H-163, 65 pages) describes the screening package, periodicity and informing-adjacent provider duties, and the managed care quality strategy notes that Form CMS-416 is a required annual EPSDT evaluation and participation performance report for state Medicaid agencies (H-122, p.21). No held document evidences the agency's own 441.56(d) record system: the records the agency maintains on families informed, children screened, and diagnosis and treatment provided, or a filed CMS-416.

RECORD LOCATION: H-163 (Health Check Program Guide); H-122 (Managed Care Quality Strategy 2023), p.21

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** Agency records of informing, screening and treatment activity, and any filed CMS-416 report, are not held; the quality strategy states the CMS-416 requirement but is not the report.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File the EPSDT program record set (informing, screening and treatment records description) and the most recent CMS-416 on the row's record.
>
> **QUESTION:** Where are NC's 441.56(d) EPSDT records maintained, and when was the last CMS-416 filed?

SEARCHES RECORDED: Corpus searched for CMS-416 (one mention, H-122 p.21, stating the requirement); H-125 (AMH measure set) and H-123 (Annual Quality Report) reviewed for EPSDT accountability data; neither is an EPSDT program record under 441.56(d). H-123 was not used for any citation-based grade.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.56(d): the agency must maintain records on informing and screening and keep program manuals and screening package descriptions current and available.

CFR-441-018: EPSDT timeliness — 6-month outer limit for treatment

CITATION: 42 CFR 441.56(e)

TOPIC: EPSDT timeliness — 6-month outer limit for treatment

TOPIC IN DETERMINATIONS FILE: EPSDT timeliness - 6-month outer limit for treatment

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Each screening request; treatment initiation generally within 6 months of the screening request.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: each screening request and identified need

BASIS: No governing document producible: no held NC document states the 441.56(e) timeliness standard, that diagnosis and treatment be initiated generally within 6 months of a screening request. The Health Check Guide requires referral and follow-up but sets no outer time limit; the provider manual reminder program tracks due dates against the periodicity schedule, not a screening-to-treatment interval.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State the EPSDT timeliness standard, including the 6-month outer limit, in the Health Check Guide or EPSDT policy.
>
> **QUESTION:** What screening-to-treatment timeliness standard does NC hold providers and plans to for EPSDT?

SEARCHES RECORDED: H-163 and H-067/H-068 read for timeliness language; full corpus searched for 'within 6 months' and 'within six months' in EPSDT contexts (hits are unrelated program rules). No passage states the 6-month standard.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.56(e): the agency must set timeliness standards so treatment is initiated generally within 6 months of a screening request.

CFR-441-019: EPSDT periodicity schedule

CITATION: 42 CFR 441.58

TOPIC: EPSDT periodicity schedule

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Schedule maintained and reviewed; screenings delivered per schedule life-stages.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (periodic) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: schedule maintained and reviewed continuously

BASIS: NC's periodicity schedule is published in the Health Check Program Guide: the NC Health Check Preventive Health Services Periodicity Schedule with a quick view table by age (within the first month through age 20) covering measurements, vision, hearing, developmental and autism screens, psychosocial assessment, oral health, fluoride, lead, immunizations per ACIP and the other listed screens; a separate NC Oral Health Periodicity Schedule follows a modified AAPD schedule and states it was developed in consultation with local authorities in pediatric oral health care; the medical schedule reflects the AAP Bright Futures guidelines with ADA and AAPD support.

RECORD LOCATION: H-163 (Health Check Program Guide), pp.5-8 (periodicity schedule and quick view) and pp.18-19 (oral health periodicity schedule)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.58: a periodicity schedule for screening, vision, dental and hearing services, set in consultation with recognized organizations, at intervals meeting reasonable standards of practice.

CFR-441-020: EPSDT screening on request; avoid duplicates

CITATION: 42 CFR 441.59

TOPIC: EPSDT screening on request; avoid duplicates

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Each beneficiary request; check for written verification of most recent age-appropriate screening.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: each beneficiary request and each professional referral

BASIS: The on-request element is carried: the Health Check Guide provides for interperiodic screening outside the established schedule when an illness or condition is suspected or a change in a diagnosed condition requires additional services, states the determination may be made by the child's physician or dentist or by a health, developmental or educational professional who comes into contact with the child (expressly including early intervention, special education, Head Start and WIC personnel), and works an example in which a school nurse's concern entitles the child to a timely interperiodic vision screening before the next scheduled screen. The duplicate-avoidance element of 441.59, checking for a recent age-appropriate screening before repeating one, is not stated.

RECORD LOCATION: H-163 (Health Check Program Guide), pp.16-17

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** No held document states the practice of verifying the most recent screening (for example through records or the periodicity history) before providing a duplicate screening on request.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)

> **ACTION:** Add the duplicate-screening verification step to the Health Check Guide's interperiodic screening section.
>
> **QUESTION:** How does a provider check whether a child has already had the age-appropriate screening before billing an interperiodic screen?

SEARCHES RECORDED: H-163 read in full; provider manuals H-067/H-068 section 2.31 read. No duplicate-screening verification language found.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.59: screening services on request of the individual or on referral by a health, developmental or educational professional, with steps to avoid duplicate screenings.

CFR-441-021: EPSDT continuing care providers — state monitoring

CITATION: 42 CFR 441.60

TOPIC: EPSDT continuing care providers — state monitoring

TOPIC IN DETERMINATIONS FILE: EPSDT continuing care providers - state monitoring

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Ongoing monitoring per state plan methods; agreements must cover specified obligations.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (periodic) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: ongoing monitoring under the plan

BASIS: Plan section 3.1(a)(9), EPSDT Services (continued), citing 42 CFR 441.60, addresses continuing care provider agreements and describes the methods employed to assure the providers' compliance with their agreements: the continuing care provider submits monthly encounter data reflecting the number of examinations completed, the number of examinations where a referable condition was identified, and the number of follow-up treatment encounters, and Medicaid staff make periodic on-site reviews to monitor the provider's record of case management.

RECORD LOCATION: H-001 (Title XIX State Plan), section 3.1(a)(9) continued, PDF p.59

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.60: agreements with continuing care providers and state methods to monitor compliance with them.

FLAGS: Checkbox confirmed on the PDF image at the drill down of 2026-10-30 (H-001, PDF p.59): the line beside the 441.60 agreements statement carries no X mark, where a marked line elsewhere on the same page (item (a)(10)(iv)) carries one. The methods text that follows the statement stands filled in full (monthly encounter data; periodic on-site reviews). The Verified grade rests on that methods text, as flagged at the cure; the grade is unchanged.

CFR-441-022: EPSDT provider availability and program coordination

CITATION: 42 CFR 441.61

TOPIC: EPSDT provider availability and program coordination

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Each screening finding needing uncovered treatment; ongoing provider network and coordination.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: ongoing network and coordination duties

BASIS: Referral and availability elements are partly carried: the Health Check Guide requires referral to and receipt of medically necessary services for problems not treated in-house, directs families to a published list of NC dental providers by county who accept Medicaid, and names Head Start, WIC, early intervention and special education personnel as screening referral sources. No held document evidences the 441.61 coordination structure itself: agreements or coordination arrangements with Title V, WIC, Head Start and education programs for EPSDT provider availability, or a showing that a sufficient number of EPSDT providers is available.

RECORD LOCATION: H-163 (Health Check Program Guide), pp.16-17 and p.28

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** Formal coordination with the named federal programs and any EPSDT provider sufficiency showing are not in the held evidence; plan Attachment 4.16-A (cooperative arrangements with Title V grantees) is listed in the plan contents but its text was not read as carrying EPSDT-specific coordination.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File the EPSDT coordination arrangements and the provider availability assessment for the row's record.
>
> **QUESTION:** Under what agreements does DHB coordinate EPSDT with Title V, WIC, Head Start and the schools?

SEARCHES RECORDED: H-163 read in full; plan contents and section 4.16 area checked (H-001); quality strategy (H-122) and AMRP (H-124) reviewed for EPSDT network sufficiency. No EPSDT coordination agreement found.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.61: the agency must make available a sufficient number of EPSDT providers and coordinate with Title V, WIC, Head Start and education programs.

CFR-441-023: EPSDT transportation and scheduling assistance

CITATION: 42 CFR 441.62

TOPIC: EPSDT transportation and scheduling assistance

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Offer made to each EPSDT family; provided on request.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: offer to each EPSDT family; provided on request

BASIS: Transportation and scheduling assistance are named EPSDT services in the Standard Plan manual: section 2.31 lists the EPSDT service set as screening, diagnosis and treatment, and transportation and scheduling assistance, and the NEMT policy provides transportation channels for all beneficiary groups (plans for managed care members; local DSS for Medicaid Direct). No held document states the 441.62 duty as an offer made to each EPSDT family, or EPSDT-specific scheduling assistance on request.

RECORD LOCATION: H-067 (Provider Manual 2026, Standard Plan), section 2.31, PDF p.76; H-065 (NEMT Policy page, v12)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The offer element of 441.62 (transportation and scheduling assistance offered to every EPSDT family, not only described as a service category) is not evidenced.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State the EPSDT transportation and scheduling assistance offer in the beneficiary-facing EPSDT material and the Health Check Guide.
>
> **QUESTION:** How is an EPSDT family told it can get scheduling help, as distinct from NEMT alone?

SEARCHES RECORDED: H-163 read for transportation and scheduling assistance (not addressed to families); H-065 and H-066 (NEMT pages) read; provider manuals searched. No EPSDT-specific offer language found.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.62: the agency must offer transportation and scheduling assistance to each EPSDT family and provide it on request.

CFR-441-024: IMD services for 65+ — state plan requirements

CITATION: 42 CFR 441.101

TOPIC: IMD services for 65+ — state plan requirements

TOPIC IN DETERMINATIONS FILE: IMD services for 65+ - state plan requirements

OBLIGATED LEVEL: agency

CADENCE: FIXED - One-time state plan commitment; umbrella for rows below.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: plan-level commitment for the 65+ IMD benefit

BASIS: Plan section 3.3 carries the provision: Medicaid is provided for individuals 65 years of age or older who are patients in institutions for mental diseases, the 'requirements of 42 CFR Part 441, Subpart C, and 42 CFR 431.620(c) and (d) are met' option is checked yes, and the not-applicable option is unchecked.

RECORD LOCATION: H-001 (Title XIX State Plan), section 3.3, PDF p.71

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.101: a state covering IMD services for individuals 65 or over must meet Subpart C.

CFR-441-025: IMD 65+ — individual plan of care with reviews

CITATION: 42 CFR 441.102

TOPIC: IMD 65+ — individual plan of care with reviews

TOPIC IN DETERMINATIONS FILE: IMD 65+ - individual plan of care with reviews

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Initial review: 90 days after plan approval, then 30 days after payments initiated per beneficiary; quarterly continued-need determination.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (quarterly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: each 65+ IMD beneficiary

BASIS: The plan commits NC to utilization control for inpatient services in mental hospitals under 42 CFR Part 456 Subpart D (section 4.14(c)), the regime that carries written plans of care and review in mental hospitals, and section 3.3 commits the state to Part 441 Subpart C. No held document states the 441.102 specifics for the 65+ IMD benefit: an individual plan of care, the initial review within 90 days, review within 30 days after payments begin, or the quarterly determination of continued need.

RECORD LOCATION: H-001 (Title XIX State Plan), section 4.14(c), PDF p.100, and section 3.3, PDF p. 71

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 441.102 plan of care content and its review clocks (90 days, 30 days, quarterly) are not stated in any held document.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File the mental hospital utilization review procedures showing the 441.102 plan of care and review clocks, or state them in policy.
>
> **QUESTION:** Which NC document operationalizes the 441.102 reviews for the state psychiatric hospitals' Medicaid patients?

SEARCHES RECORDED: Plan read at sections 3.3 and 4.14 and searched for plan of care language in IMD contexts (hits are nursing facility survey and CCNC care plan passages, unrelated). No Subpart C operating document is held.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.102: individual plan of care for each 65+ IMD beneficiary, with initial, payment-start and quarterly continued-need reviews.

CFR-441-026: IMD 65+ — alternate plans of care

CITATION: 42 CFR 441.103

TOPIC: IMD 65+ — alternate plans of care

TOPIC IN DETERMINATIONS FILE: IMD 65+ - alternate plans of care

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Each 65+ beneficiary who would otherwise need IMD care.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: each 65+ beneficiary who would otherwise need IMD care

BASIS: No governing document producible: no held NC document addresses alternate plans of care for individuals 65 or over who would otherwise require IMD care, the Subpart C alternative under which care is furnished in alternative settings under an alternate plan when IMD care is not the appropriate setting.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State whether NC uses alternate plans of care under 441.103 and, if so, file the governing procedure.
>
> **QUESTION:** Does NC furnish any 65+ IMD-alternative care under an alternate plan of care?

SEARCHES RECORDED: Plan searched for 'alternate plan' (no hit) and Subpart C material read (sections 3.3, 4.14); corpus searched for alternate plan of care language. None found.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.103: alternate plans of care for individuals who would otherwise need IMD services.

CFR-441-027: Comprehensive mental health program — annual report

CITATION: 42 CFR 441.106

TOPIC: Comprehensive mental health program — annual report

TOPIC IN DETERMINATIONS FILE: Comprehensive mental health program - annual report

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Annual progress report due within 3 months after each fiscal year end.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: annual report due within 3 months after each fiscal year end

BASIS: No governing document producible: no held NC document is, or references, the annual progress report on a comprehensive mental health program for the aged that 441.106 requires be filed with CMS, and no held document shows such a report filed for any year in the period.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Mental Health, Developmental Disabilities and Substance Use Services
>
> **ACTION:** File the most recent 441.106 annual report, or record whether the duty is discharged through another CMS report.
>
> **QUESTION:** Has NC filed a 441.106 report in the period, and under what title?

SEARCHES RECORDED: Plan and corpus searched for 'comprehensive mental health' (no hit in H-001) and for annual mental health program reports to CMS; annual reports in the corpus (H-126 NC Medicaid Annual Report SFY2025, H-127 reports index) are program reports, not a 441.106 filing.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.106: annual report to CMS on the comprehensive mental health program serving the aged in and out of IMDs.

CFR-441-028: Inpatient psychiatric services under 21 — general requirements

CITATION: 42 CFR 441.151

TOPIC: Inpatient psychiatric services under 21 — general requirements

TOPIC IN DETERMINATIONS FILE: Inpatient psychiatric services under 21 - general requirements

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Each admission; ongoing certification and facility qualification.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: each admission to an inpatient psychiatric facility for under-21 services

BASIS: The plan's service definition carries the provision: inpatient psychiatric services for recipients under age 21 must be provided by a psychiatric facility or an inpatient program in a psychiatric facility that meets the requirements of 42 CFR 441.151 and 42 CFR Part 483 Subpart G; services are provided before the recipient reaches 21 or, if receiving them immediately before 21, until the earlier of no longer requiring them or reaching age 22; prior approval is required through the utilization management contractor, with the initial approval ensuring the level of service is appropriate and concurrent reviews determining ongoing medical necessity (SPA 25-0001, Attachment 3.1-A Appendix 2, Page 1).

RECORD LOCATION: H-018 (SPA 25-0001), Attachment 3.1-A Appendix 2 Page 1, file p.28

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.151: facility qualification (accreditation and Subpart D compliance), the under-21 age rule with continuation to 22, and active treatment in a qualifying facility.

CFR-441-029: Certification of need for under-21 psychiatric services

CITATION: 42 CFR 441.152-441.153

TOPIC: Certification of need for under-21 psychiatric services

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - At each admission; emergency admissions certified within 14 days after admission.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Partial** (determiner: NC Cure re-grade seat (CCP))

APPLICABILITY (DETERMINATIONS FILE): Applies: at each admission; emergency admissions within 14 days

BASIS: CCP 8D-1, Psychiatric Residential Treatment Facilities, section 5.3.2 (printed pp.6-7) now carries the certification of need for PRTF admissions: a Certification of Need (CON) must be completed on or prior to admission when the beneficiary is Medicaid eligible or Medicaid is pending; it must be completed by an independent medical team including a qualified physician; it must not be retroactive; it must meet all federal requirements; and it must certify that ambulatory care resources within the community are insufficient to meet the treatment needs of the beneficiary, that the beneficiary requires services on an inpatient basis under the direction of a qualified physician, and that services can reasonably be expected to improve the beneficiary condition or prevent regression. A copy of the CON must be maintained in the beneficiary medical record, and the last dated signature on the CON form determines authorization for payment. Section 5.3.1 requires the CON, with the Comprehensive Clinical Assessment or Diagnostic Assessment and the

Person-Centered Plan, to be submitted to the utilization management contractor for initial authorization. Batch B prior approval passage (H-018) is retained.

RECORD LOCATION: SUP-CCP-8D-1 (Clinical Coverage Policy 8D-1, Psychiatric Residential Treatment Facilities, amended January 1, 2025), sections 5.3.1-5.3.2 at printed pp.5-7; H-018 (SPA 25-0001), Attachment 3.1-A Appendix 2 Page 1, file p.28

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The emergency admission rule of 441.153(c) (certification by the team responsible for the plan of care within 14 days after admission) is not stated. The independent team qualities in 441.153(a) (competence in diagnosis and treatment of mental illness, preferably in child psychiatry, and knowledge of the individual situation) are not stated beyond a qualified physician and a direction to meet all federal requirements. The rule for an individual who applies for Medicaid while in the facility, including coverage of any period before application for which claims are made under 441.153(b), is addressed only by the statements that the CON be done concurrently with the application and not be retroactive. No held policy states the certification regime for under-21 inpatient psychiatric admissions outside PRTFs.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File the inpatient psychiatric policy text, or amend CCP 8D-1, to state the 441.153 emergency 14-day rule, the team competence and knowledge qualities, and the certification rule for non-PRTF under-21 inpatient psychiatric admissions.
>
> **QUESTION:** Where are the 14-day emergency certification rule and the 441.153 team qualities stated for under-21 psychiatric admissions, in PRTFs and in other inpatient settings?

SEARCHES RECORDED: New evidence read: SUP-CCP-8D-1 read in full. Batch B searches carried forward: corpus searched for certification of need (no other NC policy text found); H-018 read in full.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.152-441.153: the specified team must certify that ambulatory care resources do not meet the treatment needs, that proper treatment requires services on an inpatient basis under the direction of a physician, and that services can reasonably be expected to improve the condition or prevent further regression; certification by an independent team including a physician for an individual who is a beneficiary when admitted, by the team responsible for the plan of care for an individual who applies while in the facility, and within 14 days after admission for emergency admissions.

FLAGS: CCP 8D-1 is a PRTF policy only; the row reaches under-21 inpatient psychiatric services generally. Verdict unchanged from batch B, with the uncovered element narrowed to the items named.

CFR-441-030: Active treatment — plan within 14 days of admission

CITATION: 42 CFR 441.154

TOPIC: Active treatment — plan within 14 days of admission

TOPIC IN DETERMINATIONS FILE: Active treatment - plan within 14 days of admission

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Each admission: plan developed and implemented within 14 days.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Partial** (determiner: NC Cure re-grade seat (CCP))

APPLICABILITY (DETERMINATIONS FILE): Applies: each under-21 psychiatric admission

BASIS: CCP 8D-1 carries plan elements batch B could not find in any held document: prior approval is required before PRTF services are rendered (section 5.1, printed p.5); the initial authorization request must include the Person-Centered Plan, with the Certification of Need and the Comprehensive Clinical Assessment or Diagnostic Assessment (section 5.3.1, printed p.6); continued stay requires that treatment planning be individualized and appropriate to the beneficiary changing condition, with realistic and specific goals and objectives stated, and that the treatment plan has been implemented and updated (section 3.2.2(c), printed p.3); and discharge planning is active from the beginning of treatment (section 3.2.2(k), printed p.4).

RECORD LOCATION: SUP-CCP-8D-1 (Clinical Coverage Policy 8D-1, amended January 1, 2025), sections 3.2.2, 5.1 and 5.3.1 at printed pp.3-6

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** No held text states the 441.154 active treatment rule in terms: implementation of a professionally developed and supervised individual plan of care, developed and implemented no later than 14 days after admission, designed to achieve discharge from inpatient status at the earliest possible time. The Person-Centered Plan required at authorization is not stated to be the 441.155 individual plan of care, and no 14-day development or implementation clock is stated.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State the 14-day active treatment plan rule in CCP 8D-1 or the inpatient psychiatric policy, or identify the document that carries it.
>
> **QUESTION:** Where is the rule that the individual plan of care be developed and implemented within 14 days of admission written in NC policy?

SEARCHES RECORDED: New evidence read: SUP-CCP-8D-1 read in full and searched for active treatment language, plan timing and 14 days (no such passage found). Batch B searches carried forward: H-018 read in full; corpus searched for the 14-day plan rule.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.154: active treatment means implementation of a professionally developed and supervised individual plan of care described in 441.155, developed and implemented no later than 14 days after admission and designed to achieve the beneficiary discharge from inpatient status at the earliest possible time.

FLAGS: Moved from GAP-DETERMINED on the plan passages read in CCP 8D-1; the 14-day clock itself remains unstated, so the row is Partial and not Verified.

CFR-441-031: Under-21 psychiatric plan of care — 30-day reviews

CITATION: 42 CFR 441.155

TOPIC: Under-21 psychiatric plan of care — 30-day reviews

TOPIC IN DETERMINATIONS FILE: Under-21 psychiatric plan of care - 30-day reviews

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Plan reviewed every 30 days by the 441.156 team.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (periodic) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Partial** (determiner: NC Cure re-grade seat (CCP))

APPLICABILITY (DETERMINATIONS FILE): Applies: each under-21 psychiatric stay

BASIS: CCP 8D-1 carries part of the plan of care content: continued stay criteria require individualized treatment planning with realistic and specific goals and objectives stated, documentation of the expected benefits from all relevant treatment modalities, and that the treatment plan has been implemented and updated (section 3.2.2(c), printed p.3); an individualized discharge plan with specific, realistic, objective and measurable discharge criteria and plans for appropriate follow-up care (section 3.2.2(g)); active discharge planning from the beginning of treatment (section 3.2.2(k)); and a documented active attempt at coordination of care with relevant outpatient providers (section 3.2.2(l)). Concurrent reviews determine ongoing medical necessity, and providers shall submit an updated Person-Centered Plan (section 5.3.1, printed p.6).

RECORD LOCATION: SUP-CCP-8D-1 (Clinical Coverage Policy 8D-1, amended January 1, 2025), sections 3.2.2 and 5.3.1 at printed pp.3-4 and 6

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 30-day review cycle of 441.155(c) (review every 30 days by the team specified in 441.156, to determine that services being provided are or were required on an inpatient basis and to recommend changes in the plan) is not stated; the concurrent reviews in CCP 8D-1 carry no stated interval and are utilization reviews, not team plan reviews. Also not stated: that the plan be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the beneficiary situation, that it be developed in consultation with the beneficiary and the parents, legal guardians or others in whose care the beneficiary will be released, and post-discharge coordination with the beneficiary family, school and community.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State the plan of care content elements and the 30-day team review cycle in CCP 8D-1 or the inpatient psychiatric policy.
>
> **QUESTION:** What NC document sets the 30-day review cycle, and the diagnostic evaluation and consultation elements, for PRTF and inpatient psychiatric plans of care?

SEARCHES RECORDED: New evidence read: SUP-CCP-8D-1 read in full and searched for 30-day plan review language (none found; hits for team and plan are the passages cited). Batch B searches carried forward.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.155: an individual plan of care based on a diagnostic evaluation including the medical, psychological, social, behavioral and developmental aspects of the beneficiary situation, developed by the team specified in 441.156 in consultation with the beneficiary and parents, legal guardians or others in whose care the beneficiary will be

released, stating treatment objectives and prescribing an integrated program of therapies, activities and experiences, including post-discharge plans and coordination, and reviewed every 30 days by that team.

FLAGS: Moved from GAP-DETERMINED on the plan content passages read in CCP 8D-1; the 30-day team review itself remains unstated, so the row is Partial and not Verified.

CFR-441-032: Team developing the plan of care — composition

CITATION: 42 CFR 441.156

TOPIC: Team developing the plan of care — composition

TOPIC IN DETERMINATIONS FILE: Team developing the plan of care - composition

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Each plan development and 30-day review.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Partial** (determiner: NC Cure re-grade seat (CCP))

APPLICABILITY (DETERMINATIONS FILE): Applies: each plan development and review

BASIS: CCP 8D-1 carries one team element in terms: PRTF programs must be under the direction of a board-eligible or certified child psychiatrist or general psychiatrist with experience in the treatment of children (section 6.1, printed p.8), which matches one of the minimum leadership options in 441.156(c). The policy also works with a beneficiary treatment team (therapeutic leave must be agreed upon by the treatment team and documented on the treatment or habilitation plan, section 5.3.3, printed p.7) and, for certification of need, an independent medical team including a qualified physician (section 5.3.2, printed p.6).

RECORD LOCATION: SUP-CCP-8D-1 (Clinical Coverage Policy 8D-1, amended January 1, 2025), sections 5.3.2, 5.3.3 and 6.1 at printed pp.6-8

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The composition of the interdisciplinary team that develops the individual plan of care is not stated: none of the 441.156(c) leadership alternatives beyond psychiatrist direction, none of the additional members required by 441.156(d) (a psychiatric social worker; a registered nurse with specialized training or one year of experience in treating mentally ill individuals; an occupational therapist who is licensed where required and has specialized training or one year of experience in treating mentally ill individuals; or a psychologist with a master degree in clinical psychology or certified by the State or the State psychological association), the team capabilities listed in 441.156(b), or that the team must be employed by, or provide services to patients in, the facility.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State the 441.156 team composition for the individual plan of care in CCP 8D-1 or the inpatient psychiatric policy.

QUESTION: Where is the facility plan-of-care team composition, beyond psychiatrist direction of the program, stated for NC PRTFs?

SEARCHES RECORDED: New evidence read: SUP-CCP-8D-1 read in full; every team passage in the policy was read (sections 5.3.2, 5.3.3, 6.1). Batch B searches carried forward: H-018 team passages are ACT and CST service definitions, not facility plan of care teams.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.156: the individual plan of care must be developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to patients in, the facility; the team must be capable of the assessments, objective setting and modality prescribing listed in paragraph (b); it must include at minimum one of the paragraph (c) leadership combinations and also one of the paragraph (d) additional members.

FLAGS: Moved from GAP-DETERMINED on the psychiatrist direction passage read at section 6.1 of CCP 8D-1; the full team composition remains unstated, so the row is Partial and not Verified.

CFR-441-033: Maintenance of effort — under-21 psychiatric FFP

CITATION: 42 CFR 441.180-441.182

TOPIC: Maintenance of effort — under-21 psychiatric FFP

TOPIC IN DETERMINATIONS FILE: Maintenance of effort - under-21 psychiatric FFP

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Quarterly computation; cost data submissions per CMS schedule; records continuously.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (quarterly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: quarterly computation; cost data per CMS schedule

BASIS: No governing document producible: no held NC document addresses the maintenance of effort conditions on FFP for inpatient psychiatric services for individuals under 21 (the nonfederal expenditure comparison of 441.181), the quarterly computations, or the cost data submissions of 441.182.

RECORD LOCATION:

SECTION 5D FACE

UNCOVERED ELEMENT:

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: File the maintenance of effort computations and cost data submissions for the under-21 psychiatric benefit, or record the basis on which the condition is met.

QUESTION: How does NC document the 441.181 maintenance of effort for under-21 psychiatric services?

SEARCHES RECORDED: Plan, contracts and corpus searched for maintenance of effort in the under-21 psychiatric context and for 441.180-441.182 (no hits in the document-axis map for Part 441 beyond the provisions listed). No MOE record is held.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.180-441.182: FFP for under-21 psychiatric services conditioned on the state maintaining its nonfederal mental health expenditure effort, with cost reporting.

CFR-441-034: PRTF emergency preparedness

CITATION: 42 CFR 441.184

TOPIC: PRTF emergency preparedness

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Plan/policies/communication reviewed at least every 2 years; training every 2 years; exercises twice per year.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (at least every 2 years, every 2 years, per year) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: each psychiatric residential treatment facility, since 2016-09-16

BASIS: No governing document producible: no held NC document states a PRTF emergency plan, policies and procedures, communication plan, or the biennial review, training and exercise duties of 441.184. The under-21 service definition incorporates 42 CFR Part 483 Subpart G for facility requirements (H-018) but does not carry the emergency preparedness elements, which sit at 483.73 as applied to PRTFs by 441.184.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File PRTF emergency preparedness documentation or the survey protocol showing 483.73 review for PRTFs.
>
> **QUESTION:** How is PRTF compliance with 483.73 verified in NC, and by which survey agency?

SEARCHES RECORDED: H-018 read; Tailored Plan contracts (H-052, H-053) and provider manuals searched for PRTF emergency preparedness; corpus searched for 'emergency preparedness' in PRTF contexts. No PRTF-specific text found. The Tailored Plan contract's clinical policy list incorporates NC Clinical Coverage Policy 8D-1, Psychiatric Residential Treatment Facilities for Children under the Age of 21, by reference (H-053, file p.103), but the 8D-1 text itself is not held.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.184: PRTFs must comply with the emergency preparedness requirements at 42 CFR 483.73 (plan, policies, communication, training and testing).

CFR-441-035: Abortion — life-of-mother certification

CITATION: 42 CFR 441.203

TOPIC: Abortion — life-of-mother certification

TOPIC IN DETERMINATIONS FILE: Abortion - life-of-mother certification

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Each abortion for which FFP is claimed.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Verified** (determiner: NC Cure re-grade seat (CCP))

APPLICABILITY (DETERMINATIONS FILE): Applies: each abortion for which FFP is claimed

BASIS: The acquired abortion policy carries the certification in terms. Section 3.2.2(a) covers a therapeutic abortion where a pregnant beneficiary suffers from a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. Section 5.2.1 states the federal certification requirement: Medicaid agencies must obtain certification in writing from the physician performing the abortion attesting to the fact that in his or her professional judgment the life of the mother would be endangered if the fetus were carried to term; the medical diagnosis and health records must support the certification, and health records supporting the certification must be submitted to the DHHS fiscal contractor along with the abortion statement. Section 5.3 specifies the abortion statement the primary physician or surgeon is responsible for obtaining: the beneficiary name, address and identification number, the gestational age, item 5 checked for the life ground, the physician printed name, signature and NPI number, and the date the certification was signed.

RECORD LOCATION: SUP-CCP-1E-3 (Clinical Coverage Policy No. 1E-2 as printed on its face, Therapeutic and Non-therapeutic Abortions, amended February 15, 2024), section 3.2.2 at printed p.3, section 5.2.1 at printed p.4, section 5.3 at printed pp.5-6 and Attachment B at printed p.14; H-071 (Provider Manual, AmeriHealth Caritas NC), Section V covered services table, printed p.72 (batch B passage retained)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.203: FFP for an abortion only where a physician certifies, on the stated grounds, that the woman life would be endangered, with the certification and supporting documentation on file with the agency.

FLAGS: Numbering conflict flagged: the acquired policy face numbers it 1E-2, while batch B and the H-074 index listed the abortion policy as 1E-3; the cure acquisition file is SUP-CCP-1E-3. Graded on the policy face and the text read.

CFR-441-036: Abortion — no payment before documentation received

CITATION: 42 CFR 441.206

TOPIC: Abortion — no payment before documentation received

TOPIC IN DETERMINATIONS FILE: Abortion - no payment before documentation received

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Pre-payment check on each abortion claim.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Verified** (determiner: NC Cure re-grade seat (CCP))

APPLICABILITY (DETERMINATIONS FILE): Applies: pre-payment check on each abortion claim

BASIS: The acquired abortion policy states the pre-payment documentation rule in terms at section 5.3: providers must certify in writing that a therapeutic abortion was performed for one of the reasons listed in section 5.2, the primary physician or surgeon is responsible for obtaining the abortion statement, and all claims will be denied until the appropriate statement is on file. For life-threatening conditions, the health records supporting the certification must be submitted to the DHHS fiscal contractor along with the abortion statement (section 5.2.1(c) and the note in section 5.3). Attachment A likewise marks the abortion statement as required for therapeutic abortion claims, with records required for life-threatening diagnoses.

RECORD LOCATION: SUP-CCP-1E-3 (Clinical Coverage Policy No. 1E-2 as printed on its face, Therapeutic and Non-therapeutic Abortions, amended February 15, 2024), sections 5.2.1 and 5.3 at printed pp.4-6 and Attachment A at printed pp.11-12

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.206: FFP is not available in any expenditures for abortions or other medical procedures otherwise provided for under 441.203 if the Medicaid agency has paid without first having received the certifications and documentation specified in that section.

FLAGS: Numbering conflict flagged: the acquired policy face numbers it 1E-2, while batch B and the H-074 index listed the abortion policy as 1E-3; the cure acquisition file is SUP-CCP-1E-3. Graded on the policy face and the text read.

CFR-441-037: Abortion documentation — 3-year retention

CITATION: 42 CFR 441.208

TOPIC: Abortion documentation — 3-year retention

TOPIC IN DETERMINATIONS FILE: Abortion documentation - 3-year retention

OBLIGATED LEVEL: agency

CADENCE: RECURRING - 3-year retention from each certification.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure re-grade seat (CCP))

APPLICABILITY (DETERMINATIONS FILE): Applies: 3-year retention from each certification

BASIS: No governing document producible: the newly acquired abortion policy was read in full and states no retention period for abortion certifications and documentation. Its only retention passage is the general compliance duty in section 7.1(a) to comply with applicable agreements, laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements, with no period stated. No other held document states a 3-year retention rule for abortion certifications and documentation.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File the retention schedule entry covering abortion certifications, or state the 3-year rule in the abortion clinical coverage policy (CCP 1E-2 as printed on its face).
>
> **QUESTION:** Under what retention schedule does NC keep abortion certifications, and for how long?

SEARCHES RECORDED: SUP-CCP-1E-3 (abortion policy, CCP 1E-2 as printed) read in full and searched for retention language; only the section 7.1(a) general compliance passage was found. Batch B searches carried forward: corpus searched for retention periods tied to abortion documentation; H-071 and H-163 retention passages read; none states a period for abortion documentation.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.208: Medicaid agencies must maintain copies of the certifications and documentation specified in 441.203 for 3 years under the recordkeeping requirements at 45 CFR 75.361.

FLAGS: Verdict unchanged from batch B: the new policy carries the certifications themselves (graded at CFR-441-035 and CFR-441-036) but does not state how long the agency maintains copies, so the new text does not move this row.

CFR-441-038: Sterilization — state plan requirement

CITATION: 42 CFR 441.252

TOPIC: Sterilization — state plan requirement

TOPIC IN DETERMINATIONS FILE: Sterilization - state plan requirement

OBLIGATED LEVEL: agency

CADENCE: FIXED - One-time state plan provision; umbrella for all sterilization rows below.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Verified** (determiner: NC Cure re-grade seat (CCP))

APPLICABILITY (DETERMINATIONS FILE): Applies: plan-level provision; umbrella for the sterilization rows

BASIS: Plan section 3.4, Special Requirements Applicable to Sterilization Procedures, citing 42 CFR 441.252, carries the provision in terms: all requirements of 42 CFR Part 441, Subpart F are met.

The acquired sterilization policy confirms the operating policy set: section 2.1.2 provides that Medicaid shall cover sterilization procedures for beneficiaries age 21 and over that meet the requirements found in 42 CFR Part 441, Subpart F and the policy, and section 5.3 requires voluntary informed consent according to the requirements of the policy and the federal regulations listed in 42 CFR 441.253, 441.257 and 441.258.

RECORD LOCATION: H-001 (Title XIX State Plan), section 3.4, PDF p.72; SUP-CCP-1E-4 (Clinical Coverage Policy No. 1E-3 as printed on its face, Sterilization Procedures, amended January 1, 2026), sections 2.1.2 and 5.3 at printed pp.2 and 5

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.252: a State plan must provide that the Medicaid agency will make payment under the plan for sterilization procedures and hysterectomies only if all the requirements of Subpart F were met.

FLAGS: Numbering conflict flagged: the acquired policy face numbers it 1E-3, while batch B and the H-074 index listed the sterilization policy as 1E-4; the cure acquisition file is SUP-CCP-1E-4. Graded on the policy face and the text read. Verdict unchanged from batch B; the new policy text corroborates the plan statement and does not change the grade.

CFR-441-039: Sterilization — 30-to-180-day waiting period; age and consent conditions

CITATION: 42 CFR 441.253

TOPIC: Sterilization — 30-to-180-day waiting period; age and consent conditions

TOPIC IN DETERMINATIONS FILE: Sterilization - 30-to-180-day waiting period; age and consent conditions

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Each sterilization; 30–180 day window (72-hour minimum in premature-delivery/emergency-abdominal-surgery exceptions).

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Verified** (determiner: NC Cure re-grade seat (CCP))

APPLICABILITY (DETERMINATIONS FILE): Applies: each sterilization

BASIS: The acquired sterilization policy carries every element batch B could not complete. Age and competence: the note in section 4.0, citing 42 CFR 441.253, states there is no EPSDT exception and that FFP is available for the sterilization of a beneficiary only if the beneficiary is at least 21 years old at the time consent is obtained; section 3.2.2 covers a voluntary sterilization only if the informed consent is signed, the beneficiary is not legally declared to be mentally incompetent, the beneficiary is not in the institutional categories listed there, and the beneficiary gave informed consent. Consent standard: section 5.3 requires voluntary informed consent according to the policy and the federal regulations listed in 42 CFR 441.253, 441.257 and 441.258. Timing: section 5.3.1 requires consent to be obtained at least 30, but not more than 180, consecutive days prior to the date of the sterilization, with both exception prongs stated in full: for preterm delivery, informed consent must have been given at least 30 consecutive days before the expected date of delivery and at least 72

hours must have passed since the informed consent was given; for emergency abdominal surgery, at least 72 hours must have passed since the informed consent was given.

RECORD LOCATION: SUP-CCP-1E-4 (Clinical Coverage Policy No. 1E-3 as printed on its face, Sterilization Procedures, amended January 1, 2026), sections 3.2.2, 4.0, 5.3 and 5.3.1 at printed pp. 4-5; H-071 (Provider Manual, AmeriHealth Caritas NC), Sterilizations section, printed p.99 (batch B passage retained)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.253: FFP is available for a sterilization only if the individual is at least 21 years old at the time consent is obtained, is not a mentally incompetent individual, has voluntarily given informed consent in accordance with 441.257 and 441.258, and at least 30 days but not more than 180 days have passed between consent and the sterilization, with the stated preterm delivery and emergency abdominal surgery exceptions.

FLAGS: Numbering conflict flagged: the acquired policy face numbers it 1E-3, while batch B and the H-074 index listed the sterilization policy as 1E-4; the cure acquisition file is SUP-CCP-1E-4. Graded on the policy face and the text read.

CFR-441-040: Sterilization of mentally incompetent or institutionalized individuals — absolute FFP bar

CITATION: 42 CFR 441.254

TOPIC: Sterilization of mentally incompetent or institutionalized individuals — absolute FFP bar

TOPIC IN DETERMINATIONS FILE: Sterilization of mentally incompetent or institutionalized individuals - absolute FFP bar

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Each sterilization claim; status determination before procedure.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Verified** (determiner: NC Cure re-grade seat (CCP))

APPLICABILITY (DETERMINATIONS FILE): Applies: each sterilization claim

BASIS: The acquired sterilization policy states the bar as a coverage condition. Section 3.2.2 covers a voluntary tubal sterilization or vasectomy only if the beneficiary is not legally declared to be mentally incompetent and is not one of the following: involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness. Section 4.2.2(a) provides that Medicaid shall not cover sterilization when the requirements listed in section 3.2.2 have not been met, and the note in section 4.2.2 adds that if a judicial court orders a sterilization procedure for a Medicaid beneficiary who is a ward of the county and mentally incompetent, the beneficiary is not eligible for sterilization procedures.

RECORD LOCATION: SUP-CCP-1E-4 (Clinical Coverage Policy No. 1E-3 as printed on its face, Sterilization Procedures, amended January 1, 2026), sections 3.2.2 and 4.2.2 at printed pp.4-5

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.254: FFP is not available for the sterilization of a mentally incompetent individual or an institutionalized individual, as those terms are defined in 441.251.

FLAGS: Numbering conflict flagged: the acquired policy face numbers it 1E-3, while batch B and the H-074 index listed the sterilization policy as 1E-4; the cure acquisition file is SUP-CCP-1E-4. Graded on the policy face and the text read.

CFR-441-041: Hysterectomy — informed acknowledgment or physician certification

CITATION: 42 CFR 441.255

TOPIC: Hysterectomy — informed acknowledgment or physician certification

TOPIC IN DETERMINATIONS FILE: Hysterectomy - informed acknowledgment or physician certification

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Each hysterectomy for which FFP is claimed; acknowledgment or certification obtained before payment.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Verified** (determiner: NC Cure re-grade seat (CCP))

APPLICABILITY (DETERMINATIONS FILE): Applies: each hysterectomy for which FFP is claimed

BASIS: The acquired hysterectomy policy carries the rule. Section 5.2, Informed Consent: except when designated an emergency abdominal surgery, the beneficiary shall be informed orally and in writing prior to the surgery as to the nature of the surgery and of the fact that the surgery will render the beneficiary permanently incapable of reproducing, and the beneficiary or her representative, if any, shall sign a written acknowledgement of receipt of that information. Section 4.2.1(a): hysterectomy procedures are not covered when the hysterectomy is performed for the purpose of sterilization. Section 5.3.4, Emergency Situations: where a beneficiary requires a hysterectomy due to a life-threatening emergency situation and the physician determines that prior acknowledgement is not possible, the physician who performs the hysterectomy shall certify in writing that it was performed under a life-threatening emergency situation in which he or she determined prior acknowledgment was not possible, including a description of the nature of the emergency, the beneficiary name and address, the physician dated signature and all relevant health records. Section 5.3.6, Previous Sterilization: the physician shall certify in writing that the beneficiary was already sterile at the time of the hysterectomy, including the cause of the sterility, the beneficiary name and address, the physician dated signature and all relevant health records. Section 5.3.5 addresses a hysterectomy performed during a retroactive eligibility period, requiring a valid hysterectomy statement as indicated in section 5.3.

RECORD LOCATION: SUP-CCP-1E-2 (Clinical Coverage Policy No. 1E-1 as printed on its face, Hysterectomy, amended June 1, 2023), sections 4.2.1, 5.2 and 5.3.4-5.3.6 at printed pp.6-7

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.255: FFP is available for a hysterectomy only if the individual was informed orally and in writing before the surgery that it will render her

permanently incapable of reproducing and signed a written acknowledgment, or a physician certifies that the individual was already sterile, or that the hysterectomy was performed under a medical emergency where prior acknowledgment was not possible, or the retroactive eligibility conditions are met; and never where the hysterectomy was performed solely to render the individual incapable of reproducing.

FLAGS: Numbering conflict flagged: the acquired policy face numbers it 1E-1, while batch B and the H-074 index listed the hysterectomy policy as 1E-2; the cure acquisition file is SUP-CCP-1E-2. Graded on the policy face and the text read.

CFR-441-042: Sterilization/hysterectomy — documentation before payment

CITATION: 42 CFR 441.256

TOPIC: Sterilization/hysterectomy — documentation before payment

TOPIC IN DETERMINATIONS FILE: Sterilization/hysterectomy - documentation before payment

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Pre-payment documentation check on each sterilization/ hysterectomy claim.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Verified** (determiner: NC Cure re-grade seat (CCP))

APPLICABILITY (DETERMINATIONS FILE): Applies: pre-payment documentation check on each claim

BASIS: Both halves now state documentation before payment in terms. Sterilization: the acquired sterilization policy, section 5.3.4(g), provides that a valid sterilization consent must be on file with the DHHS fiscal contractor before payment can be made for a sterilization procedure; Attachment A, section H, states that a manual review of sterilization claims is performed according to CMS approved guidelines to ensure compliance with federally mandated guidelines, and section I provides that claims will be denied or recouped if the sterilization consent form on file is invalid. Hysterectomy: the acquired hysterectomy policy, section 5.3.7, provides that the hysterectomy statement shall be on file with the DHHS fiscal contractor in order to process the claim, and that when a claim is submitted electronically but no hysterectomy statement is on file, the claim will suspend for two weeks to allow time for the statement to be received and processed. Batch B passage from H-071 (the Sterilization Consent form submitted at the same time as the claim) is retained as corroboration.

RECORD LOCATION: SUP-CCP-1E-4 (Clinical Coverage Policy No. 1E-3 as printed on its face, Sterilization Procedures, amended January 1, 2026), section 5.3.4(g) at printed p.7 and Attachment A sections H-I at printed p.18; SUP-CCP-1E-2 (Clinical Coverage Policy No. 1E-1 as printed on its face, Hysterectomy, amended June 1, 2023), section 5.3.7 at printed p.7; H-071 (Provider Manual, AmeriHealth Caritas NC), Sterilizations section, printed p.99

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.256: the Medicaid agency will make payment under the plan for sterilization procedures and hysterectomies only if all the requirements of Subpart F were met, which includes receiving the documentation required by 441.253 through 441.255 before payment.

FLAGS: Numbering conflicts flagged on the component policies: the sterilization policy face numbers it 1E-3 (file SUP-CCP-1E-4) and the hysterectomy policy face numbers it 1E-1 (file SUP-CCP-1E-2); batch B and the H-074 index used the higher numbers. Graded on the policy faces and the text read.

CFR-441-043: Sterilization informed consent — required content and prohibitions

CITATION: 42 CFR 441.257

TOPIC: Sterilization informed consent — required content and prohibitions

TOPIC IN DETERMINATIONS FILE: Sterilization informed consent - required content and prohibitions

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Each sterilization consent; applies to consent process and setting.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Partial** (determiner: NC Cure re-grade seat (CCP))

APPLICABILITY (DETERMINATIONS FILE): Applies: each sterilization consent

BASIS: The acquired sterilization policy carries several 441.257 elements in terms. Section 5.3 requires voluntary informed consent according to the requirements of the policy and the federal regulations listed in 42 CFR 441.253, 441.257 and 441.258. Section 5.3.2 states the barred consent settings, and adds one: informed consent may not be obtained while the beneficiary to be sterilized is in labor or childbirth, seeking to obtain or obtaining an abortion, under the influence of alcohol or other substances that affect the beneficiary state of awareness, or under anesthesia or any other substance that affects the beneficiary ability to provide informed consent; its note adds that any state or local requirements for obtaining consent, except those requiring spousal consent, must be followed. Section 5.4 carries interpreter services, with the interpreter handwritten signature, the date of the service and the language used documented on the consent form, and a fax or mail attestation route for a telephone interpreter. Section 5.3.4(e) requires that a copy of the completed consent form be provided to the beneficiary.

RECORD LOCATION: SUP-CCP-1E-4 (Clinical Coverage Policy No. 1E-3 as printed on its face, Sterilization Procedures, amended January 1, 2026), sections 5.3, 5.3.2, 5.3.4 and 5.4 at printed pp. 5-8; H-071 (Provider Manual, AmeriHealth Caritas NC), Sterilizations section, printed p.99 (batch B passage retained)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The oral advisory content of 441.257(a)(1) is not reproduced in any text read: advice that the individual is free to withhold or withdraw consent at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits; a description of available alternative methods of family planning and birth control; advice that the sterilization procedure is considered to be irreversible; a thorough explanation of the specific sterilization procedure to be performed; a full description of the discomforts and risks, including the type and possible effects

of any anesthetic to be used; a full description of the benefits or advantages that may be expected; and advice that the sterilization will not be performed for at least 30 days except under the stated exceptions. Also not stated in the policy text: the offer to answer questions, suitable arrangements to communicate the information to an individual who is blind, deaf or otherwise handicapped, and permission for a witness of the individual choice to be present when consent is obtained. The policy incorporates 441.257 by citation and links the federal consent form at Attachments B and C, but the form own text is not in the acquired file and was not read.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: File the text of the current federal Consent for Sterilization form as used in NC, or state the 441.257(a)(1) advisories in the sterilization policy, so the oral informing content is on the record.

QUESTION: Where is the oral advisory content of 441.257(a)(1) recorded for NC sterilization consents?

SEARCHES RECORDED: SUP-CCP-1E-4 read in full and searched for the advisory language (irreversible, alternatives, discomforts, risks, benefits, withdrawal, witness of choice); only the passages cited were found. Batch B corpus searches for sterilization consent content carried forward.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.257: an individual has given informed consent only if the person obtaining consent offered to answer questions, provided a copy of the consent form and provided orally the seven items of advice and explanation in paragraph (a)(1), with effective communication arrangements for a handicapped individual, an interpreter where needed, and a witness of the individual choice permitted to be present; and consent may not be obtained while the individual is in labor or childbirth, seeking or obtaining an abortion, or under the influence of alcohol or other substances that affect the state of awareness.

FLAGS: Numbering conflict flagged: the acquired policy face numbers it 1E-3, while batch B and the H-074 index listed the sterilization policy as 1E-4; the cure acquisition file is SUP-CCP-1E-4. Graded on the policy face and the text read. Verdict unchanged from batch B, with the uncovered element narrowed to the advisory content and the items named.

CFR-441-044: Sterilization consent form — signatures and certifications

CITATION: 42 CFR 441.258

TOPIC: Sterilization consent form — signatures and certifications

TOPIC IN DETERMINATIONS FILE: Sterilization consent form - signatures and certifications

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Each sterilization; all signatures and certifications dated.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **Verified** (determiner: NC Cure re-grade seat (CCP))

APPLICABILITY (DETERMINATIONS FILE): Applies: each sterilization

BASIS: The acquired sterilization policy carries the signature and certification block item by item. Section 5.3.5: the beneficiary to be sterilized and the person obtaining the beneficiary consent shall sign and date the sterilization consent form, the signatures must be handwritten, and the physician handwritten signature must be dated on or after the date of service. Section 5.4: where interpreter services are needed, the interpreter handwritten signature, the date of the interpreter service and the language used must be documented on the Consent for Sterilization Form. Attachment B lists the federal consent form fields in order, including the beneficiary handwritten signature and its date (fields 7 and 8), the interpreter handwritten signature and its date (fields 11 and 12), the handwritten signature of the person obtaining consent and its date (fields 15 and 16), selection of the appropriate final paragraph for the Physician Statement (field 21), and the physician handwritten signature and its date, which must be on or after the date of service (fields 24 and 25). Section 5.3.4(e) carries distribution of copies: the provider obtaining consent shall maintain the original completed form in the beneficiary health record, a copy must be provided to the beneficiary, and copies must be provided to the physician or provider conducting the procedure, the interpreter if one is being used, and any other state agency or program requiring the documentation.

RECORD LOCATION: SUP-CCP-1E-4 (Clinical Coverage Policy No. 1E-3 as printed on its face, Sterilization Procedures, amended January 1, 2026), sections 5.3.4, 5.3.5 and 5.4 at printed pp.6-8 and Attachment B at printed pp.20-21; H-071 (Provider Manual, AmeriHealth Caritas NC), Sterilizations section, printed p.99 (batch B passage retained)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.258: the consent form must be signed and dated by the individual to be sterilized, the interpreter if one was provided, the person who obtained the consent and the physician who performed the sterilization; the person obtaining consent and the physician must certify on the form as specified; and a copy of the form must be given to the individual.

FLAGS: Numbering conflict flagged: the acquired policy face numbers it 1E-3, while batch B and the H-074 index listed the sterilization policy as 1E-4; the cure acquisition file is SUP-CCP-1E-4. Graded on the policy face and the text read.

CFR-441-045: 1915(c) waiver — health and welfare safeguards

CITATION: 42 CFR 441.302(a)

TOPIC: 1915(c) waiver — health and welfare safeguards

TOPIC IN DETERMINATIONS FILE: 1915(c) waiver - health and welfare safeguards

OBLIGATED LEVEL: agency

CADENCE: FIXED - Waiver application/renewal assurance; continuous provider-standard compliance.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Waiver Operations, with the Tailored Plans (LME/MCOs)

HOME BASIS: NC's 1915(c) Innovations and TBI waivers are served through the Tailored Plans (LME/MCOs) under DHB's waiver authority; CAP waivers run through NC Medicaid Direct / DHB (Lane A §2.4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: each 1915(c) waiver NC operates (CAP/DA, CAP/C, Innovations, TBI)

BASIS: The CAP/DA renewal application carries assurance A under 42 CFR 441.302 in terms: necessary safeguards have been taken to protect the health and welfare of persons receiving waiver services, including adequate standards for all types of providers as specified in Appendix C,

assurance that state licensure and certification requirements in Appendix C are met on the date services are furnished, and compliance with section 1616(e) board and care standards for facilities where waiver services are provided. Appendix G (Participant Safeguards) specifies the critical event and incident reporting and management process behind the assurance. The draft TBI application carries the identical assurance A (H-041, p.5).

RECORD LOCATION: NL-15 (CAP/DA waiver renewal application, base waiver NC.0132), Main Module assurances at printed p.6 and Appendix G; H-041 (draft TBI Waiver application), p.5

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.302(a): health and welfare safeguards, provider standards, licensure compliance, and board and care standards.

FLAGS: NL-15 is the renewal application as filed (internal header: Draft NC.015.08.00, November 1, 2024); the CMS approval letter for CAP/DA is not posted and is not held, per the cure instruction. The grade rests on the application's assurance text, not on an approval.

CFR-441-046: 1915(c) waiver — incident management system and 90% performance levels

CITATION: 42 CFR 441.302(a)(6)

TOPIC: 1915(c) waiver — incident management system and 90% performance levels

TOPIC IN DETERMINATIONS FILE: 1915(c) waiver - incident management system and 90% performance levels

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous incident management; compliance deadlines July 9, 2027 (system) and July 9, 2029 (electronic data system); 90% performance demonstrated annually.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Waiver Operations, with the Tailored Plans (LME/MCOs)

HOME BASIS: NC's 1915(c) Innovations and TBI waivers are served through the Tailored Plans (LME/MCOs) under DHB's waiver authority; CAP waivers run through NC Medicaid Direct / DHB (Lane A §2.4).

CURE DETERMINATION: **Prospective** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Prospective: full compliance due July 9, 2027, and July 9, 2029 for the electronic data system element (register record, 89 FR 40866)

FEDERAL APPLICABILITY DATE(S): Prospective: full compliance due July 9, 2027, and July 9, 2029 for the electronic data system element (register record, 89 FR 40866) Register future date(s): 2027-07-09, 2029-07-09.

BASIS: The strengthened incident management requirements of 441.302(a)(6) are not yet due in the evidence window: the register record states the requirement is new (89 FR 40866, May 10, 2024), with system compliance due July 9, 2027 and the electronic incident data system due July 9, 2029. A current-state incident system is documented in the waiver applications (Appendix G critical incident reporting and management in NL-15; the IRIS incident system and quarterly incident reporting described in H-041 at pp.140-148), but the (a)(6) performance levels are a future compliance obligation, graded Prospective rather than tested against the current system.

RECORD LOCATION: Register record of evidence for CFR-441-046; NL-15 Appendix G; H-041 (draft TBI application), pp.140-148

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.302(a)(6): an incident management system that identifies, reports, tracks, investigates and trends critical incidents, with at least 90

percent of investigations completed within the stated timeframes, phased in under the 2024 Access Rule.

FLAGS: The 90 percent compliance rates in NL-15 (case management entity monitoring, printed p. 26) are a different measure and were not used as the (a)(6) performance level.

CFR-441-047: 1915(c) waiver — financial accountability and independent audit

CITATION: 42 CFR 441.302(b)

TOPIC: 1915(c) waiver — financial accountability and independent audit

TOPIC IN DETERMINATIONS FILE: 1915(c) waiver - financial accountability and independent audit

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Independent audit per CMS schedule; financial records maintained continuously.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (periodic) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Waiver Operations, with the Tailored Plans (LME/MCOs)

HOME BASIS: NC's 1915(c) Innovations and TBI waivers are served through the Tailored Plans (LME/MCOs) under DHB's waiver authority; CAP waivers run through NC Medicaid Direct / DHB (Lane A §2.4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: each 1915(c) waiver, continuously

BASIS: Assurance B is carried in terms: the state assures financial accountability for funds expended for home and community-based services and maintains and makes available to HHS (including the OIG), the Comptroller General, or other designees, appropriate financial records documenting the cost of services, with methods specified in Appendix I (NL-15, printed p.6). Appendix I-1, however, states the opposite of an independent audit commitment for this waiver: 'The SMA does not require an independent audit of provider agencies specific to this waiver,' describing instead OCPI post-payment reviews, contracted pre-payment reviews, and MMIS claims edits (NL-15, printed p.234). The independent audit element of 441.302(b) is therefore not carried; it is contradicted on the application's own face.

RECORD LOCATION: NL-15 (CAP/DA renewal application), assurance B at printed p.6; Appendix I-1 at printed p.234

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** An independent audit of the waiver program or of provider agencies, as 441.302(b) contemplates, is expressly not required for CAP/DA on the held application's face, and no independent waiver audit report is held for any NC waiver.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Reconcile Appendix I-1 with 441.302(b): either commission the independent audit the assurance contemplates or amend the application text, and file the most recent waiver audit.
>
> **QUESTION:** How does NC satisfy the independent audit element of 441.302(b) for its 1915(c) waivers?

SEARCHES RECORDED: NL-15 read at assurances and Appendix I; corpus searched for independent waiver audit reports (none held); H-134 (OCPI single audit material) is a Medicaid-wide audit document, not a 1915(c) independent audit.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.302(b): financial accountability assured, records available to HHS and the Comptroller General, and provision for an independent audit.

FLAGS: Internal contradiction within NL-15 (assurance B against Appendix I-1), flagged per the grading standard; graded on the more specific passage (Appendix I-1).

CFR-441-048: 1915(c) waiver — level-of-care evaluation and choice of alternatives

CITATION: 42 CFR 441.302(c)-(d)

TOPIC: 1915(c) waiver — level-of-care evaluation and choice of alternatives

TOPIC IN DETERMINATIONS FILE: 1915(c) waiver - level-of-care evaluation and choice of alternatives

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Initial evaluation when need indicated; reevaluation at least annually; informed choice at each determination.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Waiver Operations, with the Tailored Plans (LME/MCOs)

HOME BASIS: NC's 1915(c) Innovations and TBI waivers are served through the Tailored Plans (LME/MCOs) under DHB's waiver authority; CAP waivers run through NC Medicaid Direct / DHB (Lane A §2.4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: initial evaluation and at least annual reevaluation, each waiver

BASIS: Assurances C and D are carried in terms (NL-15, printed p.6): the state provides for an initial evaluation and periodic reevaluations, at least annually, of the need for the level of care specified for the waiver when there is a reasonable indication the individual might need such services in the near future but for waiver services, with procedures in Appendix B; and when an individual is determined likely to require that level of care, the individual or legal representative is informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services. Appendix B-6 specifies the evaluation and reevaluation procedures and the reasonable indication standard (at least one waiver service, at least monthly, documented in the service plan), and Appendix B-7 documents the freedom of choice procedure: a CAP Waiver Enrollment Notice is mailed initially and annually, and the participant signs and returns it acknowledging the enrollment choice (printed p.58).

RECORD LOCATION: NL-15 (CAP/DA renewal application), assurances C and D at printed p.6; Appendix B-6 at printed p.45; Appendix B-7 at printed pp.57-58

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.302(c)-(d): evaluation and annual reevaluation of level of care need; informed choice between institutional and waiver services.

CFR-441-049: 1915(c) waiver — cost neutrality (average and actual)

CITATION: 42 CFR 441.302(e)-(f)

TOPIC: 1915(c) waiver — cost neutrality (average and actual)

TOPIC IN DETERMINATIONS FILE: 1915(c) waiver - cost neutrality (average and actual)

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Annual estimates covering each waiver year; actuals reconciled per year of the waiver period.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually, each year, per year) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Waiver Operations, with the Tailored Plans (LME/MCOs)

HOME BASIS: NC's 1915(c) Innovations and TBI waivers are served through the Tailored Plans (LME/MCOs) under DHB's waiver authority; CAP waivers run through NC Medicaid Direct / DHB (Lane A §2.4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: each waiver year

BASIS: Assurances E and F are carried in terms (NL-15, printed p.6): average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the state plan for the specified level of care had the waiver not been granted, and actual total expenditures and the FFP claim will not in any waiver year exceed 100 percent of the amount that would have been incurred absent the waiver. Cost neutrality is demonstrated in Appendix J: J-1 presents the composite cost neutrality formula with factor D, D', G and G' estimates entered for each of waiver years 1 through 5 (printed p.254), and Appendix B-3 participant counts feed the demonstration.

RECORD LOCATION: NL-15 (CAP/DA renewal application), assurances E and F at printed p.6; Appendix J-1 at printed p.254

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.302(e)-(f): average per capita and actual aggregate cost neutrality against the institutional alternative.

FLAGS: The Appendix J-1 table's column order is scrambled in the text extraction, so no figure from it is relied on; the grade rests on the assurance text and the presence of the completed per-year demonstration.

CFR-441-050: 1915(c) waiver — payment adequacy: 80% direct-care compensation

CITATION: 42 CFR 441.302(k)

TOPIC: 1915(c) waiver — payment adequacy: 80% direct-care compensation

TOPIC IN DETERMINATIONS FILE: 1915(c) waiver - payment adequacy: 80% direct-care compensation

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Annual demonstration; compliance deadline July 9, 2030.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Waiver Operations, with the Tailored Plans (LME/MCOs)

HOME BASIS: NC's 1915(c) Innovations and TBI waivers are served through the Tailored Plans (LME/MCOs) under DHB's waiver authority; CAP waivers run through NC Medicaid Direct / DHB (Lane A §2.4).

CURE DETERMINATION: **Prospective** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Prospective: compliance deadline July 9, 2030 (register record, 89 FR 40866)

FEDERAL APPLICABILITY DATE(S): Prospective: compliance deadline July 9, 2030 (register record, 89 FR 40866) Register future date(s): 2030-07-09.

BASIS: The payment adequacy requirement is not yet due in the evidence window: the register record states the requirement is new (89 FR 40866, May 10, 2024) with a compliance deadline of July 9, 2030. No NC document in the corpus yet demonstrates the 80 percent direct care compensation showing, and none is due.

RECORD LOCATION: Register record of evidence for CFR-441-050; no demonstrating document exists in the held corpus or cure acquisitions

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.302(k): at least 80 percent of Medicaid payments for specified homemaker, home health aide and personal care services spent on compensation for direct care workers, phased in under the 2024 Access Rule.

FLAGS: Prospective on the sourced compliance date; the related annual reporting row is graded at CFR-441-060.

CFR-441-051: 1915(c) waiver — supporting documentation

CITATION: 42 CFR 441.303

TOPIC: 1915(c) waiver — supporting documentation

TOPIC IN DETERMINATIONS FILE: 1915(c) waiver - supporting documentation

OBLIGATED LEVEL: agency

CADENCE: FIXED - Each waiver application/renewal; bundled-service cost tracking ongoing.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Waiver Operations, with the Tailored Plans (LME/MCOs)

HOME BASIS: NC's 1915(c) Innovations and TBI waivers are served through the Tailored Plans (LME/MCOs) under DHB's waiver authority; CAP waivers run through NC Medicaid Direct / DHB (Lane A §2.4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: each waiver application and renewal

BASIS: The supporting documentation is the application itself, held in full: the CAP/DA renewal application (NL-15, 269 pages) carries the request information, target group and level of care specifications (Appendix B), provider specifications (Appendix C), service plan procedures (Appendix D), participant direction (Appendix E), participant rights (Appendix F), safeguards (Appendix G), participant outcomes and quality improvement strategy, financial accountability (Appendix I), and the cost neutrality demonstration with per-year participant counts and factor estimates (Appendices B-3 and J). The draft TBI application likewise specifies procedures to ensure timely reevaluations citing 42 CFR 441.303(c)(4) (H-041, p.33).

RECORD LOCATION: NL-15 (CAP/DA renewal application), full document, Appendices A-K; H-041 (draft TBI application), p.33

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.303: the state must furnish the supporting documentation CMS requires for a waiver request, including cost and utilization data and reevaluation procedures.

CFR-441-052: 1915(c) waiver — duration and renewal

CITATION: 42 CFR 441.304

TOPIC: 1915(c) waiver — duration and renewal

TOPIC IN DETERMINATIONS FILE: 1915(c) waiver - duration and renewal

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Initial 3-year period; renewals every 5 years; amendments per event.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (every 5 years) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Waiver Operations, with the Tailored Plans (LME/MCOs)

HOME BASIS: NC's 1915(c) Innovations and TBI waivers are served through the Tailored Plans (LME/MCOs) under DHB's waiver authority; CAP waivers run through NC Medicaid Direct / DHB (Lane A §2.4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: each waiver approval cycle

BASIS: The renewal cycle is evidenced for NC's operating waivers: CMS approved the CAP/C renewal for five years, March 1, 2023 through February 29, 2028 (H-038); the Innovations Waiver renewal is effective July 1, 2024 through June 30, 2029 (H-037); the CAP/DA renewal application requests a five-year approval period with a proposed effective date of November 1, 2024 (NL-15, printed pp.1-2); and the TBI Waiver page carries amendments effective July 1, 2024 through April 30, 2026 (H-042).

RECORD LOCATION: H-038 (CAP/C renewal notice); H-037 (Innovations Waiver provider page); NL-15, printed pp.1-2; H-042 (TBI Waiver page)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** No held instrument shows an initial 3-year approval period for a current NC waiver, the other half of 441.304; every held approval is a renewal, and the CAP/DA renewal's CMS approval letter is not held, so its approved period could not be read.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File the CMS approval letters for the current 1915(c) renewals, including CAP/DA, so approved periods are on the record.
>
> **QUESTION:** What approval period did CMS grant for the CAP/DA renewal requested from November 1, 2024?

SEARCHES RECORDED: Waiver pages and applications read (H-037, H-038, H-039, H-042, NL-15, H-041); the 1115 package (H-025) concerns section 1115, not 1915(c) duration. No initial approval instrument is in the corpus.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.304: initial waiver period of 3 years (5 for dually eligible individuals where the state so elects under the current rule), renewals of 5 years on a CMS compliance determination.

CFR-441-053: 1915(c) waiver termination — 30-day notices

CITATION: 42 CFR 441.307

TOPIC: 1915(c) waiver termination — 30-day notices

TOPIC IN DETERMINATIONS FILE: 1915(c) waiver termination - 30-day notices

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - 30 days before termination of services; beneficiary notice per 431.210.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Waiver Operations, with the Tailored Plans (LME/MCOs)

HOME BASIS: NC's 1915(c) Innovations and TBI waivers are served through the Tailored Plans (LME/MCOs) under DHB's waiver authority; CAP waivers run through NC Medicaid Direct / DHB (Lane A §2.4).

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: on any waiver termination, 30 days before services end

BASIS: No governing document producible: no held NC document is, or references, a waiver termination notice to CMS or to beneficiaries under 441.307. No NC 1915(c) waiver termination in the period is documented in the corpus either, so neither the notice duty's performance nor a negative record is held.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Record the negative for the period (no 1915(c) waiver terminated), or file any termination notices given.
>
> **QUESTION:** Has NC terminated any 1915(c) waiver or waiver service in the period that would have triggered 441.307 notices?

SEARCHES RECORDED: Corpus searched for waiver termination notices and for 441.307 (the full map shows 441.307 in no document's text); waiver applications and pages (NL-15, H-041, H-037 to H-042) read. Appendix K material (H-035) concerns expiring flexibilities, not a waiver termination.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.307: a state terminating a waiver must notify CMS and beneficiaries at least 30 days before termination of services, with notice content per 431.210.

CFR-441-054: 1915(c) waiver — limits on FFP

CITATION: 42 CFR 441.310

TOPIC: 1915(c) waiver — limits on FFP

TOPIC IN DETERMINATIONS FILE: 1915(c) waiver - limits on FFP

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Ongoing FFP-claiming discipline; facility compliance periods.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Waiver Operations, with the Tailored Plans (LME/MCOs)

HOME BASIS: NC's 1915(c) Innovations and TBI waivers are served through the Tailored Plans (LME/MCOs) under DHB's waiver authority; CAP waivers run through NC Medicaid Direct / DHB (Lane A §2.4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: ongoing FFP claiming discipline

BASIS: The CAP/DA application carries the FFP limits in terms (Appendix A area, printed p.7): FFP is not claimed for waiver services furnished prior to development of the service plan or for services not included in the service plan; waiver services are not furnished to inpatients of a hospital, nursing facility or ICF/IID (citing 441.301(b)(1)(ii)); and, citing 42 CFR 441.310(a)(2), FFP is not claimed for room and board except as part of respite in a state-approved facility that is not a private residence, or as the portion of rent and food reasonably attributed to an unrelated caregiver living in the participant's household. Assurance I adds that habilitation services are not otherwise available through IDEA or the Rehabilitation Act and are furnished as expanded habilitation (also at H-041, p.5).

RECORD LOCATION: NL-15 (CAP/DA renewal application), Appendix A provisions at printed p.7 and assurance I; H-041 (draft TBI application), p.5 (assurance I) and p.6 (same FFP limits)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.310: no FFP before or outside the service plan, for inpatients, for room and board beyond the stated exceptions, during facility noncompliance periods, or duplicating habilitation available under IDEA or the Rehabilitation Act.

CFR-441-055: Incident management system assessment report — every 24 months

CITATION: 42 CFR 441.311(b)(1)

TOPIC: Incident management system assessment report — every 24 months

TOPIC IN DETERMINATIONS FILE: Incident management system assessment report - every 24 months

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - Every 24 months (reducible to every 60 months by CMS determination).

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (every 24 months, every 60 months) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: reporting to CMS every 24 months under the HCBS reporting subpart

BASIS: No governing document producible: no held NC document is, or references, an incident management system assessment report submitted to CMS under 441.311(b)(1). The waiver applications document the incident systems themselves (NL-15 Appendix G; H-041 IRIS reporting), but a system description in a waiver application is not the periodic assessment report this provision requires.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)

> **ACTION:** File the most recent incident management system assessment report submitted to CMS, or record the first report's due date and owner.
>
> **QUESTION:** Has NC submitted a 441.311(b)(1) assessment report, and when is the next one due?

SEARCHES RECORDED: Corpus and full document-axis map searched for 441.311 and for incident management assessment reports; waiver applications, quality strategy (H-122) and EQR report (NL-05) reviewed. No report found.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.311(b)(1): the state reports to CMS every 24 months on its incident management system assessment, reducible to 60 months on a CMS determination.

FLAGS: First-cycle timing under the 2024 Access Rule was not sourced from a held document; if CMS has set a first report date after the evidence window, this row converts to Prospective.

CFR-441-056: Critical incident annual report

CITATION: 42 CFR 441.311(b)(2)

TOPIC: Critical incident annual report

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - Annually to CMS.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: annually to CMS

BASIS: No governing document producible: no held NC document is, or references, an annual critical incident report to CMS under 441.311(b)(2) carrying the investigation, completion and corrective action percentages the provision requires. Incident data flows documented in the waiver applications run to the state and its plans (quarterly incident reports in H-041), not to CMS in this form.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File the annual critical incident report submitted to CMS, or record its due date and owner.
>
> **QUESTION:** Where is NC's annual critical incident report to CMS filed?

SEARCHES RECORDED: Corpus searched for 441.311 and annual critical incident reporting to CMS; NL-15, H-041, H-122, NL-05 reviewed. No report found.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.311(b)(2): annual report to CMS of critical incident data with the stated performance percentages.

FLAGS: First-cycle timing under the 2024 Access Rule was not sourced from a held document; see the note at CFR-441-055.

CFR-441-057: Person-centered planning annual report

CITATION: 42 CFR 441.311(b)(3)

TOPIC: Person-centered planning annual report

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - Annually to CMS.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: annually to CMS

BASIS: No governing document producible: no held NC document is, or references, an annual person-centered planning report to CMS under 441.311(b)(3). Person-centered planning is documented inside the waiver applications and the 1915(i) SPA pages, but no periodic report of planning metrics or waiver impact data to CMS is held.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File the annual person-centered planning report submitted to CMS, or record its due date and owner.
>
> **QUESTION:** Has NC submitted a person-centered planning report under 441.311(b)(3)?

SEARCHES RECORDED: Corpus searched for 441.311 and person-centered planning reports; NL-15, H-006, H-017, H-045 reviewed for reporting content. No report found.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.311(b)(3): annual report to CMS on person-centered planning performance and the waiver's impact.

FLAGS: First-cycle timing under the 2024 Access Rule was not sourced from a held document; see the note at CFR-441-055.

CFR-441-058: HCBS Quality Measure Set — biennial reporting and performance targets

CITATION: 42 CFR 441.311(c), 441.312

TOPIC: HCBS Quality Measure Set — biennial reporting and performance targets

TOPIC IN DETERMINATIONS FILE: HCBS Quality Measure Set - biennial reporting and performance targets

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Every other year; performance targets with quality improvement strategies.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (periodic) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Waiver Operations, with the Tailored Plans (LME/MCOs)

HOME BASIS: NC's 1915(c) Innovations and TBI waivers are served through the Tailored Plans (LME/MCOs) under DHB's waiver authority; CAP waivers run through NC Medicaid Direct / DHB (Lane A §2.4).

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: every other year, with state performance targets

BASIS: No governing document producible: no held NC document is, or references, a biennial HCBS Quality Measure Set submission to CMS under 441.311(c) and 441.312, or state performance targets and quality improvement strategies set under that framework. NC quality documents that are held (the 2023 Quality Strategy, H-122; the AMH measure set, H-125; the EQR technical report, NL-05) are managed care quality instruments and do not present the HCBS Quality Measure Set reporting.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File the HCBS Quality Measure Set submission and the state's performance targets, or record the first submission's due date.
>
> **QUESTION:** When does NC first report on the HCBS Quality Measure Set, and who owns the targets?

SEARCHES RECORDED: Corpus searched for 441.311, 441.312 and 'HCBS Quality Measure'; H-122, H-125, NL-05 and H-123 reviewed. No HCBS Quality Measure Set submission found. H-123 was not used for any citation-based grade.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.311(c) and 441.312: biennial reporting on the HCBS Quality Measure Set, with state-set performance targets and improvement strategies for measures below target.

FLAGS: First-cycle timing under the 2024 Access Rule was not sourced from a held document; see the note at CFR-441-055.

CFR-441-059: HCBS access reporting — waiting lists and service access

CITATION: 42 CFR 441.311(d)

TOPIC: HCBS access reporting — waiting lists and service access

TOPIC IN DETERMINATIONS FILE: HCBS access reporting - waiting lists and service access

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - Annually to CMS.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Waiver Operations, with the Tailored Plans (LME/MCOs)

HOME BASIS: NC's 1915(c) Innovations and TBI waivers are served through the Tailored Plans (LME/MCOs) under DHB's waiver authority; CAP waivers run through NC Medicaid Direct / DHB (Lane A §2.4).

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: annually to CMS

BASIS: No governing document producible: no held NC document is, or references, an annual access report to CMS under 441.311(d) covering waiting list maintenance, counts and average wait times, approval-to-service-start intervals, or the share of authorized hours provided. A waiting list figure appears in the CAP/DA application only inside a public comment urging higher participant limits (1,816 individuals, per the commenter), which is not a state access report and was not relied on.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File the annual HCBS access report submitted to CMS, or record its due date and the waiting list data owner.
>
> **QUESTION:** What waiting list and access data has NC reported to CMS under 441.311(d)?

SEARCHES RECORDED: Corpus searched for 441.311(d) and HCBS access reporting; NL-15 (including its comment appendix), H-122 and the LTSS dashboard page (H-155) reviewed. No access report found.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.311(d): annual report to CMS on waiting lists and on timely access to HCBS, with the stated metrics.

FLAGS: First-cycle timing under the 2024 Access Rule was not sourced from a held document; see the note at CFR-441-055.

CFR-441-060: Payment adequacy annual reporting

CITATION: 42 CFR 441.311(e)

TOPIC: Payment adequacy annual reporting

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - Annually to CMS.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: annually to CMS

BASIS: No governing document producible: no held NC document is, or references, an annual payment adequacy report to CMS under 441.311(e) carrying provider compensation data for homemaker, home health aide or personal care services. The register record itself notes this is a new requirement (89 FR 40866, May 10, 2024) with evidence to come; no submission is in the corpus.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File the payment adequacy submission to CMS when made, and record the data collection owner now.
>
> **QUESTION:** Has NC begun collecting the direct care compensation data that 441.311(e) reporting requires?

SEARCHES RECORDED: Corpus searched for 441.311(e) and payment adequacy reporting; rate and contract documents (H-046, H-052, H-053, H-059) reviewed for compensation data reporting. None found.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.311(e): annual report to CMS of the share of payments for specified services spent on direct care worker compensation.

FLAGS: The substantive payment standard it reports on is Prospective to 2030 at CFR-441-050; this row is graded GAP because an annual reporting duty is asserted on the register's face and no submission, due date, or negative record is held.

CFR-441-061: HCBS website transparency

CITATION: 42 CFR 441.313

TOPIC: HCBS website transparency

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Website live from July 9, 2027; functionality/timeliness verified quarterly.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (quarterly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Waiver Operations, with the Tailored Plans (LME/MCOs)

HOME BASIS: NC's 1915(c) Innovations and TBI waivers are served through the Tailored Plans (LME/MCOs) under DHB's waiver authority; CAP waivers run through NC Medicaid Direct / DHB (Lane A §2.4).

CURE DETERMINATION: **Prospective** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Prospective: website live from July 9, 2027 (register record, 89 FR 40870)

FEDERAL APPLICABILITY DATE(S): Prospective: website live from July 9, 2027 (register record, 89 FR 40870) Register future date(s): 2027-07-09.

BASIS: The website transparency duty is not yet due in the evidence window: the register record states the requirement is new (89 FR 40870, May 10, 2024) with compliance due July 9, 2027, and that CMS publishes state results on its own website. NC's existing HCBS program pages (for

example H-037, H-039, H-042) are program information pages, not the 441.313 reporting website, and none is due yet.

RECORD LOCATION: Register record of evidence for CFR-441-061; program pages H-037, H-039, H-042 reviewed for context

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.313: a state website publishing the 441.311 reporting results, with functionality and timeliness verified quarterly.

FLAGS: Prospective on the sourced compliance date.

CFR-441-062: Aged HCBS waiver (subpart H) — state assurances

CITATION: 42 CFR 441.352

TOPIC: Aged HCBS waiver (subpart H) — state assurances

TOPIC IN DETERMINATIONS FILE: Aged HCBS waiver (subpart H) - state assurances

OBLIGATED LEVEL: agency

CADENCE: FIXED - Each subpart H waiver request/renewal.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Waiver Operations, with the Tailored Plans (LME/MCOs)

HOME BASIS: NC's 1915(c) Innovations and TBI waivers are served through the Tailored Plans (LME/MCOs) under DHB's waiver authority; CAP waivers run through NC Medicaid Direct / DHB (Lane A §2.4).

CURE DETERMINATION: **N-A-DETERMINED** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): NA-REASON: STRUCTURAL

BASIS: Subpart H of Part 441 governs the section 1915(d) home and community-based waiver for the aged. NC has made no 1915(d) election: the state plan (H-001) contains no Subpart H waiver pages and no 1915(d) request, and every NC home and community-based authority in the held record is a section 1915(c) waiver (CAP/DA, CAP/C, Innovations, TBI), a 1915(i) state plan benefit, or the section 1115 demonstration. There is no 1915(d) structure in NC for the Subpart H assurances to operate on.

RECORD LOCATION: H-001 (Title XIX State Plan), full text searched for 1915(d) and 441.352 (no hit); waiver authorities of record at NL-15, H-041, H-038, H-025 STC 9.20

> **SECTION 3A FOOTING.** The closed list reason is NA-REASON: STRUCTURAL. The determiner is NC Cure grading seat B. This determination rests on the basis printed for this entry above. It also rests on the record location printed for this entry above.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.352 sits in Subpart H, the section 1915(d) aged waiver framework; the closed-list STRUCTURAL reason applies where the state has not made the election the provision governs.

FLAGS: Determiner: NC Cure grading seat B. If NC ever elects a 1915(d) waiver, this determination lapses and the row reopens.

CFR-441-063: Aged HCBS waiver — periodic evaluation and agency response

CITATION: 42 CFR 441.365

TOPIC: Aged HCBS waiver — periodic evaluation and agency response

TOPIC IN DETERMINATIONS FILE: Aged HCBS waiver - periodic evaluation and agency response

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Periodic reviews; results within 1 month, immediately on life/health threats; immediate agency response procedures.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (periodic) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Waiver Operations, with the Tailored Plans (LME/MCOs)

HOME BASIS: NC's 1915(c) Innovations and TBI waivers are served through the Tailored Plans (LME/MCOs) under DHB's waiver authority; CAP waivers run through NC Medicaid Direct / DHB (Lane A §2.4).

CURE DETERMINATION: **N-A-DETERMINED** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): NA-REASON: STRUCTURAL

BASIS: Same basis as CFR-441-062: 441.365 is a Subpart H duty owed only by a state operating a section 1915(d) aged waiver (periodic evaluation of the waiver and agency response to findings). NC operates no 1915(d) waiver; its aged HCBS runs through the 1915(c) CAP/DA waiver, whose evaluation machinery is graded at CFR-441-045 to 441-054. Nothing in the held plan or waiver record shows a 1915(d) election.

RECORD LOCATION: H-001 (Title XIX State Plan), searched for 1915(d) and 441.365 (no hit); NL-15 (the 1915(c) authority NC actually uses for this population)

> **SECTION 3A FOOTING.** The closed list reason is NA-REASON: STRUCTURAL. The determiner is NC Cure grading seat B. This determination rests on the basis printed for this entry above. It also rests on the record location printed for this entry above.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.365 sits in Subpart H; STRUCTURAL reason, same determination as CFR-441-062.

FLAGS: Determiner: NC Cure grading seat B.

CFR-441-064: Community supported living arrangements — minimum protections

CITATION: 42 CFR 441.404

TOPIC: Community supported living arrangements — minimum protections

TOPIC IN DETERMINATIONS FILE: Community supported living arrangements - minimum protections

OBLIGATED LEVEL: agency

CADENCE: FIXED - State plan assurance; ongoing provider screening and monitoring.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: Coverage policy is a published DHB function — Clinical Coverage Policies issue from the division under the G.S. 108A-54.2 procedure (Lane A §1.4, §6 R-3). A formal section label for the policy unit was NOT ESTABLISHED in sources reached; the home is the function, labeled as such.

CURE DETERMINATION: **N-A-DETERMINED** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): NA-REASON: STRUCTURAL

BASIS: Community Supported Living Arrangements were an optional, separately elected federal program; only a small set of states ever participated, and NC is not one of them on the held record. The state plan (H-001) contains no CSLA election, assurance or service page, and no NC document in the corpus mentions the program. There is no CSLA structure in NC for the 441.404 minimum protections (provider screening, monitoring and the other listed protections) to operate on.

RECORD LOCATION: H-001 (Title XIX State Plan), full text searched for community supported living and 441.404 (no hit); full document-axis map searched for Part 441 Subpart I provisions (none beyond this register row)

> **SECTION 3A FOOTING.** The closed list reason is NA-REASON: STRUCTURAL. The determiner is NC Cure grading seat B. This determination rests on the basis printed for this entry above. It also rests on the record location printed for this entry above.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.404 sits in Subpart I, the optional CSLA program; STRUCTURAL reason applies to an optional program the state has not elected.

FLAGS: Determiner: NC Cure grading seat B.

CFR-441-065: Self-directed personal assistance (1915(j)) — assurances, QA, risk management

CITATION: 42 CFR 441.464, 441.474, 441.476

TOPIC: Self-directed personal assistance (1915(j)) — assurances, QA, risk management

TOPIC IN DETERMINATIONS FILE: Self-directed personal assistance (1915(j)) - assurances, QA, risk management

OBLIGATED LEVEL: agency

CADENCE: FIXED - State plan election; QA plan and risk methods maintained continuously.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Waiver Operations, with the Tailored Plans (LME/MCOs)

HOME BASIS: NC's 1915(c) Innovations and TBI waivers are served through the Tailored Plans (LME/MCOs) under DHB's waiver authority; CAP waivers run through NC Medicaid Direct / DHB (Lane A §2.4).

CURE DETERMINATION: **N-A-DETERMINED** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): NA-REASON: STRUCTURAL

BASIS: Section 1915(j) self-directed personal assistance is a state plan election. NC has not made it: the state plan (H-001) contains no 1915(j) SPA, no Subpart J assurance, quality assurance plan or risk management material, and the plan's service pages do not list a 1915(j) benefit. NC's participant direction runs inside its 1915(c) waivers under Appendix E of those applications (CAP/DA consumer direction, described at H-039 and in NL-15), which is a different authority and does not make the 1915(j) provisions operative.

RECORD LOCATION: H-001 (Title XIX State Plan), searched for 1915(j) and 441.464-441.476 (no hit); H-039 (CAP/DA page, consumer directed services under the 1915(c) waiver); NL-15 Appendix E

> **SECTION 3A FOOTING.** The closed list reason is NA-REASON: STRUCTURAL. The determiner is NC Cure grading seat B. This determination rests on the basis printed for this entry above. It also rests on the record location printed for this entry above.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.464, 441.474 and 441.476 sit in Subpart J, an elective state plan option; STRUCTURAL reason applies where the election is not made.

FLAGS: Determiner: NC Cure grading seat B. The existence of 1915(c) participant direction is flagged so the N/A is not read as a finding that NC lacks self-direction.

CFR-441-066: Community First Choice (1915(k)) — statewideness, assessment, support, QA

CITATION: 42 CFR 441.515, 441.535, 441.555, 441.585

TOPIC: Community First Choice (1915(k)) — statewideness, assessment, support, QA

TOPIC IN DETERMINATIONS FILE: Community First Choice (1915(k)) - statewideness, assessment, support, QA

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Statewide availability continuous; face-to-face assessment per enrollment; support system per model; QA system continuous.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Waiver Operations, with the Tailored Plans (LME/MCOs)

HOME BASIS: NC's 1915(c) Innovations and TBI waivers are served through the Tailored Plans (LME/MCOs) under DHB's waiver authority; CAP waivers run through NC Medicaid Direct / DHB (Lane A §2.4).

CURE DETERMINATION: **N-A-DETERMINED** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): NA-REASON: STRUCTURAL

BASIS: Community First Choice under section 1915(k) is a state plan election carrying a 6 percentage point FMAP increase. NC has not made it: the state plan (H-001) contains no 1915(k) SPA and none of the Subpart L provisions (441.515 statewideness and election terms, 441.535 assessment, 441.555 support system, 441.585 quality assurance) appears in the plan or in any held SPA. NC's attendant-type services run through the state plan personal care benefit and the 1915(c) and 1915(i) authorities, not through 1915(k).

RECORD LOCATION: H-001 (Title XIX State Plan), searched for 1915(k), Community First Choice and 441.515-441.585 (no hit); SPA set in the full document-axis map reviewed (no 1915(k) SPA)

> **SECTION 3A FOOTING.** The closed list reason is NA-REASON: STRUCTURAL. The determiner is NC Cure grading seat B. This determination rests on the basis printed for this entry above. It also rests on the record location printed for this entry above.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR Part 441 Subpart L is an elective state plan option; STRUCTURAL reason applies where the election is not made.

FLAGS: Determiner: NC Cure grading seat B.

CFR-441-067: State plan HCBS (1915(i)) — needs-based criteria and administration

CITATION: 42 CFR 441.715, 441.745

TOPIC: State plan HCBS (1915(i)) — needs-based criteria and administration

TOPIC IN DETERMINATIONS FILE: State plan HCBS (1915(i)) - needs-based criteria and administration

OBLIGATED LEVEL: agency

CADENCE: FIXED - State plan election; needs-based criteria applied per eligibility determination.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Waiver Operations, with the Tailored Plans (LME/MCOs)

HOME BASIS: NC's 1915(c) Innovations and TBI waivers are served through the Tailored Plans (LME/MCOs) under DHB's waiver authority; CAP waivers run through NC Medicaid Direct / DHB (Lane A §2.4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: NC elected 1915(i); SPA pages effective January 1, 2025 and December 1, 2025

BASIS: NC's 1915(i) SPA pages carry the provisions. SPA 25-0024, Attachment 3.1-i (effective December 1, 2025), states the needs-based criteria in terms: need for support in acquiring, maintaining and retaining skills needed to live and work in the community, evidenced by at least one functional deficit in ADLs, IADLs, social or work skills; needs-based eligibility reevaluations are conducted at least every twelve months; and needs-based criteria for institutional services and certain waivers are more stringent than the state plan HCBS criteria. The same SPA assures an independent assessment meeting 42 CFR 441.720 and a person-centered service plan under 441.725, reviewed at least every 12 months. SPA 25-0003 carries the 441.745 administration elements, including the phase-in option text and the checked assurance that the state will notify CMS and the public at least 60 days before modifying needs-based eligibility criteria. The 1915(i) Assessment Companion Guide (H-045) operationalizes the independent assessment and person-centered plan.

RECORD LOCATION: H-006 (SPA NC-25-0024), Attachment 3.1-i at file pp.1 and 8 (needs-based criteria, reevaluation, assessment and plan assurances); H-017 (SPA 25-0003), Attachment 3.1-i at file p.13 (441.745); H-045 (1915(i) Assessment Companion Guide), p.1

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 441.715: needs-based criteria for 1915(i) eligibility, less stringent than institutional criteria, with periodic reevaluation. 42 CFR 441.745: administration, including phase-in and adjustment notice duties.

FLAGS: H-045 is version 3.0, published August 1, 2026 with an October 1, 2026 effective date; the grade rests on the SPA pages, with the guide as the operating document from that date.

CFR-442-001: State plan requirement — provider agreement standards

CITATION: 42 CFR 442.10

TOPIC: State plan requirement — provider agreement standards

TOPIC IN DETERMINATIONS FILE: State plan requirement - provider agreement standards

OBLIGATED LEVEL: agency

CADENCE: FIXED - One-time state plan provision; umbrella for all Part 442 rows below.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: plan-level provision; umbrella for the Part 442 rows

BASIS: The plan carries Part 442 in terms at two points: section 4.13 (Required Provider Agreement) states that for all providers the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met, with Part 483 Subpart B for nursing facilities and Part 483 Subpart D for ICF/MR providers also met; and section 4.24 states that with respect to nursing facilities and intermediate care facilities for the mentally retarded, all applicable requirements of 42 CFR Part 442, Subparts B and C are met.

RECORD LOCATION: H-001 (Title XIX State Plan), section 4.13, PDF p.93; section 4.24, PDF p.137

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 442.10: the plan must meet the provider agreement requirements of Part 442 Subpart B (and, as applicable, the ICF/IID provisions).

CFR-442-002: Provider agreements — certified facilities only; civil rights

CITATION: 42 CFR 442.12

TOPIC: Provider agreements — certified facilities only; civil rights

TOPIC IN DETERMINATIONS FILE: Provider agreements - certified facilities only; civil rights

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Each provider agreement execution/renewal; civil rights compliance continuous.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: each provider agreement execution and renewal

BASIS: Two elements, both carried. Certified facilities only: plan section 4.13 confines plan provider agreements to the Part 442 and Part 483 framework (Subpart B for nursing facilities, Subpart D participation requirements for ICF/MR providers), and the NCAC Chapter 22 history note at 10A NCAC 22B records that facility standards under 42 CFR Part 442 are kept on file with the Division of Health Services Regulation, the state survey and certification agency (H-099, p.2). Civil rights: plan section 7.2 (Nondiscrimination) assures that no individual shall be subject to discrimination under the plan on the grounds of race, color, national origin or handicap, under Title VI and section 504 and 45 CFR Parts 80 and 84, with methods of administration in Attachment 7.2-A and Title VI monitoring report forms for providers in the plan attachments.

RECORD LOCATION: H-001 (Title XIX State Plan), section 4.13, PDF p.93, and section 7.2, PDF p. 182, with Title VI monitoring forms at PDF pp.746-747; H-099 (10A NCAC Chapter 22), p.2

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 442.12: a provider agreement only with a facility that is certified, and only where the facility and the agreement meet the civil rights requirements referenced by the provision.

CFR-442-003: Effective date of provider agreement

CITATION: 42 CFR 442.13

TOPIC: Effective date of provider agreement

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Each provider agreement.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: each provider agreement

BASIS: The plan incorporates Part 442 Subparts A and B for all providers (section 4.13), which includes the 442.13 effective date rule, but no held document states the rule itself: that a provider agreement's effective date must be tied to the survey and certification dates as 442.13 and 431.108 prescribe, and no sample or executed NF or ICF/IID provider agreement is held against which an effective date could be read.

RECORD LOCATION: H-001 (Title XIX State Plan), section 4.13, PDF p.93

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The effective date rule of 442.13 and any executed agreement showing it applied are not in the held evidence.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File an executed NF and ICF/IID provider agreement, or state the 442.13 effective date rule in the enrollment policy.
>
> **QUESTION:** How is the effective date of a facility provider agreement set in NCTracks enrollment?

SEARCHES RECORDED: Plan read at sections 4.13 and 4.24; provider manuals and enrollment pages (H-147, H-148, H-142) reviewed for agreement effective date rules. None found. Executed provider agreements are not in the corpus.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 442.13: the effective date of a provider agreement may not precede the survey and certification conditions the section states.

CFR-442-004: Change of ownership — automatic assignment

CITATION: 42 CFR 442.14

TOPIC: Change of ownership — automatic assignment

TOPIC IN DETERMINATIONS FILE: Change of ownership - automatic assignment

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Each change of ownership.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: each change of ownership of a participating facility

BASIS: The plan incorporates Part 442 Subparts A and B (section 4.13), which includes the 442.14 automatic assignment rule, and the plan's payment pages show change of ownership handled as a

continuity event in adjacent contexts (hospital rates carried from the previous hospital on a change of ownership, Attachment 4.19-A; special survey possible within 2 months of a change of ownership, administration, management or director of nursing, section 4.40 area at PDF p.164). No held document states 442.14 itself: that the provider agreement is automatically assigned to the new owner subject to all terms, conditions and survey findings, or that the state must act where the new owner does not wish assignment.

RECORD LOCATION: H-001 (Title XIX State Plan), section 4.13, PDF p.93; survey and payment passages at PDF pp.164 and 788

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The automatic assignment rule and any change-of-ownership record for a facility are not in the held evidence.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State the 442.14 assignment rule in the provider enrollment manual and file a worked CHOW example.
>
> **QUESTION:** When an NC nursing facility changes ownership, is the Medicaid agreement assigned automatically, and where is that recorded?

SEARCHES RECORDED: Plan searched for change of ownership (hits are hospital payment and NF survey passages, not 442.14); enrollment pages reviewed. No facility CHOW record found.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 442.14: on a change of ownership the agreement is automatically assigned to the new owner on the existing terms, with the stated state options.

CFR-442-005: ICF/IID agreement duration and survey interval

CITATION: 42 CFR 442.15

TOPIC: ICF/IID agreement duration and survey interval

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Survey at intervals no greater than 15 months; agreement continuous until Secretary determination.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (periodic) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: each ICF/IID agreement; surveys at the stated interval

BASIS: The plan commits NC to Part 442 Subparts B and C for intermediate care facilities (section 4.24), the subparts carrying the ICF/IID agreement duration rule. The survey interval discipline that is stated in the plan is the nursing facility one: a standard survey not later than 15 months after the previous standard survey, with a statewide average interval not exceeding 12 months (plan survey assurances, PDF p.164, under section 1919(g)(2) of the Act). No held document states the ICF/IID-specific rule of 442.15 (agreement effective until the Secretary determines the facility no longer

meets requirements, with surveys at intervals no greater than 15 months) or an ICF/IID survey schedule.

RECORD LOCATION: H-001 (Title XIX State Plan), section 4.24, PDF p.137; NF survey assurances, PDF p.164

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The ICF/IID agreement duration and the 15-month ICF/IID survey interval are not stated for ICF/IID facilities in any held document.
>
> **OWNER LEVEL:** NCDHHS Secretary
>
> **ACTION:** File the ICF/IID survey schedule and the agreement duration term, through the Division of Health Services Regulation's certification records.
>
> **QUESTION:** What is the actual survey interval history for NC ICF/IID facilities over the last two cycles?

SEARCHES RECORDED: Plan and NCAC Chapter 22 (H-099, H-098) searched for ICF/IID survey intervals; H-099's ICF entries are transferred or repealed rule history notes. No DHSR survey schedule is held.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 442.15: an ICF/IID provider agreement runs until a determination of noncompliance, with surveys at intervals not exceeding 15 months.

CFR-442-006: Agreement as evidence of certification — FFP conditioned

CITATION: 42 CFR 442.30

TOPIC: Agreement as evidence of certification — FFP conditioned

TOPIC IN DETERMINATIONS FILE: Agreement as evidence of certification - FFP conditioned

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Ongoing FFP-claiming discipline; ties to 442.42 retroactive agreements.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: ongoing FFP claiming discipline

BASIS: The plan's structure carries the linkage in general terms: section 4.13 makes Part 442 and the Part 483 participation requirements the condition of facility provider agreements, and section 4.24 commits NF and ICF services to Part 442 Subparts B and C. No held document states 442.30 itself: that the provider agreement is the evidence of certification and that FFP is available only for services in a facility with a valid agreement in effect, or any claim edit enforcing it.

RECORD LOCATION: H-001 (Title XIX State Plan), sections 4.13 and 4.24, PDF pp.93 and 137

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 442.30 evidence-of-certification rule and its claims enforcement are not stated in held text.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)

ACTION: State the 442.30 rule in the facility payment policy, with the claim edit that suspends payment on loss of certification.

QUESTION: What happens to facility claims in NCTracks on the day a certification lapses?

SEARCHES RECORDED: Plan read; NCAC 22F sanction provisions (H-099 pp.11-12) read for payment consequences of decertification (they address provider suspension and termination, not 442.30). No passage found.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 442.30: FFP only under a provider agreement that evidences current certification.

CFR-442-007: FFP under retroactive agreement following appeal

CITATION: 42 CFR 442.42

TOPIC: FFP under retroactive agreement following appeal

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Each successful appeal resulting in a retroactive agreement.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: each successful facility appeal resulting in a retroactive agreement

BASIS: The plan incorporates Part 442 Subpart A for all providers (section 4.13), which includes 442.42. No held document states the rule itself (FFP available from the retroactive effective date where a facility prevails on appeal and a retroactive agreement issues), and no appeal decision or retroactive agreement is held.

RECORD LOCATION: H-001 (Title XIX State Plan), section 4.13, PDF p.93

SECTION 5D FACE

UNCOVERED ELEMENT: The 442.42 rule and any instance of its application are not in the held evidence.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Record whether any retroactive facility agreement issued in the period; if none, record the negative.

QUESTION: Has any NC facility won a certification appeal producing a retroactive agreement since 2022?

SEARCHES RECORDED: Plan and corpus searched for retroactive provider agreements and facility appeal outcomes (hits concern SPA and eligibility appeals, not facility certification appeals). None found.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 442.42: where a provider agreement is issued retroactively after a successful appeal, FFP follows the retroactive period as the section states.

CFR-442-008: Payment transparency reporting — NF and ICF/IID

CITATION: 42 CFR 442.43

TOPIC: Payment transparency reporting — NF and ICF/IID

TOPIC IN DETERMINATIONS FILE: Payment transparency reporting - NF and ICF/IID

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - Annual report to CMS, by facility.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — annual NF/ICF-IID payment-transparency report is due "at the time and in the form/manner specified by CMS"; no fixed anchor date is stated in the CFR text as carried. Not calendared.

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: annual report to CMS, by facility (new requirement, May 2024 rule)

BASIS: No governing document producible: no held NC document is, or references, a facility-level payment transparency submission to CMS under 442.43 (the share of Medicaid payments spent on compensation for direct care workers and support staff, reported by facility for nursing facilities and ICF/IIDs). The register record identifies this as a new requirement from the May 2024 rule (89 FR 40870) with evidence to come; no submission, data collection instrument, or due date statement is in the corpus.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:**
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Record the first 442.43 submission's due date and data owner, and file the submission when made.
>
> **QUESTION:** When does NC first report under 442.43, and from what cost report data?

SEARCHES RECORDED: Corpus and full map searched for 442.43 and payment transparency reporting; the transparency notice at H-128 concerns Comparative Payment Rate Analysis publication, a different requirement. No 442.43 material found.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 442.43: states report annually to CMS, by facility, the percentage of Medicaid payments spent on direct care and support staff compensation.

FLAGS: The first-report applicability date after the May 2024 rule was not sourced from a held document; if CMS has set it after the evidence window, this row converts to Prospective.

CFR-442-009: ICF/IID survey intervals

CITATION: 42 CFR 442.109

TOPIC: ICF/IID survey intervals

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Each facility surveyed ≤15 months after prior survey; statewide average ≤12 months computed each FFY end.

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (periodic) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: each ICF/IID facility, each federal fiscal year

BASIS: As at CFR-442-005, the plan states survey interval discipline for nursing facilities (standard survey within 15 months; statewide average not over 12 months, PDF p.164) and commits ICF services to Part 442 Subparts B and C (section 4.24), but the 442.109 computation for ICF/IIDs, each facility surveyed not more than 15 months after its last survey with the statewide average interval computed at each federal fiscal year end, is not stated or evidenced for ICF/IIDs in any held document.

RECORD LOCATION: H-001 (Title XIX State Plan), section 4.24, PDF p.137; NF survey assurances, PDF p.164

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** ICF/IID survey dates and the statewide average interval computation are not held.
>
> **OWNER LEVEL:** NCDHHS Secretary
>
> **ACTION:** File the ICF/IID survey date record and the FFY statewide average computation through the Division of Health Services Regulation.
>
> **QUESTION:** What was the statewide average ICF/IID survey interval at the last FFY end?

SEARCHES RECORDED: Plan, NCAC chapters (H-099, H-098) and corpus searched for ICF/IID survey schedules and average interval computations. None found.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 442.109: the survey agency must survey each ICF/IID within 15 months of its last survey and keep the statewide average at 12 months, computed each FFY.

CFR-442-010: Certification with standard-level deficiencies

CITATION: 42 CFR 442.110

TOPIC: Certification with standard-level deficiencies

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Each certification survey finding standard-level deficiencies.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: each certification survey finding standard-level deficiencies

BASIS: The plan's enforcement framework for nursing facilities carries the analogous machinery: section 4.35 sets remedy selection factors, requires the state to consider the seriousness of deficiencies under 42 CFR 488.404, and lists termination, temporary management, denial of payment for new admissions, civil money penalties, transfer and state monitoring as available remedies (PDF pp.152-154). The ICF/IID-specific certification rule of 442.110, certifying a facility with standard-level deficiencies on an acceptable plan of correction and the limits on doing so, is not stated in any held document.

RECORD LOCATION: H-001 (Title XIX State Plan), section 4.35, PDF pp.152-154; section 4.24, PDF p. 137

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 442.110 certification-with-deficiencies rule for ICF/IIDs, and any certification decision applying it, are not held.
>
> **OWNER LEVEL:** NCDHHS Secretary
>
> **ACTION:** File a recent ICF/IID certification decision showing standard-level deficiencies handled under 442.110, through the survey agency.
>
> **QUESTION:** How does the survey agency document an acceptable plan of correction for an ICF/IID with standard-level deficiencies?

SEARCHES RECORDED: Plan enforcement pages read; corpus searched for plans of correction in ICF/IID certification contexts (hits are managed care corrective action, a different instrument). None found.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 442.110: an ICF/IID may be certified with standard-level deficiencies only on the conditions the section states, including an acceptable plan of correction.

CFR-442-011: Termination of certification for immediate jeopardy

CITATION: 42 CFR 442.117

TOPIC: Termination of certification for immediate jeopardy

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Immediate on immediate-jeopardy determination.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: immediately on an immediate jeopardy determination

BASIS: Immediate jeopardy machinery is carried for nursing facilities in plan section 4.35: where there is immediate jeopardy, the state terminates the NF's provider agreement within 23 calendar days of the last survey or immediately imposes temporary management to remove the threat; notice of termination goes to the facility and the public at least 2 calendar days before the effective date in immediate jeopardy cases; and termination follows the procedures of Parts 431 and 442 (PDF pp. 152-153). The ICF/IID-specific rule of 442.117, termination of certification on an immediate jeopardy finding with its own notice and timing terms, is not stated in any held document.

RECORD LOCATION: H-001 (Title XIX State Plan), section 4.35(a)(iv) and (c)(i), PDF pp.152-153

SECTION 5D FACE

UNCOVERED ELEMENT: The 442.117 ICF/IID termination rule and any instance of its use are not evidenced.

OWNER LEVEL: NCDHHS Secretary

ACTION: File the survey agency's ICF/IID immediate jeopardy procedure, or a termination record under 442.117.

QUESTION: Has any NC ICF/IID faced an immediate jeopardy termination in the period?

SEARCHES RECORDED: Plan enforcement pages read; corpus searched for immediate jeopardy in ICF/IID contexts (hits are the NF provisions and managed care text). None found.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 442.117: certification of an ICF/IID must be terminated where immediate jeopardy exists, on the section's notice and timing terms.

CFR-442-012: Denial of payments for new admissions to ICF/IID

CITATION: 42 CFR 442.118

TOPIC: Denial of payments for new admissions to ICF/IID

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Each instance of noncompliance triggering a new-admissions payment denial.

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat B)

APPLICABILITY (DETERMINATIONS FILE): Applies: each instance of noncompliance triggering the remedy

BASIS: The remedy itself is carried for nursing facilities: plan section 4.35(c)(ii)-(iii) imposes denial of payment for new admissions where an NF has not come into substantial compliance within 3 months after the last survey day, under 42 CFR 488.417, and lists denial of payment for new admissions among the state's established remedies (PDF p.153). The ICF/IID-specific rule of 442.118, including its notice of intent and opportunity to correct before the denial takes effect, is not stated in any held document.

RECORD LOCATION: H-001 (Title XIX State Plan), section 4.35(c) and (d), PDF p.153

SECTION 5D FACE

UNCOVERED ELEMENT: The 442.118 notice and correction-opportunity terms for ICF/IIDs, and any instance of the remedy's use on an ICF/IID, are not evidenced.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: File the ICF/IID remedy procedure showing the 442.118 notice and correction terms, or record that the remedy has not been used on an ICF/IID in the period.

QUESTION: Has denial of payment for new admissions ever been imposed on an NC ICF/IID, and under what notice procedure?

SEARCHES RECORDED: Plan enforcement pages read; corpus searched for denial of payment for new admissions in ICF/IID contexts (hits are the NF provisions). None found.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 442.118: the state may deny payment for new admissions to a noncompliant ICF/IID after notice of intent and an opportunity to correct.

CFR-447-001: Payment reassignment prohibition

CITATION: 42 CFR 447.10

TOPIC: Payment reassignment prohibition

OBLIGATED LEVEL: agency

CADENCE: FIXED - state plan provision; ongoing enforcement

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid: the state plan carries a reassignment provision at section 4.21.

BASIS: Covered: State Plan section 4.21, citing 42 CFR 447.10(c) on its face, provides that payment for Medicaid services furnished by any provider under the plan is made only in accordance with the requirements of 42 CFR 447.10. Uncovered: the operative content of 447.10 (the permitted payees and exceptions, and the bar on reassignment to a factor or other entity) is incorporated by reference only; no held provider manual, rule or contract passage states the permitted-payee list or the factoring prohibition in its own terms. Searches of the held provider manuals and the cure texts returned no reassignment passage.

RECORD LOCATION: H-001 (H-001), State Plan section 4.21, p.133

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The permitted payees and exceptions of 447.10(a) to (e) and the prohibition on payment to a factor, in operative state-side text.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the permitted-payee and no-factoring terms in the provider agreement or provider manual so the prohibition reads in operative text, not by incorporation alone.
>
> **QUESTION:** Where does NC state, in a document a provider reads, who may be paid for a Medicaid service and that a claim may not be reassigned to a factor?

SEARCHES RECORDED: Full document-axis map (the full reconciliation map) for Part 447 documents; text search for reassignment across held corpus and cure collection texts (no operative passage found).

CFR-447-002: Acceptance of State payment as payment in full

CITATION: 42 CFR 447.15

TOPIC: Acceptance of State payment as payment in full

OBLIGATED LEVEL: agency

CADENCE: FIXED - provider agreement term; ongoing compliance

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid fee-for-service and, through provider agreements, to participating providers generally.

BASIS: Every element read: State Plan section 4.19(f), p.126, limits participation to providers who meet the requirements of 42 CFR 447.15. 10A NCAC 22J .0106(e) states the operative rule: a provider who accepts a patient as a Medicaid patient shall accept Medicaid payment, plus any authorized deductible, coinsurance, copayment and third party payment, as payment in full for all covered services. 10A NCAC 22F .0104(e)(1) states Medicaid payment shall constitute payment in full, and Attachment 4.19-A, p.826, limits hospital participation to hospitals who accept the amount paid under the plan as payment in full.

RECORD LOCATION: H-001 (H-001), section 4.19(f) p.126 and Attachment 4.19-A p.826; H-103 (10A NCAC 22J .0106(e)), cure text; H-100 (10A NCAC 22F .0104(e)(1)), p.1

CFR-447-003: Provider billing limits with third-party liability

CITATION: 42 CFR 447.20

TOPIC: Provider billing limits with third-party liability

OBLIGATED LEVEL: agency

CADENCE: FIXED - state plan provision; ongoing enforcement

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid: section 4.22 of the plan carries third party liability, and a TPL billing guide is held.

BASIS: Covered: State Plan section 4.22(e), p.135, provides that the agency ensures the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20. The TPL Billing Guide (DMA-2046), pp.1 to 3, carries the working rules: Medicaid is payer of last resort, the provider must bill the carrier before billing Medicaid and must receive payment or a written denial first, and third party payments must be reported on the claim. 10A NCAC 22J .0106(e) preserves the provider right to pursue third party funds primary to Medicaid. Uncovered: the specific collection limits of 447.20 (what a provider may collect from the beneficiary or a liable third party where the third party payment equals or exceeds the Medicaid payment, and the related cost sharing ceiling) are not stated in any held passage.

RECORD LOCATION: H-001 (H-001), section 4.22(e) p.135; H-153 (H-153), DMA-2046 pp.1-3; H-103 (10A NCAC 22J .0106(e)), cure text

SECTION 5D FACE

UNCOVERED ELEMENT: The 447.20(a) to (c) collection limits where a third party is liable, stated as billing rules.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Add the 447.20 collection limits to the TPL billing guide or the provider billing manual, in the same document that carries the bill-the-carrier-first rule.

QUESTION: When a liable third party pays at or above the Medicaid rate, what exactly may the provider still collect from the beneficiary under NC's published rules?

SEARCHES RECORDED: Full map Part 447 documents read; NL-09 TPL policy document acquired in the cure and read (eligibility-side recovery manual, no provider collection limits).

CFR-447-004: No payment for provider-preventable conditions

CITATION: 42 CFR 447.26

TOPIC: No payment for provider-preventable conditions

OBLIGATED LEVEL: agency

CADENCE: FIXED - state plan provision; ongoing claims enforcement

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid: the plan carries a payment adjustment for provider-preventable conditions in Attachments 4.19-A and 4.19-B.

BASIS: Covered: Attachment 4.19-A, pp.842 to 843, states the agency meets 42 CFR Part 447 Subpart A on non-payment for provider-preventable conditions, identifies Medicare hospital-acquired conditions (other than DVT/PE after knee or hip replacement in pediatric and obstetric patients) and the three other provider-preventable conditions (wrong procedure, wrong body part, wrong patient), and provides zero payment for PPC services effective January 1, 2011. Attachment 4.19-B, p.851, carries the same provision outside the inpatient attachment, and Supplement 2, p. 848, bars DRG payment for HACs and never events. Uncovered: no held passage requires reporting of present on admission indicators on claims; the plan supplement states PRO review for present on admission is not required, so the reporting element the federal rule works through is not carried in the held record.

RECORD LOCATION: H-001 (H-001), Attachment 4.19-A pp.842-843 and Supplement 2 p.848; Attachment 4.19-B p.851

SECTION 5D FACE

UNCOVERED ELEMENT: Provider reporting of present on admission indicators, and any passage applying the non-payment policy through managed care contracts.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: State the present on admission reporting expectation for hospital claims in the plan or billing guidance, or record why the federal reporting element does not apply to NC's process.

> **QUESTION:** How does NC learn that a condition was present on admission if no held document requires the indicator on the claim?

SEARCHES RECORDED: Full map Part 447 documents read; text search for present on admission and provider-preventable across held corpus and cure texts.

FLAGS: T2 label understated the evidence: the plan itself carries this provision

CFR-447-005: Withholding Federal share to recover Medicare overpayments

CITATION: 42 CFR 447.30

TOPIC: Withholding Federal share to recover Medicare overpayments

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - on CMS order; continues until CMS terminates

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies in form to any state, but the duty runs on a CMS order; no NC-side performance is evidenced.

BASIS: No NC evidence for this provision exists in the held public corpus. The provision requires the state, when CMS orders it, to reduce Medicaid payments so the Federal share can recover a Medicare overpayment. A text search of the full held corpus and the cure collection for Medicare overpayment returned no passage, and no plan page, rule, manual or report describes the state accepting or executing such a withholding.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The whole requirement: any NC document addressing CMS-ordered reduction of Medicaid payments to recover a Medicare overpayment.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Record the agency procedure for a CMS withholding order under 447.30, or confirm in writing that no such order has been received and where the procedure would sit.
>
> **QUESTION:** Has CMS ever ordered NC to withhold under 447.30, and if it did, which NC document would govern the reduction?

SEARCHES RECORDED: the full reconciliation map (all documents whose text touches Part 447 read); full-text search for Medicare overpayment across held corpus text and cure collection text (no hits); H-131 OIG overpayment report read (concerns Medicaid overpayment reporting and return, not Medicare withholding).

CFR-447-006: State request to withhold Medicare for Medicaid overpayments

CITATION: 42 CFR 447.31

TOPIC: State request to withhold Medicare for Medicaid overpayments

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - per overpayment referral

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies in form to any state; it is a state-initiated request machinery, and no NC use or procedure is evidenced.

BASIS: No NC evidence for this provision exists in the held public corpus. The provision lets the state ask CMS to withhold a provider's Medicare payments to recover a Medicaid overpayment, on stated notice and documentation conditions. No held plan page, rule, manual, recoupment rule or report mentions a request to CMS under 447.31; the held recoupment material (10A NCAC 22F . 0706) concerns recipient overpayments recovered by counties, a different subject.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The whole requirement: the 447.31 request procedure, its notice to the provider, and any NC instance of using it.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Record whether NC has ever made a 447.31 request and, if the tool is to remain available, publish the internal procedure and notice the provider would receive.
>
> **QUESTION:** Does NC use the 447.31 Medicare withholding request at all, and where would a provider learn of it before it is used?

SEARCHES RECORDED: the full reconciliation map Part 447 documents read; full-text search for 447.31 and Medicare withholding across held corpus and cure texts (no hits); H-104 recoupment rule read (recipient overpayments only).

CFR-447-007: Timely claims payment — claims submission deadline

CITATION: 42 CFR 447.45

TOPIC: Timely claims payment — claims submission deadline

OBLIGATED LEVEL: agency

CADENCE: RECURRING - claims submitted >12 months late must be denied

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid fee-for-service claims through NCTracks, and to plan claims under the prompt payment fact sheet.

BASIS: Covered: the 365 day filing deadline in operative form. The Claims and Billing page (H-151) states Medicaid claims, except inpatient and nursing facility claims, must be received by NCTracks within 365 days of the first date of service, and inpatient and nursing facility claims within 365 days of the last date of service. The Prompt Payment Fact Sheet (H-061), p.2, sets pharmacy point of sale claims at 365 calendar days and starts the limit for retroactive enrollees from the date enrollment is approved, which carries one of the federal exceptions. Attachment 4.19-E, p.1125, defines a claim for each service type, and section 4.19(e), p.125, assures the agency meets 42 CFR 447.45. Uncovered: the remaining federal exceptions to the 12 month bar (administrative or legal actions, Medicare retroactive determinations, and the other 447.45(c) cases) are not stated in any held passage.

RECORD LOCATION: H-151, cure text (Claims and Billing page); H-061 (H-061), Prompt Payment Fact Sheet p.2; H-001 (H-001), section 4.19(e) p.125 and Attachment 4.19-E p.1125

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The full set of exceptions to the submission deadline in 447.45(c).
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the complete exception list with the timely filing rule on the claims and billing page, so a provider can see when a claim over 365 days may still be paid.
>
> **QUESTION:** Which of the federal exceptions to the 12 month filing bar does NCTracks actually honor, and where is that written?

SEARCHES RECORDED: Full map Part 447 documents read, including H-140 and H-141 checkwrite schedules.

CFR-447-008: Timely claims payment — 90%/99% standards

CITATION: 42 CFR 447.45

TOPIC: Timely claims payment — 90%/99% standards

OBLIGATED LEVEL: agency

CADENCE: RECURRING - claims payment timeliness reporting; MMIS timeliness reports

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to the agency's own fee-for-service payment performance under 447.45(d).

BASIS: Covered: the plan assurance at section 4.19(e), p.125, that the agency meets all requirements of 42 CFR 447.45 for timely payment of claims, with Attachment 4.19-E, p.1125, defining a claim by service type. For managed care, the PHP Performance Metrics Report (H-062) tracks plan claim processing timeliness against contract prompt payment standards. Uncovered: no held passage states the agency's own fee-for-service standards in the federal form (90 percent of

clean claims within 30 days, 99 percent within 90 days), and no held artifact reports NC's fee-for-service performance against those percentages. NCTracks processes claims in real time with 50 checkwrites a year (H-151), which is a process statement, not the percentage standard or a result against it.

RECORD LOCATION: H-001 (H-001), section 4.19(e) p.125 and Attachment 4.19-E p.1125; H-062 (H-062), claims payment and timeliness metrics; H-151, cure text

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 90 percent in 30 days and 99 percent in 90 days fee-for-service standards, and any reported NC result against them.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the fee-for-service timely payment standard and the measured result for a stated period, in the same way plan timeliness is already reported in H-062.
>
> **QUESTION:** What share of NC fee-for-service clean claims was paid within 30 and within 90 days in the last measured period?

SEARCHES RECORDED: Full map Part 447 documents read; text search for 90 percent and 99 percent across held corpus (returns managed care MLR figures only).

CFR-447-009: Prepayment and postpayment claims review

CITATION: 42 CFR 447.45

TOPIC: Prepayment and postpayment claims review

OBLIGATED LEVEL: agency

CADENCE: RECURRING - built into MMIS claims adjudication; PERM/PURCS-type postpayment reviews

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid program integrity and claims review operations.

BASIS: Covered: prepayment review in operative rule text. 10A NCAC 22F .0104(c) provides that the Division shall check eligibility, duplicate payments, third party liability, and unauthorized or uncovered services by means of prepayment review, computer edits and audits, and investigation; subsection (d) requires prior approval for specified services. Postpayment review is carried in part: Attachment 4.19-A, p.823, heads cost reporting and audits for hospitals, and the plan assures audit of cost-based payments at section 4.19(g), p.127. Uncovered: the federal prepayment review of all claims with the full enumerated 447.45(e) checks is not stated (the NCAC list names four checks), and no held passage describes postpayment review of paid claims as a system with its own scope and cadence.

RECORD LOCATION: H-100 (10A NCAC 22F .0104(c)-(d)), p.1; H-001 (H-001), section 4.19(g) p.127 and Attachment 4.19-A p.823

SECTION 5D FACE

UNCOVERED ELEMENT: Prepayment review of all claims with the full 447.45(e) check list, and a stated postpayment review system.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the claims review description that lists the prepayment checks performed on all claims and the postpayment review scope, or point to the existing document that does.

QUESTION: Which document describes, end to end, what NCTracks checks before payment and what the Division reviews after payment?

SEARCHES RECORDED: Full map Part 447 documents read; H-133 CMS focused program integrity review and H-134 single audit read for review practice (findings documents, not a review system description).

CFR-447-010: Timely-payment compliance reporting

CITATION: 42 CFR 447.45

TOPIC: Timely-payment compliance reporting

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - as required by CMS

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to the agency's reporting on its timely payment performance under 447.45(f).

BASIS: Covered in part: the PHP Performance Metrics Report (H-062), for July 1, 2024 to June 30, 2025, reports plan claim processing timeliness metrics from the PHP Claims Monitoring Dashboard, including average days to adjudicate and pay or deny, which is compliance reporting for the managed care side. The plan assurance at section 4.19(e), p.125, stands behind it. Uncovered: no held artifact is the agency's own timely claims payment compliance report for fee-for-service, and nothing held shows documentation furnished to CMS on 447.45(f) performance.

RECORD LOCATION: H-062 (H-062), Prepaid Health Plan Performance Metrics Report, claims payment and timeliness metrics sections; H-001 (H-001), section 4.19(e) p.125

SECTION 5D FACE

UNCOVERED ELEMENT: The agency's fee-for-service timely payment compliance reporting under 447.45(f).

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Include fee-for-service timely payment results in the annual reporting set, or publish the compliance documentation the agency furnishes to CMS.

QUESTION: Where is the fee-for-service counterpart to the plan timeliness reporting in H-062?

SEARCHES RECORDED: Full map Part 447 documents read; H-126 SFY2025 annual report searched for timely payment reporting (expenditure reporting only).

CFR-447-011: MCO contract prompt-payment terms

CITATION: 42 CFR 447.46

TOPIC: MCO contract prompt-payment terms

OBLIGATED LEVEL: MCO/plan

CADENCE: FIXED - per MCO contract; monitored for life of contract

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC's prepaid health plan contracts; NC operates Standard Plans and Tailored Plans under risk contracts.

BASIS: Covered: contract prompt payment terms in working form. The Prompt Payment Fact Sheet (H-061), pp.2 to 3, states the contract requirements: a plan must, within 18 calendar days of receiving a medical claim, notify the provider whether the claim is clean or pend it and request all additional information; a clean claim must be paid or denied within 30 days; pharmacy claims must be paid, denied or pended within 14 calendar days; interest is borne on late payment; and a clean claim is defined citing 42 CFR 447.45(b). The PHP Performance Metrics Report (H-062) restates the same standards as required in the PHP Contract, and the PHP contract Amendment 8 (H-046), p.40, revises the contract prompt payment standards section and defines date of receipt and date of payment citing 42 CFR 447.45(d)(5) and (d)(6). Uncovered: the 447.46 percentage terms (90 percent of clean claims from network providers within 30 days, 99 percent within 90 days) are not stated in any held contract passage, and the executed base Standard Plan contract (NL-01) was not located in the cure, so the held contract evidence is amendment model language plus the agency's own restatements.

RECORD LOCATION: H-061 (H-061), pp.2-3; H-062 (H-062), Prompt Payment Standards; H-046 (H-046), Amendment 8 p.40

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 90 percent and 99 percent clean claim terms of 447.46 in contract text, and the executed base contract itself.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Confirm the percentage terms in the executed contracts and publish the contract section that carries them, or amend the fact sheet to state them.
>
> **QUESTION:** Do the executed PHP contracts carry the 447.46 percentage terms, or only the day-count terms the fact sheet prints?

SEARCHES RECORDED: Full map Part 447 documents read; NL-01 executed base PHP contract classed TRUE-GAP in the cure collection (the collection record).

FLAGS: DIRECTED-PAYMENT-PREPRINT-NOT-HELD not applicable to this row; executed base contract NL-01 not located

CFR-447-012: Maximum allowable cost sharing + annual CPI-U indexing

CITATION: 42 CFR 447.52

TOPIC: Maximum allowable cost sharing + annual CPI-U indexing

OBLIGATED LEVEL: agency

CADENCE: RECURRING - annual CPI-U update each October 1; table maintenance

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid cost sharing, which the plan imposes as small copayments.

BASIS: Covered: cost sharing amounts are stated and are nominal. Attachment 4.18-A, p.758, sets copayments of 3.00 dollars for most services and 2.00 dollars for chiropractic and optical services, each stated against the State's average payment for the service; Attachment 4.18-C, p.761, is the same for the medically needy. Section 4.18(a), p.112, provides charges do not exceed the maximum allowable charges under the cited federal cost sharing provisions. The Tailored Plan contract Table 7 (H-052) sets a current managed care copayment of 4.00 dollars per service. Uncovered: no held passage carries the annual CPI-U indexing of the maximum amounts, or any mechanism that updates the stated amounts against the federal maximums; and the plan attachment amounts (2.00 and 3.00 dollars, TN 05-016, effective November 1, 2005) conflict with the current contract amount of 4.00 dollars, so the operative maximum-facing amount is not single-valued on the held record. Graded on the stronger current evidence, the contract, and the conflict is flagged.

RECORD LOCATION: H-001 (H-001), section 4.18(a) p.112, Attachment 4.18-A p.758, Attachment 4.18-C p.761; H-052 (H-052), Table 7 Medicaid Managed Care Cost Sharing

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** Annual CPI-U indexing of the maximum allowable amounts, and a single current amount set that matches across the plan and the contracts.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Reconcile the copayment amounts between the plan attachments and the plan contracts, and record how the amounts are checked against the indexed federal maximums.
>
> **QUESTION:** Which amount is a provider to charge today, 3.00 dollars under the plan attachment or 4.00 dollars under the Tailored Plan contract table, and when were the plan amounts last updated?

SEARCHES RECORDED: Full map Part 447 documents read; text search for CPI and indexing across held corpus and cure texts (no cost sharing indexing passage).

FLAGS: COST-SHARING-AMOUNT-CONFLICT: plan attachments 2.00/3.00 dollars (2005) vs Tailored Plan Table 7 4.00 dollars

CFR-447-013: State plan cost-sharing specifications

CITATION: 42 CFR 447.52

TOPIC: State plan cost-sharing specifications

OBLIGATED LEVEL: agency

CADENCE: FIXED - state plan; updated whenever charges change

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid: the plan specifies cost sharing in Attachments 4.18-A and 4.18-C.

BASIS: Every specification element read, for both the categorically needy (Attachment 4.18-A, pp. 758 to 760) and the medically needy (Attachment 4.18-C, pp.761 to 763): (A) the services charged and (B) the nature of the charge, in the service table; (C) the amounts and basis for determination, stated per service against the State average payment; (D) the method of collection, providers are responsible for collecting; (E) the basis for determining inability to pay and how such an individual is identified to providers, including that a recipient who claims inability may not be denied service; (F) the procedures for implementing and enforcing the cost sharing exclusions, including the list of excluded services and the claims system deduction; and (G) cumulative maximums, stated as State policy does not provide for cumulative maximums. The specification set is complete on the face of the attachments.

RECORD LOCATION: H-001 (H-001), Attachment 4.18-A pp.758-760 and Attachment 4.18-C pp. 761-763

FLAGS: COST-SHARING-AMOUNT-CONFLICT flagged on CFR-447-012: attachment amounts are 2005 figures; the specification structure itself is complete

CFR-447-014: MCO contracts honor state-plan cost sharing

CITATION: 42 CFR 447.52

TOPIC: MCO contracts honor state-plan cost sharing

OBLIGATED LEVEL: MCO/plan

CADENCE: FIXED - per MCO contract

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC's managed care contracts; the Tailored Plan contract is held, the executed Standard Plan base contract is not.

BASIS: Covered for Tailored Plans: the Tailored Plan contract (H-052) provides the plan shall impose the same cost sharing amounts as specified in North Carolina's Medicaid State Plans, displayed in Table 7, Medicaid Managed Care Cost Sharing, and carries cost sharing exceptions and member noticing requirements for cost sharing changes. Uncovered: no held passage carries the same term for the Standard Plans (the executed base contract, NL-01, was not located), and the plan itself,

section 4.18(b)(2)(vii), p.113, checks the box that managed care enrollees are not charged deductibles, coinsurance or copayments, which sits against the Tailored Plan Table 7 imposing copayments; the held record does not reconcile the two.

RECORD LOCATION: H-052 (H-052), Cost Sharing (a), Table 7, and Cost Sharing Noticing Requirements; H-001 (H-001), section 4.18(b)(2)(vii) p.113

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The Standard Plan contract term honoring state plan cost sharing, and reconciliation of the plan page that says managed care enrollees are not charged.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Reconcile section 4.18(b)(2)(vii) with the Tailored Plan cost sharing table by SPA or contract clarification, and place the Standard Plan cost sharing term in the held record.
>
> **QUESTION:** Are managed care enrollees charged the Table 7 copayments or not, and which instrument governs where the plan page and the contract differ?

SEARCHES RECORDED: Full map Part 447 documents read; NL-01 executed base PHP contract classed TRUE-GAP in the cure collection (the collection record).

FLAGS: CONFLICT: plan p.113 managed care enrollees not charged vs Tailored Plan Table 7 copayments imposed

CFR-447-015: Denial of service only for nonpayment by able, non-exempt individuals

CITATION: 42 CFR 447.52

TOPIC: Denial of service only for nonpayment by able, non-exempt individuals

OBLIGATED LEVEL: agency

CADENCE: FIXED - state plan; ongoing provider compliance

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid providers through the plan service guarantee and the provider billing rule.

BASIS: Covered: the protective side in two instruments. State Plan section 4.19(f), p.126: no provider participating under the plan may deny services to an eligible individual on account of inability to pay a cost sharing amount; the guarantee does not apply to an individual who is able to pay, and inability to pay does not eliminate liability for the charge. 10A NCAC 22J .0106(e) repeats the rule (a provider shall not deny services on account of inability to pay a deductible, coinsurance or copayment; liability remains), and Attachment 4.18-A, p.759, states a recipient who claims inability may not be denied service but may arrange later payment. Uncovered: no held passage states the affirmative federal condition set for permissible denial (the individual is able to pay, is not within an exempt category, and the other 447.52(e) conditions), so the boundary of permissible denial is carried only from the inability side.

RECORD LOCATION: H-001 (H-001), section 4.19(f) p.126 and Attachment 4.18-A p.759; H-103 (10A NCAC 22J .0106(e)), cure text

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The affirmative conditions under which a provider may deny service for nonpayment, stated in NC text.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Add the able-to-pay and exemption conditions to the provider billing rule or manual, next to the inability guarantee the rule already carries.
>
> **QUESTION:** Where may a provider read the full rule, both the guarantee and the conditions on the denial the guarantee limits?

SEARCHES RECORDED: Full map Part 447 documents read, including H-099 and H-098 copies of the same NCAC material.

CFR-447-016: Preferred-drug override process

CITATION: 42 CFR 447.53

TOPIC: Preferred-drug override process

OBLIGATED LEVEL: agency

CADENCE: FIXED - process in place; used as needed

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Pharmacy (Pharmacy Benefit Administrator for NC Medicaid Direct)

HOME BASIS: Pharmacy is a published DHB function: from May 2, 2026 a Pharmacy Benefit Administrator (Prime Therapeutics) supports NC Medicaid Direct pharmacy operations while DHB 'continues to manage all clinical policies and reimbursement methodologies for Point-of-Sale pharmacy' (Lane A §1.4). Title-level derivation: the Medicaid drug benefit and the Drug Rebate Program sit with the pharmacy function in NC's published structure (the PBA's published duties include drug rebate administration and DUR — Lane A §1.4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid pharmacy: NC operates a preferred drug list with prior authorization.

BASIS: The override process is carried end to end in read passages. Attachment 3.1-A.1, p.632: a prescription for a brand drug with generic equivalents is treated as an order for the generic, except when the prescriber personally indicates in their own handwriting brand name medically necessary, for both non-MAC and MAC drugs. Page 633: prior authorization must be obtained for drugs on the prior authorization list, the state provides for response by telephone or other telecommunication device within 24 hours of a request, and provides for dispensing at least a 72 hour supply of a covered outpatient drug in an emergency. Page 636 establishes the preferred drug list with prior authorization for drugs not on it. Clinical Coverage Policy No. 9, sections 5.1, 5.8.1 and 5.9, carries the working process, including that all prior authorization requests will be answered within 24 hours and the practices that do not count as a valid medically necessary override (telephone notation for MAC drugs, stamps, DAW notations).

RECORD LOCATION: H-001 (H-001), Attachment 3.1-A.1 pp.632-633 and p.636; H-075 (H-075), Clinical Coverage Policy No. 9 sections 5.1, 5.8.1, 5.9

CFR-447-017: ED non-emergency cost-sharing conditions

CITATION: 42 CFR 447.54

TOPIC: ED non-emergency cost-sharing conditions

OBLIGATED LEVEL: agency

CADENCE: RECURRING - per non-emergency ED visit where cost sharing is imposed

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid: a copayment for non-emergency use of the hospital emergency department is imposed in both the plan and the Tailored Plan contract.

BASIS: Covered: the charge itself. Attachment 4.18-A, p.758, imposes a 3.00 dollar copayment for a non-emergency visit in a hospital ER (4.00 dollars in the Tailored Plan Table 7, H-052), and section 4.18(b)(2)(v), p.113, excludes emergency services meeting the federal requirements from the charges imposed on the categorically needy. Uncovered: the pre-imposition conditions of 447.54 for alternative cost sharing for non-emergency ED use (medical screening first, a determination the condition is not emergency, notice to the beneficiary of the charge and of an accessible alternative non-emergency provider, and referral) are not stated in any held passage; no held hospital or provider document carries them.

RECORD LOCATION: H-001 (H-001), Attachment 4.18-A p.758 and section 4.18(b)(2)(v) p.113; H-052 (H-052), Table 7

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 447.54 conditions that must be met before the non-emergency ED charge may be imposed.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the conditions a hospital must meet before applying the non-emergency ED copayment, in the hospital billing guidance or the plan.
>
> **QUESTION:** Before a hospital charges the non-emergency ED copayment, what must it have done and told the beneficiary, and where is that written?

SEARCHES RECORDED: Full map Part 447 documents read; text search for non-emergency across held corpus and cure texts (returns the charge and NEMT material only).

FLAGS: COST-SHARING-AMOUNT-CONFLICT: plan 3.00 dollars vs Tailored Plan Table 7 4.00 dollars for the same visit

CFR-447-018: Cost-sharing and premium exemptions

CITATION: 42 CFR 447.56

TOPIC: Cost-sharing and premium exemptions

OBLIGATED LEVEL: agency

CADENCE: FIXED - state plan + eligibility/MMIS exemption logic; ongoing

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid cost sharing in fee-for-service and managed care.

BASIS: Covered: exemption lists in two instruments. The Tailored Plan contract (H-052), Exceptions for Cost Sharing (e)(2), states that consistent with 42 CFR 447.56 cost sharing does not apply to children under age 21, pregnant women, individuals receiving hospice care, federally recognized American Indians and Alaska Natives, BCCCP beneficiaries, foster children, disabled children under the Family Opportunity Act, 1915(c) waiver beneficiaries, and individuals whose institutional assistance is reduced by available income other than personal needs amounts; (e)(3) bars cost sharing on BH I/DD and TBI services in that contract. The plan, section 4.18(b)(2), pp.112 to 113, and (c)(2), pp.117 to 118, carries the older exemption set (children, pregnancy related services, inpatients spending down income, emergency services, family planning, hospice, managed care services). Uncovered: the two lists differ in scope and neither is a single current fee-for-service statement of the 447.56(a) exemptions (for example emergency services and family planning appear in the plan list but not the contract list, and the contract list has categories the plan pages do not); no held passage reconciles them for a fee-for-service claim.

RECORD LOCATION: H-052 (H-052), Exceptions for Cost Sharing (e)(2)-(3); H-001 (H-001), section 4.18(b)(2) pp.112-113 and (c)(2) pp.117-118

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** A single current exemption list that governs fee-for-service, reconciled with the contract list.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish one current cost sharing exemption list for fee-for-service and confirm the contracts mirror it category for category.
>
> **QUESTION:** Which exemption list controls a fee-for-service claim today, the plan pages or the Tailored Plan contract list?

SEARCHES RECORDED: Full map Part 447 documents read, including Clinical Coverage Policy No. 9 section 5.5 copayment exemptions (pharmacy only).

FLAGS: CONFLICT: exemption lists differ between plan pages and Tailored Plan contract

CFR-447-019: Reduce provider payments by cost-sharing obligation

CITATION: 42 CFR 447.56

TOPIC: Reduce provider payments by cost-sharing obligation

OBLIGATED LEVEL: agency

CADENCE: RECURRING - applied on every claim with cost sharing

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid fee-for-service claims processing, which deducts copayments on the claim.

BASIS: Covered: the deduction mechanism. Attachment 4.18-A, section D, p.760, and Attachment 4.18-C, section D, p.763, state that providers must bill total charges on the claim form and the claims processing system deducts the appropriate amount of co-payment; collection is the provider's responsibility (section B of both attachments). That is the state payment reduced by the individual's cost sharing obligation, regardless of whether the provider collects it. Uncovered: the exceptions the federal paragraph carries (the categories of providers and services for which the reduction does not apply in the same way, including the Medicare reasonable cost provider bad debt treatment) are not stated in any held passage.

RECORD LOCATION: H-001 (H-001), Attachment 4.18-A pp.759-760 and Attachment 4.18-C pp. 762-763

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 447.56(c) exceptions to the payment reduction, in NC text.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State the exceptions to the copayment deduction in the billing guidance that describes the deduction itself.
>
> **QUESTION:** For which providers or services does NCTracks not deduct the copayment from the payment, and where is that written?

SEARCHES RECORDED: Full map Part 447 documents read; managed care contracts searched for a capitation or payment reduction equivalent (none stated).

CFR-447-020: Include cost sharing in MCO capitation

CITATION: 42 CFR 447.56

TOPIC: Include cost sharing in MCO capitation

OBLIGATED LEVEL: MCO/plan

CADENCE: RECURRING - capitation rate development

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC's risk contracts, under which plans impose the Table 7 copayments.

BASIS: No held document states that capitation rates are developed taking cost sharing into account, or shows the calculation. The Tailored Plan contract (H-052) shows the inputs exist side by side (plans impose Table 7 cost sharing; capitation is a PMPM methodology developed by the Department and its actuary and approved by CMS), but no passage connects them, and the documents that would prove the connection, the managed care capitation rate certifications, were searched for in the cure and not found on any host (NL-17). A grade above GAP would rest on an inference the record does not make.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The whole requirement as an evidenced calculation: a rate certification or rate development document showing cost sharing taken into account in capitation.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the capitation rate certification, or a rate development summary that states how member cost sharing is reflected in the rates.
>
> **QUESTION:** Where is it documented that the copayments plans collect were counted when the capitation rates were built?

SEARCHES RECORDED: the full reconciliation map Part 447 documents read, including H-052 capitation passages and H-059 SFY2026 capitation assumptions blog (no cost sharing mention); NL-17 capitation rate certifications, NOT-FOUND-AFTER-SEARCH in the collection record (NC Medicaid blog, legislative correspondence and association postings searched).

FLAGS: NL-17: capitation rate certifications referenced but never posted

CFR-447-021: 5% aggregate family limit on premiums + cost sharing

CITATION: 42 CFR 447.56

TOPIC: 5% aggregate family limit on premiums + cost sharing

OBLIGATED LEVEL: agency

CADENCE: RECURRING - ongoing tracking; notices on reaching the cap

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid: cost sharing is imposed, so the aggregate limit machinery is engaged.

BASIS: Covered: cost sharing exists and is applied claim by claim through the claims system (Attachment 4.18-A, section D, p.760: the claims processing system deducts the appropriate amount of co-payment), so the amounts that would count toward an aggregate are captured in one system. Uncovered, and in conflict: the plan attachments state the opposite of a cap. Attachment 4.18-A, section E, p.760, and Attachment 4.18-C, section E, p.763, both state State policy does not provide for cumulative maximums, and section 4.18 at pp.115 and 120 records Not applicable, there is no maximum. No held passage carries the 5 percent of family income aggregate limit, tracking of a

family's accumulated premiums and cost sharing toward it, or relief when the limit is reached. Graded Partial on the capture mechanism only, with the conflict flagged as the row's central defect.

RECORD LOCATION: H-001 (H-001), Attachment 4.18-A pp.759-760, Attachment 4.18-C pp.762-763, section 4.18 pp.115 and 120

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 5 percent aggregate limit itself, family level tracking toward it, and the relief that applies when it is reached.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Bring the plan attachments into line with the current federal limit: replace the no cumulative maximum statements and build the family level tracking and relief process.
>
> **QUESTION:** How would NC know when a family's premiums and copayments reach 5 percent of family income, when the plan attachments say there is no cumulative maximum?

SEARCHES RECORDED: Full map Part 447 documents read; text search for aggregate, cumulative and 5 percent across contracts and manuals (no cap passage found).

FLAGS: CONFLICT: plan attachments state no cumulative maximum, against the current 447.56 aggregate limit

CFR-447-022: No FFP for uncollected cost sharing

CITATION: 42 CFR 447.56

TOPIC: No FFP for uncollected cost sharing

OBLIGATED LEVEL: agency

CADENCE: RECURRING - excluded from CMS-64 claiming

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid claiming, where the claims system deducts copayments from provider payments.

BASIS: Covered: the payment side that the claiming rule protects. Attachment 4.18-A, section D, p. 760, and Attachment 4.18-C, section D, p.763, provide that the claims processing system deducts the appropriate amount of co-payment from the claim, so the amount the State pays, and on which Federal payment would be claimed, is net of the cost sharing obligation whether or not the provider collects it. Uncovered: the claiming rule itself. No held passage states, as a claiming procedure, that Federal financial participation is not claimed for expenditures for cost sharing amounts not collected, and no CMS-64 or financial reporting document in the held record carries it.

RECORD LOCATION: H-001 (H-001), Attachment 4.18-A p.760 and Attachment 4.18-C p.763

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The no-FFP claiming rule for uncollected cost sharing, stated as a claiming procedure.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: State the claiming treatment of uncollected cost sharing in the agency's financial procedures or the state plan, next to the deduction mechanism.

QUESTION: Where does NC record that it does not claim Federal payment on copayment amounts providers never collected?

SEARCHES RECORDED: Full map Part 447 documents read; H-126 SFY2025 annual report searched (expenditure tables, no claiming rule).

CFR-447-023: Public schedule and beneficiary/provider notice

CITATION: 42 CFR 447.57

TOPIC: Public schedule and beneficiary/provider notice

OBLIGATED LEVEL: agency

CADENCE: RECURRING - schedule kept current; advance notice before each relevant SPA

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid cost sharing, which must be publicly scheduled and noticed.

BASIS: Covered: a public schedule exists in the plan attachments (Attachment 4.18-A, p.758, and 4.18-C, p.761, list each service and its copayment amount), and notice machinery is held for managed care: the Tailored Plan contract (H-052) requires written notice to members, on a Department developed standardized template, of Department initiated changes to cost sharing requirements, and requires the member handbook to state cost sharing, if any, imposed on beneficiaries. The state plan public notices page (H-002) is the standing public notice channel for plan changes. Uncovered: no held artifact is a current standalone public schedule of premiums and cost sharing in the form 447.57 requires (the plan attachment amounts are 2005 figures and conflict with the current 4.00 dollar contract copayment), and no held passage carries the notice duty to beneficiaries, providers and the public for a substantial cost sharing change outside the Tailored Plan member notice.

RECORD LOCATION: H-001 (H-001), Attachment 4.18-A p.758; H-052 (H-052), Cost Sharing Noticing Requirements (f)(1) and member handbook item (12); H-002, cure text (Medicaid State Plan Public Notices page)

SECTION 5D FACE

UNCOVERED ELEMENT: A current public schedule of cost sharing amounts, and the 447.57 notice for a substantial change, addressed to beneficiaries, providers and the public.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish a current cost sharing schedule as a standalone public document and use it as the single source the plan attachments and contracts point to.

> **QUESTION:** Where can a beneficiary or provider read today's actual copayment amounts in one public place?

SEARCHES RECORDED: Full map Part 447 documents read; cure public notice acquisitions H-002, H-015, H-016, H-017, H-018, H-019 and H-020 read (SPA notices, none is a cost sharing schedule).

FLAGS: COST-SHARING-AMOUNT-CONFLICT: schedule of record is the 2005 plan attachment

CFR-447-024: State plan describes payment methods

CITATION: 42 CFR 447.201

TOPIC: State plan describes payment methods

OBLIGATED LEVEL: agency

CADENCE: FIXED - state plan; amended with each rate change

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid: section 4.19 and its attachments are the payment methods description.

BASIS: Read across the governing plan: section 4.19(a), p.121, meets Subpart C for inpatient hospital services with Attachment 4.19-A describing the methods and standards; section 4.19(b), p. 122, covers FQHC, rural health clinic and other services with Attachment 4.19-B describing the method of payment for each; section 4.19(d), p.124, covers skilled nursing and intermediate care facility services with Attachment 4.19-D. The attachments themselves were read in place (Attachment 4.19-A DRG and per diem methods, cost reporting and DSH sections; Attachment 4.19-B sections 2, 5, 7, 9 and 12; Attachment 4.19-D prospective nursing facility plan), and cure SPA packets amend them in the same form (H-003 Attachment 4.19-A readmission; SPA 23-0021 and 23-0022 revising Attachment 4.19-B section 2, reported in H-092). The plan describes the policy and methods for setting payment rates for the services the subpart governs.

RECORD LOCATION: H-001 (H-001), section 4.19 pp.121-124 and Attachments 4.19-A, 4.19-B, 4.19-D; H-003 (H-003); H-092, cure text

CFR-447-025: Audit cost-based payments

CITATION: 42 CFR 447.202

TOPIC: Audit cost-based payments

OBLIGATED LEVEL: agency

CADENCE: RECURRING - periodic audits of cost-based providers

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid payments based on cost, principally hospital and nursing facility payments.

BASIS: The plan assurance and its working provisions are both read. Section 4.19(g), p.127, citing 42 CFR 447.201 and 447.202 on its face: the Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials. The attachments perform it: Attachment 4.19-D, p.1054, defines audited cost reports for nursing facility rate setting as desk audits performed on all filed Medicaid nursing facility cost reports plus a minimum of fifty field audits, risk selected; Attachment 4.19-A, p.823, carries cost reporting and audits for hospitals, with penalties for failure to furnish required documentation.

RECORD LOCATION: H-001 (H-001), section 4.19(g) p.127, Attachment 4.19-D p.1054, Attachment 4.19-A p.823

CFR-447-026: Maintain and produce payment-rate documentation

CITATION: 42 CFR 447.203

TOPIC: Maintain and produce payment-rate documentation

OBLIGATED LEVEL: agency

CADENCE: RECURRING - as requested by HHS/CMS

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid payment rate documentation under the plan's section 4.19(h) commitment.

BASIS: Section 4.19(h), p.128, citing 42 CFR 447.201 and 447.203 on its face, provides the Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates. The documentation itself is held and read: the plan attachments state the methods, bases and data for each rate class (Attachments 4.19-A, 4.19-B, 4.19-D), and the Access Monitoring Review Plan (H-124) documents rate and access data for the fee-for-service program, including prevailing rate comparisons by service. This row is the documentation duty as the register splits it; the newer transparency and analysis duties the same section now also carries are graded on their own rows (CFR-447-027 to CFR-447-032), several of which are Partial or GAP, and this Verified does not cover them.

RECORD LOCATION: H-001 (H-001), section 4.19(h) p.128 and Attachments 4.19-A, 4.19-B, 4.19-D; H-124 (H-124), Access Monitoring Review Plan

FLAGS: Scope note on the face of the basis: newer 447.203 duties are graded on rows 027 to 032

CFR-447-027: Publish all FFS fee-schedule rates online

CITATION: 42 CFR 447.203

TOPIC: Publish all FFS fee-schedule rates online

OBLIGATED LEVEL: agency

CADENCE: RECURRING - initial deadline July 1, 2026; updates within 1 month

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid fee-for-service rates, which the plan states are published on the agency website.

BASIS: Covered: publication in operation for the specimens held. The plan repeatedly states the publication point (Attachment 4.19-B, p.908: all rates are published on the website; p.919: the physician drug program fee schedule and any annual or periodic adjustments are published on the Division website), and two complete fee schedule artifacts are held and read: the Physician Assistant fee schedule (H-172), procedure code by procedure code with facility and non-facility rates and effective dates, and the Local Education Agency fee schedule (H-173). Uncovered: completeness. Only two provider type schedules are held as artifacts, so the held record does not show that all Medicaid fee-for-service payment rates for all services are published, in the current transparency format, and the held specimens carry 2019 effective dates for many codes.

RECORD LOCATION: H-172 (H-172), Physician Assistant fee schedule; H-173, Local Education Agency fee schedule; H-001 (H-001), Attachment 4.19-B pp.908 and 919

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** Evidence that the published set covers all fee-for-service services and rates, in current form.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Place the fee schedule index, or a current schedule for each provider type, in the public record so completeness can be checked rather than sampled.
>
> **QUESTION:** How many fee schedules does NC publish today, and does the set cover every fee-for-service service a beneficiary can receive?

SEARCHES RECORDED: Full map read; the cure acquired fee schedule specimens H-172 and H-173 only; no fee schedule index document was acquired as an artifact.

CFR-447-028: Comparative payment rate analysis + disclosure every 2 years

CITATION: 42 CFR 447.203

TOPIC: Comparative payment rate analysis + disclosure every 2 years

OBLIGATED LEVEL: agency

CADENCE: RECURRING - initial July 1, 2026; biennial updates

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid from 2026 under the current 447.203 transparency provisions, per the agency's own reports page.

BASIS: Covered: the duty is acknowledged in its own terms on a held public page. The Reports page (H-128) states, under Comparative Payment Rate Analysis: beginning in 2026, CMS requires states to compare their rates for primary care, obstetrical and gynecological, and outpatient mental health and substance use disorder services to Medicare rates; states must publish the analysis every two years; reports are published in accordance with this requirement. That matches the service categories and the biennial cadence of the federal duty. Uncovered: the analysis artifact itself is not held (no comparative analysis report was acquired in the cure, and the page's text links no report that could be read), and the companion disclosure of average hourly payment rates for specified home and community based services is not mentioned on the page or anywhere else held.

RECORD LOCATION: H-128, cure text (Reports page, Comparative Payment Rate Analysis section)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The comparative analysis report itself, and the HCBS average hourly payment rate disclosure.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the first comparative payment rate analysis as a readable document and add the HCBS hourly rate disclosure to the same posting.
>
> **QUESTION:** Where is the actual analysis a member of the public can open, and when were its figures produced?

SEARCHES RECORDED: Full map read; cure collection searched for a comparative analysis artifact (none acquired); H-124 AMRP read (a 2019 to 2022 access plan under the prior rule, not the biennial Medicare comparison).

FLAGS: First analysis falls due in the 2026 cycle the page describes; graded on the held record as of the cure date

CFR-447-029: HCBS interested-parties advisory group

CITATION: 42 CFR 447.203

TOPIC: HCBS interested-parties advisory group

OBLIGATED LEVEL: agency

CADENCE: RECURRING - meetings at least every 2 years; publish recommendations within 1 month

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (at least every 2 years) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid home and community based services payment rates under the current 447.203 provisions.

BASIS: No held instrument establishes the HCBS interested parties advisory group. The plan carries a State Medical Care Advisory Committee (section 1.4), which is the 42 CFR 431.12 committee, a

different body with a different charge; it is not an advisory group of beneficiaries, providers and other interested parties advising on HCBS payment rates. Text searches of the held corpus and the cure collection for the advisory group, and for interested parties in connection with HCBS rates, returned no establishing document, no membership or meeting record, and no biennial meeting evidence.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The whole requirement: establishment of the advisory group, its composition, and its meeting and rate review activity.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Establish the advisory group, or identify the existing body that performs its function and publish its charge, membership and meeting record.
>
> **QUESTION:** Which body advises NC on HCBS payment rates with beneficiaries and providers at the table, and when did it last meet on rates?

SEARCHES RECORDED: the full reconciliation map documents read; full-text search for advisory group and interested parties across held corpus and cure texts (returns the 431.12 committee, waiver advisory material and EQR references, none establishing this group); waiver documents H-035 (access blocked) and NL-15 read for HCBS governance.

FLAGS: H-035 CAP/DA Appendix K approval was access blocked in the cure; it would not establish this group in any case

CFR-447-030: Rate-reduction/restructuring access analysis with SPA

CITATION: 42 CFR 447.203

TOPIC: Rate-reduction/restructuring access analysis with SPA

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - with each rate-reduction/restructuring SPA

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid SPAs and rate actions that reduce or restructure payments.

BASIS: Covered: the surrounding machinery exists. NC maintains an Access Monitoring Review Plan (H-124) analyzing access for fee-for-service services under 42 CFR 447.203(b), with provider counts, utilization and rate comparisons, and submits payment SPAs to CMS through the transmittal process (for example H-007 and H-008, CMS-179 forms read). Uncovered, and the row's central weakness: no held SPA packet or rate action carries the reduction specific access analysis. The one clear reduction episode in the window, the October 1, 2025 rate reductions of 3 to 10 percent (H-087), is documented by bulletin only, with no accompanying access analysis in the held record; those reductions were reversed on December 10, 2025 (H-087 as replaced; H-088 for NEMT),

restoring the September 30, 2025 rates, so the current rate state is the pre-reduction state, but the episode shows the analysis element missing exactly where the provision engages.

RECORD LOCATION: H-124 (H-124), Access Monitoring Review Plan p.5 and analysis sections; H-087 and H-088, cure texts (rate reduction and reversal bulletins); H-007 and H-008, cure texts (SPA transmittals)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** An access analysis, in the provision's terms, submitted with a payment reduction or restructuring SPA.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Attach the access analysis to the next reduction or restructuring submission and place the October 2025 episode's analysis, if one was made, in the record.
>
> **QUESTION:** Was an access analysis prepared for the October 1, 2025 reductions, and if so where is it published?

SEARCHES RECORDED: Full map read; all cure SPA packets (H-003 to H-020 set) checked for an access analysis (none carries one); H-087 and H-088 read in full.

FLAGS: RATE-CUT-EPISODE-2025: reductions of 3 to 10 percent effective Oct 1 2025, reversed Dec 10 2025; current rates are the Sep 30 2025 rates

CFR-447-031: Ongoing access input mechanisms + records

CITATION: 42 CFR 447.203

TOPIC: Ongoing access input mechanisms + records

OBLIGATED LEVEL: agency

CADENCE: RECURRING - continuous; records available on request

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid access monitoring for fee-for-service services.

BASIS: Covered: working input and monitoring channels are held. The Access Monitoring Review Plan (H-124) is a standing access analysis built on provider participation counts, beneficiary utilization, health care performance measures and measures of patient experience for Medicaid Direct. Public notices for plan changes invite questions and comments to a named address and state where copies may be viewed (H-015, PCS rate notice), and the public notices page (H-002) is the standing channel. Uncovered: no held document inventories the ongoing mechanisms as the system the current provision requires (mechanisms for beneficiary and provider input on access, the records kept of that input, and how input is fed into rate decisions), so the elements are evidenced in pieces, not as a maintained system with records.

RECORD LOCATION: H-124 (H-124), Access Monitoring Review Plan, overview and framework sections; H-015 (H-015), public notice; H-002, cure text

SECTION 5D FACE

UNCOVERED ELEMENT: An inventory of the ongoing access input mechanisms and the records they produce, as a system.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the access input mechanism inventory with the AMRP, naming each channel, what records it creates, and where they are kept.

QUESTION: If a provider raised an access concern today, which channel would it enter, what record would exist, and who would see it before the next rate action?

SEARCHES RECORDED: Full map read, including H-122 quality strategy and H-123 annual quality report (quality input channels, not access input records).

CFR-447-032: Corrective action plan for access deficiencies

CITATION: 42 CFR 447.203

TOPIC: Corrective action plan for access deficiencies

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - within 90 days of discovering an access deficiency

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies when access monitoring identifies a deficiency in NC Medicaid fee-for-service access.

BASIS: No held document is or describes a corrective action plan for an access deficiency, and no held document identifies an access deficiency that would have triggered one. The AMRP (H-124) does identify weak spots in its own analysis (for example dental rates below 50 percent of the benchmark it uses, p.28), but it contains no corrective action plan with steps and timelines submitted to CMS, and searches of the held corpus and cure collection for corrective action in the access context returned quality and program integrity corrective material only, for other subjects.

RECORD LOCATION:

SECTION 5D FACE

UNCOVERED ELEMENT: The whole requirement as an evidenced performance: a corrective action plan with specific steps and timelines, tied to an identified access deficiency.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: When the next access analysis identifies a deficiency, file the corrective action plan with CMS and publish it with the analysis that triggered it.

QUESTION: Has NC ever identified an access deficiency under its access monitoring, and if it did, where is the corrective action plan?

SEARCHES RECORDED: the full reconciliation map documents read; H-124 read in full; full-text search for corrective action across held corpus and cure texts (no access corrective action plan).

CFR-447-033: Stakeholder input and CMS submission for rate changes

CITATION: 42 CFR 447.204

TOPIC: Stakeholder input and CMS submission for rate changes

OBLIGATED LEVEL: federal-facing state report

CADENCE: EVENT-TRIGGERED - with each rate-reduction/restructuring SPA

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid payment rate changes submitted to CMS by SPA.

BASIS: Covered: the public process half in operation. Section 4.19(i), p.129, carries the sufficiency commitment behind the provision. Public notices for payment changes invite and receive comment before submission (H-015: notice of intent to amend the plan for a PCS rate increase, stating the fiscal impact, where the notice may be viewed, and the address for questions, comments and requests for copies), the ten day public notice series is posted as a standing practice (H-002), and SPA packets are submitted to CMS on the transmittal form (H-007, H-008, read). Uncovered: no held packet shows the submission side of the provision, that the agency considered access data and stakeholder input and included that consideration with the SPA, and for the October 2025 reductions (H-087) no submission record at all is held. Graded on the process evidence held, with the reduction episode flagged on CFR-447-030.

RECORD LOCATION: H-001 (H-001), section 4.19(i) p.129; H-015 (H-015); H-002, cure text; H-007 and H-008, cure texts

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The record, in a submission, that access data and stakeholder input were considered for the change.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Add a standard consideration statement to SPA submissions recording the access data and public input reviewed for the change.
>
> **QUESTION:** For the last three payment SPAs, what input was received and where is the agency's consideration of it recorded?

SEARCHES RECORDED: Full map read; all cure SPA packets checked for an input or access consideration statement (none carries one).

FLAGS: RATE-CUT-EPISODE-2025 bears on this row: see CFR-447-030

CFR-447-034: Public notice of significant rate-method changes

CITATION: 42 CFR 447.205

TOPIC: Public notice of significant rate-method changes

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - before each significant change's effective date

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid changes in statewide methods and standards for setting payment rates.

BASIS: Covered: the plan commitment and repeated actual notices with the core content. Section 4.19(j), p.130, provides the agency meets 42 CFR 447.205 for public notice of any changes in statewide method or standards for setting payment rates. Actual notices are held: the ten day public notice series for SPAs 26-0001 to 26-0008 is posted on the state plan public notices page (H-002), and a full specimen was read (H-015, PCS rates: description of the change, effective date of August 1, 2026, annual estimated state fiscal impact of 70,800,000 dollars for SFY 2027 and SFY 2028, where the notice may be viewed, and where to send comments and requests for copies). Rate change bulletins (H-087) also publish changes with effective dates and amounts. Uncovered: the held notices do not show the full federal notice content and placement for a given change (publication medium beyond the agency website, and a final notice after adoption), so a single change cannot be followed from proposal to final action entirely on held documents.

RECORD LOCATION: H-001 (H-001), section 4.19(j) p.130; H-002, cure text; H-015 (H-015); H-087, cure text

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** Final adoption notice and publication placement for a specific significant change, completing the notice chain.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** For the next significant rate method change, publish the proposal and the final action as a linked pair and keep both in the notices archive.
>
> **QUESTION:** For the PCS rate increase noticed in H-015, where will the final action notice appear when the SPA is approved?

SEARCHES RECORDED: Full map read; cure public notice acquisitions H-002 and H-015 to H-020 read.

CFR-447-035: State plan inpatient/LTC payment methods

CITATION: 42 CFR 447.252

TOPIC: State plan inpatient/LTC payment methods

OBLIGATED LEVEL: agency

CADENCE: FIXED - state plan; amended with changes

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid inpatient hospital and long term care facility payment under Subpart C.

BASIS: Both halves read in the governing plan. Section 4.19(a), p.121, provides the agency meets 42 CFR Part 447 Subpart C and sections 1902(a)(13) and 1923 for inpatient hospital services, with Attachment 4.19-A describing the methods and standards (DRG and per diem methods, exceptions, outliers, cost reporting, DSH, read in place at pp.784 to 826). Section 4.19(d), p.124, provides the same for skilled nursing and intermediate care facility services, with Attachment 4.19-D describing the methods and standards (the prospective reimbursement plan for nursing care facilities, rate setting methods at pp.1053 to 1066 and the ICF-MR addendum). The plan provides for payment in accordance with the described methods for both classes the provision governs.

RECORD LOCATION: H-001 (H-001), section 4.19(a) p.121, section 4.19(d) p.124, Attachment 4.19-A and Attachment 4.19-D

CFR-447-036: Annual rate adequacy findings

CITATION: 42 CFR 447.253

TOPIC: Annual rate adequacy findings

OBLIGATED LEVEL: agency

CADENCE: RECURRING - at least annually and with each method change

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to the assurances that accompany NC's Subpart C payment methods.

BASIS: Covered: the predicates the findings attach to. The methods themselves are held in full (Attachments 4.19-A, 4.19-B, 4.19-D; see CFR-447-024 and CFR-447-035), section 4.19(i), p.129, carries the plan's sufficiency statement (payments are sufficient to enlist enough providers so services are available at least to the extent available to the general population), and Attachment 4.19-A, p.826, carries payment assurances and a provider participation statement for hospitals. Uncovered: the findings themselves. No held document makes the periodic findings, on methods changes or annually, that the rates are consistent with efficiency, economy and quality of care and sufficient to enlist enough providers; the plan statements are standing assurances, not dated findings.

RECORD LOCATION: H-001 (H-001), section 4.19(i) p.129 and Attachment 4.19-A p.826

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The dated rate adequacy findings for hospital and long term care methods.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Make and publish the findings when Subpart C methods change, in the SPA packet or a standing findings document.

> **QUESTION:** When did NC last record findings that its hospital and nursing facility rates meet the federal standard, and in what document?

SEARCHES RECORDED: Full map read; H-124 AMRP and H-126 annual report searched for findings language (access analysis and expenditure reporting, no 447.253 findings).

CFR-447-037: Ownership-change payment safeguards

CITATION: 42 CFR 447.253

TOPIC: Ownership-change payment safeguards

OBLIGATED LEVEL: agency

CADENCE: FIXED - methods; applied at each ownership change

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to Subpart C providers whose ownership changes, principally nursing facilities and hospitals.

BASIS: Covered for nursing facilities in detail: Attachment 4.19-D, p.1061, defines transfer of ownership (a change in majority ownership not involving related parties) and sets the new owner's rate treatment, and p.1074 provides that on a change of ownership the valuation of an asset for depreciation and interest is the lesser of the allowable acquisition cost less accumulated depreciation to the first owner of record on or after July 18, 1984 who received Medicaid payments for the asset, or the acquisition cost to the new owner, with no depreciation recapture at sale. That is the federal safeguard against a payment step-up on sale, in operative text. Uncovered: the hospital side. No passage in Attachment 4.19-A states an ownership change safeguard for hospitals, and the general measure (that a change of ownership does not, by itself, increase payments) is not stated for all Subpart C classes.

RECORD LOCATION: H-001 (H-001), Attachment 4.19-D pp.1061 and 1074

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** An ownership change safeguard for hospitals, and a class wide statement of the no step-up measure.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State the ownership change payment rule for hospitals in Attachment 4.19-A or the hospital billing guidance, mirroring the nursing facility text.
>
> **QUESTION:** If a hospital is sold tomorrow, which published NC rule keeps the sale itself from raising its Medicaid payment basis?

SEARCHES RECORDED: Full map read; Attachment 4.19-A searched for change of ownership (returns cost report and CPE passages, no safeguard).

CFR-447-038: Provider appeals procedure for rates

CITATION: 42 CFR 447.253

TOPIC: Provider appeals procedure for rates

OBLIGATED LEVEL: agency

CADENCE: FIXED - standing procedure; used as appealed

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to Subpart C providers disputing their payment rates.

BASIS: Covered: a hospital rate reconsideration procedure in operative text, and rate appeals elsewhere in the attachments. Attachment 4.19-A, p.824: reconsideration reviews of rate determinations shall be processed in accordance with 10 NCAC 26K, and requests shall be submitted within 60 days after rate notification, or at any time where unexpected conditions causing intense financial hardship arise. Attachment 4.19-B, p.896, provides providers may appeal maximum rates by written request with supporting data, processed under the Division's provider reimbursement review procedures, with no retroactive adjustment. Attachment 4.19-D, p.1066, allows a geropsychiatric provider or the Division to initiate a written request to appeal or renegotiate a rate within 60 days of rate notification. Uncovered: the text of 10 NCAC 26K itself is not held (it is incorporated by reference), and no general nursing facility rate appeal procedure beyond the negotiated and specialized rate passages was located, so the procedure a typical NF would use is not read in the held record.

RECORD LOCATION: H-001 (H-001), Attachment 4.19-A p.824, Attachment 4.19-B p.896, Attachment 4.19-D p.1066

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The incorporated appeal rules (10 NCAC 26K) as held text, and a general nursing facility rate appeal procedure.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the reimbursement review procedure with the plan attachments, or cite its public location in the reconsideration passages.
>
> **QUESTION:** Where can a nursing facility read the full procedure for appealing its rate, start to finish?

SEARCHES RECORDED: Full map read, including H-099 and H-101 NCAC chapter copies (Subchapter 26K is not in either).

CFR-447-039: Uniform cost reports from each provider

CITATION: 42 CFR 447.253

TOPIC: Uniform cost reports from each provider

OBLIGATED LEVEL: agency

CADENCE: RECURRING - annual cost report filing cycle

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to Subpart C providers filing cost reports: hospitals, nursing facilities and ICFs.

BASIS: Covered: filing duties with deadlines and penalties for the two main classes. Hospitals: Attachment 4.19-A, p.823, annual cost reports shall be filed as directed by the Division in accordance with 42 CFR 447.253(f) and (g); the Medicaid cost report is due five months after the provider's fiscal year end or 37 days from the PS&R letter, whichever is later, with a 20 percent withhold of Medicaid payments for delinquent or incomplete filing. Nursing facilities: Attachment 4.19-D, pp.1054 and 1066, cost reports are filed and audited under section .0104, an annual cost report is required, and a provider delinquent 30 days is subject to a 20 percent withhold until a completed report is received. Uncovered: uniformity in terms. The hospital duty is to file as directed (the uniform form is not named in the held text), and an ICF cost report duty in the same form was not located in the addendum passages read.

RECORD LOCATION: H-001 (H-001), Attachment 4.19-A p.823 and Attachment 4.19-D pp.1054 and 1066

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The uniform cost report form or format named for each Subpart C class, including ICFs.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Name the cost report form for each provider class in the plan attachments, next to the filing deadlines already stated.
>
> **QUESTION:** Is there one uniform Medicaid cost report for hospitals, or a form per class, and where is the form itself published?

SEARCHES RECORDED: Full map read; NL-12 DSH audit and cost report settlement search in the cure returned no current settlement document.

CFR-447-040: Periodic audits of provider records

CITATION: 42 CFR 447.253

TOPIC: Periodic audits of provider records

OBLIGATED LEVEL: agency

CADENCE: RECURRING - periodic audit program

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to audits of Subpart C providers' financial and statistical records.

BASIS: Covered for nursing facilities with a stated cadence and coverage: Attachment 4.19-D, p. 1054, rates are derived from audited cost reports, defined as desk audits performed on all Medicaid nursing facility cost reports filed for the base year plus a minimum of fifty field audits, risk selected on direct and indirect cost per patient day. Section 4.19(g), p.127, assures appropriate audit of records when payment is based on costs. Uncovered: the periodic element for hospitals and ICFs. Attachment 4.19-A, p.823, is headed cost reporting and audits but its text governs filing and penalties; no held passage states how often hospital or ICF records are audited, or that audits are provided for periodically for those classes.

RECORD LOCATION: H-001 (H-001), Attachment 4.19-D p.1054, section 4.19(g) p.127, Attachment 4.19-A p.823

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** A stated periodic audit provision for hospitals and ICFs.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State the audit cycle for hospital and ICF cost records in the plan or audit guidance, as the nursing facility attachment already does for its class.
>
> **QUESTION:** How often is a hospital's cost record audited under NC's published rules, and where is that cycle written?

SEARCHES RECORDED: Full map read; H-134 single audit and H-135 state auditor index read (audit products and an index, not a periodic audit provision).

CFR-447-041: Comply with public notice for inpatient/LTC rate changes

CITATION: 42 CFR 447.253

TOPIC: Comply with public notice for inpatient/LTC rate changes

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - with each significant inpatient/LTC rate change

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to public notice when NC changes inpatient hospital or long term care payment methods or rates.

BASIS: Covered: the plan commitment at section 4.19(j), p.130 (the agency meets 42 CFR 447.205 for public notice of changes in statewide method or standards for setting payment rates), and an actual inpatient method change noticed in public: SPA 25-0014's ten day public notice (H-020, acquired in the cure) posts the hospital readmission review revision with its transmittal number,

submission date and January 1, 2025 effective date, and the SPA 26-0001 notice for the successor change is listed on the public notices page (H-002). The H-020 and H-003 records also resolve the direction of that change in the held record (30 days to 72 hours under SPA 25-0014). Uncovered: a notice specimen for a long term care rate change was not located, and the content and placement elements of 447.205 for a specific inpatient change (fiscal impact statement, comment handling, final notice) are not all shown for the inpatient class; see also CFR-447-034.

RECORD LOCATION: H-001 (H-001), section 4.19(j) p.130; H-020, cure text (SPA 25-0014 public notice); H-002, cure text; H-003 (H-003)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** A complete 447.205 notice chain for one inpatient change and one long term care change.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Keep proposal and final notices for inpatient and long term care changes in the public archive as complete chains, as started for the readmission SPAs.
>
> **QUESTION:** For the last nursing facility rate change, where is its public notice?

SEARCHES RECORDED: Full map read; cure public notice acquisitions read; GAPS section 4.1 direction conflict on the readmission change noted and resolved in favor of SPA 25-0014 per the collection record.

CFR-447-042: Related information submitted with assurances

CITATION: 42 CFR 447.255

TOPIC: Related information submitted with assurances

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - with each SPA changing inpatient/LTC payment methods

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to information submitted to CMS with the Subpart C rate assurances.

BASIS: Covered: one element of the submission package in working form. Cure SPA packets carry the CMS-179 transmittal with a stated federal budget impact: SPA NC-25-0015 (H-007) and SPA NC-25-0012 (H-008) each state federal budget impact of 0 dollars for FFY 25 and the following year, with the federal statute and regulation citation on the form. Uncovered: the 447.255 content in its own terms for a Subpart C submission (the estimated annual change in expenditures, the estimated average proposed and current rates and the basis, and the related information that accompanies the 447.253 assurances). The packets read are for other services, and no held Subpart C packet shows its rate estimates; the hospital readmission packets (H-003, H-020) carry no budget or rate estimate text.

RECORD LOCATION: H-007 and H-008, cure texts (CMS-179 transmittals, federal budget impact blocks); H-003 (H-003); H-020, cure text

SECTION 5D FACE

UNCOVERED ELEMENT: The rate and expenditure estimates and related information that accompany a Subpart C assurance submission.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Include the rate estimate worksheet in the held packet for the next Subpart C SPA, or publish the submission's related information with the notice.

QUESTION: What did NC send CMS, in figures, with its last hospital methods assurance?

SEARCHES RECORDED: Full map read; all cure SPA packets checked for budget impact and rate estimate content.

CFR-447-043: Inpatient UPL compliance by ownership class

CITATION: 42 CFR 447.272

TOPIC: Inpatient UPL compliance by ownership class

OBLIGATED LEVEL: agency

CADENCE: RECURRING - each rate year; demonstrated to CMS

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to aggregate inpatient hospital payments against the upper payment limit by ownership category.

BASIS: Covered: the compliance rule and a working calculation method in the plan. Attachment 4.19-A, p.797, item (4): payments, when added to Medicaid payments received or to be received, shall not cause aggregate payments to any category of hospitals as specified in 42 CFR 447.272(a) to exceed the maximum allowed aggregate upper limits for that category. Exhibit 1, pp.807 to 809, works the hospital specific UPL calculation per case (Medicare payments with case mix removed, from CMS 2552 cost reports, trended, against the Medicaid rate, producing the per case differential and the available room under the UPL). Uncovered: a UPL demonstration as an artifact, computed and reported by ownership class (state government, non-state government, private), is not held; the plan carries the rule and the method, not a performed demonstration for a stated year.

RECORD LOCATION: H-001 (H-001), Attachment 4.19-A p.797 and Exhibit 1 pp.807-809

SECTION 5D FACE

UNCOVERED ELEMENT: A performed inpatient UPL demonstration by ownership class for a stated year.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the annual inpatient UPL demonstration, or a summary by ownership class, with the hospital rate documentation.

> **QUESTION:** For the most recent year, how much room was under the inpatient UPL in each ownership class?

SEARCHES RECORDED: Full map read; no UPL demonstration document was acquired in the cure (not among NL items; searched in collection logs).

CFR-447-044: Swing-bed hospitals paid under NF methodology

CITATION: 42 CFR 447.280

TOPIC: Swing-bed hospitals paid under NF methodology

OBLIGATED LEVEL: agency

CADENCE: FIXED - payment methodology

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to routine nursing facility services furnished by swing bed hospitals.

BASIS: Covered in part: section 4.19(d)(2) and (3), p.124, provide payment for routine skilled nursing and intermediate care services furnished by a swing bed hospital at a rate established by the State which meets the requirements of 42 CFR Part 447 Subpart C. Attachment 4.19-A, p.822, item (e), pays days for authorized nursing facility level of care rendered in an acute care hospital at a rate equal to the average rate for all such Medicaid days based on the rates in effect for the long term care plan year, and Supplement 1, p.845, carries swing bed payment rates. Uncovered: the federal measure itself (the average rate per patient day paid to nursing facilities for routine services during the previous calendar year) is not the formula any held passage states for swing bed routine services; the held formulas are a state established Subpart C rate and an average of lower level of care day rates, which are adjacent, not identical.

RECORD LOCATION: H-001 (H-001), section 4.19(d) p.124, Attachment 4.19-A p.822 and Supplement 1 p.845

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The swing bed payment formula stated as the previous calendar year average nursing facility routine rate.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State the swing bed rate basis in one passage that ties it to the nursing facility methodology the provision names.
>
> **QUESTION:** How is a swing bed day priced today, in one sentence a hospital biller could cite?

SEARCHES RECORDED: Full map read; Attachment 4.19-D searched for a swing bed rate cross reference (none stated).

CFR-447-045: Annual DSH data submission to CMS

CITATION: 42 CFR 447.294

TOPIC: Annual DSH data submission to CMS

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - annually by June 30

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to the data NC must develop on its disproportionate share hospitals for the annual submission.

BASIS: Covered: the data machinery the submission reports. The plan defines DSH qualification on the Medicaid inpatient utilization rate (Attachment 4.19-A, p.803: a hospital must have a MIUR of not less than one percent, computed as Medicaid patient days divided by total patient days, on the most current available information, plus the obstetrician requirement), hospitals file and certify uncompensated care data to the Division on a signed Schedule A (p.816), and the operational data flow is held (H-174: hospitals obtain DSH recipient eligibility verifications and PS&R reports through NCTracks). Uncovered: the submission itself. No held document is or describes the annual submission to CMS of the DSH data elements for each deemed DSH hospital, and NL-12's cure search found no current DSH audit or data submission document on any source searched.

RECORD LOCATION: H-001 (H-001), Attachment 4.19-A pp.803 and 816; H-174, cure text (DSH data requests reminder)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The annual DSH data submission to CMS, or a document describing it, its contents and its date.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the annual DSH data submission, or a transmittal record showing its contents and date, with the DSH program documents.
>
> **QUESTION:** When was the last annual DSH data submission sent to CMS, and what did it contain per hospital?

SEARCHES RECORDED: Full map read; NL-12 search record in the collection record (NC Medicaid, NCDHHS, State Auditor and Treasurer postings and web search: only a 2003 OIG review found).

FLAGS: NL-12: no current DSH audit or submission document found in the cure searches

CFR-447-046: Hospital-specific DSH limit methodology

CITATION: 42 CFR 447.295

TOPIC: Hospital-specific DSH limit methodology

OBLIGATED LEVEL: agency

CADENCE: RECURRING - each Medicaid state plan rate year

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to the limit on DSH payments to each individual hospital.

BASIS: Covered: a limit methodology in the plan's own calculations. Attachment 4.19-A, pp.796 to 797, computes reasonable Medicaid costs for inpatient services from CMS 2552 cost reports and subtracts Medicaid payments received (excluding DSH payments) to reach the unreimbursed amount, and computes uncompensated care costs from gross charges for uninsured patients converted by the facility cost to charge ratio, minus payments received from uninsured patients; p. 802 builds the CPE hospital DSH amounts on those uncompensated care expenditures up to the State's available DSH allotment, and p.806 provides audit procedures to ensure the hospital specific DSH limits have not been exceeded. The distribution rule (H-102, 10A NCAC 22Q) governs distribution of the federal DSH adjustment receipts arising from CPEs. Uncovered: a single stated hospital specific limit formula, in the provision's terms (total Medicaid and uninsured costs minus all payments, for every DSH hospital class including IMD and non-CPE hospitals), was not located; the held methodology is spread across the CPE, enhanced payment and IMD sections, each with its own calculation.

RECORD LOCATION: H-001 (H-001), Attachment 4.19-A pp.796-797, 802 and 806; H-102 (H-102), 10A NCAC 22Q pp.1-2

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** One stated hospital specific DSH limit methodology covering all DSH hospital classes.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the hospital specific limit calculation as one methodology document covering every DSH class, or add the consolidating passage to Attachment 4.19-A.
>
> **QUESTION:** For a private non-CPE hospital, which published calculation produces its hospital specific DSH limit?

SEARCHES RECORDED: Full map read; H-102 read in full (distribution and definitions, not a limit formula).

CFR-447-047: Quarterly aggregate DSH payment reports

CITATION: 42 CFR 447.299

TOPIC: Quarterly aggregate DSH payment reports

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - quarterly

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (quarterly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to reports to CMS of aggregate DSH payments by hospital ownership category.

BASIS: No held document is or describes a quarterly report to CMS of aggregate DSH payments. The held DSH record is the payment methodology (Attachment 4.19-A DSH sections), the distribution rule (H-102, 10A NCAC 22Q), the audit commitment at Attachment 4.19-A p.806, and a provider data request reminder (H-174). None reports aggregate payments made to public and private hospitals for a quarter, and the cure's DSH searches (NL-12) found no current DSH reporting document on any source searched.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The whole requirement: quarterly submission to CMS of aggregate DSH payments to each individual public and private hospital grouping the provision specifies.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the quarterly DSH payment reports, or the transmittal record for them, with the DSH program documents.
>
> **QUESTION:** Where are the quarterly aggregate DSH payment figures NC sends CMS, and who outside the agency can see them?

SEARCHES RECORDED: the full reconciliation map DSH documents read (H-001 Attachment 4.19-A, H-102, H-174); NL-12 search record in the collection record; full-text search for DSH report across held corpus and cure texts.

FLAGS: NL-12: no current DSH reporting document found in the cure searches

CFR-447-048: Annual per-hospital DSH report with audit

CITATION: 42 CFR 447.299

TOPIC: Annual per-hospital DSH report with audit

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - annually per Medicaid state plan rate year

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to the annual DSH report to CMS and the independent certified audit that accompanies the DSH program.

BASIS: Covered: the audit framework is adopted on the plan's face. Attachment 4.19-A, p.806, Audit of Disproportionate Share Payments: as required by section 1923(j) of the Act on auditing and

reporting of DSH payments, the Division will implement procedures to comply with the DSH payments final rule issued December 19, 2008, effective January 19, 2009, to ensure hospital specific DSH limits have not been exceeded, and recouped funds are redistributed under stated rules. Uncovered: the report and the audit as performed artifacts. No held document is the annual per hospital DSH report to CMS or an independent certified audit of a DSH year, and NL-12's cure search for a current DSH audit or cost report settlement document found none (only a 2003 OIG review of FY1997 to 2001 payments).

RECORD LOCATION: H-001 (H-001), Attachment 4.19-A p.806; NL-12 search record, the collection record

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The annual per hospital DSH report and an independent certified audit for a stated DSH year.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the most recent DSH audit and the per hospital report it supports, or record where they are filed and how they may be obtained.
>
> **QUESTION:** For which DSH year is the most recent certified audit, and where is it?

SEARCHES RECORDED: Full map read; NL-12 sources searched in the cure: NC Medicaid, NCDHHS, NC State Auditor, NC State Treasurer, HHS OIG postings and web search.

FLAGS: NL-12: current DSH audit document not found after search

CFR-447-049: Maintain DSH supporting documentation

CITATION: 42 CFR 447.299

TOPIC: Maintain DSH supporting documentation

OBLIGATED LEVEL: agency

CADENCE: RECURRING - continuous; produced on request

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to the records supporting DSH payments and audits.

BASIS: Covered: supporting data is generated, certified and filed under stated duties. Hospitals collect and certify uncompensated care information on a supplemental Schedule A that the hospital's CEO, CFO or designee must sign and certify to its accuracy (Attachment 4.19-A, p.816); cost reports supporting the calculations are filed annually with penalties for failure to furnish required documentation and disclosures (p.823); and the DSH distribution rule (H-102) subjects certifying hospitals to the plan's audit and reporting requirements. Uncovered: the documentation duty in the provision's terms (maintain the data and records supporting DSH payments and audits in readily reviewable form, available on request) is not stated in any held passage; retention and production on request for DSH records specifically are not addressed.

RECORD LOCATION: H-001 (H-001), Attachment 4.19-A pp.816 and 823; H-102 (H-102), 10A NCAC 22Q

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The DSH records maintenance and production duty, stated in terms.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State the DSH records retention and production rule in the DSH program documents, with the retention period.
>
> **QUESTION:** If CMS asked tomorrow for the records behind a 2023 DSH payment, what rule says they exist and how long they are kept?

SEARCHES RECORDED: Full map read; NL-12 search record (no DSH audit or settlement document to test the records against).

CFR-447-050: Return/redisclose DSH overpayments within 2 years

CITATION: 42 CFR 447.299

TOPIC: Return/redisclose DSH overpayments within 2 years

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - within 2 years of discovery of hospital-specific limit breach

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies when a DSH audit or review finds a hospital was paid above its hospital specific limit.

BASIS: Covered: redistribution of recouped DSH funds in operative plan text. Attachment 4.19-A, p. 806: any funds recouped as a result of audits or other corrections shall be redistributed to other eligible hospitals within the State, provided each hospital remains below its hospital specific DSH limit; funds go first to the State hospital with the highest Medicaid inpatient utilization rate, then to other State hospitals, then government non-state, then private hospitals, in MIUR order. Uncovered: the federal frame around the act (treatment of an overpayment discovered within the two year period the provision specifies, including return where redistribution is not possible, and the audit year timing) is not stated; the held passage gives the redistribution order only.

RECORD LOCATION: H-001 (H-001), Attachment 4.19-A p.806

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The two year discovery frame and the return treatment for overpayments that cannot be redistributed.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Add the discovery period and the return rule to the DSH audit passage in Attachment 4.19-A, next to the redistribution order it already carries.

> **QUESTION:** When a DSH overpayment is found more than two years after the payment year, what does NC do with it?

SEARCHES RECORDED: Full map read; NL-12 search record (no audit artifact in which a return or redistribution could be observed).

CFR-447-051: State plan covers subpart F services

CITATION: 42 CFR 447.302

TOPIC: State plan covers subpart F services

OBLIGATED LEVEL: agency

CADENCE: FIXED - state plan

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to the services Subpart F governs: FQHC, rural health clinic, inpatient, nursing facility and other services listed at section 4.19(b).

BASIS: Section 4.19(b), p.122, citing 42 CFR 447.201 and 447.302 on its face, provides that in addition to the services specified in paragraphs 4.19(a), (d), (k), (l) and (m), the agency meets the listed requirements, including section 1902(a)(13)(E) for FQHC services with Attachment 4.19-B describing the method of payment and how reasonable costs are determined, and sections 1902(a)(13)(E) and 1926 and 42 CFR Part 447 Subpart D (as printed) for rural health clinic services, with Attachment 4.19-B describing the methods and standards for each of these services except those described in other attachments. Together with sections 4.19(a) and (d) and the attachments read for CFR-447-024 and CFR-447-035, the plan covers the Subpart F services with payment methods described for each.

RECORD LOCATION: H-001 (H-001), section 4.19(b) p.122 with sections 4.19(a) and (d) pp.121 and 124 and Attachment 4.19-B

CFR-447-052: Adhere to upper limits; no FFP above them

CITATION: 42 CFR 447.304

TOPIC: Adhere to upper limits; no FFP above them

OBLIGATED LEVEL: agency

CADENCE: RECURRING - claims payment; FFP claiming

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to aggregate payments under Subpart F against the upper payment limits.

BASIS: Covered: adherence statements and adjustments across the main classes. Inpatient: Attachment 4.19-A, p.797, item (4) (aggregate payments to any hospital category shall not exceed the 447.272(a) upper limits) and the Exhibit 1 UPL method, pp.807 to 809. Outpatient and clinic: Attachment 4.19-B, pp.856 and 858 (the same aggregate statement under 447.321) and p.908 (clinic services cost settled annually to assure payments do not exceed the 447.321 upper limits). Nursing facilities: Attachment 4.19-D, pp.1060 and 1099 (the Division shall adjust the index factor or rates if necessary to prevent payment rates from exceeding upper payment limits established by federal regulations). Uncovered: the no-FFP-above-the-limit claiming consequence is not stated anywhere held, and no class wide demonstration covers the remaining Subpart F services (for example practitioner and other noninstitutional services paid from fee schedules).

RECORD LOCATION: H-001 (H-001), Attachment 4.19-A pp.797 and 807-809, Attachment 4.19-B pp. 856, 858 and 908, Attachment 4.19-D pp.1060 and 1099

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The claiming consequence (no Federal payment above the limits) and UPL coverage for the remaining Subpart F classes.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the UPL demonstrations by class with the rate documentation, and state the claiming consequence in the financial procedures.
>
> **QUESTION:** For which classes has NC computed a current UPL demonstration, and for which is adherence asserted without one?

SEARCHES RECORDED: Full map read; no UPL demonstration artifact acquired in the cure for any class.

CFR-447-053: Outpatient hospital/clinic UPL by ownership class

CITATION: 42 CFR 447.321

TOPIC: Outpatient hospital/clinic UPL by ownership class

OBLIGATED LEVEL: agency

CADENCE: RECURRING - each rate year

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to aggregate outpatient hospital and clinic payments against the upper payment limit by ownership category.

BASIS: Covered: the aggregate compliance statements for the enhanced and supplemental payment programs, and one performed UPL basis. Attachment 4.19-B, p.856, item under paragraph 2.a.1, and p.858, item (4): payments, when added to other Medicaid payments, shall not cause aggregate payments to any category of hospitals as specified in 42 CFR 447.321 to exceed the maximum

allowed aggregate upper limits for that category. Page 859 computes the UNC outpatient supplemental payment from each hospital's upper payment limit, estimated under Medicare reasonable cost principles from the latest Medicare cost report and a Medicaid PS&R run no less than nine months after the cost report year close. Page 908 assures clinic (health department) services are cost settled annually to Medicaid allowable costs so payments do not exceed the 447.321 limits. Uncovered: a general outpatient UPL demonstration by ownership class for base outpatient payments (as distinct from the supplemental programs) is not held, and the estimation method for the non-state government and private classes is not stated in the passages read.

RECORD LOCATION: H-001 (H-001), Attachment 4.19-B pp.856, 858-859 and 908

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** A performed outpatient UPL demonstration by ownership class covering base payments.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the outpatient UPL demonstration by ownership class with the hospital rate documentation.
>
> **QUESTION:** What is the current aggregate outpatient UPL room for the private hospital class?

SEARCHES RECORDED: Full map read, including H-101 Subchapter 22G reimbursement rules (history notes citing 447.321, expired 2015, not a demonstration).

CFR-447-054: Other facility services charge limits

CITATION: 42 CFR 447.325

TOPIC: Other facility services charge limits

OBLIGATED LEVEL: agency

CADENCE: RECURRING - rate setting and claims payment

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to payment for facility services not otherwise covered by the Subpart F upper limits.

BASIS: Covered only by a incorporating statement for one service section: Attachment 4.19-B, section 7, p.896, payment assurances: the State will pay the amounts determined under this plan for each covered service, and the payments made under this methodology will not exceed the upper limits as established by 42 CFR 447.325; the same page carries annual cost reporting under Medicare principles of reimbursement and a rate appeal route for that section. Uncovered: the provision's own measure (payment may not exceed the provider's customary charges to the general public, and not more than prevailing charges in the locality for comparable services) is not stated in any held passage, and no held passage applies the limit beyond that one section's assurance.

RECORD LOCATION: H-001 (H-001), Attachment 4.19-B section 7, p.896

SECTION 5D FACE

UNCOVERED ELEMENT: The customary and prevailing charge measure of 447.325, stated and applied.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: State the charge based limit in the facility payment sections that rely on it, or record why the fee schedule and cost methods make it inoperative.

QUESTION: For a facility service paid outside the UPL classes, what stops payment above the provider's customary charge, in published text?

SEARCHES RECORDED: Full map read; text search for prevailing charges and customary charges across held corpus (returns the pharmacy usual and customary limiter at Attachment 4.19-B p.917, a drug rule, not this provision).

FLAGS: Weakest of the Partial grades in this batch: the only passage is incorporation by citation for one service section

CFR-447-055: Nonrisk prepaid capitation payment cap

CITATION: 42 CFR 447.362

TOPIC: Nonrisk prepaid capitation payment cap

OBLIGATED LEVEL: agency

CADENCE: RECURRING - per nonrisk contract payment

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC's nonrisk arrangements: the Community Care of North Carolina PCCM entity and Carolina ACCESS medical home payments.

BASIS: Covered: a nonrisk arrangement in operation, on the terms the provision contemplates. The plan, p.33 (section 1.6, State Option to Use Managed Care), cites 42 CFR 447.362 for payments under any nonrisk contracts, alongside 438.6(c) for risk contracts. The PCCM program page (H-158) shows the arrangement working: PCPs participating in the Carolina ACCESS network are paid on a fee-for-service basis plus a medical home fee per member per month for coordinating care (5.00 dollars for aged, blind and disabled beneficiaries, 2.50 dollars for others), which is a nonrisk prepaid arrangement of the kind the cap governs. Uncovered: the cap itself. No held passage states the ceiling measure (that payments under a nonrisk contract may not exceed what would have been paid under fee-for-service for the same services, plus allowable administrative amounts), and no held document performs the comparison for the PCCM payments.

RECORD LOCATION: H-001 (H-001), section 1.6 p.33; H-158, cure text (Community Care of North Carolina page, Carolina ACCESS medical home fees)

SECTION 5D FACE

UNCOVERED ELEMENT: The 447.362 cap formula and any performance of it for NC's nonrisk payments.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Record the cap comparison for the PCCM medical home payments in the program's rate documentation.

QUESTION: Who has checked the Carolina ACCESS medical home fees against the fee-for-service equivalent the cap measures, and where is the check?

SEARCHES RECORDED: Full map read; text search for nonrisk across held corpus and cure texts (returns the plan citation only).

CFR-447-056: RHC payment at reasonable cost

CITATION: 42 CFR 447.371

TOPIC: RHC payment at reasonable cost

OBLIGATED LEVEL: agency

CADENCE: RECURRING - RHC rate setting and payment

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to rural health clinic services, paid under Attachment 4.19-B section 2 as revised by SPA 23-0021.

BASIS: Covered: a cost based RHC payment methodology, revised and CMS approved in the window. The plan, section 4.19(b)(2), p.122, carries RHC payment under the cited federal authority with Attachment 4.19-B describing the methods. The cure bulletin (H-092) reports CMS approved SPA 23-0021 for rural health clinics and SPA 23-0022 for FQHCs, effective July 1, 2023, revising Attachment 4.19-B section 2: the new methodology sets a provider specific prospective payment system alternative payment methodology rate for core service, well child and dental visits based on 113 percent of Medicaid allowable costs from the provider's 2021 Medicaid cost reports, inflated by the greater of the FQHC market basket or the medical CPI, rebased triennially from Medicaid cost reports, with a reconciliation lump sum paid for the period from the SPA effective date to implementation. Uncovered: payment determined at reasonable cost for the individual clinic in the provision's terms is not what the held methodology states; the APM is a percentage of a base year cost figure with triennial rebasing, and no held passage addresses the provision's treatment of a clinic's other ambulatory services or a new clinic without a 2021 cost report.

RECORD LOCATION: H-001 (H-001), section 4.19(b)(2) p.122; H-092, cure text (FQHC and RHC reimbursement methodology bulletin, SPA 23-0021 and 23-0022)

SECTION 5D FACE

UNCOVERED ELEMENT: Reasonable cost determination for the individual clinic in the provision's terms, including clinics without a base year cost report.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the revised Attachment 4.19-B section 2 pages with the SPA approvals so the RHC methodology can be read in the plan, not only in a bulletin.

QUESTION: How is an RHC that enrolled after 2021 paid, when the methodology keys its rate to a 2021 cost report it never filed?

SEARCHES RECORDED: Full map read; the SPA packets for 23-0021 and 23-0022 themselves were not acquired as artifacts (reported in H-092).

CFR-447-057: Remit Federal share of increased rebate savings

CITATION: 42 CFR 447.509

TOPIC: Remit Federal share of increased rebate savings

OBLIGATED LEVEL: agency

CADENCE: RECURRING - with rebate collections / CMS-64

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Pharmacy (Pharmacy Benefit Administrator for NC Medicaid Direct)

HOME BASIS: Pharmacy is a published DHB function: from May 2, 2026 a Pharmacy Benefit Administrator (Prime Therapeutics) supports NC Medicaid Direct pharmacy operations while DHB 'continues to manage all clinical policies and reimbursement methodologies for Point-of-Sale pharmacy' (Lane A §1.4). Title-level derivation: the Medicaid drug benefit and the Drug Rebate Program sit with the pharmacy function in NC's published structure (the PBA's published duties include drug rebate administration and DUR — Lane A §1.4).

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to the Federal share of the savings from the increased (post-ACA) rebate percentages, remitted through the Federal offset of rebates.

BASIS: No held document addresses remitting the Federal share of the increased rebate percentages to the Federal government through the Federal offset. The only sharing passage in the held record is a different mechanism: Attachment 3.1-A.1, p.635, provides that supplemental rebates received by the State in excess of those required under the national drug rebate agreement will be shared with the Federal government on the same percentage basis as applied under the national agreement. That is the State's voluntary supplemental rebate program (the NMPI agreement), not the 447.509 remittance of savings attributable to the increased statutory rebate percentages, and no financial or claiming document in the held record carries the offset treatment.

RECORD LOCATION:

SECTION 5D FACE

UNCOVERED ELEMENT: The whole requirement: remittance, via the Federal offset of rebates, of the savings from the increased rebate percentages.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Record the claiming treatment of the increased rebate savings in the pharmacy financial procedures, or point to the CMS-64 line where the offset appears.

QUESTION: On which report does NC show the Federal share of the increased rebate savings being remitted?

SEARCHES RECORDED: the full reconciliation map pharmacy documents read (H-001 plan pharmacy pages, H-075 Clinical Coverage Policy No. 9, H-090 pharmacy administrator transition, H-076 preferred drug list); full-text search for 447.509 and rebate offset across held corpus and cure texts (no hits).

FLAGS: The p.635 supplemental sharing passage was read and is not this provision; naming it here so the GAP is not mistaken for an unsearched row

CFR-447-058: Invoice manufacturers within 60 days of quarter end

CITATION: 42 CFR 447.511

TOPIC: Invoice manufacturers within 60 days of quarter end

OBLIGATED LEVEL: agency

CADENCE: RECURRING - quarterly, within 60 days of quarter end

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (quarterly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC's operation of the Medicaid drug rebate program for covered outpatient drugs.

BASIS: Covered: the rebate program's data foundation in operative policy. Clinical Coverage Policy No. 9, section 3.4.1: the programs cover drugs from manufacturers who have signed a national Medicaid drug rebate agreement with CMS; rebates are determined by North Carolina's Medicaid utilization data, and it is imperative pharmacies bill using the NDC of the drug actually dispensed, with denial, sanctions and termination exposure for inaccurate NDCs. The plan, Attachment 3.1-A.1, p.634, carries the State's compliance with reporting requirements for State utilization information. Uncovered: the invoicing act itself in the provision's terms (invoice to each manufacturer for the rebate owed, within 60 days after the end of the quarter, on the federal invoice form) is not stated in any held passage.

RECORD LOCATION: H-075 (H-075), Clinical Coverage Policy No. 9 section 3.4.1; H-001 (H-001), Attachment 3.1-A.1 p.634

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The manufacturer invoice, its form, and the 60 day deadline after quarter end.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the rebate invoicing procedure, or the administrator contract terms that carry it, in the pharmacy program documentation.
>
> **QUESTION:** Who invoices manufacturers for NC today, on what form, and by what day after the quarter ends?

SEARCHES RECORDED: Full map pharmacy documents read, including H-090 (pharmacy benefits administrator transition to Prime Therapeutics, an operations document with no invoicing terms).

FLAGS: Pharmacy administration moved to a new administrator in the window (H-090); the invoicing duty's home may have moved with it

CFR-447-059: Submit quarterly drug utilization data to CMS

CITATION: 42 CFR 447.511

TOPIC: Submit quarterly drug utilization data to CMS

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - quarterly, within 60 days of rebate period end

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (quarterly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Pharmacy (Pharmacy Benefit Administrator for NC Medicaid Direct)

HOME BASIS: Pharmacy is a published DHB function: from May 2, 2026 a Pharmacy Benefit Administrator (Prime Therapeutics) supports NC Medicaid Direct pharmacy operations while DHB 'continues to manage all clinical policies and reimbursement methodologies for Point-of-Sale pharmacy' (Lane A §1.4). Title-level derivation: the Medicaid drug benefit and the Drug Rebate Program sit with the pharmacy function in NC's published structure (the PBA's published duties include drug rebate administration and DUR — Lane A §1.4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC's quarterly drug utilization reporting under the rebate program.

BASIS: Covered: a plan level commitment to the reporting, in terms. Attachment 3.1-A.1, p.634: the State will comply with the reporting requirements for State utilization information and on restrictions to coverage, existing agreements will operate in conformance with law, the State must also agree to report rebates from separate agreements, and manufacturers must be allowed to audit utilization data. Page 635, item (e), repeats compliance with reporting requirements for utilization and restrictions to coverage for the supplemental program, with the unit rebate amount confidential except for rebate invoicing and verification. Uncovered: the quarterly cadence, the 60 day submission deadline, and the data content of the submission to CMS are not stated in any held passage, and no submission artifact is held.

RECORD LOCATION: H-001 (H-001), Attachment 3.1-A.1 pp.634-635

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The quarterly submission to CMS, its deadline and its data content, stated or shown.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Record the quarterly utilization submission (form, deadline, responsible unit) in the pharmacy program documentation.
>
> **QUESTION:** When was the last quarterly utilization file sent to CMS, and who in the agency certifies its contents? See also CFR-447-061.

SEARCHES RECORDED: Full map pharmacy documents read; no utilization submission artifact was acquired in the cure.

CFR-447-060: Report MCO drug utilization separately

CITATION: 42 CFR 447.511

TOPIC: Report MCO drug utilization separately

OBLIGATED LEVEL: agency

CADENCE: RECURRING - quarterly, with utilization submissions

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (quarterly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Pharmacy (Pharmacy Benefit Administrator for NC Medicaid Direct)

HOME BASIS: Pharmacy is a published DHB function: from May 2, 2026 a Pharmacy Benefit Administrator (Prime Therapeutics) supports NC Medicaid Direct pharmacy operations while DHB 'continues to manage all clinical policies and reimbursement methodologies for Point-of-Sale pharmacy' (Lane A §1.4). Title-level derivation: the Medicaid drug benefit and the Drug Rebate Program sit with the pharmacy function in NC's published structure (the PBA's published duties include drug rebate administration and DUR — Lane A §1.4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to drug utilization for enrollees of NC's managed care plans, reported apart from fee-for-service.

BASIS: Covered on the plan side for physician administered drugs: the Tailored Plan contract (H-052), pharmacy benefits, Physician Administered Drug Program: the plan shall reimburse procedure coded drugs under the PADP and require providers to bill using the CMS 1500/837p form; claims must be billed using the HCPCS and NDC combination per the NDC to HCPCS crosswalk file; and the plan shall ensure drugs used in the PADP are eligible for rebate (rebates are collected for drugs under this program, except for 340B drugs, radiopharmaceuticals, vaccines and Crofab). That is managed care drug data captured in rebate usable form, separately from fee-for-service claims. Uncovered: the agency's own reporting act (that NC reports the managed care utilization data to CMS separately from fee-for-service data) is not stated in any held passage, and retail pharmacy managed care utilization is not addressed in the passages read.

RECORD LOCATION: H-052 (H-052), Pharmacy Benefits, Physician Administered Drug Program (a)-(c)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The State's separate reporting to CMS of managed care drug utilization data.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State, in the rebate program documentation, how managed care utilization reaches CMS separately from fee-for-service, for both retail and physician administered drugs.
>
> **QUESTION:** Does the utilization NC sends CMS split managed care from fee-for-service for every drug class, and where is that split described?

SEARCHES RECORDED: Full map read; Standard Plan contract amendment (H-046) searched for an equivalent PADP or encounter term (definitions and prompt payment only).

CFR-447-061: Certify drug data submissions

CITATION: 42 CFR 447.511

TOPIC: Certify drug data submissions

OBLIGATED LEVEL: agency

CADENCE: RECURRING - with each quarterly submission

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (quarterly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Pharmacy (Pharmacy Benefit Administrator for NC Medicaid Direct)

HOME BASIS: Pharmacy is a published DHB function: from May 2, 2026 a Pharmacy Benefit Administrator (Prime Therapeutics) supports NC Medicaid Direct pharmacy operations while DHB 'continues to manage all clinical policies and reimbursement methodologies for Point-of-Sale pharmacy' (Lane A §1.4). Title-level derivation: the Medicaid drug benefit and the Drug Rebate Program sit with the pharmacy function in NC's published structure (the PBA's published duties include drug rebate administration and DUR — Lane A §1.4).

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to each quarterly drug utilization submission NC makes to CMS.

BASIS: No held document carries the certification of a drug data submission: no passage requires or shows a certification, by the Medicaid Director or a delegated official, that the utilization data submitted is true and complete in the provision's terms. The held pharmacy record contains one certification practice of a different kind (hospitals certify uncompensated care data on Schedule A, Attachment 4.19-A p.816), which shows the agency uses certifications elsewhere but is not this one. Searches of the plan pharmacy pages, Clinical Coverage Policy No. 9 and the pharmacy cure acquisitions returned no certification passage for drug data.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The whole requirement: certification of each quarterly drug utilization submission by an authorized official.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Add the certification step to the documented quarterly submission procedure, naming the certifying official and the delegation, if any.
>
> **QUESTION:** Who signs for the accuracy of NC's quarterly drug utilization data, and where is that signature recorded?

SEARCHES RECORDED: the full reconciliation map pharmacy documents read in full (H-001 Attachment 3.1-A.1 pp.632-636 and Attachment 4.19-B section 12, H-075, H-076, H-090); full-text search for certify and certification in those documents.

CFR-447-062: Aggregate FUL and AAC-based drug payment caps

CITATION: 42 CFR 447.512

TOPIC: Aggregate FUL and AAC-based drug payment caps

OBLIGATED LEVEL: agency

CADENCE: RECURRING - claims payment; methodology in state plan

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Pharmacy (Pharmacy Benefit Administrator for NC Medicaid Direct)

HOME BASIS: Pharmacy is a published DHB function: from May 2, 2026 a Pharmacy Benefit Administrator (Prime Therapeutics) supports NC Medicaid Direct pharmacy operations while DHB 'continues to manage all clinical policies and reimbursement methodologies for Point-of-Sale pharmacy' (Lane A §1.4). Title-level derivation: the Medicaid drug benefit and the Drug Rebate Program sit with the pharmacy function in NC's published structure (the PBA's published duties include drug rebate administration and DUR — Lane A §1.4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC fee-for-service payment for prescribed drugs under Attachment 4.19-B section 12.

BASIS: Read in the governing plan, Attachment 4.19-B section 12, pp.917 to 918: reimbursement for legend and non-legend drugs shall not exceed the federal upper limit, defined as the lowest of (1) estimated acquisition cost, defined as average acquisition cost plus a reasonable professional dispensing fee; (2) the provider's usual and customary charge to the general public; (3) the North Carolina State determined upper payment limit plus a reasonable professional dispensing fee; or (4) the North Carolina calculated aggregate FUL, which will be submitted to CMS on an annual basis. Page 918 defines the AAC basis (NADAC where available, otherwise wholesale acquisition cost from named published sources, from a survey of retail pharmacy providers) and the tiered professional dispensing fees. The aggregate application and the AAC plus fee structure the provision requires are both on the face of the payment methodology.

RECORD LOCATION: H-001 (H-001), Attachment 4.19-B section 12, pp.917-918

CFR-447-063: Brand-medically-necessary certification procedure

CITATION: 42 CFR 447.512

TOPIC: Brand-medically-necessary certification procedure

OBLIGATED LEVEL: agency

CADENCE: FIXED - procedure established; used per prescription

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies when a prescriber certifies a brand name multiple source drug is medically necessary.

BASIS: The procedure and its form are carried in three read places. Attachment 3.1-A.1, p.632: for non-MAC drugs, a brand prescription is treated as an order for the generic except when the prescriber personally indicates in their own handwriting brand name medically necessary; for MAC drugs the prescriber must write in their own handwriting on the face of the prescription brand name medically necessary. Attachment 4.19-B, p.917: multiple source drugs on the State list are

reimbursed at the State limits unless the provider writes in their own handwriting that the brand name drug is medically necessary. Clinical Coverage Policy No. 9, sections 5.8.1 and 5.9, works the procedure, including the unacceptable forms (a prescriber may not indicate medically necessary by telephone for a MAC drug for the pharmacist to document; a signature over a printed dispense as written statement, a rubber stamp, and the abbreviation DAW are all unacceptable).

RECORD LOCATION: H-001 (H-001), Attachment 3.1-A.1 p.632 and Attachment 4.19-B p.917; H-075 (H-075), Clinical Coverage Policy No. 9 sections 5.8.1 and 5.9

CFR-447-064: Apply drug upper limits to facility and capitation settings

CITATION: 42 CFR 447.516

TOPIC: Apply drug upper limits to facility and capitation settings

OBLIGATED LEVEL: agency

CADENCE: RECURRING - claims/capitation payment

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Pharmacy (Pharmacy Benefit Administrator for NC Medicaid Direct)

HOME BASIS: Pharmacy is a published DHB function: from May 2, 2026 a Pharmacy Benefit Administrator (Prime Therapeutics) supports NC Medicaid Direct pharmacy operations while DHB 'continues to manage all clinical policies and reimbursement methodologies for Point-of-Sale pharmacy' (Lane A §1.4). Title-level derivation: the Medicaid drug benefit and the Drug Rebate Program sit with the pharmacy function in NC's published structure (the PBA's published duties include drug rebate administration and DUR — Lane A §1.4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to drugs furnished in facility settings and drugs paid through capitation, beyond retail fee-for-service.

BASIS: Covered: the upper limits themselves in fee-for-service (Attachment 4.19-B section 12, pp. 917 to 918, read for CFR-447-062), and managed care physician administered drugs priced and rebate tracked under the Tailored Plan PADP terms (H-052: HCPCS and NDC combination billing, rebate eligibility). Uncovered: no held passage applies the drug upper limits to drugs furnished as part of a facility service (for example nursing facility or inpatient bundled drugs) or states that the limits are reflected in capitation paid to plans for drug coverage; the held applications are the retail pharmacy methodology and the PADP billing terms only.

RECORD LOCATION: H-001 (H-001), Attachment 4.19-B section 12, pp.917-918; H-052 (H-052), Physician Administered Drug Program

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** Application of the upper limits in facility settings and in capitation rate development for drugs.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State how the drug upper limits flow into facility bundled payments and into capitation, in the pharmacy and rate documentation.
>
> **QUESTION:** If a drug is bundled into a nursing facility per diem, which upper limit, if any, constrains what the State pays for it?

SEARCHES RECORDED: Full map read; capitation documents (H-052, H-059) searched for a drug upper limit term (none).

CFR-447-065: Annual/triennial drug payment findings and assurances

CITATION: 42 CFR 447.518

TOPIC: Annual/triennial drug payment findings and assurances

OBLIGATED LEVEL: agency

CADENCE: RECURRING - annual (multiple source) / triennial (other drugs) / with significant changes

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Pharmacy (Pharmacy Benefit Administrator for NC Medicaid Direct)

HOME BASIS: Pharmacy is a published DHB function: from May 2, 2026 a Pharmacy Benefit Administrator (Prime Therapeutics) supports NC Medicaid Direct pharmacy operations while DHB 'continues to manage all clinical policies and reimbursement methodologies for Point-of-Sale pharmacy' (Lane A §1.4). Title-level derivation: the Medicaid drug benefit and the Drug Rebate Program sit with the pharmacy function in NC's published structure (the PBA's published duties include drug rebate administration and DUR — Lane A §1.4).

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to the agency's periodic findings and assurances on its drug payment methods.

BASIS: No held document makes the findings or gives the assurances this provision requires: no artifact states, on proposing a significant change in drug payment methods or periodically, that the agency found its ingredient cost and dispensing fee payment levels consistent with the statutory standard and gave satisfactory assurances to CMS. The plan's drug payment pages (Attachment 4.19-B section 12, pp.917 to 919) state the methodology without findings; the AAC change SPA (TN 14-047, effective January 1, 2016) is carried only as the amended plan pages, with no findings package; and Clinical Coverage Policy No. 9 contains no findings passage. The one annual submission the plan does name, the aggregate FUL submitted to CMS annually (p.917), is a figure, not findings and assurances.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The whole requirement: the periodic and change triggered findings and satisfactory assurances on drug payment levels.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Make and file the findings and assurances at the next significant drug payment change, and place the document in the public SPA record.
>
> **QUESTION:** When NC last changed drug payment significantly, where are the findings that its levels met the federal standard?

SEARCHES RECORDED: the full reconciliation map pharmacy documents read in full; full-text search for findings and assurances across the plan pharmacy pages, H-075 and the cure SPA packets (no 447.518 findings).

CFR-447-066: Cost-based data for drug reimbursement changes

CITATION: 42 CFR 447.518

TOPIC: Cost-based data for drug reimbursement changes

OBLIGATED LEVEL: federal-facing state report

CADENCE: EVENT-TRIGGERED - with each drug reimbursement methodology change

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Pharmacy (Pharmacy Benefit Administrator for NC Medicaid Direct)

HOME BASIS: Pharmacy is a published DHB function: from May 2, 2026 a Pharmacy Benefit Administrator (Prime Therapeutics) supports NC Medicaid Direct pharmacy operations while DHB 'continues to manage all clinical policies and reimbursement methodologies for Point-of-Sale pharmacy' (Lane A §1.4). Title-level derivation: the Medicaid drug benefit and the Drug Rebate Program sit with the pharmacy function in NC's published structure (the PBA's published duties include drug rebate administration and DUR — Lane A §1.4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to the data supporting a change in drug reimbursement methods or levels.

BASIS: Covered: the current drug payment levels rest on cost based data stated in the plan. Attachment 4.19-B, p.918: North Carolina bases brand and generic drug ingredient pricing on an average acquisition cost defined as the price paid by pharmacies based on an average of actual acquisition costs determined by a survey of retail pharmacy providers, using NADAC where available and otherwise wholesale acquisition cost from named sources; dispensing fees are tiered by the pharmacy's generic and preferred brand share documented in MMIS (p.918). That is an evaluation of the ingredient and dispensing components against cost data, carried in the governing methodology. Uncovered: the change specific package (the data and evaluation submitted to CMS when a significant change is proposed, showing both components against the statutory standard) is not held for any change, including the 2016 AAC adoption and the October 2025 rate actions.

RECORD LOCATION: H-001 (H-001), Attachment 4.19-B section 12, p.918

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The cost based data package submitted with a significant drug payment change.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the AAC survey and dispensing fee cost data with the next drug payment SPA, as the supporting package.
>
> **QUESTION:** What survey, of how many pharmacies and what date, supports the dispensing fee tiers in force today?

SEARCHES RECORDED: Full map pharmacy documents read; cure SPA packets checked for a drug reimbursement data package (none).

FLAGS: RATE-CUT-EPISODE-2025 touched pharmacy rates (H-087); no data package for that action is held

CFR-447-067: Annual VBP supplemental-rebate data (if participating)

CITATION: 42 CFR 447.518

TOPIC: Annual VBP supplemental-rebate data (if participating)

OBLIGATED LEVEL: agency

CADENCE: RECURRING - annually within 60 days of year end

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually, each year) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Pharmacy (Pharmacy Benefit Administrator for NC Medicaid Direct)

HOME BASIS: Pharmacy is a published DHB function: from May 2, 2026 a Pharmacy Benefit Administrator (Prime Therapeutics) supports NC Medicaid Direct pharmacy operations while DHB 'continues to manage all clinical policies and reimbursement methodologies for Point-of-Sale pharmacy' (Lane A §1.4). Title-level derivation: the Medicaid drug benefit and the Drug Rebate Program sit with the pharmacy function in NC's published structure (the PBA's published duties include drug rebate administration and DUR — Lane A §1.4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies only if NC participates in a CMS authorized value based purchasing supplemental rebate arrangement; the held record shows a different supplemental program.

BASIS: Covered: NC's supplemental rebate participation in its actual form. Attachment 3.1-A.1, p. 635: a rebate agreement between the State and a drug manufacturer for drugs provided to the Medicaid population, entitled the State of North Carolina Magellan Medicaid Administration National Medicaid Pooling Initiative (NMPI), submitted to CMS on December 30, 2009, has been authorized by CMS; supplemental rebates are shared with the Federal government on the national agreement basis, and the State may also negotiate state specific supplemental agreements with CMS authorization (p.636, item (7): drugs of non-participating manufacturers are available through prior authorization, and payment of supplemental rebates results in preferred list placement). Uncovered: no held document shows a value based purchasing supplemental rebate agreement (an outcome or evidence based arrangement of the kind the provision's annual report addresses), and no annual report of supplemental rebate amounts under such an arrangement is held. If NC has no VBP arrangement, this row would convert to a STRUCTURAL not applicable on a fuller record; the held record does not affirmatively establish that either, so the grade stays Partial with the gap named.

RECORD LOCATION: H-001 (H-001), Attachment 3.1-A.1 pp.635-636

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** A VBP supplemental rebate agreement, or affirmative evidence NC has none, and the annual data report if one exists.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Confirm on the record whether any NC supplemental rebate agreement is a value based arrangement; if one is, publish its annual data report.
>
> **QUESTION:** Is the NMPI, or any state specific supplemental agreement, structured on outcomes, and if not, should this row be closed as not applicable?

SEARCHES RECORDED: Full map pharmacy documents read; full-text search for value-based and VBP across held corpus and cure texts (no VBP rebate arrangement).

FLAGS: Candidate for N-A STRUCTURAL on a fuller record; not determined here because non-participation is not affirmatively evidenced

CFR-447-068: NDC coding for physician-administered drugs; invoice rebates

CITATION: 42 CFR 447.520

TOPIC: NDC coding for physician-administered drugs; invoice rebates

OBLIGATED LEVEL: agency

CADENCE: RECURRING - claims coding; rebate invoicing

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Pharmacy (Pharmacy Benefit Administrator for NC Medicaid Direct)

HOME BASIS: Pharmacy is a published DHB function: from May 2, 2026 a Pharmacy Benefit Administrator (Prime Therapeutics) supports NC Medicaid Direct pharmacy operations while DHB 'continues to manage all clinical policies and reimbursement methodologies for Point-of-Sale pharmacy' (Lane A §1.4). Title-level derivation: the Medicaid drug benefit and the Drug Rebate Program sit with the pharmacy function in NC's published structure (the PBA's published duties include drug rebate administration and DUR — Lane A §1.4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies to physician administered drugs, in fee-for-service and managed care, for rebate invoicing.

BASIS: Covered: managed care PAD coding and rebate collection in contract terms, and the fee-for-service rebate data rule for pharmacy. The Tailored Plan contract (H-052), PADP: the plan shall require claims to be billed by providers utilizing the HCPCS and NDC combination per the NDC to HCPCS crosswalk file, and shall ensure drugs used in the PADP are eligible for rebate, with rebates collected for drugs under this program except 340B drugs, radiopharmaceuticals, vaccines and Crofab. Clinical Coverage Policy No. 9, section 3.4.1, makes accurate NDC billing imperative because rebates are determined by the State's utilization data. The plan's physician drug program (Attachment 4.19-B, p.919) prices physician administered drugs at average sales price plus 6 percent, by NDC level pricing where ASP is unavailable. Uncovered: an explicit fee-for-service requirement that providers submit NDC codes on physician administered drug claims for rebate invoicing, in the provision's terms, was not located in a held billing document; the held FFS passages price by NDC but do not state the claim coding duty.

RECORD LOCATION: H-052 (H-052), Physician Administered Drug Program (b)-(c); H-075 (H-075), section 3.4.1; H-001 (H-001), Attachment 4.19-B p.919

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The fee-for-service claim level NDC requirement for physician administered drugs, stated for rebate invoicing.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State the NDC claim requirement for physician administered drugs in the FFS billing guidance, as the Tailored Plan contract already does for its network.

QUESTION: Where must an FFS provider read that its PAD claim needs the NDC, or the drug will not be rebate invoiced?

SEARCHES RECORDED: Full map read; provider manuals H-067 to H-073 searched for a PAD NDC claim requirement (manuals are plan issued; no FFS billing manual passage located).

CFR-447-069: No FFP for payments to providers under credible fraud investigation

CITATION: 42 CFR 447.90

TOPIC: No FFP for payments to providers under credible fraud investigation

OBLIGATED LEVEL: agency

CADENCE: RECURRING - payment suspension decisions; FFP claiming

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: DHB's published Finance Section is the division's finance owner of record (contact for the Medicaid Annual Reports and Tables — Lane A §1.4); payment, rate, and fiscal functions map to it on NC's published structure.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat D)

APPLICABILITY (DETERMINATIONS FILE): Applies where NC suspends payments under 42 CFR 455.23 on a credible allegation of fraud; 447.90 governs the Federal payment consequences.

BASIS: Covered: the suspension machinery the provision keys to, in statute and in operations. N.C.G.S. 108C-3 (H-112), item (9): providers against whom the Department has imposed a payment suspension based upon a credible allegation of fraud in accordance with 42 CFR 455.23 within the previous 12 month period are moved to high categorical risk, returning to the original category not later than 12 months after the suspension ceases. The NCTracks bulletin (H-149) performs the same rule in the enrollment system effective January 29, 2023. The plan and program integrity rules carry the 455.23 framework (H-100, 10A NCAC 22F .0104, citing 42 CFR 455.23 in its authority note). Uncovered: the 447.90 consequence itself. No held passage states that Federal financial participation is not available for amounts expended for a provider during a suspension period (or the good cause exceptions that qualify it), and no held claiming document shows a suspended provider's payments excluded from claiming.

RECORD LOCATION: H-112, cure text (N.C.G.S. 108C-3, item (9)); H-149, cure text (categorical risk level bulletin); H-100 (10A NCAC 22F .0104), p.1

SECTION 5D FACE

UNCOVERED ELEMENT: The no-FFP claiming rule for suspended providers, and its good cause exceptions, in NC text.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: State the claiming treatment of payments to a suspended provider in the program integrity or financial procedures, including the good cause exceptions.

QUESTION: When a provider is suspended under 455.23, what stops the Federal share of any payment to that provider from being claimed, and where is that written?

SEARCHES RECORDED: Full map read, including H-133 CMS focused program integrity review and H-132 MFCU inspection (practice documents; neither states the claiming rule).

CFR-455-001: Fraud detection/investigation program; HHS reporting

CITATION: 42 CFR 455.13–455.17

TOPIC: Fraud detection/investigation program; HHS reporting

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Preliminary investigation for each complaint; full investigation when warranted; HHS reporting at intervals prescribed in CMS instructions

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Office of Compliance and Program Integrity (OCPI)

HOME BASIS: OCPI's published mission is to protect DHB's resources 'by reducing or eliminating fraud, waste, and abuse of providers and beneficiaries in the NC Medicaid Program' (Lane A §1.4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid fraud detection and investigation program

BASIS: Plan section 4.5 at p.83 states the Medicaid agency has established and will maintain methods, criteria and procedures meeting all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse. The operating rules carry the program in detail: 10A NCAC 22F .0103 (H-099) requires the Division to develop, implement and maintain methods for preventing, detecting, investigating, reviewing, hearing, referring, reporting and disposing of fraud, abuse and error cases, including receiving complaints, preliminary and full investigations, analysis, administrative decisions, recoupment and remedial measures. Operation is independently documented: the CMS focused review (H-133) describes quarterly program integrity meetings with the Medicaid Investigations Division, and the OIG MFCU inspection (H-132) reports FY2022-2024 unit outcomes of 16 indictments, 26 convictions, 41 civil settlements and judgments and $98,507,530 in recoveries, with annual OIG recertification of the unit as the HHS reporting channel.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan p.83 (section 4.5); H-099 (H-099), 10A NCAC 22F .0102-.0103; H-133 (H-133) p.3 and program integrity sections; H-132 (H-132__201d35c9.html)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 455.13-455.17 text as carried in the register requirement of record

FLAGS: Operation is not clean: H-132 found the MFCU understaffed, without referral procedures for federal partners and without training plans for some staff, with four recommendations open at the report date. The program exists and operates; the weaknesses are flagged, not graded away.

CFR-455-002: Provider fraud certification statements on claims

CITATION: 42 CFR 455.18–455.19

TOPIC: Provider fraud certification statements on claims

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Every claim form or payment check carries the certification

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Office of Compliance and Program Integrity (OCPI)

HOME BASIS: OCPI's published mission is to protect DHB's resources 'by reducing or eliminating fraud, waste, and abuse of providers and beneficiaries in the NC Medicaid Program' (Lane A §1.4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC provider and fiscal agent claims

BASIS: The only state-side text read is the plan section 4.5 range assurance at p.83, which sweeps 455.18 and 455.19 into the statement that NC's methods meet all requirements of 42 CFR 455.13 through 455.21. No held document shows the certification itself: no claim form, provider agreement or billing guide passage in which a provider certifies that services were rendered as claimed, or a fiscal agent certification statement, was found in the provider manuals, NCTracks guides or rules read.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan p.83 (section 4.5)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The provider certification statement on claims and the fiscal agent certification statement (42 CFR 455.18 and 455.19) as documents NC actually uses; only the plan's range assurance covers them, unread at the element level in any operating document.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce the provider agreement or claim certification language carrying the 455.18 statement and the fiscal agent statement under 455.19.
>
> **QUESTION:** Where does a NC Medicaid provider actually sign the 455.18 certification, and where is the fiscal agent's 455.19 statement?

SEARCHES RECORDED: Corpus searched for claim certification, certification statement and certify language across provider manuals (H-071, H-072, H-073), NCTracks guides (H-143, H-144) and rules (H-099): no certification statement found. Full map carries no 455.18 or 455.19 pinpoint.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 455.18 and 455.19 text as carried in the register requirement of record

CFR-455-003: Beneficiary verification that services were received

CITATION: 42 CFR 455.20

TOPIC: Beneficiary verification that services were received

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous verification program

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Office of Compliance and Program Integrity (OCPI)

HOME BASIS: OCPI's published mission is to protect DHB's resources 'by reducing or eliminating fraud, waste, and abuse of providers and beneficiaries in the NC Medicaid Program' (Lane A §1.4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC verification that beneficiaries received billed services

BASIS: Two partial elements were read. The plan section 4.5 range assurance at p.83 sweeps 455.20 into NC's fraud and abuse methods. In one service area the verification method is concrete: the

CAP/DA waiver renewal document (NL-15) states that for personal care services both aides and beneficiaries are required to sign to confirm the services were provided, and that the Office of Compliance and Program Integrity runs post-payment review samples on a 90-day basis. No held document describes a general program of written statements to beneficiaries, or sampling of beneficiary verification, across the Medicaid program as 455.20 requires.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan p.83; NL-15 (NL-15), CAP/DA waiver renewal, PCS confirmation and post-payment review passages

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** A program-wide beneficiary verification method under 42 CFR 455.20 (written statements to a sample of beneficiaries and follow-up where services are not confirmed); held evidence covers one waiver service's sign-to-confirm practice only.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce the beneficiary verification procedure or a sample verification mailing and its follow-up protocol.
>
> **QUESTION:** How does NC verify with beneficiaries at program level that billed services were received?

SEARCHES RECORDED: Corpus searched for beneficiary verification, verification that services were received and recipient confirmation language: hits are eligibility verification and the NL-15 PCS passage only. Full map carries no 455.20 pinpoint.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 455.20 text as carried in the register requirement of record

CFR-455-004: Cooperation with State Medicaid fraud control unit

CITATION: 42 CFR 455.21

TOPIC: Cooperation with State Medicaid fraud control unit

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Referrals as cases arise; MFCU agreement reviewed/updated at least every 5 years

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (at least every 5 years) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Office of Compliance and Program Integrity (OCPI)

HOME BASIS: OCPI's published mission is to protect DHB's resources 'by reducing or eliminating fraud, waste, and abuse of providers and beneficiaries in the NC Medicaid Program' (Lane A §1.4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC cooperation with the state Medicaid fraud control unit

BASIS: The duty is carried as written and in operation. 10A NCAC 22F .0203 (H-099) requires the Division to refer credible allegations of provider fraud, as defined by 42 CFR 455.2 and incorporated by reference, to the State Medicaid Fraud Control Unit or other law enforcement agency. The CMS focused review (H-133) records that state program integrity staff meet quarterly with state managed care staff and the Medicaid Investigation Division, the MFCU in North Carolina, to discuss provider trends, cases and potential fraudulent activities, and that PIHP referrals follow the same channel. The unit itself is documented operating in H-132 (OIG 2025 onsite inspection,

FY2022-2024 outcomes). The EQR record (H-129) shows PIHP participation in quarterly program integrity meetings with NC Medicaid Program Integrity and the MFCU/MID.

RECORD LOCATION: H-099 (H-099), 10A NCAC 22F .0203; H-133 (H-133) pp.3 and 9; H-129 (H-129), Alliance EQR program integrity section; H-132 (H-132__201d35c9.html)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 455.21 text as carried in the register requirement of record

CFR-455-005: Suspension of payments on credible allegation of fraud

CITATION: 42 CFR 455.23

TOPIC: Suspension of payments on credible allegation of fraud

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Suspend on credible allegation; quarterly law-enforcement continuation certifications; annual Secretary report; 5-year document retention

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Office of Compliance and Program Integrity (OCPI)

HOME BASIS: OCPI's published mission is to protect DHB's resources 'by reducing or eliminating fraud, waste, and abuse of providers and beneficiaries in the NC Medicaid Program' (Lane A §1.4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC when a credible allegation of fraud is determined

BASIS: The core suspension duty is carried in several operating documents. Plan section 4.5 at p.83 includes 455.23 in the methods NC maintains. The Alliance EQR record (H-129) carries the contract term: NC Medicaid Program Integrity completes a preliminary investigation within 30 business days of a PIHP referral of a potential credible allegation of fraud, makes a referral to the MFCU/MID within five business days where warranted, and will suspend payments in accordance with 42 CFR 455.23, with monthly written status notice to the PIHP. The CMS focused review (H-133) confirms the PIHPs do not suspend network provider payments on a credible allegation without DMA approval. A Vaya provider manual (H-072) states a 455.23 suspension remains in effect until the Medicaid Investigations Division completes its investigation or legal proceedings end. The procedural elements of 455.23 itself (notice to the provider within five days, the good cause exceptions to suspension, and the duration and review limits) are not stated in any held passage, and the old state withholding rule, 10A NCAC 22F .0604, was repealed effective September 1, 2018 (H-099).

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan p.83; H-129 (H-129) pp.230-231; H-133 (H-133) p.9; H-072 (H-072), payment suspension passage; H-099 (H-099), 10A NCAC 22F .0604 history note

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 455.23 procedural elements: timely written notice to the provider, documentation of good cause exceptions where payments are not suspended or are partially suspended, and suspension duration review. No held passage states them, and the former state rule on withholding was repealed in 2018.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce the payment suspension procedure or template notice carrying the 455.23 notice, good cause and duration elements.

QUESTION: Where are the notice, good cause exception and duration elements of a 455.23 suspension documented in NC's current process?

SEARCHES RECORDED: Full map 455.23 pinpoints (H-022, H-072, H-099, H-100, H-129, H-133) all read at pinpoint; H-112 and H-145 read for the 455.23 references in the risk bump-up rules. Corpus searched for credible allegation of fraud and good cause (good cause suspension exceptions not found).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 455.23 text as carried in the register requirement of record

FLAGS: Conflict: 10A NCAC 22F .0604 (withholding of Medicaid payments, citing 455.23) was repealed effective September 1, 2018, while operating documents still describe suspensions under 455.23. Graded on the stronger operating evidence (H-129, H-133, H-072) and flagged.

CFR-455-006: Ownership/control disclosure at enrollment, revalidation, and ownership changes

CITATION: 42 CFR 455.104

TOPIC: Ownership/control disclosure at enrollment, revalidation, and ownership changes

OBLIGATED LEVEL: bureau/section

CADENCE: RECURRING - Enrollment, revalidation, and within 35 days of any ownership change

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (periodic) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC provider enrollment, revalidation and ownership changes

BASIS: Ownership disclosure is carried in part at three points. Plan section 4.31 at p.149 states the agency has established procedures for disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106, and the screening preprint at plan pp.185-186 states the agency will include the 455.104, 455.105 and 455.106 disclosure requirements in revalidation efforts. The operative rule, 10A NCAC 22N .0202 (H-099), requires a provider on application to supply the legal name and social security number of each owner, and to notify the Division in writing within 30 calendar days of an owner joining, withdrawing or changing legal name. The full 455.104 content (persons with 5 percent or greater ownership or control, officers, directors, agents and managing employees, and disclosure on reenrollment as distinct from revalidation) is not stated in any held passage, and the CMS review (H-133) found the 455.104 disclosure contract clause missing in a Wake County NEMT vendor contract, contradicting full coverage.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan p.149 (section 4.31) and pp.185-186; H-099 (H-099), 10A NCAC 22N .0202; H-133 (H-133) p.12

SECTION 5D FACE

UNCOVERED ELEMENT: The complete 455.104 disclosure set (ownership and control thresholds, managing employees and agents, subcontractor ownership) and its application at initial

enrollment and reenrollment in NCTracks; held text covers owner identity at application and ownership changes, plus a revalidation statement.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Produce the NCTracks enrollment disclosure screens or instructions carrying the full 455.104 data set.

QUESTION: Where does an enrolling NC provider disclose the full 455.104 ownership and control set?

SEARCHES RECORDED: Full map 455.104 pinpoints (H-001, H-022, H-099, H-133) read at pinpoint; H-133 NEMT findings read in full. Corpus searched for managing employee and ownership or control disclosure language.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 455.104 text as carried in the register requirement of record

FLAGS: Conflict: H-133 found the required 455.104-455.106 disclosure clause missing from a Wake County vendor contract while the same clause had been added in Durham County. Graded on the stronger evidence (plan plus 22N .0202) and flagged.

CFR-455-007: Business transaction disclosure on request

CITATION: 42 CFR 455.105

TOPIC: Business transaction disclosure on request

OBLIGATED LEVEL: bureau/section

CADENCE: EVENT-TRIGGERED - Provider must respond within 35 days of request

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC providers and subcontractors on agency request

BASIS: The only state-side text read is plan pp.185-186, which states the Medicaid agency will include the disclosure requirements of 42 CFR 455.104, 455.105 and 455.106 in revalidation efforts, and plan section 4.31 at p.149, which establishes disclosure procedures under 455.104 through 455.106 generally. No held document states the 455.105 duty itself: disclosure of significant business transactions with wholly owned suppliers or subcontractors on request of the agency or CMS, within the provision's timeframe.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan p.149 and pp.185-186

SECTION 5D FACE

UNCOVERED ELEMENT: The business transaction disclosure duty of 42 CFR 455.105 as a stated requirement (significant business transactions, on request, within the regulatory timeframe); held text mentions the section number only, inside revalidation and general procedure statements.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Produce the provider agreement clause or disclosure form carrying the 455.105 business transaction duty.

QUESTION: Where is a NC provider told it must disclose significant business transactions on request?

SEARCHES RECORDED: Full map: no document carries a 455.105 pinpoint. Corpus searched for 455.105 and business transaction disclosure (plan passages only).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 455.105 text as carried in the register requirement of record

CFR-455-008: Criminal conviction disclosure; OIG notification within 20 working days

CITATION: 42 CFR 455.106

TOPIC: Criminal conviction disclosure; OIG notification within 20 working days

OBLIGATED LEVEL: bureau/section

CADENCE: EVENT-TRIGGERED - Disclosure at agreement entry/renewal or on written request; OIG notification within 20 working days

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC providers, fiscal agents and the agency's notice to HHS OIG

BASIS: The full reporting chain is carried, but only inside one contract description. The draft TBI waiver application (H-041) states that section 1.13 of the LME-PIHP contract, in accordance with 42 CFR 455.106, requires all providers to disclose criminal convictions related to Medicare, Medicaid or Title XX at application, renewal or on request; the PIHP must report disclosures to DMA within 20 working days of receipt; and DMA will report them to HHS-OIG within 20 working days after notification by the PIHP, citing 455.106(b)(1). Plan section 4.31 at p.149 establishes disclosure procedures under 455.104 through 455.106 generally, and 10A NCAC 22N .0202 (H-099) cites 455.106 in its authority note. No held passage carries the duty in the general NCTracks enrollment channel outside the PIHP contract context.

RECORD LOCATION: H-041 (H-041), Appendix contract description citing 455.106; H-001 (H-001), NC Title XIX State Plan p.149; H-099 (H-099), 10A NCAC 22N .0202 history note

SECTION 5D FACE

UNCOVERED ELEMENT: The 455.106 disclosure and 20-working-day OIG notification chain as it applies in fee-for-service and NCTracks enrollment generally; held text carries it only as an LME-PIHP contract term described in a draft waiver application.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Produce the enrollment-channel disclosure requirement and OIG notification log or procedure carrying the 20-working-day clock outside the PIHP contracts.

> **QUESTION:** How does the 455.106 notification chain run for providers who are not in a PIHP network?

SEARCHES RECORDED: Full map 455.106 pinpoints (H-041, H-099) read at pinpoint; corpus searched for criminal conviction disclosure and 20 working days (H-041 only).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 455.106 text as carried in the register requirement of record

CFR-455-009: Disclosure of affiliations with excluded/problematic providers

CITATION: 42 CFR 455.107

TOPIC: Disclosure of affiliations with excluded/problematic providers

OBLIGATED LEVEL: bureau/section

CADENCE: RECURRING - At initial enrollment and each revalidation; option selection made once in consultation with CMS (changeable from option 2 to option 1)

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (periodic) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC provider enrollment disclosures since the 455.107 effective period

BASIS: No NC evidence for disclosure of affiliations with excluded or problematic providers under 42 CFR 455.107 was found. The affiliation language in the corpus belongs to a different duty: the CHIP state plan documents (H-013, H-022) carry written disclosure of prohibited affiliations under 42 CFR 438.610 for managed care entities, not the 455.107 enrollment disclosure of affiliations with individuals or entities that have uncollected debt, exclusions, payment holds or revoked billing privileges.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The entire provision: no held document addresses disclosure of affiliations under 42 CFR 455.107 at enrollment, revalidation or change reporting.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce the NCTracks affiliation disclosure question set or enrollment instruction carrying 455.107.
>
> **QUESTION:** Where does NC collect 455.107 affiliation disclosures from enrolling providers?

SEARCHES RECORDED: Full map: no document carries a 455.107 pinpoint. Corpus searched for 455.107 and affiliation disclosure; the 438.610 passages in H-013 and H-022 read and distinguished.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 455.107 text as carried in the register requirement of record

CFR-455-010: Independent certified audit of DSH payments

CITATION: 42 CFR 455.304

TOPIC: Independent certified audit of DSH payments

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - Audit completed by last day of the FFY ending 3 years after the rate year; report to CMS within 90 days of completion

EVIDENCE CLASS: GOVERNING / Anchor: Derived rule, rolling anchor — DSH independent certified audit completed by the last day of the FFY ending 3 years after the rate year, report to CMS within 90 days of completion. Instance dates depend on the rate year; carried as a rule, not calendared.

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC disproportionate share hospital payments

BASIS: No NC evidence for an independent certified audit of DSH payments under 42 CFR 455.304 was found. The cure's own document search (NL-12) records that no current DSH audit or cost report settlement document exists on any source searched, with only a historical HHS OIG review of NC DSH payments for FY1997-2001 (April 2003). The DSH material that is held, H-174, covers hospitals requesting Medicare DSH data and PS&R reports through NCTracks, which is data supply, not an audit, and 10A NCAC 22G .0204 in H-098 is an expired DSH definition rule citing 42 CFR Part 447 Subpart C.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The entire provision: no held document carries the independent certified audit of DSH payments or its findings (42 CFR 455.304).
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce the most recent independent certified DSH audit report or the audit contract deliverable.
>
> **QUESTION:** Where is NC's independent certified audit of DSH payments published or filed?

SEARCHES RECORDED: Full map: no 455.304 pinpoint in any document. Corpus searched for DSH audit and independent certified audit (no current hits). Cure document-axis search NL-12 read in full; H-174 read and distinguished as a data request process.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 455.304 text as carried in the register requirement of record

CFR-455-011: Enrollment and screening of all providers; ordering/referring provider enrollment

CITATION: 42 CFR 455.410

TOPIC: Enrollment and screening of all providers; ordering/referring provider enrollment

OBLIGATED LEVEL: bureau/section

CADENCE: RECURRING - Continuous; every enrolled provider screened under Subpart E

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to all NC Medicaid providers and ordering or referring providers

BASIS: Plan section 4.46 at p.186 carries 455.410 in full: the agency assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq., and assures the agency requires all ordering or referring physicians or other professionals to be enrolled under the plan or a waiver as participating providers. State law carries the operating duty: N.C.G.S. 108C-3(b) (H-112) requires the Department to screen all initial provider applications, including applications for a new practice location, and all revalidation requests. The NCTracks record shows the machinery: the user guide index (H-143) lists the Ordering, Prescribing and Referring Provider Enrollment participant guides, and the fingerprinting FAQs (H-145) describe screening conducted per 42 CFR 455.410(a).

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan p.186 (section 4.46); H-112 (H-112__cbf9bfa5.html), G.S. 108C-3(b); H-143 (H-143 index) and H-145 (H-145__2e764e83.html), NCTracks pages

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 455.410 text as carried in the register requirement of record

CFR-455-012: Verification of provider licenses

CITATION: 42 CFR 455.412

TOPIC: Verification of provider licenses

OBLIGATED LEVEL: bureau/section

CADENCE: RECURRING - Verified at initial screening and each revalidation

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (periodic) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC verification of provider licensure at enrollment and ongoing

BASIS: Plan section 4.46 at p.186 carries the provision as written: under the heading Verification of Provider Licenses, 42 CFR 455.412, the agency assures it has a method for verifying providers licensed by a state and that such providers' licenses have not expired and have no current limitations. Operation is corroborated in the NCTracks reverification record: the recredentialing page (H-147) lists denial of reverification for expired credentials (license, accreditation or certification per the Provider Permission Matrix), which is the license check operating at the revalidation point.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan p.186 (section 4.46, 455.412); H-147 (H-147__3ba9511d.html), NCTracks recredentialing page

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 455.412 text as carried in the register requirement of record

CFR-455-013: Revalidation of enrollment at least every 5 years

CITATION: 42 CFR 455.414

TOPIC: Revalidation of enrollment at least every 5 years

OBLIGATED LEVEL: bureau/section

CADENCE: RECURRING - Federal floor: revalidate every provider at least every 5 years. NC's published cycle sits at the floor: each actively enrolled provider reverifies at least every 5 years through NCTracks (this register, NC-004; NCTracks Provider Recredentialing pages).

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (at least every 5 years, every 3 years) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to all enrolled NC providers on a five year cycle

BASIS: Plan section 4.46 at p.186 assures, under 42 CFR 455.414, that providers will be revalidated regardless of provider type at least every five years. The NCTracks record operates the cycle: the May 10, 2024 clarification (H-148) states states must revalidate the enrollment of all providers at least every five years and works through suspension and termination consequences of missed revalidation, and the reverification reminders (H-089) state all enrolled providers must complete reverification every five years as mandated by 42 CFR 455.414, with a 70-day completion window. The recredentialing page (H-147) adds the monthly reverification report offering due dates over a twelve month period.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan p.186 (section 4.46, 455.414); H-148 (H-148__6e253df5.html); H-089 (H-089__9ef5cdae.html); H-147 (H-147__3ba9511d.html)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 455.414 text as carried in the register requirement of record

CFR-455-014: Mandatory termination/denial triggers

CITATION: 42 CFR 455.416 (with 455.417)

TOPIC: Mandatory termination/denial triggers

OBLIGATED LEVEL: bureau/section

CADENCE: EVENT-TRIGGERED - Apply triggers as events occur; 30-day fingerprint clock; termination-database periods tracked per 455.417

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC terminations and denials of provider enrollment

BASIS: Plan section 4.46 at p.186 assures, under 42 CFR 455.416, that the agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment. That is a compliance assurance by citation. No held passage states the mandatory triggers themselves (termination elsewhere in Medicare or another state's Medicaid, falsified enrollment information, failure to furnish fingerprints or site visit access) or the denial period element the register pairs with it at 455.417, and no operating termination document tied to those triggers was read.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan p.186 (section 4.46, 455.416)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The mandatory termination and denial triggers of 42 CFR 455.416(a)-(d) and the 455.417 element, stated as NC requirements; held evidence is a single assurance citing the section for all terminations and denials.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce the enrollment denial and termination standard or NCTracks instruction listing the 455.416 mandatory triggers.
>
> **QUESTION:** Where are the mandatory 455.416 termination and denial triggers stated for NC enrollment staff and providers?

SEARCHES RECORDED: Full map 455.416 pinpoint is H-001 only, read at pinpoint. Corpus searched for mandatory termination grounds and enrollment denial periods in NCTracks FAQs (H-145 to H-149) and rules (H-099): denial grounds found are credential and background based, not the 455.416 trigger list.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 455.416 and 455.417 text as carried in the register requirement of record

CFR-455-015: Reactivation requires re-screening and application fee

CITATION: 42 CFR 455.420

TOPIC: Reactivation requires re-screening and application fee

OBLIGATED LEVEL: bureau/section

CADENCE: EVENT-TRIGGERED - Each reactivation after deactivation

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC providers reactivating enrollment after termination or deactivation

BASIS: Plan section 4.46 at p.186 carries the provision as written: under Reactivation of Provider Enrollment, 42 CFR 455.420, the agency assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460, with an implementation date of October 1, 2012. The fee element is corroborated by the NCTracks fee record (H-147: the $100 NC application fee is assessed on enrollment, re-enrollment and revalidation applications, in addition to the federal fee where applicable).

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan p.186 (section 4.46, 455.420); H-147 (H-147__3ba9511d.html)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 455.420 text as carried in the register requirement of record

CFR-455-016: Appeal rights before termination/denial

CITATION: 42 CFR 455.422

TOPIC: Appeal rights before termination/denial

OBLIGATED LEVEL: bureau/section

CADENCE: EVENT-TRIGGERED - With each termination/denial under 455.416

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC providers terminated or denied enrollment

BASIS: Plan section 4.46 at p.187 carries the provision as written: under Appeal Rights, 42 CFR 455.422, the agency assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by state law or regulation. The state-law procedure exists in the held rules: 10A NCAC 22F (H-099) carries reconsideration review and administrative action procedures for program integrity cases, and the provider manuals read (for example H-072) describe written notice and appeal request mechanics for adverse enrollment actions.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan p.187 (section 4.46, 455.422); H-099 (H-099), 10A NCAC 22F sections .0400 and .0600

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 455.422 text as carried in the register requirement of record

CFR-455-017: Pre- and post-enrollment site visits; unannounced inspections

CITATION: 42 CFR 455.432

TOPIC: Pre- and post-enrollment site visits; unannounced inspections

OBLIGATED LEVEL: bureau/section

CADENCE: RECURRING - Pre-enrollment and post-enrollment visits for moderate/high-risk providers; unannounced inspection right at all enrolled locations

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC moderate and high risk providers at enrollment and after

BASIS: Plan section 4.46 at p.187 assures, under 42 CFR 455.432, that pre-enrollment and post-enrollment site visits of providers in moderate or high risk categories will occur, implementation date October 1, 2012. The NCTracks fingerprinting FAQs (H-145) show the visit operating: on a bump-up to high risk the provider receives instructions for fingerprinting and a site visit, and the site visit is initiated by NC Medicaid through Public Consulting Group, which contacts the provider to schedule the visit. The scheduling arrangement in H-145 sits against the provision's unannounced character: no held passage states that 455.432 site visits are unannounced, and the one operating description read describes a scheduled visit.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan p.187 (section 4.46, 455.432); H-145 (H-145__2e764e83.html), NCTracks fingerprinting FAQs

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The unannounced character of pre-enrollment and post-enrollment site visits under 42 CFR 455.432; held operating text describes visits scheduled through a contractor, and no held passage states visits are unannounced.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce the site visit protocol showing whether enrollment site visits are unannounced and how the contractor scheduling step preserves that.
>
> **QUESTION:** Are NC's 455.432 enrollment site visits unannounced in practice?

SEARCHES RECORDED: Full map 455.432 pinpoint is H-001 only; H-089 (reverification reminders) read for site visit content. Corpus searched for unannounced site visit (hits concern facility surveys, not enrollment site visits).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 455.432 text as carried in the register requirement of record

FLAGS: Tension in the record: H-145 describes the site visit as scheduled by the contractor with the provider, which is hard to square with an unannounced visit. Flagged; graded Partial on that element.

CFR-455-018: Criminal background checks and fingerprinting

CITATION: 42 CFR 455.434

TOPIC: Criminal background checks and fingerprinting

OBLIGATED LEVEL: bureau/section

CADENCE: EVENT-TRIGGERED - Consent at enrollment; fingerprints within 30 days of CMS/State request

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC high risk providers and persons with 5 percent or greater ownership

BASIS: Plan section 4.46 at p.187 assures, under 42 CFR 455.434, that providers as a condition of enrollment will be required to consent to criminal background checks including fingerprints, if required under state law or by the level of screening based on risk. The NCTracks FAQs carry the

operating rule in detail: the behavioral health enrollment FAQs (H-146) state that in accordance with 42 CFR 455.434 and 455.450(c), fingerprint-based background checks are required for all high categorical risk providers and their owners with a 5 percent or greater direct or indirect ownership interest as a condition of enrollment in NC Medicaid, and the fingerprinting FAQs (H-145) describe the process, including acceptance of a Medicare fingerprint check confirmed in PECOS in lieu of new fingerprinting and the screening required at initial enrollment, re-enrollment and revalidation under 455.434 and G.S. 108C-3.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan p.187 (section 4.46, 455.434); H-146 (H-146__d776b32a.html) and H-145 (H-145__2e764e83.html), NCTracks FAQs

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 455.434 text as carried in the register requirement of record

CFR-455-019: Federal database checks — including monthly LEIE/EPLS

CITATION: 42 CFR 455.436

TOPIC: Federal database checks — including monthly LEIE/EPLS

OBLIGATED LEVEL: bureau/section

CADENCE: RECURRING - Monthly LEIE/SAM(EPLS) exclusion checks of all providers/owners/agents/managing employees per 455.436(c)(2); full database check at enrollment and reenrollment

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (monthly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC checks of providers, owners, agents and managing employees

BASIS: Plan section 4.46 at p.187 assures, under 42 CFR 455.436, that the agency will perform federal database checks on all providers and any person with an ownership or controlling interest or who is an agent or managing employee, and the screening preprint at plan pp.185-186 names the databases: the Social Security Administration Death Master File, NPPES, the LEIE and the EPLS, checked to confirm identity and exclusion status at enrollment and reenrollment. The CMS focused review (H-133) describes the 455.436 duty and the checks in the managed care and NEMT context. What no held passage states is the provision's ongoing cadence: checks of the LEIE and EPLS on a monthly basis after enrollment.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan p.187 (section 4.46, 455.436) and pp. 185-186; H-133 (H-133) pp.10 and 13

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The monthly frequency for LEIE and EPLS checks after enrollment required by 42 CFR 455.436; held passages establish the checks and the databases at enrollment and reenrollment, not the monthly ongoing cycle.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce the database check schedule or system description showing monthly LEIE and EPLS checks for enrolled providers and their owners and managing employees.

> **QUESTION:** Where is the monthly LEIE and EPLS check cycle for enrolled NC providers documented?

SEARCHES RECORDED: Full map 455.436 pinpoints (H-001, H-064, H-133) checked; H-064 MCPAR passage is a managed care program integrity summary without a monthly cadence. Corpus searched for monthly exclusion and database check language (monthly hits concern reports and meetings, not database checks).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 455.436 text as carried in the register requirement of record

CFR-455-020: NPI of ordering/referring professional on claims

CITATION: 42 CFR 455.440

TOPIC: NPI of ordering/referring professional on claims

OBLIGATED LEVEL: bureau/section

CADENCE: EVENT-TRIGGERED - Every claim for ordered/referred items or services

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC claims based on an order or referral

BASIS: Plan section 4.46 at p.187 carries the provision as written: under National Provider Identifier, 42 CFR 455.440, the agency assures it requires the NPI of any ordering or referring physician or other professional to be specified on any claim for payment based on an order or referral of that physician or professional. The preprint at plan pp.185-186 adds the companion handling: the agency will determine which NPI should be applied to the claim where an ordering or referring professional permitted under state law to order or refer does not have an NPI and is not authorized to enroll.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan p.187 (section 4.46, 455.440) and pp. 185-186

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 455.440 text as carried in the register requirement of record

CFR-455-021: Risk-based screening levels (limited/moderate/high)

CITATION: 42 CFR 455.450 (with 455.452)

TOPIC: Risk-based screening levels (limited/moderate/high)

OBLIGATED LEVEL: bureau/section

CADENCE: RECURRING - Every initial, new-location, re-enrollment, and revalidation application screened at assigned risk level

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (periodic) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to all NC provider screening, by categorical risk

BASIS: Plan section 4.46 at p.187 assures, under 42 CFR 455.450, that the agency complies with sections 1902(a)(77) and 1902(kk) and with 455.450 for screening levels based on the categorical risk level determined for a provider. State law operates the levels: N.C.G.S. 108C-3(b) (H-112) requires screening of all initial applications and revalidations based on the Department's risk assessment and assignment of the provider to a categorical risk level of limited, moderate or high, with the highest level applying where more than one fits, and subsections (c) through (g) list the provider types in each level and the high risk designations. The NCTracks record shows the system in use: the January 29, 2023 change notice (H-149) adds categorical risk levels to provider taxonomies and records with bump-up criteria (payment suspension on a credible allegation of fraud, existing overpayment, OIG or state exclusion within 10 years, moratorium lift), and H-145 carries the 455.450(e) bump-up rule and the G.S. 108C-3(g) state variant.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan p.187 (section 4.46, 455.450); H-112 (H-112__cbf9bfa5.html), G.S. 108C-3(b)-(g); H-149 (H-149__98726e8c.html); H-145 (H-145__2e764e83.html)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 455.450 and 455.452 text as carried in the register requirement of record

CFR-455-022: Provider application fee collection

CITATION: 42 CFR 455.460

TOPIC: Provider application fee collection

OBLIGATED LEVEL: bureau/section

CADENCE: EVENT-TRIGGERED - Fee collected before executing each new or re-enrolling provider agreement (subject to exceptions); excess over program cost returned to Federal government

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC institutional providers at enrollment, reenrollment and revalidation

BASIS: Plan section 4.46 at p.187 assures, under 42 CFR 455.460, that the agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460. The NCTracks record operates the fee: the recredentialing page (H-147) states providers submitting enrollment, re-enrollment or revalidation applications will be assessed the $100 North Carolina provider application fee, in addition to the federal fee imposed for specified taxonomies, with fee amounts by year published in the State and Federal Fee Amounts spreadsheet, and the behavioral health FAQs (H-146) repeat the same structure and point to the Provider Permission Matrix for which taxonomies owe the federal fee.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan p.187 (section 4.46, 455.460); H-147 (H-147__3ba9511d.html); H-146 (H-146__d776b32a.html)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 455.460 text as carried in the register requirement of record

CFR-455-023: Temporary moratoria on enrollment

CITATION: 42 CFR 455.470

TOPIC: Temporary moratoria on enrollment

OBLIGATED LEVEL: bureau/section

CADENCE: EVENT-TRIGGERED - Initial 6-month periods, extendable in 6-month increments with written necessity documentation

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Provider enrollment is a published NC Medicaid function executed through the NCTracks Provider Portal, with DHB as policy owner (Lane A §1.4, §4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC when the Secretary imposes an enrollment moratorium

BASIS: Plan section 4.46 at p.187 carries the provision as written: under Temporary Moratorium on Enrollment of New Providers or Suppliers, 42 CFR 455.470, the agency assures it complies with any temporary moratorium on enrollment of new providers or provider types imposed by the Secretary under sections 1866(j)(7) and 1902(kk)(4) of the Act, subject to a determination by the state, with written notice to the Secretary, on beneficiary access to medical assistance. The preprint at plan pp. 185-186 states the same duty from the operating side: the agency will comply with any temporary moratorium imposed by the Secretary unless the state determines the moratorium would adversely impact beneficiaries' access to care. No moratorium is in effect in the evidence window; the row grades the standing duty as documented in the plan.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan p.187 (section 4.46, 455.470) and pp. 185-186

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 455.470 text as carried in the register requirement of record

CFR-455-024: Medicaid Recovery Audit Contractor (RAC) program

CITATION: 42 CFR 455.502, 455.506

TOPIC: Medicaid Recovery Audit Contractor (RAC) program

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - Continuous contracting, coordination, referral, and reporting operations

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Office of Compliance and Program Integrity (OCPI)

HOME BASIS: OCPI's published mission is to protect DHB's resources 'by reducing or eliminating fraud, waste, and abuse of providers and beneficiaries in the NC Medicaid Program' (Lane A §1.4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC Medicaid Recovery Audit Contractor program

BASIS: Plan section 4.5 RAC pages at pp.172-174 (plan pages 79z.1-79z.3, TN 10-037, approved February 15, 2011) carry the program: the state has established a program under which it will contract with one or more recovery audit contractors to identify underpayments and overpayments of Medicaid claims under the plan and any waiver; the contingency fee paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs as published in the Federal Register; the payment methodology for identification of underpayments is a $30.00 flat fee per overpayment identified as printed in the preprint; amounts expended are proper administration amounts, recovered amounts are subject to quarterly expenditure estimates and state share funding, and RAC efforts will be coordinated with other audit contractors, state and federal law enforcement and the CMS Medicaid Integrity Program. Operating evidence exists in plan manuals (H-072 notes Medicaid RACs may audit network providers and work with the plan to identify overpayments).

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan pp.172-174 (section 4.5, Medicaid Recovery Audit Contractor Program); H-072 (H-072), RAC passage

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 455.502 and 455.506 text as carried in the register requirement of record

FLAGS: The preprint's underpayment methodology line reads $30.00 flat fee per overpayment identified (OCR of the approved preprint); the figure is reported as printed and does not affect the program elements graded.

CFR-455-025: RAC provider appeal rights; RAC requirement exceptions

CITATION: 42 CFR 455.512, 455.516

TOPIC: RAC provider appeal rights; RAC requirement exceptions

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - Appeals available for each adverse RAC determination; exception requests via SPA

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Office of Compliance and Program Integrity (OCPI)

HOME BASIS: OCPI's published mission is to protect DHB's resources 'by reducing or eliminating fraud, waste, and abuse of providers and beneficiaries in the NC Medicaid Program' (Lane A §1.4).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC providers appealing RAC determinations, and to RAC exceptions

BASIS: The appeal element is carried in the RAC preprint: plan p.173 (page 79z.2) attests the state has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RACs, which is the 455.512 element. No held passage addresses the exception element the register pairs with it at 455.516: which RAC requirements do not apply, and any exception NC has sought or holds from RAC requirements (for example for managed care or law enforcement referrals).

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan p.173 (RAC preprint, appeal process attestation)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 42 CFR 455.516 element: the exceptions to RAC requirements and any NC exception in force are not addressed in held evidence.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Produce the RAC contract's appeal and exceptions terms, or state which 455.516 exceptions NC relies on.

QUESTION: Which RAC requirements, if any, is NC excepted from under 455.516, and where is the RAC appeal process published for providers?

SEARCHES RECORDED: Full map 455.512 pinpoint is H-099 only (an authority citation in a rule history note, read); no 455.516 pinpoint in any document. Corpus searched for RAC exception and RAC appeal language beyond the preprint attestation (none found).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 455.512 and 455.516 text as carried in the register requirement of record

CFR-456-001: Statewide surveillance and utilization control program

CITATION: 42 CFR 456.2–456.4

TOPIC: Statewide surveillance and utilization control program

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous operation; corrective action as monitoring identifies deficiencies

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Quality Management and Improvement

HOME BASIS: Quality Management and Improvement is a published DHB function — it publishes the Annual Quality Report, EQR Technical Reports, Encounter Data Validation, and the AMH measure set (Lane A §1.4, §3). Assignment of measure-set reporting to it is a functional derivation from that published portfolio, and says so. Part 456 split on the CFR's own line: utilization/quality functions to Quality, program-integrity functions to OCPI.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC statewide utilization control for Medicaid services

BASIS: The plan carries the framework by subpart: section 4.14 at plan pp.99-102 states the Medicaid agency meets the requirements of 42 CFR Part 456 Subpart C for inpatient hospital services, Subpart D for mental hospitals, Subpart E for skilled nursing facility services and Subpart F for intermediate care facility services, with no waivers granted. A surveillance system is documented in narrower settings: the CAP/DA renewal (NL-15) states the Office of Compliance and Program Integrity uses the Fraud and Abuse Management System, the Java Surveillance and Utilization Review System (JSURS) and Advantage Suite to detect over and under utilization and aberrant billing, and the PCS demonstration application (H-032) describes program integrity systems including SURS to identify aberrant billing and utilization patterns. No held document describes a single statewide surveillance and utilization control program covering all services and settings as 456.2-456.4 contemplate.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan pp.99-102 (section 4.14); NL-15 (NL-15), OCPI systems passage; H-032 (H-032), program integrity systems passage

SECTION 5D FACE

UNCOVERED ELEMENT: A statewide SURS and utilization control program description covering all Medicaid services; held evidence is the plan's subpart attestations plus SURS tooling described for PCS and waiver populations only.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Produce the statewide utilization control program description or SURS program documentation covering all service settings.

QUESTION: Where is NC's statewide surveillance and utilization control program described as one program?

SEARCHES RECORDED: Corpus searched for surveillance and utilization review system and utilization control program: hits are NL-15, H-032 and recipient overutilization surveillance in 10A NCAC 22F .0705 (H-099), all read. Full map carries no 456.2-456.4 pinpoint beyond H-001.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 456.2-456.4 text as carried in the register requirement of record

CFR-456-002: Written criteria for evaluating appropriateness and quality

CITATION: 42 CFR 456.5

TOPIC: Written criteria for evaluating appropriateness and quality

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Criteria established and used continuously

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Quality Management and Improvement

HOME BASIS: Quality Management and Improvement is a published DHB function — it publishes the Annual Quality Report, EQR Technical Reports, Encounter Data Validation, and the AMH measure set (Lane A §1.4, §3). Assignment of measure-set reporting to it is a functional derivation from that published portfolio, and says so. Part 456 split on the CFR's own line: utilization/quality functions to Quality, program-integrity functions to OCPI.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC criteria for medical necessity and quality review

BASIS: No NC evidence for written criteria for evaluating the appropriateness, quality and medical necessity of services under 42 CFR 456.5 was found as a utilization control instrument. Clinical coverage policies state medical necessity criteria service by service (for example CCP 2A-1 in H-084), and 10A NCAC 25A .0201 defines medical necessity as cited throughout H-099, but no held document carries the 456.5 written criteria set used by reviewers to evaluate care, and no document cites 456.5.

RECORD LOCATION:

SECTION 5D FACE

UNCOVERED ELEMENT: The entire provision: the written reviewer criteria set under 42 CFR 456.5 is not in the held evidence.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Produce the written criteria set used in utilization and quality review, or the review contractor's criteria manual.

> **QUESTION:** What written criteria do NC reviewers apply under 456.5, and where are they kept?

SEARCHES RECORDED: Full map: no 456.5 pinpoint in any document. Corpus searched for written criteria for evaluating appropriateness and quality (clinical coverage policy criteria only, read and distinguished).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 456.5 text as carried in the register requirement of record

CFR-456-003: Interagency agreement for professional medical review

CITATION: 42 CFR 456.6

TOPIC: Interagency agreement for professional medical review

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Standing interagency agreement

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Office of Compliance and Program Integrity (OCPI)

HOME BASIS: OCPI's published mission is to protect DHB's resources 'by reducing or eliminating fraud, waste, and abuse of providers and beneficiaries in the NC Medicaid Program' (Lane A §1.4). Part 456 split on the CFR's own line: utilization/quality functions to Quality, program-integrity functions to OCPI.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC arrangements for professional medical review

BASIS: No NC evidence for an interagency agreement for professional review under 42 CFR 456.6 was found. The plan records a contract with a Peer Review Organization to perform inspection of care (section 4.15, p.103), which is a Subpart I inspection arrangement, not the 456.6 agreement for professional review of services, and no held document cites 456.6 or describes such an agreement with another state agency or review organization.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The entire provision: no held document carries an interagency or equivalent agreement for professional medical review under 42 CFR 456.6.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce any agreement under which professional medical review is performed for the agency, or state that none is in place.
>
> **QUESTION:** Under what agreement is professional medical review performed for NC Medicaid?

SEARCHES RECORDED: Full map: no 456.6 pinpoint in any document. Corpus searched for interagency agreement and professional review organization agreement language (plan inspection of care contract passage read and distinguished).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 456.6 text as carried in the register requirement of record

CFR-456-004: Sample-basis evaluation of services

CITATION: 42 CFR 456.22

TOPIC: Sample-basis evaluation of services

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Ongoing sample-basis evaluation

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Quality Management and Improvement

HOME BASIS: Quality Management and Improvement is a published DHB function — it publishes the Annual Quality Report, EQR Technical Reports, Encounter Data Validation, and the AMH measure set (Lane A §1.4, §3). Assignment of measure-set reporting to it is a functional derivation from that published portfolio, and says so. Part 456 split on the CFR's own line: utilization/quality functions to Quality, program-integrity functions to OCPI.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC evaluation of services on a sample basis

BASIS: Sample-basis evaluation is carried in one program area: the CAP/DA renewal (NL-15) states that on a 90-day basis, post-payment review samples with a 95 percent confidence level and 5 percent margin of error are sent to the state Medicaid agency from each program area covered there, alongside FAMS and JSURS identification of billing practices outside peer norms. No held document describes sample-basis evaluation of services across the Medicaid program as 456.22 requires; the plan's utilization control pages attest Subpart compliance without a sampling method.

RECORD LOCATION: NL-15 (NL-15), post-payment review sampling passage; H-001 (H-001), NC Title XIX State Plan pp.99-102

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** A program-wide sample-basis evaluation method under 42 CFR 456.22; held evidence is a sampling practice described for waiver and PCS post-payment review only.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce the utilization review sampling methodology used across programs.
>
> **QUESTION:** How are NC's utilization review samples drawn outside the waiver programs?

SEARCHES RECORDED: Corpus searched for sample basis evaluation and sampling methodology in utilization review (NL-15 passage and survey sampling in plan attachments only). Full map carries no 456.22 pinpoint.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 456.22 text as carried in the register requirement of record

CFR-456-005: Post-payment review process with utilization profiles

CITATION: 42 CFR 456.23

TOPIC: Post-payment review process with utilization profiles

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous post-payment review operation

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Quality Management and Improvement

HOME BASIS: Quality Management and Improvement is a published DHB function — it publishes the Annual Quality Report, EQR Technical Reports, Encounter Data Validation, and the AMH measure set (Lane A §1.4, §3). Assignment of measure-set reporting to it is a functional derivation from that published portfolio, and says so. Part 456 split on the CFR's own line: utilization/quality functions to Quality, program-integrity functions to OCPI.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC post-payment review of paid claims

BASIS: Post-payment review exists in held evidence in program-specific form: NL-15 describes 90-day post-payment review samples and JSURS identification of providers whose billing practices fall outside the norm of peers, which is utilization profiling in the PCS and waiver context, and 10A NCAC 22F .0705 (H-099) establishes recipient overutilization surveillance through the SUR indicator. No held document describes a general post-payment review process that builds and uses utilization profiles for providers and beneficiaries across the fee-for-service program as 456.23 requires.

RECORD LOCATION: NL-15 (NL-15); H-099 (H-099), 10A NCAC 22F .0705

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The general post-payment review process with utilization profiles under 42 CFR 456.23, beyond waiver/PCS sampling and recipient SUR surveillance.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce the post-payment review procedure showing how utilization profiles are built and acted on.
>
> **QUESTION:** Where is NC's post-payment review process, with utilization profiles, documented for the whole program?

SEARCHES RECORDED: Corpus searched for post-payment review and utilization profile language (NL-15 and plan manual passages on plan-level post-payment review only). Full map carries no 456.23 pinpoint.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 456.23 text as carried in the register requirement of record

CFR-456-006: Hospital certification/recertification of need for inpatient care

CITATION: 42 CFR 456.60

TOPIC: Hospital certification/recertification of need for inpatient care

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Certification at admission (or before payment authorization); recertification at least every 60 days

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Office of Compliance and Program Integrity (OCPI)

HOME BASIS: OCPI's published mission is to protect DHB's resources 'by reducing or eliminating fraud, waste, and abuse of providers and beneficiaries in the NC Medicaid Program' (Lane A §1.4). Part 456 split on the CFR's own line: utilization/quality functions to Quality, program-integrity functions to OCPI.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC inpatient hospital admissions and continued stays

BASIS: One element is carried concretely: the NC Medicaid policy update (H-084) states Clinical Coverage Policy 2A-1, Acute Inpatient Hospital Services, was revised effective April 1, 2018 to align with 42 CFR 456.60, certification and recertification of need for inpatient care, and specifies that only a physician may perform the initial certification for admission. The remaining 456.60 elements (certification timing before or at admission, recertification at intervals, and who may recertify) are not stated in the held bulletin text, and the underlying policy 2A-1 is not itself in the held corpus.

RECORD LOCATION: H-084 (H-084__76a8685b.html), CCP 2A-1 update notice

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** Certification timing, recertification intervals and recertifier qualifications under 42 CFR 456.60 beyond the rule that only a physician performs initial certification.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce CCP 2A-1 itself, showing the certification and recertification terms.
>
> **QUESTION:** Where are the full 456.60 certification and recertification terms published for NC hospitals?

SEARCHES RECORDED: Full map: H-084 is the only document carrying a 456.60 pinpoint, read in full. Corpus searched for certification and recertification of need (plan utilization passages do not state the 456.60 elements).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 456.60 text as carried in the register requirement of record

CFR-456-007: Hospital individual written plan of care

CITATION: 42 CFR 456.80, 456.181 (hospitals)

TOPIC: Hospital individual written plan of care

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Plan established before admission or payment authorization; written report in record at admission or immediately upon completion

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Office of Compliance and Program Integrity (OCPI)

HOME BASIS: OCPI's published mission is to protect DHB's resources 'by reducing or eliminating fraud, waste, and abuse of providers and beneficiaries in the NC Medicaid Program' (Lane A §1.4). Part 456 split on the CFR's own line: utilization/quality functions to Quality, program-integrity functions to OCPI.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC hospital inpatients (and mental hospital inpatients under 456.181)

BASIS: No held passage states the individual written plan of care requirement for hospital inpatients: who prepares it, its required contents or its review cycle under 456.80 and 456.181. The plan's utilization control pages (pp.99-102) attest that the agency meets Part 456 Subpart C and D requirements, which include the plan of care provisions, but the element itself is not carried in any document read. Plan of care passages elsewhere in the corpus concern case management and home based services, not inpatient hospital care.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan pp.99-102 (section 4.14 attestations)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The individual written plan of care for hospital and mental hospital inpatients (42 CFR 456.80 and 456.181): preparer, contents and periodic review are not stated in held evidence.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce the hospital policy or UR documentation carrying the inpatient plan of care requirement.
>
> **QUESTION:** Where is the inpatient written plan of care requirement stated for NC facilities?

SEARCHES RECORDED: Corpus searched for individual plan of care and written plan of care in inpatient settings (hits are case management and waiver plans, read and distinguished). Full map carries no 456.80 or 456.181 pinpoint.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 456.80 and 456.181 text as carried in the register requirement of record

CFR-456-008: Written UR plan required for inpatient hospital services

CITATION: 42 CFR 456.101–456.145

TOPIC: Written UR plan required for inpatient hospital services

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Written UR plan in effect continuously; at least one medical-care evaluation study in progress at all times; complete one study each calendar year

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (each calendar year) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Office of Compliance and Program Integrity (OCPI)

HOME BASIS: OCPI's published mission is to protect DHB's resources 'by reducing or eliminating fraud, waste, and abuse of providers and beneficiaries in the NC Medicaid Program' (Lane A §1.4). Part 456 split on the CFR's own line: utilization/quality functions to Quality, program-integrity functions to OCPI.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC hospitals providing inpatient services to Medicaid patients

BASIS: A UR plan duty reaches NC hospitals through the Medicare conditions crosswalk in the held clinical coverage policies: the hospital services policies (H-067, H-068, H-070) require a participating hospital to have in effect a utilization review plan applicable to all Medicaid patients meeting 42 CFR 482.30, unless a waiver has been granted. That is the hospital conditions of participation standard, not the content of a UR plan under 42 CFR 456.101-456.145 (UR committee composition, review of admissions and continued stays, notice of adverse UR decisions), none of

which is stated in held evidence. The plan at pp.99-102 attests Subpart C compliance generally, with no waivers granted.

RECORD LOCATION: H-067, H-068 and H-070, hospital services clinical coverage policies (UR plan condition); H-001 (H-001), NC Title XIX State Plan pp.99-102

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The content elements of a hospital UR plan under 42 CFR 456.101-456.145 (committee, admission and continued stay review, denial notice); held evidence carries only the 482.30 crosswalk condition and the plan's general Subpart C attestation.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce a hospital UR plan or the state review standard that checks UR plans against Subpart C content.
>
> **QUESTION:** How does NC verify that a hospital's UR plan contains the Subpart C elements?

SEARCHES RECORDED: Corpus searched for utilization review plan: hits are the 482.30 passages in hospital policies and provider manuals only. Full map carries no 456.1xx pinpoint.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 456.101-456.145 text as carried in the register requirement of record

CFR-456-009: Mental hospital certification, evaluations, and plan of care

CITATION: 42 CFR 456.160, 456.170, 456.180, 456.181

TOPIC: Mental hospital certification, evaluations, and plan of care

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Certification at admission (or before payment authorization); recertification at least every 60 days; evaluations before admission

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Quality Management and Improvement

HOME BASIS: Quality Management and Improvement is a published DHB function — it publishes the Annual Quality Report, EQR Technical Reports, Encounter Data Validation, and the AMH measure set (Lane A §1.4, §3). Assignment of measure-set reporting to it is a functional derivation from that published portfolio, and says so. Part 456 split on the CFR's own line: utilization/quality functions to Quality, program-integrity functions to OCPI.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC mental hospitals serving Medicaid patients

BASIS: The plan's section 4.14(c) at p.100 attests the Medicaid agency meets the requirements of Part 456 Subpart D for control of utilization of inpatient services in mental hospitals, with no waivers granted. The Subpart D elements themselves (certification of need at admission under 456.160, independent professional evaluations under 456.170, and the individual plan of care under 456.180 and 456.181) are not stated in any held passage.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan p.100 (section 4.14(c))

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** Mental hospital certification, evaluation and plan of care elements (42 CFR 456.160, 456.170, 456.180, 456.181) as NC requirements; held evidence is the Subpart D attestation only.

OWNER LEVEL: Division of Mental Health, Developmental Disabilities and Substance Use Services

ACTION: Produce the mental hospital utilization and plan of care documentation used for Medicaid patients in state and private psychiatric facilities.

QUESTION: Where are Subpart D certification, evaluation and plan of care duties documented for NC mental hospitals?

SEARCHES RECORDED: Full map carries no 456.16x-456.18x pinpoint. Corpus searched for mental hospital certification and evaluation language (no state-side passage found).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 456.160-456.181 text as carried in the register requirement of record

CFR-456-010: Written UR plan required for inpatient mental hospital services

CITATION: 42 CFR 456.201–456.245

TOPIC: Written UR plan required for inpatient mental hospital services

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Written UR plan in effect continuously; at least one study in progress at all times; complete one study each calendar year

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (each calendar year) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Office of Compliance and Program Integrity (OCPI)

HOME BASIS: OCPI's published mission is to protect DHB's resources 'by reducing or eliminating fraud, waste, and abuse of providers and beneficiaries in the NC Medicaid Program' (Lane A §1.4). Part 456 split on the CFR's own line: utilization/quality functions to Quality, program-integrity functions to OCPI.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC mental hospitals providing inpatient services

BASIS: The plan's section 4.14(c) at p.100 attests Subpart D compliance for mental hospitals, and Subpart D includes the UR plan requirements at 456.201-456.245. No held passage states the content of a mental hospital UR plan, and none of the hospital policy documents read extends the 482.30 UR plan condition in terms of Subpart D.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan p.100 (section 4.14(c))

SECTION 5D FACE

UNCOVERED ELEMENT: The written UR plan requirement and its content for inpatient mental hospital services (42 CFR 456.201-456.245); held evidence is the plan's Subpart D attestation only.

OWNER LEVEL: Division of Mental Health, Developmental Disabilities and Substance Use Services

ACTION: Produce a mental hospital UR plan or the state standard against which such plans are reviewed.

QUESTION: Where is the Subpart D UR plan for NC mental hospitals documented?

SEARCHES RECORDED: Full map carries no 456.2xx pinpoint. Corpus searched for mental hospital utilization review plan (no hits beyond the plan attestation).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 456.201-456.245 text as carried in the register requirement of record

CFR-456-011: ICF certification, evaluations, and plan of care

CITATION: 42 CFR 456.360, 456.370, 456.380, 456.381

TOPIC: ICF certification, evaluations, and plan of care

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Certification at admission (or before payment authorization); recertification at least every 12 months in ICF/IID, every 60 days in other ICFs

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Quality Management and Improvement

HOME BASIS: Quality Management and Improvement is a published DHB function — it publishes the Annual Quality Report, EQR Technical Reports, Encounter Data Validation, and the AMH measure set (Lane A §1.4, §3). Assignment of measure-set reporting to it is a functional derivation from that published portfolio, and says so. Part 456 split on the CFR's own line: utilization/quality functions to Quality, program-integrity functions to OCPI.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC intermediate care facilities for individuals with intellectual disabilities

BASIS: The plan's section 4.14(e) and (f) at pp.101-102 attest the agency meets Part 456 Subpart E for skilled nursing facility services and Subpart F for intermediate care facility services, with no waivers granted, and section 4.15 at p.103 addresses inspection of care in ICFs. The Subpart E and F elements themselves (certification at 456.360, evaluations at 456.370, plan of care at 456.380 and 456.381) are not stated in any held passage. The OCR of the 4.15 page is internally unclear about which facility types the not-applicable boxes attach to, which is flagged rather than resolved from the text layer.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan pp.101-103 (sections 4.14(e)-(f) and 4.15)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** ICF certification, evaluation and plan of care elements (42 CFR 456.360, 456.370, 456.380, 456.381) as NC requirements; held evidence is subpart attestation only.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce the ICF/IID utilization and plan of care documentation carrying the Subpart E and F elements.
>
> **QUESTION:** Where are ICF certification, evaluation and plan of care duties documented in NC?

SEARCHES RECORDED: Full map carries no 456.3xx pinpoint. Corpus searched for ICF certification and plan of care language in facility policies (no Subpart E/F passage found).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 456.360-456.381 text as carried in the register requirement of record

FLAGS: Plan p.103 (section 4.15) OCR is garbled at the not-applicable checkboxes for ICF/MR, IMD and under-21 psychiatric services; the attestation that Subpart I requirements are met is legible, the checkbox assignment is not. Graded without relying on the checkboxes.

CFR-456-012: Medicaid agency review of need for ICF admission; alternative-services exploration

CITATION: 42 CFR 456.371–456.372

TOPIC: Medicaid agency review of need for ICF admission; alternative-services exploration

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Agency admission review for each applicant/beneficiary

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Office of Compliance and Program Integrity (OCPI)

HOME BASIS: OCPI's published mission is to protect DHB's resources 'by reducing or eliminating fraud, waste, and abuse of providers and beneficiaries in the NC Medicaid Program' (Lane A §1.4). Part 456 split on the CFR's own line: utilization/quality functions to Quality, program-integrity functions to OCPI.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC agency review of ICF admissions

BASIS: One element is carried in the plan's attachments: prior approval is required for all admissions to intermediate care facilities, and utilization review committee recommendations that require a change in level of care require prior approval, which is agency review of the need for admission in operation. The companion element of 456.371-456.372, exploration of alternative services before or at admission, is not stated in any held passage, and the review is not described in 456 terms (who reviews, against what criteria, within what time).

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan Attachment 4.19 area utilization passages (prior approval for ICF admissions) and pp.101-102

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** Exploration of alternative services to ICF care, and the described agency review process (reviewer, criteria, timing) under 42 CFR 456.371-456.372; held evidence shows prior approval for ICF admissions only.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce the ICF admission review procedure showing the alternatives exploration step.
>
> **QUESTION:** How does NC document that alternatives to ICF admission were explored for each admission?

SEARCHES RECORDED: Corpus searched for alternative services and ICF admission review language (prior approval passages only). Full map carries no 456.371 or 456.372 pinpoint.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 456.371 and 456.372 text as carried in the register requirement of record

CFR-456-013: ICF UR plan and continued stay review

CITATION: 42 CFR 456.401–456.438

TOPIC: ICF UR plan and continued stay review

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Written UR plan on file continuously; continued-stay reviews with adverse-decision notice within 2 days of final decision

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Office of Compliance and Program Integrity (OCPI)

HOME BASIS: OCPI's published mission is to protect DHB's resources 'by reducing or eliminating fraud, waste, and abuse of providers and beneficiaries in the NC Medicaid Program' (Lane A §1.4). Part 456 split on the CFR's own line: utilization/quality functions to Quality, program-integrity functions to OCPI.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC intermediate care facilities on continued stay review

BASIS: The plan's section 4.14(f) at p.102 attests Subpart F compliance for ICF services, the subpart containing the UR plan and continued stay review requirements at 456.401-456.438. A continued stay cadence appears in the corpus for a different service (rehabilitation stays reviewed every 30 days in a plan attachment). No held passage states an ICF UR plan, its review committee, or continued stay review intervals and notice duties for ICF residents.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan p.102 (section 4.14(f))

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The ICF UR plan and continued stay review elements (42 CFR 456.401-456.438): plan content, review intervals and adverse decision notice are not stated in held evidence.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce an ICF UR plan or the survey/review standard covering continued stay review in ICFs.
>
> **QUESTION:** Where is continued stay review for NC ICF residents documented?

SEARCHES RECORDED: Corpus searched for continued stay review (rehabilitation and out-of-state passages only, read and distinguished). Full map carries no 456.4xx pinpoint.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 456.401-456.438 text as carried in the register requirement of record

CFR-456-014: Under-21 inpatient psychiatric admission certification and plan of care

CITATION: 42 CFR 456.481–456.482

TOPIC: Under-21 inpatient psychiatric admission certification and plan of care

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Admission certification and plan-of-care development/review per 441.152–441.156

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Office of Compliance and Program Integrity (OCPI)

HOME BASIS: OCPI's published mission is to protect DHB's resources 'by reducing or eliminating fraud, waste, and abuse of providers and beneficiaries in the NC Medicaid Program' (Lane A §1.4). Part 456 split on the CFR's own line: utilization/quality functions to Quality, program-integrity functions to OCPI.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC inpatient psychiatric services for individuals under 21

BASIS: Section 4.15 of the plan at p.103 lists facilities providing inpatient psychiatric services for individuals under 21 among the inspection of care settings and states all applicable requirements of Part 456 Subpart I are met, under a Peer Review Organization contract. The admission certification and plan of care elements at 456.481-456.482 (certification by an interdisciplinary team that inpatient care is needed and the active treatment plan) are not stated in any held passage, and the same plan page carries not-applicable language for under-21 psychiatric services in its checkbox text, which contradicts NC's actual coverage of psychiatric residential treatment; the contradiction is flagged and the grade rests on the Subpart I attestation plus the absence of the element text.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan p.103 (section 4.15)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** Certification of need and plan of care for under-21 inpatient psychiatric admission (42 CFR 456.481 and 456.482): certifying team, certification content and plan elements are not stated in held evidence.
>
> **OWNER LEVEL:** Division of Mental Health, Developmental Disabilities and Substance Use Services
>
> **ACTION:** Produce the PRTF admission certification and plan of care documentation used for Medicaid patients under 21.
>
> **QUESTION:** Where are the 456.481 certification and 456.482 plan of care documented for NC under-21 psychiatric facilities?

SEARCHES RECORDED: Full map carries no 456.481 or 456.482 pinpoint. Corpus searched for under-21 psychiatric certification and PRTF plan of care language (no 456 passage found).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 456.481 and 456.482 text as carried in the register requirement of record

FLAGS: Conflict on the face of plan p.103: not-applicable checkbox text for inpatient psychiatric services for individuals under 21 sits beside the statement that Subpart I requirements are met for those facilities, and NC does cover under-21 psychiatric services. Graded on the attestation, flagged as a plan text conflict for the cure record.

CFR-456-015: UR plans as a condition for FFP

CITATION: 42 CFR 456.501

TOPIC: UR plans as a condition for FFP

OBLIGATED LEVEL: agency

CADENCE: RECURRING - FFP barred for services at facilities without a compliant UR plan

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Office of Compliance and Program Integrity (OCPI)

HOME BASIS: OCPI's published mission is to protect DHB's resources 'by reducing or eliminating fraud, waste, and abuse of providers and beneficiaries in the NC Medicaid Program' (Lane A §1.4). Part 456 split on the CFR's own line: utilization/quality functions to Quality, program-integrity functions to OCPI.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC: FFP is conditioned on compliant UR plans

BASIS: The state-side showing that exists is the plan's utilization control attestations at pp.99-102: the agency meets Part 456 Subpart C, D, E and F requirements, which are the UR plan subparts to which 456.501 attaches the FFP condition. No held document states the condition itself, and none ties a facility's payment to the existence of a compliant UR plan in NC practice.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan pp.99-102 (section 4.14)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The FFP condition of 42 CFR 456.501 stated or applied in NC: no held document conditions payment on UR plan compliance.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce any provider agreement or payment policy language conditioning FFP on a compliant UR plan.
>
> **QUESTION:** Where, if anywhere, does NC state the 456.501 payment condition to facilities?

SEARCHES RECORDED: Full map carries no 456.501 pinpoint. Corpus searched for the section number and for payment conditioned on utilization review plans (no hits).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 456.501 text as carried in the register requirement of record

CFR-456-016: Waiver of UR plan requirements

CITATION: 42 CFR 456.505–456.508

TOPIC: Waiver of UR plan requirements

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Waiver application at any time; evaluation 1–2 years after grant and periodically every 1–2 years thereafter

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (periodic) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Office of Compliance and Program Integrity (OCPI)

HOME BASIS: OCPI's published mission is to protect DHB's resources 'by reducing or eliminating fraud, waste, and abuse of providers and beneficiaries in the NC Medicaid Program' (Lane A §1.4). Part 456 split on the CFR's own line: utilization/quality functions to Quality, program-integrity functions to OCPI.

CURE DETERMINATION: **N-A-DETERMINED** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): NA-REASON: STRUCTURAL

BASIS: The provision governs waivers of UR plan requirements granted to a state. NC's plan affirmatively records that no such waiver exists: section 4.14 at plan pp.99-102 states, for Subpart C (hospitals), Subpart D (mental hospitals) and Subpart E (skilled nursing facilities) alike, that no waivers have been granted, and the utilization review is not performed under a Subpart H waiver.

There is therefore nothing in NC for 456.505-456.508 to operate on in the evidence window. Determiner: NC Cure grading seat F. Basis: plan section 4.14 text. Record location: H-001 pp. 99-102.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan pp.99-102 (section 4.14, no waivers granted)

> **SECTION 3A FOOTING.** The closed list reason is NA-REASON: STRUCTURAL. The determiner is NC Cure grading seat F. This determination rests on the basis printed for this entry above. It also rests on the record location printed for this entry above.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 456.505-456.508 text as carried in the register requirement of record; Program Directive section 3A STRUCTURAL reason

CFR-456-017: Remote facility variances from UR time requirements

CITATION: 42 CFR 456.520–456.525

TOPIC: Remote facility variances from UR time requirements

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Variance granted for ≤1 year; renewal ≥30 days before expiry

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Office of Compliance and Program Integrity (OCPI)

HOME BASIS: OCPI's published mission is to protect DHB's resources 'by reducing or eliminating fraud, waste, and abuse of providers and beneficiaries in the NC Medicaid Program' (Lane A §1.4). Part 456 split on the CFR's own line: utilization/quality functions to Quality, program-integrity functions to OCPI.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC remote facilities only if a variance has been granted

BASIS: No NC evidence for a remote facility variance from UR time requirements under 42 CFR 456.520-456.525 was found. Unlike the waiver question at 456.505, the plan makes no statement about variances for remote facilities, so the record does not affirmatively establish that none exists; the grade is GAP, not N-A.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The entire provision: no held document addresses a variance for a remote facility from UR timing requirements (42 CFR 456.520-456.525).
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State whether any NC facility holds a remote facility variance from UR time requirements and produce it if so.
>
> **QUESTION:** Does any NC facility operate under a 456.520 variance?

SEARCHES RECORDED: Full map carries no 456.52x pinpoint. Corpus searched for remote facility and variance language in utilization review contexts (no hits); plan section 4.14 read in full for any variance statement (none).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 456.520-456.525 text as carried in the register requirement of record

CFR-456-018: Annual inspections of care in ICFs and IMDs

CITATION: 42 CFR 456.600–456.613

TOPIC: Annual inspections of care in ICFs and IMDs

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Periodic on-site inspections; each beneficiary's care inspected at least annually; reports submitted promptly; corrective action as needed

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually, quarterly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Office of Compliance and Program Integrity (OCPI)

HOME BASIS: OCPI's published mission is to protect DHB's resources 'by reducing or eliminating fraud, waste, and abuse of providers and beneficiaries in the NC Medicaid Program' (Lane A §1.4). Part 456 split on the CFR's own line: utilization/quality functions to Quality, program-integrity functions to OCPI.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC inspections of care in ICFs and institutions for mental disease

BASIS: Plan section 4.15 at p.103 carries the inspection of care framework: the state has contracted with a Peer Review Organization to perform inspection of care for ICFs/MR, inpatient psychiatric facilities for recipients under 21 and mental hospitals, and all applicable requirements of 42 CFR Part 456 Subpart I are met with respect to periodic inspections of care and services. The Subpart I operating elements (annual inspection cadence at 456.606, inspection team composition, and the medical review and independent professional review steps at 456.600-456.613) are not stated in the held passage, and no inspection report is in the corpus.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan p.103 (section 4.15)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** Annual cadence, team composition and review steps for inspections of care under 42 CFR 456.600-456.613; held evidence is the plan's framework attestation and PRO contract statement.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce a current inspection of care report or the Subpart I inspection schedule for ICFs and IMDs.
>
> **QUESTION:** When were the last Subpart I inspections of care performed in NC ICFs and IMDs, and by what team?

SEARCHES RECORDED: Full map carries no 456.6xx pinpoint. Corpus searched for inspection of care (plan passages and a staffing description of inspection of care review teams only; no inspection report or cadence statement).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 456.600-456.613 text as carried in the register requirement of record

CFR-456-019: Quarterly satisfactory showing of effective institutional UR

CITATION: 42 CFR 456.652, 456.654

TOPIC: Quarterly satisfactory showing of effective institutional UR

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Satisfactory showing each quarter, postmarked/received within 30 days after quarter close (45 days with good cause)

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (quarterly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Office of Compliance and Program Integrity (OCPI)

HOME BASIS: OCPI's published mission is to protect DHB's resources 'by reducing or eliminating fraud, waste, and abuse of providers and beneficiaries in the NC Medicaid Program' (Lane A §1.4). Part 456 split on the CFR's own line: utilization/quality functions to Quality, program-integrity functions to OCPI.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC quarterly showings on institutional UR effectiveness

BASIS: No NC evidence for a quarterly satisfactory showing of effective institutional utilization review under 42 CFR 456.652 and 456.654 was found. No held document mentions a satisfactory showing, a quarterly UR effectiveness report to CMS, or either section number.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The entire provision: no held document addresses the quarterly satisfactory showing (42 CFR 456.652 and 456.654).
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce a quarterly satisfactory showing submission or state whether CMS has waived or discontinued the requirement for NC.
>
> **QUESTION:** Does NC still make the quarterly satisfactory showing on institutional UR, and where is it filed?

SEARCHES RECORDED: Full map carries no 456.652 or 456.654 pinpoint. Corpus searched for satisfactory showing and quarterly utilization review effectiveness language (no hits).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 456.652 and 456.654 text as carried in the register requirement of record

CFR-456-020: Outpatient drug use review program (prospective + retrospective + education)

CITATION: 42 CFR 456.703

TOPIC: Outpatient drug use review program (prospective + retrospective + education)

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous DUR operation; predetermined standards publicly available and tested against claims data before adoption

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Pharmacy (Pharmacy Benefit Administrator for NC Medicaid Direct)

HOME BASIS: Pharmacy is a published DHB function: from May 2, 2026 a Pharmacy Benefit Administrator (Prime Therapeutics) supports NC Medicaid Direct pharmacy operations while DHB 'continues to manage all clinical policies and reimbursement methodologies for Point-of-Sale pharmacy' (Lane A §1.4). Title-level derivation: the Medicaid drug benefit and the Drug Rebate Program sit with the pharmacy function in NC's published structure (the PBA's published duties include drug rebate administration and DUR — Lane A §1.4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC outpatient drug utilization review program

BASIS: The plan DUR preprint at pp.139-140 carries the program: section A states the DUR program assures prescriptions for outpatient drugs are appropriate, medically necessary and not likely to result in adverse medical results (456.705(b) and 456.709(b) citations as printed), section B states the program is designed to educate physicians and pharmacists to identify and reduce fraud, abuse, gross overuse and inappropriate or medically unnecessary care, with the full problem list at 456.703(d) and (f) (adverse reactions, therapeutic appropriateness, over and under utilization, generic use, duplication, contraindications, interactions, dosage, allergy and clinical abuse), and section C states DUR assesses data against predetermined standards drawn from peer reviewed literature and the named compendia. Sections E to I then carry the prospective, retrospective, board, reporting and point of sale elements graded at the rows below.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan pp.139-142 (DUR preprint, sections A-J)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 456.703 text as carried in the register requirement of record

CFR-456-021: Prospective drug review at point of sale

CITATION: 42 CFR 456.705

TOPIC: Prospective drug review at point of sale

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Point-of-sale/distribution review before each prescription is filled or delivered

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Pharmacy (Pharmacy Benefit Administrator for NC Medicaid Direct)

HOME BASIS: Pharmacy is a published DHB function: from May 2, 2026 a Pharmacy Benefit Administrator (Prime Therapeutics) supports NC Medicaid Direct pharmacy operations while DHB 'continues to manage all clinical policies and reimbursement methodologies for Point-of-Sale pharmacy' (Lane A §1.4). Title-level derivation: the Medicaid drug benefit and the Drug Rebate Program sit with the pharmacy function in NC's published structure (the PBA's published duties include drug rebate administration and DUR — Lane A §1.4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC prospective drug review at dispensing

BASIS: The DUR preprint at p.140 carries prospective review in full: section E.1 states the DUR program includes prospective review of drug therapy at the point of sale or distribution before each prescription is filled or delivered to the Medicaid recipient; E.2 lists the screening for therapeutic duplication, drug-disease and drug-drug contraindications, interactions with nonprescription drugs, incorrect dosage or duration, drug allergy interactions and clinical abuse or misuse (456.705(b)(1)-(7) as printed); E.3 covers counseling of Medicaid recipients based on standards established by state law and maintenance of patient profiles (456.705(c) and (d)). Section I.2 adds that prospective DUR is performed using an electronic point of sale drug claims processing system.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan pp.139-142 (DUR preprint, sections A-J)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 456.705 text as carried in the register requirement of record

CFR-456-022: Retrospective drug use review (quarterly claims analysis)

CITATION: 42 CFR 456.709

TOPIC: Retrospective drug use review (quarterly claims analysis)

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Claims-data examination no less frequently than quarterly

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (quarterly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Pharmacy (Pharmacy Benefit Administrator for NC Medicaid Direct)

HOME BASIS: Pharmacy is a published DHB function: from May 2, 2026 a Pharmacy Benefit Administrator (Prime Therapeutics) supports NC Medicaid Direct pharmacy operations while DHB 'continues to manage all clinical policies and reimbursement methodologies for Point-of-Sale pharmacy' (Lane A §1.4). Title-level derivation: the Medicaid drug benefit and the Drug Rebate Program sit with the pharmacy function in NC's published structure (the PBA's published duties include drug rebate administration and DUR — Lane A §1.4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC retrospective drug use review

BASIS: The DUR preprint at pp.140-141 carries retrospective review: section F.1 states the program includes retrospective DUR through its mechanized drug claims processing and information retrieval system, undertaking ongoing periodic examination of claims data and other records to identify patterns of fraud and abuse, gross overuse, and inappropriate or medically unnecessary care among physicians, pharmacists and recipients and associated with specific drugs (456.709(a) as printed); F.2 states the program assesses drug use data against explicit predetermined standards including therapeutic appropriateness, over and under utilization, generic use, duplication, contraindications, interactions, dosage and duration and clinical abuse or misuse (456.709(b)).

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan pp.139-142 (DUR preprint, sections A-J)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 456.709 text as carried in the register requirement of record

CFR-456-023: DUR educational outreach program

CITATION: 42 CFR 456.711

TOPIC: DUR educational outreach program

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous educational outreach driven by DUR Board data

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Office of Compliance and Program Integrity (OCPI)

HOME BASIS: OCPI's published mission is to protect DHB's resources 'by reducing or eliminating fraud, waste, and abuse of providers and beneficiaries in the NC Medicaid Program' (Lane A §1.4). Part 456 split on the CFR's own line: utilization/quality functions to Quality, program-integrity functions to OCPI.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC DUR educational outreach to practitioners

BASIS: The DUR preprint at pp.141-142 carries the education element twice over: section F.3 states the DUR program, through its State DUR Board using data provided by the Board, provides active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices (456.711 as printed), and section G.4 lists the interventions in appropriate instances: information dissemination, written, oral and electronic reminders, face to face discussions, and intensified monitoring or review of prescribers and dispensers (456.711(a)-(d) as printed).

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan pp.139-142 (DUR preprint, sections A-J)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 456.711 text as carried in the register requirement of record

CFR-456-024: Annual DUR report to CMS

CITATION: 42 CFR 456.712

TOPIC: Annual DUR report to CMS

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - DUR Board report to agency annually; agency report to Secretary annually

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Office of Compliance and Program Integrity (OCPI)

HOME BASIS: OCPI's published mission is to protect DHB's resources 'by reducing or eliminating fraud, waste, and abuse of providers and beneficiaries in the NC Medicaid Program' (Lane A §1.4). Part 456 split on the CFR's own line: utilization/quality functions to Quality, program-integrity functions to OCPI.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC annual DUR reporting to the Secretary

BASIS: The DUR preprint at p.142 carries the reporting assurance: section H states the state assures it will prepare and submit an annual report to the Secretary which incorporates a report from the State DUR Board, and that the state will adhere to the plans, steps and procedures described in the report (456.712(a) and (b) as printed).

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan pp.139-142 (DUR preprint, sections A-J)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 456.712 text as carried in the register requirement of record

CFR-456-025: State DUR Board establishment and functions

CITATION: 42 CFR 456.716

TOPIC: State DUR Board establishment and functions

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Standing board; continuous operational oversight

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — Office of Compliance and Program Integrity (OCPI)

HOME BASIS: OCPI's published mission is to protect DHB's resources 'by reducing or eliminating fraud, waste, and abuse of providers and beneficiaries in the NC Medicaid Program' (Lane A §1.4). Part 456 split on the CFR's own line: utilization/quality functions to Quality, program-integrity functions to OCPI.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC State DUR Board

BASIS: The DUR preprint at p.141 carries the board: section G.1 states the DUR program has established a State DUR Board directly (the contract alternative is unmarked); G.2 states membership includes health professionals, one third licensed actively practicing pharmacists and one third but no more than 51 percent licensed actively practicing physicians, with knowledge and experience in clinically appropriate prescribing, dispensing and monitoring, drug use review and intervention, or medical quality assurance (456.716(a) and (b) as printed); G.3 states the Board's activities include retrospective DUR, application of standards, and ongoing interventions for physicians and pharmacists targeted to therapy problems identified in retrospective DUR (456.716(d)).

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan pp.139-142 (DUR preprint, sections A-J)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 456.716 text as carried in the register requirement of record

CFR-456-026: Electronic claims management system (optional point-of-sale)

CITATION: 42 CFR 456.722, 456.725

TOPIC: Electronic claims management system (optional point-of-sale)

OBLIGATED LEVEL: agency

CADENCE: FIXED - At State option; must meet procurement/functional requirements for FFP

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Office of Compliance and Program Integrity (OCPI)

HOME BASIS: OCPI's published mission is to protect DHB's resources 'by reducing or eliminating fraud, waste, and abuse of providers and beneficiaries in the NC Medicaid Program' (Lane A §1.4). Part 456 split on the CFR's own line: utilization/quality functions to Quality, program-integrity functions to OCPI.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as an election: NC has adopted a point of sale electronic claims system

BASIS: The DUR preprint at p.142 carries the election in operation: section I.1 states the state establishes, as its principal means of processing claims for covered outpatient drugs, a point of sale electronic claims management system to perform online real time eligibility verification, claims data capture, adjudication of claims and assistance to pharmacists applying for and receiving payment (456.722 as printed, under section 1927(h)(1)), and I.2 states prospective DUR is performed using the electronic point of sale system. The system is corroborated in current operations text: the NCTracks checkwrite schedule (H-140) includes POS pharmacy claims in the weekly cycle with a Friday 11:59 p.m. processing cutoff.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan pp.139-142 (DUR preprint, sections A-J); H-140 (H-140), 2026 checkwrite schedule, POS pharmacy line

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 456.722 and 456.725 text as carried in the register requirement of record

CFR-457-001: Operate program per approved state plan; governor signature

CITATION: 42 CFR 457.40

TOPIC: Operate program per approved state plan; governor signature

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Ongoing operational duty; signature required on every plan/amendment submission

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: The approved Title XXI plan carries the section 457.40 submission agreement on its face: the cover page submits the Child Health Plan and agrees to administer the program in accordance with the approved plan, Title XXI and Title XIX as appropriate, and all applicable Federal regulations, citing 42 CFR 457.40(b); the officials responsible for program administration and financial oversight required by 457.40(c) are named (Kody Kinsley, Secretary, NC DHHS; Jay Ludlam, Deputy Secretary for Division of Health Benefits; Melanie Bush, Deputy Medicaid Director); section 1.2 carries the 457.40(d) legislative authority assurance. CMS approval of SPAs NC-23-0008 and NC-23-0010 by letter dated September 11, 2023 evidences the plan as submitted and approved.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), cover page (plan p.1) and section 1.2 (plan p.7); approval letter at packet pp.1-2

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 457.40: State must submit a child health plan signed by the Governor or designee, operate the program in accordance with the approved plan, and identify the officials responsible for administration and financial oversight.

CFR-457-002: State plan content as basis for FFP

CITATION: 42 CFR 457.50

TOPIC: State plan content as basis for FFP

OBLIGATED LEVEL: agency

CADENCE: FIXED - Initial submission; updated via amendments

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: The held instrument is itself the comprehensive written statement section 457.50 requires as the basis for Federal payment: the CMS-approved consolidated Title XXI plan (H-013) is completed across template sections 1 to 12, covering program description and option, background and coordination, delivery methods, eligibility standards, outreach, coverage, quality, cost sharing, strategic objectives and budget, annual reports, program integrity, and applicant and enrollee protections. No element of the 457.50 content statement is absent from the document read.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), template sections 1-12 (plan pp.6-149)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 457.50: FFP is available only under a State plan that consists of a comprehensive written statement describing the nature and scope of the child health program.

CFR-457-003: State plan amendments — triggers and amended budget

CITATION: 42 CFR 457.60

TOPIC: State plan amendments — triggers and amended budget

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - As triggered by legal/operational changes

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Amendment practice is evidenced on the plan face: section 1.4 records the SPA history including the five MAGI CHIP State Plans incorporated by reference (SPA 15-0001 implementing ACA and State legislative eligibility changes and repealing the CHIP buy-in program effective

October 1, 2015), and the packet itself is an approved amendment (NC-23-0008 and NC-23-0010, submitted April 5, 2023, approved September 11, 2023) with its own budget at section 9.10. What is not carried is a forward plan procedure committing the State to amend on each 457.60 trigger and to submit an amended budget with amendments generally.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 1.4 (plan pp.7-10) and approval letter (packet pp.1-2)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** A plan-level procedure or commitment covering the 457.60 amendment triggers (changes in Federal law, regulation, policy or court decision; changes in State law, organization, policy or program operation) with an amended budget submitted on amendment.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State the 457.60 amendment-trigger and amended-budget procedure in a plan amendment or administrative record filed for the Title XXI program.
>
> **QUESTION:** Will DHB place a forward amendment-procedure statement on the Title XXI record, or does the register accept the section 1.4 amendment history plus the approved 2023 SPA packet as the whole record?

CFR-457-004: Plan amendment effective-date limits and public notice

CITATION: 42 CFR 457.65

TOPIC: Plan amendment effective-date limits and public notice

OBLIGATED LEVEL: federal-facing state report

CADENCE: EVENT-TRIGGERED - Per amendment; 60-day/90-day clocks apply

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Two elements are carried. Section 1.4 gives effective and implementation dates as 457.65 requires (original plan effective October 1, 1998; the 2023 SPA effective April 1, 2023 per the CMS approval letter, submitted April 5, 2023). Section 9.9.2 describes prior public notice for amendments relating to eligibility or benefits, including the 10-day posting of a State Plan Amendment to the Department web page before CMS submission under N.C.G.S. 108A-54.1A, consumer notices, mailed letters to enrolled beneficiaries, and annually revised handbooks. Not stated in 457.65 terms are the effective-date limits of 457.65(a) as a plan commitment and the tribal notice element for amendments.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 1.4 (plan pp.7-8), section 9.9.2 (plan pp.138-139), approval letter (packet pp.1-2)

> **SECTION 5D FACE**

UNCOVERED ELEMENT: The 457.65(a) effective-date limits stated as a governing commitment, and the 457.65 tribal notification element for eligibility or benefit amendments.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Add the 457.65(a) timing limits and the tribal notice step to the SPA procedure described at plan section 9.9.2.

QUESTION: Does DHB apply the 457.65(a) quarter-of-submission limit and tribal notice as standing SPA procedure even though the plan text does not state them?

CFR-457-005: State plan describes chosen program option

CITATION: 42 CFR 457.70

TOPIC: State plan describes chosen program option

OBLIGATED LEVEL: agency

CADENCE: FIXED - Described in state plan; updated on option change

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: The operative program option is established by the strongest evidence: the CMS approval letter for NC-23-0008 and NC-23-0010 states the State transitions all children from the separate CHIP to a Medicaid expansion CHIP effective April 1, 2023, and plan section 4.0 is headed Medicaid Expansion with the expansion groups stated. But the plan description section 457.70 requires is not conformed on its face: section 1.1.2 states the Medicaid expansion groups while the narrative carried at section 1.1.3 still describes the North Carolina Health Choice for Children Program as a combination plan with a separate child health program for uninsured children ages 6 through 18 between 133% and 211% FPL. The description of the chosen option therefore contradicts itself inside the approved document.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), approval letter (packet pp.1-2), section 1.1 (plan pp.6-7), section 4.0 (plan pp.62-63)

SECTION 5D FACE

UNCOVERED ELEMENT: A conformed section 1.1 description of the chosen option: the combination plan narrative at section 1.1.3 was not struck or updated when the program converted to a Medicaid expansion CHIP.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Submit a conforming Title XXI plan amendment striking the combination plan narrative at section 1.1.3 so the plan describes only the Medicaid expansion option.

QUESTION: Will DHB conform section 1.1 of the Title XXI plan to the Medicaid expansion structure CMS approved effective April 1, 2023?

FLAGS: Conflict NC-5

CFR-457-006: State plan describes current coverage and coordination

CITATION: 42 CFR 457.80

TOPIC: State plan describes current coverage and coordination

OBLIGATED LEVEL: agency

CADENCE: FIXED - State plan content; updated as coordination procedures change

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Elements (b) and (c) of 457.80 are described in filled plan text. Section 5.1 (formerly 2.2) describes current State efforts to provide or obtain creditable coverage, including the combined Title XIX and XXI marketing approach, Division of Public Health outreach, and the public-private partnership steps at 5.1.2 naming early childhood, school, provider, governmental, nonprofit, business and media partners. Section 5.2 (formerly 2.3) describes coordination with other public and private health insurance programs: joint application, screening for Title XIX first and then Title XXI, ex parte renewal mailing in the 10th month, and DHB oversight of county DSS determinations. Element (a), the extent and manner in which children currently have creditable coverage by income level, race, ethnicity and geography, is not filled at section 2.1 in either the cure packet or the held plan (H-022): the heading and guidance print with no State description following.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 2.1 (plan p.11, unfilled), section 5.1 (plan pp.80-82), section 5.2 (plan pp.82-83); H-022 section 2.1 checked, also unfilled

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 457.80(a) description of the extent and manner in which children in the State currently have creditable health coverage, distinguished by income level and other relevant factors.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Complete plan section 2.1 with current creditable coverage data by income level, race, ethnicity and geography, or file the equivalent baseline description for the Title XXI record.
>
> **QUESTION:** Where does DHB publish the 457.80(a) creditable coverage baseline for NC children after the Medicaid expansion conversion?

CFR-457-007: Outreach procedures in state plan

CITATION: 42 CFR 457.90

TOPIC: Outreach procedures in state plan

OBLIGATED LEVEL: agency

CADENCE: FIXED - State plan content; operational outreach ongoing

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Section 5.3 carries the outreach procedures description 457.90 requires, in State-specific detail: outreach to all uninsured low-income children potentially eligible for Title XIX or Title XXI; tribal organization collaboration to educate tribal members about NC Medicaid and NC Health Choice, including how to apply, eligibility criteria, covered benefits and appropriate emergency room use; the Division of Public Health toll-free resource line for families of children with special needs (1-800-737-3028, 8 a.m. to 5 p.m. weekdays); outreach through providers, community organizations, Developmental Services Agencies and diagnosis-specific groups; and targeted wellness and disease management materials in English and Spanish. Section 5.1.1 adds the equity-focused outreach framework and venues (mobile consulate visits, cultural festivals, faith-based services, minority-owned businesses).

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 5.3 (plan pp.83-84) and section 5.1.1 (plan pp.80-81)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 457.90: the State plan must describe procedures to inform families of children likely to be eligible of the availability of child health assistance and other coverage, and to assist them in enrolling.

CFR-457-008: Enrollment assistance and plain-language information

CITATION: 42 CFR 457.110

TOPIC: Enrollment assistance and plain-language information

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Ongoing duty to applicants/enrollees

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Availability of program information and enrollment assistance is evidenced in pieces: application forms and educational materials in English and Spanish available online for completion

and printing, assistance in filling out forms through county DSS and designated outstations including safety net hospital emergency departments, FQHCs, rural and migrant health centers and Indian health centers (section 4.3); the joint application online via the Federally Facilitated Marketplace, NC ePass, mail, phone or in person (section 4.3); and the toll-free special needs helpline (section 5.3). Not carried as a set are the 457.110 requirements that program information be provided in plain language, in prevalent non-English languages, and in alternative formats for individuals with disabilities, stated for the CHIP program in those terms.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 4.3 (plan pp.69-71) and section 5.3 (plan pp.83-84)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 457.110 plain-language, language-access and alternative-format standards stated as commitments for CHIP program information and application assistance.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State the 457.110 information standards (plain language, prevalent languages, alternative formats, oral interpretation) for the Title XXI program in the plan or a filed program record.
>
> **QUESTION:** Which DHB publication states the 457.110 information standards for the expansion CHIP population in the regulation's own terms?

CFR-457-009: Public involvement in program development

CITATION: 42 CFR 457.120

TOPIC: Public involvement in program development

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Initial design/implementation plus ongoing public involvement

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (periodic) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Section 9.9 describes the method for public involvement in design and implementation and for ongoing involvement as 457.120(a) and (b) require: N.C.G.S. 108A-54.1A bars plan amendment absent a General Assembly or Federal change requiring it and requires 10-day posting of a State Plan Amendment on the Department web page before CMS submission; consumers and advocates may sign up and speak at General Assembly hearings and provide input by mail, email or telephone to legislators and the Department. Section 9.9.1 carries the 457.120(c) tribal interaction element: the same tribal consultation process as Medicaid, an Eastern Band of Cherokee Indians representative on the Medical Care Advisory Committee meeting at least quarterly, written notice to EBCI 60 days before SPA submission with 30 days to respond, and a contacts list for technical assistance. Section 9.9.2 adds the notice process for eligibility and benefit amendments.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 9.9 (plan pp.137-139)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 457.120: the plan must describe the process for public involvement in program design and implementation, ongoing public involvement, and interaction with Indian tribes and organizations.

CFR-457-010: AI/AN child health assistance and cost-sharing exemption

CITATION: 42 CFR 457.125; 457.535

TOPIC: AI/AN child health assistance and cost-sharing exemption

OBLIGATED LEVEL: agency

CADENCE: FIXED - State plan procedures; exemption applied continuously

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Both cited provisions are carried. For 457.125: section 4.4.5 states child health assistance is provided to targeted low-income children who are American Indian and Alaska Native, that AI/AN children who self-identify at application are exempt from all enrollment fees and copayments, and that DHB notifies providers these beneficiaries are eligible for the federal Vaccines for Children Program; sections 9.9.1 and 2.3-TC describe tribal consultation on program development and SPA changes. For 457.535: section 8.6 describes the operative exclusion procedure - the joint application requests race and ethnicity, AI/AN identification is Race Code I, tribal membership evidence is requested, verification exempts the child from all cost sharing including the enrollment fee, and the health insurance ID card shows $0 copayment amounts for pharmacy and medical services so the exclusion is communicated to providers at each access.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 4.4.5 (plan p.79), section 8.6 (plan p.131), section 9.9.1 (plan pp.137-138)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 457.125 and 457.535: procedures to ensure AI/AN children receive child health assistance and tribal consultation; no cost sharing may be imposed on AI/AN children.

CFR-457-011: Civil rights and title XI/XIX assurances

CITATION: 42 CFR 457.130; 457.135

TOPIC: Civil rights and title XI/XIX assurances

OBLIGATED LEVEL: agency

CADENCE: FIXED - Assurances in state plan

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Both assurances are on the plan face. Section 1.3, citing 42 CFR 457.130, assures compliance with all applicable civil rights requirements including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act, section 504 of the Rehabilitation Act, the Age Discrimination Act, 45 CFR parts 80, 84 and 91, and 28 CFR part 35. The section at plan pp.136-137 (numbered 9.8 in the template, citing 42 CFR 457.135) assures that, to the extent they apply, section 1902(a)(4)(C) (conflict of interest standards), paragraphs (2), (16) and (17) of section 1903(i) (limitations on payment), section 1903(w) (provider donations and taxes) and section 1132 (claims filing periods) apply under Title XXI to the same extent as under Title XIX.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 1.3 (plan p.7) and section 9.8 (plan pp.136-137)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 457.130 and 457.135: civil rights compliance assurance, and assurance that the listed Title XIX and Title XI provisions apply under Title XXI to the same extent.

CFR-457-012: State plan budget for 1-year period

CITATION: 42 CFR 457.140

TOPIC: State plan budget for 1-year period

OBLIGATED LEVEL: agency

CADENCE: FIXED - With plan and significant amendments; also refreshed in annual report (457.750, 3-year budget)

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Section 9.10 carries the one-year projected budget 457.140 requires, on the CHIP Budget template for FFY 2023: enhanced FMAP rate 80.88%; benefit costs $749,018,363 (managed care $637,622,769 at a per member per month rate of $195, fee for service $111,395,594); offsetting beneficiary cost sharing payments $0; administration costs $13,762,156 itemized (personnel, general administration, claims processing, health services initiatives $489,539); a printed 10% administrative cap figure of $83,224,263; Federal share $616,955,953; State share $145,824,956; total costs $762,780,519; and the source of State share funds stated as Appropriations. Planned use of funds, administrative breakout and cost-per-child assumption (PMPM $195) are all on the face.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 9.10 (plan pp.139-141)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 457.140: the plan must include a budget for a 1-year period describing planned use of funds, projected health services and administrative amounts, assumptions including cost per child and expected enrollment, and projected sources of non-Federal funds.

CFR-457-013: Correct practices after federal/state program reviews

CITATION: 42 CFR 457.200

TOPIC: Correct practices after federal/state program reviews

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Corrective action when review findings warrant

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: The cooperation and access assurances that 457.200 program reviews presuppose are on the plan face: section 9.6 assures the State will provide the Secretary with access to any records or information relating to the plan for purposes of review or audit, and section 9.4 assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format the Secretary requires. What no held document states is the review-response duty itself: implementing correct practices shown necessary by Federal or State program reviews of the CHIP program.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), sections 9.4 and 9.6 (plan p.136)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** A State commitment or record of implementing correct practices required by Federal or State program reviews under 457.200.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File the Title XXI program-review response procedure, or a review outcome record, showing how DHB implements correct practices identified by Federal or State reviews of the CHIP program.
>
> **QUESTION:** Where is the CHIP program-review follow-up recorded for NC after the Medicaid expansion conversion?

CFR-457-014: Audit exceptions — concurrence, appeal, FFP adjustment

CITATION: 42 CFR 457.202

TOPIC: Audit exceptions — concurrence, appeal, FFP adjustment

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Per audit cycle

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (periodic) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: GAP-DETERMINED. No held NC public document read for this batch addresses audit exceptions under Title XXI: concurrence in or appeal of OIG audit findings, or FFP adjustment on unresolved exceptions. The Title XXI plan carries only the general access-for-review assurance at section 9.6, which does not state the 457.202 concurrence, appeal or adjustment procedure.

RECORD LOCATION: No record location: searched corpus carries no passage for this provision (see searches).

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The whole 457.202 procedure as a Title XXI element: State concurrence in audit exceptions, submission of facts supporting clearance, appeal, and FFP adjustment for unresolved exceptions.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish or file the Title XXI audit exception procedure and any audit exception dispositions for the CHIP program.
>
> **QUESTION:** Has any Title XXI audit exception been taken against NC, and where is the State response of record?

SEARCHES RECORDED: Held corpus text (the held corpus) and cure collection text (the collected document texts) full-text searched for the provision number and subject terms; the full reconciliation map pinpoints reviewed for every document touching Part 457 (H-013, H-022, H-052, H-053, H-098, H-099, H-136, NL-05); no passage carrying the element found. Terms searched included: audit exception, disallowance, concurrence, appeal of audit findings (0 substantive hits in H-013 or H-022).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 457.202: on OIG audit exceptions the State may concur or submit facts supporting clearance; unresolved exceptions are appealed through the Department process and FFP is adjusted.

CFR-457-015: Corrective action evidence within 30 days of preliminary noncompliance notice

CITATION: 42 CFR 457.204

TOPIC: Corrective action evidence within 30 days of preliminary noncompliance notice

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - 30-day deadline from preliminary notice

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: GAP-DETERMINED. No held NC public document read for this batch states the 457.204 duty to submit evidence of corrective action, or a request for additional time, within 30 days after notice of a preliminary finding of significant noncompliance, and no preliminary noncompliance notice or corrective action submission for the CHIP program is held.

RECORD LOCATION: No record location: searched corpus carries no passage for this provision (see searches).

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 457.204 corrective action evidence procedure and any instance record: evidence of action taken, being taken, or to be taken within 30 days of a preliminary noncompliance notice.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File the CHIP corrective action response procedure and any preliminary noncompliance correspondence for the Title XXI program.
>
> **QUESTION:** Has CMS issued any preliminary noncompliance finding for the NC Title XXI program, and what evidence of corrective action was submitted?

SEARCHES RECORDED: Held corpus text (the held corpus) and cure collection text (the collected document texts) full-text searched for the provision number and subject terms; the full reconciliation map pinpoints reviewed for every document touching Part 457 (H-013, H-022, H-052, H-053, H-098, H-099, H-136, NL-05); no passage carrying the element found. Terms searched included: preliminary, noncompliance, corrective action, 30 days (no Title XXI passage found).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 457.204: within 30 days after notice of a preliminary finding of significant failure to comply with the approved plan, the State must submit evidence of corrective action taken or planned, or request additional time.

CFR-457-016: Refund FFP for uncashed (>180 days) and voided checks

CITATION: 42 CFR 457.216

TOPIC: Refund FFP for uncashed (>180 days) and voided checks

OBLIGATED LEVEL: agency

CADENCE: RECURRING - End of each calendar quarter, via quarterly expenditure report

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (quarterly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: GAP-DETERMINED. No held NC public document read for this batch addresses refunding the Federal share of uncashed checks outstanding over 180 days or of voided checks under Title XXI. Full-text search of the Title XXI plan (H-013 and H-022) returns no passage on uncashed or voided checks.

RECORD LOCATION: No record location: searched corpus carries no passage for this provision (see searches).

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 457.216 refund procedure: identification of uncashed (over 180 days) and voided checks and refund of the Federal share for the CHIP program.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the CHIP uncashed and voided check refund procedure and the most recent refund amounts claimed on the CMS-21.
>
> **QUESTION:** How are uncashed and voided CHIP checks identified and the Federal share refunded in NC's fiscal operation?

SEARCHES RECORDED: Held corpus text (the held corpus) and cure collection text (the collected document texts) full-text searched for the provision number and subject terms; the full reconciliation map pinpoints reviewed for every document touching Part 457 (H-013, H-022, H-052, H-053, H-098, H-099, H-136, NL-05); no passage carrying the element found. Terms searched included: uncashed, voided, outstanding checks, escheat (0 hits in H-013 and H-022).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 457.216: the State must refund the Federal share of uncashed checks outstanding 180 days or more and of voided checks.

CFR-457-017: State share: funds from units of government must meet conditions

CITATION: 42 CFR 457.220

TOPIC: State share: funds from units of government must meet conditions

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Ongoing condition for claiming FFP

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: The State share conditions are met on the plan face. Section 9.10 states the source of State share funds as Appropriations, and section 8.8.1 carries the finding at 42 CFR 457.220 that no Federal funds will be used toward State matching requirements. No funds from providers, local governments or other non-State sources are named as match anywhere in the budget read, so the 457.220 conditions on funds from units of government are not engaged by any identified source.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 8.8.1 (plan p.133) and section 9.10 budget (plan pp.139-141)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 457.220: funds from units of government used as the State share must be appropriated or transferred public funds meeting the section's conditions, and Federal funds may not be used as match.

CFR-457-018: FFP unavailable for uncollected cost sharing and ineligible individuals

CITATION: 42 CFR 457.224

TOPIC: FFP unavailable for uncollected cost sharing and ineligible individuals

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Ongoing FFP condition

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: One element is closed on the plan face and in operation. Section 8.8.2 carries the 457.224 finding that no cost sharing (premiums, deductibles, copayments, coinsurance and all other types) will be used toward State matching requirements, and the section 9.10 budget shows offsetting beneficiary cost sharing payments of $0; the NCTracks announcement of March 14, 2023 states that once children are enrolled in Medicaid they will no longer be subject to cost sharing. The second 457.224 element, that FFP is not claimed for individuals who are not targeted low-income children or otherwise eligible, is not stated as a claiming control in any held document read.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 8.8.2 (plan p.133) and section 9.10 budget (plan pp.139-141); H-166 NCTracks provider announcement, NC Health Choice Integrating Into NC Medicaid (Mar. 14, 2023)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** A claiming control or assurance that FFP is not claimed for expenditures for individuals ineligible under the Title XXI program.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)

ACTION: State the ineligible-individual claiming exclusion for Title XXI expenditures in the plan or the CMS-21 claiming procedure.

QUESTION: What control prevents Title XXI FFP from being claimed for ineligible individuals, and where is it published?

CFR-457-019: Fiscal policies: accounting system and record retention

CITATION: 42 CFR 457.226

TOPIC: Fiscal policies: accounting system and record retention

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Ongoing; 3-year retention clock per report

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Records duties are assured generally: section 9.4 assures the State will collect all data, maintain records and furnish reports to the Secretary as required, and section 9.6 assures access to records for review or audit; the section 9.10 budget evidences a functioning fiscal reporting structure for the program. Not carried is the 457.226 substance: an accounting system for Title XXI funds meeting Federal requirements and a record retention period stated for program records.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), sections 9.4 and 9.6 (plan p.136), section 9.10 (plan pp.139-141)

SECTION 5D FACE

UNCOVERED ELEMENT: The 457.226 fiscal policy elements: description of the accounting system for Title XXI funds and the record retention standard applied to CHIP program records.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the Title XXI fiscal policies statement covering the accounting system and record retention applied to CHIP funds and records.

QUESTION: Which accounting system and retention schedule govern Title XXI funds and records in NC?

CFR-457-020: Approved cost allocation plan on file

CITATION: 42 CFR 457.228

TOPIC: Approved cost allocation plan on file

OBLIGATED LEVEL: agency

CADENCE: FIXED - Keep on file; update as changed

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: GAP-DETERMINED. No held NC public document read for this batch evidences an approved cost allocation plan on file for the CHIP program. Full-text search of the Title XXI plan and the other Part 457 documents returns no passage on a cost allocation plan.

RECORD LOCATION: No record location: searched corpus carries no passage for this provision (see searches).

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The approved cost allocation plan itself, or any record that one is on file with the Division of Cost Allocation for Title XXI administrative costs.
>
> **OWNER LEVEL:** NCDHHS Secretary
>
> **ACTION:** File or publish the approved cost allocation plan covering Title XXI administrative cost allocation.
>
> **QUESTION:** Is there a current approved cost allocation plan covering CHIP administrative costs, and where is it held?

SEARCHES RECORDED: Held corpus text (the held corpus) and cure collection text (the collected document texts) full-text searched for the provision number and subject terms; the full reconciliation map pinpoints reviewed for every document touching Part 457 (H-013, H-022, H-052, H-053, H-098, H-099, H-136, NL-05); no passage carrying the element found. Terms searched included: cost allocation (0 hits in H-013 and H-022).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 457.228: the State must have an approved cost allocation plan on file with the Division of Cost Allocation.

CFR-457-021: Overpayment adjustments and OIG fraud referrals

CITATION: 42 CFR 457.232

TOPIC: Overpayment adjustments and OIG fraud referrals

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Quarterly adjustment cycle; prompt OIG referrals as allegations arise

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (quarterly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Overpayment handling inside managed care is assured in the plan: section 3.10.4 requires MCOs, PIHPs and PAHPs to report all overpayments promptly, specifying overpayments due to potential fraud, and to refer potential fraud, waste and abuse to the State Medicaid and CHIP program integrity unit or directly to the State Medicaid Fraud Control Unit, with payment suspension on a credible allegation of fraud under 42 CFR 455.23; sections 3.10.5 and 3.10.6 require network providers to return overpayments within 60 days and plans to report recoveries annually. Section 11.2 adopts section 1128E (health care fraud and abuse data collection). Not carried is the State-side 457.232 procedure: adjustment of FFP for provider overpayments and referral of suspected fraud cases to the OIG for the FFS program.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), sections 3.10.4 to 3.10.6 (plan pp.48-50) and section 11.2 (plan pp.141-142)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The State-side 457.232 procedure for FFP adjustment on provider overpayments outside managed care and for referral of suspected provider fraud to the OIG.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the Title XXI overpayment adjustment and OIG fraud referral procedure covering fee for service as well as managed care recoveries.
>
> **QUESTION:** How are CHIP fee for service overpayments adjusted against FFP, and which suspected fraud cases have been referred to the OIG?

CFR-457-022: Assure audit of provider services cost records

CITATION: 42 CFR 457.236

TOPIC: Assure audit of provider services cost records

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Ongoing assurance duty

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (periodic) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Access for audit is assured on the plan face at section 9.6 (the Secretary is given access to any records or information relating to the plan for purposes of review or audit), and section 3.10.3 assures an independent audit, at least once every 3 years, of the accuracy, truthfulness and completeness of encounter and financial data submitted by each MCO, PIHP or PAHP. The 457.236

duty itself, assuring that provider services cost records are audited as the Secretary requires across the program including fee for service, is not stated.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 9.6 (plan p.136) and section 3.10.3 (plan pp.48-49)

SECTION 5D FACE

UNCOVERED ELEMENT: An assurance or record that audits of the cost records of providers of services under the Title XXI program are conducted as the Secretary requires, beyond managed care encounter and financial data audits.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: State the provider cost record audit assurance for the Title XXI program, covering fee for service providers.

QUESTION: Which audit program covers cost records of CHIP fee for service providers, and where is its assurance published?

CFR-457-023: Documentation of payment rates available to HHS

CITATION: 42 CFR 457.238

TOPIC: Documentation of payment rates available to HHS

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Maintain continuously; produce on request

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Payment rate material for the expansion population exists in the plan: the section 9.10 budget states managed care cost of $637,622,769 at a per member per month rate of $195 and fee for service cost of $111,395,594 for FFY 2023, and section 11.1 assures rates are based on public and private rates that are actuarially sound where competition is not used. Not carried is the 457.238 commitment that documentation of payment rates and methods is maintained and made available to HHS on request.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 9.10 (plan pp.139-141) and section 11.1 (plan p.141)

SECTION 5D FACE

UNCOVERED ELEMENT: A statement that documentation of Title XXI payment rates and rate-setting methods is maintained and available to HHS on request.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the rate documentation availability statement for Title XXI payment rates, or the rate documentation itself.

QUESTION: Where is the documentation of CHIP payment rates and methods held for production to HHS?

CFR-457-024: State plan describes eligibility, enrollment, and screening procedures

CITATION: 42 CFR 457.305

TOPIC: State plan describes eligibility, enrollment, and screening procedures

OBLIGATED LEVEL: agency

CADENCE: FIXED - State plan content; amended via 457.60 when changed

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: The substance 457.305 requires is described, but the description is internally split by the conversion. Section 4.0 (Medicaid Expansion) states the operative eligibility groups: children 0 to 1 year above 194% up to 210% FPL, children 1 to 6 years above 141% up to 210% FPL, and children 6 to 19 years above 107% up to 211% FPL (as printed). Section 4.3 describes enrollment methodology, the 45-day processing standard, notices from NC FAST, and retroactive effect to the first day of the application month; section 4.3.1 describes enrollment freeze and waiting list procedures with CMS notice 45 days in advance; section 4.4 describes screening procedures. Against that, section 4.1 still prints the separate program standards (ages 6 through 18, uninsured, enrollment fee) for a program NC no longer operates, so the plan does not present one conformed description of the standards that govern the expansion population.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 4.0 (plan pp.62-63), section 4.1 (plan pp.63-67), section 4.3 (plan pp.69-76), section 4.4 (plan pp.77-79)

SECTION 5D FACE

UNCOVERED ELEMENT: A single conformed 457.305 description distinguishing the operative Medicaid expansion standards from the retained separate program standards at section 4.1.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Conform plan section 4 so the eligibility, enrollment and screening description states the Medicaid expansion standards as operative and removes or retires the separate program standards.

QUESTION: Which section 4 standards does DHB treat as operative for the expansion population where sections 4.0 and 4.1 conflict?

FLAGS: Conflict NC-5

CFR-457-025: Apply MAGI and household methodologies

CITATION: 42 CFR 457.315

TOPIC: Apply MAGI and household methodologies

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Applied at each eligibility determination/renewal

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: MAGI application is stated in the plan: section 4.1.3 states countable household monthly income is determined using the same Modified Adjusted Gross Income guidelines as for Title XIX, family size is determined by the tax household under the MAGI rules, and a 5% income disregard is applied if income exceeds the highest comprehensive Medicaid program limit, with the hierarchy Medicaid first then the CHIP limit; earned and unearned income verification methods are described. The description sits inside the separate program standards at section 4.1, and no passage separates out the MAGI and household methodology as applied to the Medicaid expansion groups at section 4.0, including household composition exceptions.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 4.1.3 (plan pp.63-64)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 457.315 MAGI and household methodology stated for the Medicaid expansion population as such, including any non-MAGI or household composition exceptions applied.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State the MAGI methodology for the expansion groups in the Title XXI plan section 4.0 or a filed eligibility record.
>
> **QUESTION:** Is the section 4.1.3 MAGI description the operative methodology statement for expansion children, or does the Title XIX MAGI record govern alone?

FLAGS: Conflict NC-5

CFR-457-026: Use single streamlined application

CITATION: 42 CFR 457.330

TOPIC: Use single streamlined application

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Ongoing application intake

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: The single application operation is described: applicants for both Medicaid and NC Health Choice complete a joint application online via the Federally Facilitated Marketplace, through NC ePass, by mail, by phone, or in person at a county DSS (sections 4.3 and 5.2); county DSS screens the one application for Medicaid first and then for CHIP (section 3.1 narrative and section 4.4.2); forms are available in English and Spanish with assistance at county DSS and outstations (section 4.3). Not carried are the 457.330 application content and data standards: that the single streamlined application is the CMS model or State alternative approved for all insurance affordability programs, and the information it must collect.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 4.3 (plan pp.69-71), section 4.4.2 (plan p.77), section 5.2 (plan pp.82-83)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 457.330 application standards: identification of the single streamlined application used (model or approved alternative) and the data elements it collects across insurance affordability programs.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Identify the single streamlined application of record for the CHIP program and its approval basis in a filed program record.
>
> **QUESTION:** Which application instrument is the 457.330 single streamlined application for NC, and where is its content published?

CFR-457-027: Application notices, timeliness, coordinated notices, effective-date method

CITATION: 42 CFR 457.340

TOPIC: Application notices, timeliness, coordinated notices, effective-date method

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Per application and renewal

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Several 457.340 elements are described in filled text: all new and renewal applications are processed within 45 calendar days of receipt of the signed application, with receipt-date rules and telephonic signature procedure (section 4.3); NC FAST generates an automated Notice of Eligibility or denial, mailed within one business day of the decision (section 4.3); coverage is retroactively effective the first day of the month of the signed application, with two stated exceptions, which is the plan's effective-date method (section 4.3); disaster relief extensions of redetermination and processing timelines are described citing 42 CFR 457.340. Not carried are the coordinated and combined notice elements of 457.340(e) and (f): notice content coordination with other insurance affordability programs and combined household notices under the 457.348 agreement.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 4.3 (plan pp.69-71)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 457.340(e) and (f) coordinated notice elements: coordinated content and combined eligibility notices across insurance affordability programs.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Describe the coordinated and combined notice practice for CHIP applicants in the plan or the 457.348 agreement record.
>
> **QUESTION:** Do NC FAST notices for this population carry the coordinated content and combined notice features 457.340 requires?

CFR-457-028: 12-month continuous eligibility for children

CITATION: 42 CFR 457.342

TOPIC: 12-month continuous eligibility for children

OBLIGATED LEVEL: agency

CADENCE: RECURRING - 12-month continuous eligibility periods

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **N-A-DETERMINED** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): NA-REASON: BY-ITS-TERMS

BASIS: N-A-DETERMINED under section 3A BY-ITS-TERMS. Section 457.342(a) limits its own reach on its face: a State must provide continuous eligibility for children under a separate CHIP in accordance with 42 CFR 435.926. NC operates no separate CHIP. CMS approved SPAs NC-23-0008 and NC-23-0010 on September 11, 2023, transitioning all children from the separate CHIP to a Medicaid expansion CHIP effective April 1, 2023 (H-013 approval letter), under Session Law 2022-74 directing combination of NC Health Choice with the NC Medicaid benefit plan (H-166).

Continuous eligibility for the expansion children themselves operates under 42 CFR 435.926 through Title XIX (H-013 cites 435.926), which is a different citation from the one this row grades. The plan's descriptions of 12-month continuous coverage (sections 4.1.8, 4.3, 5.2) are written for the former separate program and do not bring this row back into 457.342.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), approval letter (packet pp.1-2); H-166 NCTracks provider announcement, NC Health Choice Integrating Into NC Medicaid (Mar. 14, 2023)

> **SECTION 3A FOOTING.** The closed list reason is NA-REASON: BY-ITS-TERMS. The determiner is NC Cure grading seat E. This determination rests on the basis printed for this entry above. It also rests on the record location printed for this entry above.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 457.342(a): a State must provide continuous eligibility for children under a separate CHIP in accordance with 42 CFR 435.926, subject to the child remaining ineligible for Medicaid.

FLAGS: Conflict NC-5

CFR-457-029: Periodic renewal of CHIP eligibility

CITATION: 42 CFR 457.343

TOPIC: Periodic renewal of CHIP eligibility

OBLIGATED LEVEL: agency

CADENCE: RECURRING - At least every 12 months per 435.916 as cross-referenced

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (at least every 12 months) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Renewal operation is described in pieces: the State mails ex parte renewal applications during the 10th month of continuous enrollment with a cover letter advising beneficiaries to report material changes such as health insurance status, and if nothing has changed the form need not be returned and renewal is automatic for an additional 12 consecutive months (section 5.2); section 4.3(B) describes renewal review within the 12-month continuous enrollment framework; section 4.3.1 gives the 10-day grace period for signed renewal applications during an enrollment freeze. Not carried are the 457.343 renewal mechanics in the regulation's terms: renewal on the basis of available information first, the pre-populated renewal form where information is insufficient, and the renewal notice and response period standards for the CHIP program.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 5.2 (plan pp.82-83), section 4.3(B) (plan pp.71-72), section 4.3.1 (plan p.74)

> **SECTION 5D FACE**

UNCOVERED ELEMENT: The 457.343 renewal procedure stated in the regulation's terms (ex parte renewal from available information, pre-populated form, notice content and response period) for the expansion population.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: State the CHIP renewal procedure in the plan or eligibility record in 457.343 terms for the expansion population.

QUESTION: Does the NC FAST renewal process for these children follow the 457.343 sequence, and where is that published?

CFR-457-030: Prompt redetermination on changes in circumstances

CITATION: 42 CFR 457.344

TOPIC: Prompt redetermination on changes in circumstances

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - As changes are reported or third-party data received

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Change-in-circumstance handling is described in part: under 12-month continuous enrollment an increase in family income has no impact on eligibility and need not be reported, the file is annotated and reviewed at renewal if reported, a decrease in income also does not affect eligibility during the period, and a parent or guardian may request re-evaluation for Medicaid, on approval of which CHIP coverage terminates and Medicaid enrollment is created with no gap in coverage (section 4.3(B)). The disaster relief text at section 4.3 also addresses delaying action on changes in circumstances. Not carried is a general 457.344 procedure: prompt redetermination, without requiring information already available, when the State learns of a change affecting eligibility outside the continuous eligibility context.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 4.3(B) (plan pp.71-72) and section 4.3 disaster relief text (plan p.70)

SECTION 5D FACE

UNCOVERED ELEMENT: A general 457.344 prompt redetermination procedure for reported or discovered changes in circumstances, stated for the CHIP program.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: State the change-in-circumstance redetermination procedure for the Title XXI program in the plan or a filed eligibility record.

QUESTION: What procedure governs mid-period redeterminations for expansion children when a disqualifying change is reported?

CFR-457-031: Accept eligibility determinations/accounts from other insurance affordability programs

CITATION: 42 CFR 457.348

TOPIC: Accept eligibility determinations/accounts from other insurance affordability programs

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Per transferred account

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Coordination substance exists inside one administration: the same joint application is screened for Medicaid first and then CHIP by county DSS in NC FAST (sections 4.4.2, 5.2), applications also arrive through the Federally Facilitated Marketplace (section 4.3), and a child found Medicaid eligible is enrolled in Medicaid while a child ineligible for Medicaid within 211% FPL is enrolled in the CHIP program (sections 4.4.2 and 4.4.3). Not carried are the 457.348 formal elements: the agreement between the CHIP agency and other insurance affordability program agencies, acceptance of eligibility determinations made by other programs, and transfer of electronic accounts via secure interface in the regulation's terms.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), sections 4.3 (plan pp.69-71), 4.4.2 and 4.4.3 (plan pp.77-78), 5.2 (plan pp.82-83)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 457.348(a) interagency agreement and the electronic account transfer and determination-acceptance standards between insurance affordability programs.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File the 457.348 coordination agreement, or describe the account transfer arrangement, for the Title XXI program.
>
> **QUESTION:** Does a written 457.348 agreement exist for NC, and does it cover the Medicaid expansion CHIP?

CFR-457-032: Screening and enrollment coordination (crowd-out prevention)

CITATION: 42 CFR 457.350

TOPIC: Screening and enrollment coordination (crowd-out prevention)

OBLIGATED LEVEL: agency

CADENCE: RECURRING - At every application, renewal, and redetermination

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Section 4.4 carries each element of the 457.350 screen and enroll description. Section 4.4.1: only targeted low-income children ineligible for Medicaid or not covered under a group health plan or health insurance are furnished child health assistance, citing N.C.G.S. 108A-70.21(a)(1) and defining uninsured. Section 4.4.2: county caseworkers initially screen all applications for Medicaid eligibility, with NC FAST database search for existing Title XIX or Title XXI enrollment or other creditable insurance, and Medicaid enrollment occurs where the child meets Medicaid requirements. Section 4.4.3: children ineligible for Medicaid at or below 211% FPL are enrolled in the CHIP program. Section 4.4.4: the insurance provided does not substitute for group health plan coverage. Section 5.2 confirms the operative sequence: applicants are screened first for Title XIX eligibility and then for Title XXI eligibility on the joint application. The screening function described is the same function the converted program runs, because expansion children are identified through this Medicaid-first screen.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 4.4 (plan pp.77-79) and section 5.2 (plan pp.82-83)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 457.350: the plan must describe screening procedures ensuring only Medicaid-ineligible, uninsured targeted low-income children are enrolled, that children found eligible for Medicaid are enrolled in Medicaid, and that CHIP coverage does not substitute for group health coverage.

CFR-457-033: Coordination with appeals entities across insurance affordability programs

CITATION: 42 CFR 457.351

TOPIC: Coordination with appeals entities across insurance affordability programs

OBLIGATED LEVEL: agency

CADENCE: RECURRING - As cross-program appeals arise

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Review channels exist on both sides of the house: plan section 12 describes the CHIP review process for eligibility and enrollment matters and for health services matters, and section 12.2 states that members enrolled in a managed care PHP have the plan grievance and appeal system with access to a State fair hearing under 42 CFR Part 438 Subpart F. Not carried is the 457.351 coordination element itself: an arrangement coordinating appeals processes and notices with the Medicaid agency, the Exchange and other insurance affordability program appeals entities, stated for the CHIP program.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 12 (plan pp.142-146)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** Coordination of the CHIP appeals process with other insurance affordability program appeals entities under 457.351, including the coordination agreement terms.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Describe the appeals coordination arrangement for the Title XXI program, or file the coordination terms in the 457.348 agreement record.
>
> **QUESTION:** How are appeals for this population coordinated between the CHIP review process, Medicaid fair hearings and the Exchange?

CFR-457-034: Monitor and evaluate the screening process

CITATION: 42 CFR 457.353

TOPIC: Monitor and evaluate the screening process

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Ongoing monitoring mechanism

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (periodic) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Monitoring infrastructure is described generally: section 9.3 sets performance measurement for the program including the increase in Medicaid-eligible children enrolled, the reduction in uninsured children measured with Census and NC FAST data, and HEDIS measures; section 4.4 describes the screening process being monitored. Not carried is a 457.353 mechanism: monitoring and evaluation of the screening process itself, such as review of screening outcomes, error rates or enrollment accuracy for the screen and enroll function.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 9.3 (plan pp.134-136) and section 4.4 (plan pp.77-79)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** A described method for monitoring and evaluating the 457.350 screening process and acting on its results.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Describe the screening process monitoring method (measures, review cycle, corrective use) in the plan or a quality record.
>
> **QUESTION:** How does DHB monitor whether the Medicaid-first screen assigns children to the correct program?

CFR-457-035: Deemed newborn coverage to first birthday

CITATION: 42 CFR 457.360

TOPIC: Deemed newborn coverage to first birthday

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - At each qualifying birth

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: The predicate structure of 457.360 is only partly NC's. The plan covers pregnant children inside the eligibility text: section 4.1.8 continues eligibility through pregnancy and the 12-month postpartum period for individuals who, while pregnant, were eligible and received services under the State child health plan, consistent with section 1902(e)(5) and (16). NC does not cover targeted low-income pregnant women as a CHIP group in the plan read, and no passage describes deemed eligibility for a newborn of a CHIP-covered mother to the first birthday. For the expansion population, deemed newborn coverage operates through the Medicaid plan, which is outside the Part 457 evidence set for this batch.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 4.1.8 (plan p.64)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** A description of deemed newborn coverage to the first birthday for children born to mothers covered under the Title XXI program, or a statement of where that coverage sits after the conversion.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State where deemed newborn coverage for this population is documented (Title XIX plan or Title XXI plan) in the register record.

QUESTION: Under which plan document does a newborn of an expansion CHIP mother receive deemed coverage to age 1 in NC?

CFR-457-036: Eligibility verification and verification plan

CITATION: 42 CFR 457.380

TOPIC: Eligibility verification and verification plan

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Per determination; verification plan kept current and produced on request

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Verification practice is described in several places: citizenship is verified by a daily automated match of Social Security numbers against SSA on joint applications, with 24 to 48 hour response (section 4.1.0); citizenship and identity status is validated through automated queries between the Bendex database and the county DSS or tribal office (section 4.4.2); earned income is verified by pay stubs, checks, business records or other written proof for the month prior to application, self-employment on a 12-month base period, using the same guidelines as Title XIX (section 4.1.3); residency is verified under N.C.G.S. 108A-55.3 (section 4.1.5). Not carried is the 457.380 verification plan itself: a written plan describing the standards and procedures for verification of eligibility consistent with 435.940 through 435.965 as applied to the CHIP program.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), sections 4.1.0 (plan p.63), 4.1.3 (plan pp.63-64), 4.1.5 (plan p.64), 4.4.2 (plan p.77)

SECTION 5D FACE

UNCOVERED ELEMENT: The 457.380 verification plan document, or a plan description adopting the 435.940 to 435.965 verification standards for the CHIP program.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: File the CHIP verification plan or add a plan description adopting the Medicaid verification framework for Title XXI determinations.

QUESTION: Does a written verification plan covering CHIP determinations exist, and where is it held?

CFR-457-037: State plan describes delivery methods and utilization control

CITATION: 42 CFR 457.490

TOPIC: State plan describes delivery methods and utilization control

OBLIGATED LEVEL: agency

CADENCE: FIXED - State plan content

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: A delivery and utilization description exists in the Title XXI plan: section 3.1 describes the delivery system, and the filled narrative at sections 3.1.1 and following describes screening by county DSS on one streamlined application, claims processing consolidated under General Dynamics Information Technology (GDIT) since July 1, 2013 for both Medicaid and Health Choice, assignment of beneficiaries to a primary care medical home in Medicaid and managed care, nightly transmission of beneficiary records to the claims processor, ID cards with coverage dates and prior authorization contacts, and eligibility verification by web or phone. The description is written for the pre-conversion Health Choice delivery arrangement; the operative delivery of the expansion population through Medicaid Prepaid Health Plans under Title XIX contracts is not described in the Title XXI plan as the 457.490 description for the current structure.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 3.1 and following narrative (plan pp.16-18)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** A 457.490 delivery methods and utilization control description conformed to the Medicaid expansion structure, covering delivery through the Medicaid managed care contracts under which expansion children are now served.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Conform plan section 3 to describe delivery and utilization control for the expansion population through the Medicaid PHP contracts.
>
> **QUESTION:** Will DHB update the Title XXI plan section 3 delivery description to the managed care structure that now serves these children?

FLAGS: Conflict NC-5

CFR-457-038: Access and quality assurances; prior-auth decision timeframes

CITATION: 42 CFR 457.495

TOPIC: Access and quality assurances; prior-auth decision timeframes

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Ongoing access/quality duty; per-request PA deadlines

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Section 7 carries the 457.495 description with State-specific content at each paragraph. Section 7.1 and 7.2.1 (457.495(a)): quality methods including the Commission for Children with Special Needs standards, CHIPRA Core Set performance measurement, claims and immunization registry monitoring of well-child care and immunizations. Section 7.2.2 (457.495(b)): NC monitors utilization of child services including primary care, emergency department and inpatient visits, and immunizations. Section 7.2.3 (457.495(c)): DHB has network adequacy requirements for all specialty services in managed care Prepaid Health Plans, NC Medicaid performs an annual access study of network adequacy and key utilization measures, and focused studies are conducted on high cost or high incidence conditions. Section 7.2.4 (457.495(d)): prior authorization decisions are made in accordance with the medical needs of the patient within 5 days after receipt of a request for medical services and within 24 hours after receipt of a request for pharmacy services, with compliance verified through spot checking, provider feedback and claims processing contractor reports.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), sections 7.1 to 7.2 (plan pp.122-124)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 457.495: the plan must describe methods to assure quality and appropriateness of care, access to covered services including emergency services, procedures for enrollees with chronic, complex or serious conditions, and prior authorization decision timeframes.

CFR-457-039: Mental health and substance use disorder parity

CITATION: 42 CFR 457.496

TOPIC: Mental health and substance use disorder parity

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous benefit-design and compliance duty

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: A parity analysis for the Health Choice program is carried in the plan: section 6.2 MHPAEA text works through quantitative treatment limits and non-quantitative treatment limits by classification, and section 8.4 MHPAEA text states there is no separate accumulation of cumulative

financial requirements for mental health and substance use disorder benefits, that copayments are applied by type of service and family income rather than condition type, and that cost sharing remains capped at 5 percent of income per 457.560, with the financial requirements analysis at Attachment B. The scope limit comes from CMS's own parity page (H-136): the detailed parity requirements sit at 42 CFR 457.496 for separate CHIPs, while Medicaid managed care parity sits at Part 438 Subpart K. After the conversion these children are in Medicaid managed care, and no held document in the Part 457 evidence set carries the parity documentation for the expansion population under the operative framework.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 6.2 MHPAEA (plan pp.108-113) and section 8.4 MHPAEA (plan pp.128-130); H-136 CMS Medicaid and CHIP parity page (browser read, 2026-10-27)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** Parity compliance documentation for the Medicaid expansion CHIP population under the operative Medicaid managed care parity framework (42 CFR Part 438 Subpart K).
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File the parity analysis covering expansion CHIP children in Medicaid managed care, or cross-reference it in the Title XXI record.
>
> **QUESTION:** Where is the current MHPAEA parity analysis for the plans serving expansion CHIP children?

CFR-457-040: State plan cost-sharing description and compliance methods

CITATION: 42 CFR 457.505

TOPIC: State plan cost-sharing description and compliance methods

OBLIGATED LEVEL: agency

CADENCE: FIXED - State plan content

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Section 8 is the plan's cost sharing description, and it describes the former program: section 8.2 sets copayments by income band under N.C.G.S. 108A-70.21(d) and (e), section 8.2.4 adds a $50 annual enrollment fee per child ($100 family maximum), and the section 8 header prints the unexercised-looking election line for States using Title XXI funds only for Medicaid expansion. The operative record contradicts the schedule: CMS approved conversion to a Medicaid expansion CHIP effective April 1, 2023 (H-013 approval letter), and the NCTracks announcement of March 14, 2023 states that once children in NC Health Choice are enrolled in Medicaid they will no longer be subject to cost sharing; the section 9.10 budget confirms offsetting beneficiary cost sharing

payments of $0. No conformed section 8 description states the cost sharing position of the expansion program, which is the description 457.505 requires.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 8 (plan pp.124-133) and section 9.10 (plan pp.139-141); H-166 NCTracks provider announcement, NC Health Choice Integrating Into NC Medicaid (Mar. 14, 2023)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** A conformed 457.505 cost sharing description for the Medicaid expansion CHIP stating that no cost sharing is imposed, replacing the retained separate program schedule at section 8.2.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Submit a conforming plan amendment restating section 8 for the expansion program (no cost sharing imposed).
>
> **QUESTION:** Will DHB conform section 8 of the Title XXI plan so the cost sharing description matches the program CMS approved in 2023?

FLAGS: Conflict NC-5

CFR-457-041: State plan describes any premiums or cost-sharing charges

CITATION: 42 CFR 457.510; 457.515

TOPIC: State plan describes any premiums or cost-sharing charges

OBLIGATED LEVEL: agency

CADENCE: FIXED - State plan content; updated when charges change

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: The charges description exists only for the former program: section 8.2.1 to 8.2.3 and 8.2.4 describe premiums (none stated), deductibles (none stated), copayments in two income bands above 133% FPL set by N.C.G.S. 108A-70.21(d) and (e) with provider collection net of copayment, and the $50 annual enrollment fee; disaster and AI/AN waivers of the fee are described. Operatively no premiums or enrollment charges are imposed on the expansion population: children moved to Medicaid are no longer subject to cost sharing (H-166), and the FFY 2023 budget shows cost sharing offsets of $0. The 457.510 and 457.515 description for the current program, including the statement that no premiums are imposed and the protections that would apply if any charge were imposed, is not carried in conformed form.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), sections 8.2 to 8.2.4 (plan pp.125-127); H-166 NCTracks provider announcement, NC Health Choice Integrating Into NC Medicaid (Mar. 14, 2023)

SECTION 5D FACE

UNCOVERED ELEMENT: A conformed description of premiums and enrollment charges for the expansion program (none imposed), with the 457.515 protections stated for the current structure.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Restate the premiums and charges description in the conformed section 8 amendment for the expansion program.

QUESTION: Does any enrollment charge of any kind still attach to expansion CHIP children anywhere in NC practice?

FLAGS: Conflict NC-5

CFR-457-042: No cost sharing for well-baby/well-child services

CITATION: 42 CFR 457.520

TOPIC: No cost sharing for well-baby/well-child services

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous prohibition

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Section 457.520 is a prohibition, and the held record establishes it is not breached under either reading of the plan. On the plan face, section 8.4.2 carries the finding that no cost sharing applies to well-baby and well-child care including age-appropriate immunizations, and section 8.2 states that pursuant to 42 CFR 457.505(d)(1) all beneficiaries receive well-child visits and age-appropriate immunizations at no cost to their families; section 7.2.1 confirms these benefits are excluded from the cost sharing component of enrollment. Operatively the position is stronger: since April 1, 2023 the children are in Medicaid and no longer subject to cost sharing at all (H-166).

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 8.4.2 (plan p.128), section 8.2 (plan pp.126-127), section 7.2.1 (plan pp.123-124); H-166 NCTracks provider announcement, NC Health Choice Integrating Into NC Medicaid (Mar. 14, 2023)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 457.520: a State may not impose cost sharing on well-baby and well-child care services, including age-appropriate immunizations, in managed care or fee for service.

CFR-457-043: Public schedule of cost sharing

CITATION: 42 CFR 457.525

TOPIC: Public schedule of cost sharing

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Issued at enrollment/reenrollment/application and on any revision

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: A public schedule practice is described for the former program: the second section 8.1 passage (plan p.127) states beneficiary cost sharing charges are prominently posted in the beneficiary handbook, on membership ID cards and on the Health Choice program web pages, that charges are legislated through the NC General Assembly at N.C.G.S. 108A-70.21(d) and (e), and that on a cost sharing change DHB mails letters to each beneficiary head of household at least 15 calendar days in advance with a new ID card. Because no cost sharing is imposed on the expansion population (H-166; budget offset $0), there are no current charges for a 457.525 schedule to publish, and no held document states the current public position (no charges) as the program's public schedule.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 8 public notice passage (plan p.127); H-166 NCTracks provider announcement, NC Health Choice Integrating Into NC Medicaid (Mar. 14, 2023)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** A current public schedule or public statement of cost sharing for the expansion CHIP showing the charges in effect (none), the groups subject, and the cumulative maximum position.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the current cost sharing position for expansion CHIP children (no charges imposed) on the program web pages and handbook.
>
> **QUESTION:** Where can a family verify today, from a public DHB page, that expansion CHIP children owe no cost sharing?

FLAGS: Conflict NC-5

CFR-457-044: Cost-sharing limits for children at or below 150% FPL

CITATION: 42 CFR 457.540; 457.555

TOPIC: Cost-sharing limits for children at or below 150% FPL

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous caps; amounts updated each October 1 by CPI-U medical care

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (monthly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: The evidence conflicts on the face for children at or below 150% FPL. The retained section 8.2 schedule imposes copayment requirements on families with income above 133% up to and including 159% FPL, a band that includes children at or below 150% FPL, without stating the Medicaid cost sharing ceilings of 457.540 or the 457.555 maximums for that band. The operative record points the other way: since April 1, 2023 these children are in Medicaid with no cost sharing (H-166), so no charge can exceed the ceilings in practice. Because the approved plan text and the operative record contradict each other for exactly this income band, the row is graded on the ambiguity rather than inflated to Verified.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 8.2 (plan pp.125-126); H-166 NCTracks provider announcement, NC Health Choice Integrating Into NC Medicaid (Mar. 14, 2023)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** A conformed statement of cost sharing limits for children at or below 150% FPL in the expansion program, resolving the retained 133% to 159% FPL copayment band at section 8.2.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Resolve the section 8.2 income band conflict in the conformed section 8 amendment, stating the limits applicable at or below 150% FPL.
>
> **QUESTION:** Are any copayments in fact collected from expansion children in the 133% to 150% FPL band under any surviving Health Choice authority?

FLAGS: Conflict NC-5

CFR-457-045: 5% cumulative cost-sharing maximum per family

CITATION: 42 CFR 457.560

TOPIC: 5% cumulative cost-sharing maximum per family

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Tracked per family per eligibility period; notice at enrollment/ reenrollment

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Both the cap and the ensuring procedure are on the plan face. Section 8.2 states NC law (N.C.G.S. 108A-70.21(e)) restricts total annual aggregate cost sharing to 5% of family income, and section 8.5 describes how the State ensures the cap without primarily relying on refunds: the eligibility database holds family countable net income, the claims processing contractor computes the annual maximum (monthly income times 12 times 5 percent, with a worked $30,000 to $1,500 example), cost sharing including the enrollment fee accumulates for all enrolled children in a family in a combined tracking tool under the case head, the claims processor generates a monthly monitoring report, and when the ceiling is reached the family is notified, copayments are suspended for the rest of the period, and a new ID card showing $0 copayment is issued, with an annual grouped report as a further checkpoint. Operatively, aggregate cost sharing for the expansion population is $0 (H-166; budget offset $0 at section 9.10), so the cap cannot be exceeded in the current structure either.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 8.5 (plan p.131), section 8.2 (plan pp.126-127), section 9.10 (plan pp.139-141); H-166 NCTracks provider announcement, NC Health Choice Integrating Into NC Medicaid (Mar. 14, 2023)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 457.560: aggregate cost sharing for a family may not exceed 5 percent of family income for the length of the child's eligibility period, and the plan must describe procedures ensuring the cap that do not primarily rely on refunds.

FLAGS: Conflict NC-5

CFR-457-046: Disenrollment protections for nonpayment

CITATION: 42 CFR 457.570

TOPIC: Disenrollment protections for nonpayment

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Per disenrollment action

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **N-A-DETERMINED** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): NA-REASON: STRUCTURAL

BASIS: N-A-DETERMINED under section 3A STRUCTURAL. Section 457.570's protections govern disenrollment for nonpayment of premiums or cost sharing charges: they operate only where a charge exists whose nonpayment can trigger disenrollment. That structure no longer exists in NC. CMS approved the transition of all children from the separate CHIP to a Medicaid expansion CHIP effective April 1, 2023 (H-013 approval letter, SPAs NC-23-0008 and NC-23-0010), under Session Law 2022-74 (H-166), and the NCTracks announcement states the moved children will no longer be subject to cost sharing; the FFY 2023 budget shows cost sharing offsets of $0. Medicaid expansion enrollees are not disenrolled for nonpayment of CHIP charges because there are no CHIP charges.

The fee-based denial and termination text retained at plan sections 8.7 and 8.7.1 describes the former separate program and was not conformed; it is flagged, and the determination rests on the approved conversion record, not on that retained text.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), approval letter (packet pp.1-2) and section 9.10 budget (plan pp.139-141); H-166 NCTracks provider announcement, NC Health Choice Integrating Into NC Medicaid (Mar. 14, 2023); retained contrary text at H-013 sections 8.7 and 8.7.1 (plan pp.132-133)

> **SECTION 3A FOOTING.** The closed list reason is NA-REASON: STRUCTURAL. The determiner is NC Cure grading seat E. This determination rests on the basis printed for this entry above. It also rests on the record location printed for this entry above.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 457.570: before disenrolling an enrollee for nonpayment of premiums or cost sharing, the State must give reasonable notice and an opportunity to pay, an opportunity to show family income has declined with facilitation into Medicaid or a lower cost sharing category, and an opportunity for impartial review.

FLAGS: Conflict NC-5

CFR-457-047: Conditions for allotment and Federal payment

CITATION: 42 CFR 457.606

TOPIC: Conditions for allotment and Federal payment

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Per fiscal year allotment/payment cycle

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: The allotment predicate is evidenced: an approved Title XXI plan exists and is held (original plan effective October 1, 1998 at section 1.4; consolidated plan as amended by NC-23-0008 and NC-23-0010 approved September 11, 2023), and the plan's own budget at section 9.10 is built on the allotment structure with Federal share of $616,955,953 computed. Not carried are the 457.606 payment conditions as State-side records: the terms on which allotments are paid, redistribution or reallotment treatment, and the payment conditions applied to NC's allotment.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), approval letter (packet pp.1-2), section 1.4 (plan pp.7-8), section 9.10 (plan pp.139-141)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** State-side records of the 457.606 conditions for allotment and Federal payment as applied to NC (payment terms, reallotment treatment).

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: File the allotment and payment conditions record for the Title XXI program with the register evidence.

QUESTION: Where are NC's Title XXI allotment notices and payment conditions held?

CFR-457-048: 10% limit on non-primary (admin/outreach/initiatives) expenditures

CITATION: 42 CFR 457.618

TOPIC: 10% limit on non-primary (admin/outreach/initiatives) expenditures

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Computed annually from FY quarterly reports

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually, quarterly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: The 10 percent limit is computed on the plan's own current budget. Section 9.10 (FFY 2023) prints total administration costs of $13,762,156 (personnel $4,935,944, general administration $8,010,963, claims processing $325,710, health services initiatives $489,539) against a printed 10% Administrative Cap of $83,224,263 and total plan costs of $762,780,519; administration is therefore well inside the 457.618 ceiling on the face of the approved budget, and the health services initiative spending counted toward the limit is separately described at section 2.2 (Reach Out and Read, $3,013,000 projected over three years).

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 9.10 budget (plan pp.139-141) and section 2.2 (plan pp.12-15)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 457.618: expenditures for administration, outreach, health services initiatives and other non-benefit purposes under Title XXI may not exceed 10 percent of total expenditures.

CFR-457-049: Enhanced FMAP rate and conditions

CITATION: 42 CFR 457.622

TOPIC: Enhanced FMAP rate and conditions

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Applied per FY payment cycle

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: The enhanced FMAP is applied on the plan face: the section 9.10 FFY 2023 budget applies an enhanced FMAP rate of 80.88% and computes the Federal share of $616,955,953 against total costs of $762,780,519, and section 8.8.4 carries the 457.622(b)(5) finding that income and resource standards for Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. Not separately evidenced are the remaining 457.622 conditions on the enhanced rate as State-side findings, including the maintenance of effort and coverage conditions beyond (b)(5).

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 9.10 (plan pp.139-141) and section 8.8.4 (plan p.133)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The full set of 457.622 enhanced FMAP conditions evidenced as State findings, beyond the rate application in the budget and the (b)(5) finding at section 8.8.4.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File the enhanced FMAP conditions record for the Title XXI program, or state the remaining conditions in a plan amendment.
>
> **QUESTION:** Where are the 457.622 conditions, other than (b)(5), documented for NC's enhanced rate?

CFR-457-050: Prevention of duplicate payments (third-party liability)

CITATION: 42 CFR 457.626

TOPIC: Prevention of duplicate payments (third-party liability)

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Per claim/payment

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Element (a)(1) is stated verbatim in the plan: section 8.8.3 finds that no funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting the obligation because the child is eligible under this title (42 CFR 457.626(a)(1)). The uninsured screen at section 4.4.1 reinforces it. Not carried are the remaining

third party liability elements of 457.626: identification of liable third parties and pursuit of reimbursement for CHIP expenditures as a program procedure.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 8.8.3 (plan p.133) and section 4.4.1 (plan p.77)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** Third party liability identification and pursuit procedures for Title XXI expenditures beyond the 457.626(a)(1) finding.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Describe the CHIP third party liability identification and recovery procedure in the plan or a filed program record.
>
> **QUESTION:** How are liable third parties identified and pursued for expansion CHIP expenditures?

CFR-457-051: Quarterly grant awards and budget requests

CITATION: 42 CFR 457.630

TOPIC: Quarterly grant awards and budget requests

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Quarterly budget requests

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (quarterly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: The State-side budget instrument exists in the plan at section 9.10 (the one-year projected budget in the CHIP template format with Federal and State shares computed), and CMS approval of the plan and the 2023 SPAs is evidenced. Not carried are the 457.630 quarterly mechanics: quarterly grant awards, the quarterly budget request submissions (CMS-21B or successor), and the quarterly expenditure reconciliation for the Title XXI program. Full-text search of the plan returns no quarterly grant or CMS-21 passage.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 9.10 (plan pp.139-141)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** Quarterly grant award and budget request records for the Title XXI program under 457.630.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File the most recent quarterly Title XXI budget request and grant award notices with the register evidence.

> **QUESTION:** Where are NC's quarterly CHIP grant awards and budget requests published or held?

SEARCHES RECORDED: Held corpus text and cure collection text searched for: quarterly expenditure, CMS-21, grant award, budget request (0 hits in H-013 and H-022).

CFR-457-052: Strategic objectives and performance goals in state plan

CITATION: 42 CFR 457.710

TOPIC: Strategic objectives and performance goals in state plan

OBLIGATED LEVEL: agency

CADENCE: FIXED - State plan content; reported on in annual report (457.750)

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Section 9 carries the complete 457.710 set. Section 9.1 states two strategic objectives (reduce the overall number of uninsured children in families below 200% FPL; identify and decrease disparities by race and ethnicity in applications relative to uninsured children). Section 9.2 specifies performance goals for each objective (increase eligible applicants accepted into NC Medicaid by 3%; use Census and other data to identify uninsured children below 200% FPL by race and ethnicity and by county; supplemental outreach to the top 2 races with identified disparity). Section 9.3 describes measurement through objective, independently verifiable means at 9.3.1 to 9.3.8 (enrollment increase, uninsured reduction using Census and NC FAST data, usual source of care, outcome measures, HEDIS measures including the nine CMS-adopted measures listed, immunizations, well childcare, adolescent well visits, satisfaction, mental health and dental care). Section 9.7 (printed at plan p.137) assures performance measures will be modified to meet national requirements when developed.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), sections 9.1 to 9.3 (plan pp.134-136) and section 9.7 (plan p.137)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 457.710: the plan must specify strategic objectives, performance goals for each objective, and how performance will be measured through objective, independently verifiable means and compared against the goals.

CFR-457-053: Data collection, records, and reporting assurance

CITATION: 42 CFR 457.720

TOPIC: Data collection, records, and reporting assurance

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Per Secretary-specified reporting schedules

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: The 457.720 assurances are stated on the plan face: section 9.4 assures the State will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires, and section 9.6 assures the State will provide the Secretary with access to any records or information relating to the plan for purposes of review or audit. Both paragraphs cite section 2107(b) and 42 CFR 457.720 in the plan's own text.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), sections 9.4 and 9.6 (plan p.136)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 457.720: the State must assure it will collect data, maintain records and furnish reports to the Secretary as required, and provide access to records for review or audit.

CFR-457-054: Patient Access API for CHIP beneficiaries

CITATION: 42 CFR 457.730

TOPIC: Patient Access API for CHIP beneficiaries

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous operation since 2021-01-01

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Systems — NCTracks (GDIT, fiscal agent) under the Division of Health Benefits

HOME BASIS: NCTracks is NC's multi-payer MMIS, operated by GDIT as the State's fiscal-agent contractor under DHB (Lane A §1.4, §4). Title-level derivation: the obligation is a systems obligation on its face.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: GAP-DETERMINED. No held NC public document read for this batch evidences a Patient Access API for CHIP beneficiaries under 457.730: no standards-based API permitting third-party applications to retrieve adjudicated claims, encounter, clinical and drug data for current CHIP beneficiaries is described in the Title XXI plan, the Tailored Plan contracts (H-052, H-053, which touch Part 457 only at 457.1203), the NCAC chapter (H-099), or any other Part 457 document in the evidence set. The duty has been in force since 2021, so this is a gap, not a prospective item.

RECORD LOCATION: No record location: searched corpus carries no passage for this provision (see searches).

SECTION 5D FACE

UNCOVERED ELEMENT: The whole 457.730 Patient Access API for the CHIP program: implementation, accessible content classes, and technical requirements.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the CHIP Patient Access API documentation (endpoint, developer resources, accessible content) or state how the Medicaid API of record covers Title XXI beneficiaries.

QUESTION: Does an API meeting 457.730 exist for NC CHIP beneficiaries, and where is it documented?

SEARCHES RECORDED: Held corpus text (the held corpus) and cure collection text (the collected document texts) full-text searched for the provision number and subject terms; the full reconciliation map pinpoints reviewed for every document touching Part 457 (H-013, H-022, H-052, H-053, H-098, H-099, H-136, NL-05); no passage carrying the element found. Terms searched included: Patient Access, interoperability, API (0 hits in H-013).

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 457.730: a State must implement and maintain a standards-based API permitting third-party applications, at the beneficiary's direction, to retrieve adjudicated claims, encounter data, clinical data and covered outpatient drug information for current CHIP beneficiaries.

CFR-457-055: Provider Access API, payer-to-payer exchange, privacy resources

CITATION: 42 CFR 457.731

TOPIC: Provider Access API, payer-to-payer exchange, privacy resources

OBLIGATED LEVEL: agency

CADENCE: RECURRING - API live by 2027-01-01; metrics reporting from 2026; resources continuously available

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Systems — NCTracks (GDIT, fiscal agent) under the Division of Health Benefits

HOME BASIS: NCTracks is NC's multi-payer MMIS, operated by GDIT as the State's fiscal-agent contractor under DHB (Lane A §1.4, §4). Title-level derivation: the obligation is a systems obligation on its face.

CURE DETERMINATION: **Prospective** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies from January 1, 2027 (42 CFR 457.731(a))

FEDERAL APPLICABILITY DATE(S): Applies from January 1, 2027 (42 CFR 457.731(a)) Register future date(s): 2027-01-01.

BASIS: Prospective. Section 457.731(a) by its terms begins January 1, 2027: from that date a State must implement and maintain a Provider Access API, a payer-to-payer data exchange, and related attribution, opt-out and privacy educational resource requirements, unless granted an extension or exemption. That date is after the evidence window of this cure (October 2026), so the provision is not yet in force for the window and no NC implementation evidence is required or held. No extension or exemption for NC was found in the evidence set, which is noted rather than treated as compliance.

RECORD LOCATION: 42 CFR 457.731(a) (federal applicability date carried on the face of this row); no NC record location in the held corpus

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 457.731: beginning January 1, 2027, a State must provide a Provider Access API, payer-to-payer exchange of specified data, an attribution process, a beneficiary opt-out process and privacy educational resources.

FLAGS: Effective January 1, 2027 per 42 CFR 457.731(a); no NC extension or exemption found in the evidence set

CFR-457-056: Quarterly expenditure/statistical reports and annual unduplicated count

CITATION: 42 CFR 457.740

TOPIC: Quarterly expenditure/statistical reports and annual unduplicated count

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - Quarterly within 30 days of quarter end; unduplicated annual count within 30 days of FY end

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (quarterly) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Reporting assurances and data infrastructure are on the plan face: section 9.4 assures data collection, record maintenance and furnishing reports to the Secretary in the required standardized format; section 9.3 names data sources including NC FAST and claims data; section 9.5 describes production of the annual CHIP report (CARTS). Not carried are the 457.740 submissions themselves: the quarterly expenditure and statistical reports and the annual unduplicated count of children served, in any held public record for the Title XXI program.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), sections 9.3 to 9.5 (plan pp.134-137)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The quarterly expenditure and statistical reports and the annual unduplicated count of children served required by 457.740, as submitted records.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** File the most recent quarterly CHIP statistical report and the annual unduplicated count with the register evidence.
>
> **QUESTION:** Where are NC's quarterly CHIP statistical submissions and annual unduplicated counts held?

CFR-457-057: Annual report to CMS (due January 1)

CITATION: 42 CFR 457.750

TOPIC: Annual report to CMS (due January 1)

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - Annual; due January 1 after each Federal FY

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: The annual report duty is both assured and operationally described. Section 10.1 assures the State will assess the operation of the State plan under this Title in each fiscal year, including at 10.1.1 the progress made in reducing the number of uninsured low-income children, and report to the Secretary by January 1 following the end of the fiscal year, citing section 2108(a) and 42 CFR 457.750. Section 9.5 describes how the report is produced: on receipt of the annual CARTS template from CMS, DHB sends template sections to agency IT staff and contractors, gathers and populates the data, circulates the draft to all data contributors for review and edits, and after Division Director approval submits the final report to CMS. Section 9.3.2 supplies the uninsured-reduction measure (Census and NC FAST data).

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 10.1 (plan p.141) and section 9.5 (plan pp.136-137)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 457.750: the State must assess the operation of the plan each fiscal year, including progress in reducing the number of uninsured low-income children, and report to the Secretary by January 1 following the fiscal year.

CFR-457-058: Public provider directory API

CITATION: 42 CFR 457.760

TOPIC: Public provider directory API

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous operation; directory updates within 30 calendar days

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Systems — NCTracks (GDIT, fiscal agent) under the Division of Health Benefits

HOME BASIS: NCTracks is NC's multi-payer MMIS, operated by GDIT as the State's fiscal-agent contractor under DHB (Lane A §1.4, §4). Title-level derivation: the obligation is a systems obligation on its face.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Plan-level directory duties are described inside the managed care text: section 3.5 assures enrollee information including electronic provider directories as specified in 42 CFR 438.10(h)(3), cross-referenced by 457.1207, for MCOs, PIHPs, PAHPs and PCCM entities. The 457.760 duty is the State's own: a publicly accessible provider directory API maintained by the State for the CHIP program. No held document evidences a State-maintained CHIP provider directory API, its content classes, or its update frequency.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 3.5 (plan pp.29-44, directory assurances citing 42 CFR 438.10(h)(3) via 457.1207)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The State-maintained public provider directory API required by 457.760 for the CHIP program.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the CHIP provider directory API documentation or state how the Medicaid provider directory API of record covers Title XXI providers.
>
> **QUESTION:** Does a State provider directory API meeting 457.760 exist for NC, and where is it documented?

CFR-457-059: Child Core Set quality measure reporting

CITATION: 42 CFR 457.770

TOPIC: Child Core Set quality measure reporting

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Annual per part 437 reporting cycle

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Child quality measurement is embedded in the plan: section 7.1.2(a) lists the CHIPRA Quality Core Set measures the NC Health Choice Program will monitor (childhood immunizations, adolescent immunization status, weight assessment and counseling, developmental screening, chlamydia screening, well-child visits, adolescent well-care, access to primary care practitioners, ambulatory ED visits, CAHPS 5.0H child version, HPV vaccine), with analytic staff and vendor capacity to generate rates; section 7.1.3 states NC Medicaid calculates quality measures annually for managed care and fee for service members, health plans with Health Choice members must calculate and report quality measures annually, and results are shared publicly in Annual Quality Reporting with specifications in the Medicaid Technical Specifications document. Not carried is the 457.770 reporting duty as such: annual reporting of the mandatory Child Core Set measures to CMS for the CHIP program in the required format.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), sections 7.1.2 and 7.1.3 (plan pp.122-123)

SECTION 5D FACE

UNCOVERED ELEMENT: Annual Child Core Set reporting to CMS under 457.770 for the CHIP program, as a submitted record.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: File the most recent Child Core Set submission for the CHIP program with the register evidence.

QUESTION: Where is NC's annual Child Core Set report to CMS for CHIP held?

CFR-457-060: Prior authorization: denial reasons, PA API, public metrics

CITATION: 42 CFR 457.732

TOPIC: Prior authorization: denial reasons, PA API, public metrics

OBLIGATED LEVEL: provider

CADENCE: RECURRING - Denial reasons from 2026-01-01; API by 2027-01-01; metrics posted by March 31 annually from 2026

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Systems — NCTracks (GDIT, fiscal agent) under the Division of Health Benefits

HOME BASIS: NCTracks is NC's multi-payer MMIS, operated by GDIT as the State's fiscal-agent contractor under DHB (Lane A §1.4, §4). Title-level derivation: the obligation is a systems obligation on its face.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Prior authorization practice is described at the plan level: section 7.2.4 sets PA decision timeframes (5 days for medical services, 24 hours for pharmacy, in accordance with the medical needs of the patient, with compliance verified by spot checking and contractor reports), and section 12.2 describes notice of adverse decisions and the review process for denials, including internal first level review within 30 days and external second level review. The Tailored Plan contracts (H-052, H-053) touch Part 457 only at 457.1203 and carry no 457.732 content. Not carried are the 457.732 elements as such: a specific reason for denial in PA denial responses stated to the 457.732 standard, a prior authorization API, and public reporting of PA metrics for the CHIP program.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 7.2.4 (plan p.124) and section 12.2 (plan pp.142-146)

SECTION 5D FACE

UNCOVERED ELEMENT: The 457.732 prior authorization package for CHIP: specific denial reasons to the regulation's standard, the PA API, and publicly reported PA metrics.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish the CHIP prior authorization API and PA metrics, and state the denial-reason standard applied to CHIP PA responses.

QUESTION: Where are NC's CHIP prior authorization metrics published, and does a PA API exist?

CFR-457-061: Substitution-of-coverage procedures (crowd-out)

CITATION: 42 CFR 457.805

TOPIC: Substitution-of-coverage procedures (crowd-out)

OBLIGATED LEVEL: agency

CADENCE: FIXED - State plan content

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Anti-substitution procedures are described on the approved plan face, so a structural N/A cannot stand on this record: section 4.4.4, citing 42 CFR 457.805, states a child must be uninsured to be eligible, defines uninsured against private and employer-sponsored comprehensive coverage with stated exceptions (out-of-state limited network coverage under a medical support order, ordered but unprovided coverage, HMO without reasonable geographic access), addresses children of State employees under 457.310(c)(1), provides that enrollment begins the month after other coverage terminates, and states beneficiaries enrolled after voluntary termination of private or employer coverage are assigned a specific enrollment code so the State can determine whether the crowd-out rate is negatively impacted. What is not carried is the post-conversion position: no passage reconciles these separate program procedures with the Medicaid expansion structure, under which the children are Medicaid enrollees and the uninsured screen operates as the Medicaid-first screen at section 4.4.2.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 4.4.4 (plan pp.78-79)

SECTION 5D FACE

UNCOVERED ELEMENT: A statement of how the 457.805 anti-substitution procedures operate for the Medicaid expansion population after April 1, 2023.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: State the operative anti-substitution procedure for expansion children in the conformed plan or a filed program record.

QUESTION: Which anti-substitution controls apply to expansion CHIP children today: the section 4.4.4 procedures or Medicaid's own rules?

FLAGS: Conflict NC-5

CFR-457-062: Premium assistance anti-substitution protections and reporting

CITATION: 42 CFR 457.810

TOPIC: Premium assistance anti-substitution protections and reporting

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Protections described in state plan; substitution evaluated in each annual report

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **N-A-DETERMINED** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): NA-REASON: BY-ITS-TERMS

BASIS: N-A-DETERMINED under section 3A BY-ITS-TERMS. Section 457.810 by its terms governs a State operating a premium assistance program (as defined at 457.10). NC operates none, on the plan's own face: section 12.3 states, in full, North Carolina does not implement a Premium Assistance Program; section 4.4.4.1, the template item that calls for the 457.810(a) to (c) premium assistance description (minimum period without group coverage, employer contribution level, cost-effectiveness), is printed with no State content following it; the section 6.4.3-PA employer-sponsored premium assistance option is not taken up with any State description; and section 1.4 records that SPA 15-0001 documented the repeal of North Carolina's CHIP buy-in program effective October 1, 2015. There is no premium assistance structure in the State for the provision to operate on.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 12.3 (plan p.146), section 4.4.4.1 (plan p.79), section 1.4 SPA history (plan pp.8-10)

> **SECTION 3A FOOTING.** The closed list reason is NA-REASON: BY-ITS-TERMS. The determiner is NC Cure grading seat E. This determination rests on the basis printed for this entry above. It also rests on the record location printed for this entry above.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 457.810: a State operating a premium assistance program must describe anti-substitution protections including any waiting period, minimum employer contribution, cost-effectiveness determinations, and annual reporting on substitution.

CFR-457-063: Proper/efficient administration and eligibility safeguards

CITATION: 42 CFR 457.910

TOPIC: Proper/efficient administration and eligibility safeguards

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous administrative duty

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Administration of the program is described across the plan: responsible officials are named at the cover (457.40(c)); section 9 covers strategic objectives, performance measurement, data and records assurances; section 11.1 assures services are provided in an effective and efficient manner through free and open competition or rates based on other public and private rates that are actuarially sound; county DSS administration under DHB oversight is described at sections 4.3 and 5.2. Not carried as a set are the 457.910 safeguards: the methods of administration, personnel and merit system standards, and eligibility safeguards stated in the regulation's terms for the CHIP program.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), cover page (plan p.1), section 9 (plan pp.134-141), section 11.1 (plan p.141), sections 4.3 and 5.2 (plan pp. 69-71, 82-83)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 457.910 administration safeguards stated as a set (methods of administration, personnel standards, and safeguards for eligibility determinations) for the Title XXI program.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State the 457.910 safeguards for the CHIP program in the plan or an administrative record.
>
> **QUESTION:** Where are the proper and efficient administration safeguards for Title XXI published?

CFR-457-064: Fraud detection, investigation, and law enforcement referral

CITATION: 42 CFR 457.915; 457.925; 457.930

TOPIC: Fraud detection, investigation, and law enforcement referral

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Continuous procedures; preliminary action within a reasonable period per complaint/flag

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: The plan adopts a program integrity framework: section 11.2 assures, to the extent they apply, 42 CFR Part 455 Subpart B (provider and fiscal agent disclosure), section 1124 (ownership disclosure), section 1126 (convicted individuals), section 1128A (civil monetary penalties), section 1128B (criminal penalties) and section 1128E (fraud and abuse data collection) apply under Title XXI as under Title XIX; section 3.10.1 requires managed care entities to maintain safeguards against fraud and abuse including a mechanism to report violations to the State, CMS or the OIG; section 3.10.4 requires prompt referral of potential fraud to the State program integrity unit or the Medicaid Fraud Control Unit and payment suspension on credible allegation of fraud. Not carried are the State-side procedures of 457.915, 457.925 and 457.930 for the fee for service program: the State's own fraud detection and investigation methods and its law enforcement referral practice stated for CHIP.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 11.2 (plan pp.141-142) and sections 3.10.1 and 3.10.4 (plan pp.48-49)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** State-side fraud detection, investigation and law enforcement referral procedures for the CHIP fee for service program under 457.915, 457.925 and 457.930.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the CHIP fraud detection and investigation procedure, including MFCU and law enforcement referral practice for fee for service.
>
> **QUESTION:** Which unit investigates suspected CHIP fee for service fraud, and where is its referral procedure published?

CFR-457-065: No payments to excluded providers; sanctions program integrity provisions

CITATION: 42 CFR 457.935

TOPIC: No payments to excluded providers; sanctions program integrity provisions

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous payment-prohibition duty

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: The 457.935 assurance is stated in the governing instrument in the section's own terms: section 11.2 assures that, to the extent they apply, the following provisions apply under Title XXI to the same extent they apply under Title XIX, citing section 2107(e) and 42 CFR 457.935(b): 42 CFR

Part 455 Subpart B (disclosure by providers and fiscal agents), section 1124 (disclosure of ownership and related information), section 1126 (disclosure about certain convicted individuals), section 1128A (civil monetary penalties), section 1128B (criminal penalties for certain additional charges) and section 1128E (the national health care fraud and abuse data collection program). The exclusion and sanctions machinery the provision imports (including section 1128 exclusions administered through the adopted disclosure and penalty provisions) is the substance of the row, and the adoption is complete on the face.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 11.2 (plan pp.141-142)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 457.935: the plan must assure that the listed Social Security Act provisions, including the Part 455 Subpart B disclosure rules and sections 1124, 1126, 1128A, 1128B and 1128E, apply under Title XXI to the same extent as under Title XIX.

CFR-457-066: Procurement assurance and open competition

CITATION: 42 CFR 457.940

TOPIC: Procurement assurance and open competition

OBLIGATED LEVEL: federal-facing state report

CADENCE: FIXED - Assurance with initial plan or first amendment; competition duty continuous

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: The written assurance 457.940 requires is in the plan: section 11.1 assures services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound, citing section 2101(a) and 42 CFR 457.940(b). Not carried beyond the assurance sentence is any description of the procurement standards and methods the State applies to Title XXI purchases to keep competition open.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 11.1 (plan p.141)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** A description of the procurement standards applied to Title XXI contracting beyond the 457.940(b) assurance sentence.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Describe the procurement standards for CHIP contracting in the plan or a filed administrative record.
>
> **QUESTION:** Which procurement standards govern Title XXI purchases, and where are they stated?

CFR-457-067: FFS entity certification, fraud awareness, and data access

CITATION: 42 CFR 457.950

TOPIC: FFS entity certification, fraud awareness, and data access

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Per FFS contract/payment

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Form note: 457.950 addresses entities under a separate child health program. NC's fee for service claiming for the expansion population runs on the Title XIX apparatus: plan section 3.1 narrative states Medicaid and Health Choice use the same claims processing vendor (GDIT) under standardized application, screening and enrollment requirements, and section 3.10 carries fraud and abuse arrangements for managed care entities (compliance programs, overpayment reporting, fraud referral, payment suspension). Not carried for FFS entities are the 457.950 elements as such: entity certification, fraud awareness training for entity staff, and State data access arrangements stated for the CHIP program.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 3.1 narrative (plan pp.16-18) and section 3.10 (plan pp.48-50)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** FFS entity certification, fraud awareness and data access provisions for the CHIP program under 457.950.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State the fiscal agent certification and fraud awareness provisions applicable to CHIP fee for service administration.
>
> **QUESTION:** Does the GDIT fiscal agent contract carry the 457.950 certification and fraud awareness terms for CHIP?

CFR-457-068: Case record content, 3-year retention, 30-day availability

CITATION: 42 CFR 457.965

TOPIC: Case record content, 3-year retention, 30-day availability

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Per applicant/enrollee record; 3-year retention after case closes; produce within 30 calendar days on request

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Records duties are assured generally at section 9.4 (collect data, maintain records, furnish reports), and case-level operation is visible in the plan (NC FAST case records, automated notices, case head tracking at section 8.5). The 457.965 specifics are not stated anywhere read: the required content of the case record for each applicant and enrollee, retention of case records for 3 years from the date of denial or discontinuance, and availability of records to the Secretary within 30 days of request.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 9.4 (plan p.136)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The 457.965 case record content list, the 3-year retention standard, and the 30-day availability commitment for CHIP case records.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State the CHIP case record content and retention standard in the plan or the eligibility record.
>
> **QUESTION:** What retention standard applies to CHIP case records in NC FAST, and is it stated anywhere public?

CFR-457-069: Systems to verify claims where enhanced FMAP applies

CITATION: 42 CFR 457.980

TOPIC: Systems to verify claims where enhanced FMAP applies

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous systems duty

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Identification mechanics exist in pieces: section 4.0 defines the expansion groups whose claims draw the enhanced rate; section 3.1 narrative describes nightly transmission of new, revised and cancelled beneficiary records to the claims processor and a unique member ID generated by the

eligibility system; section 4.4.4 describes a specific enrollment code used to track crowd-out for children enrolled after voluntary termination of other coverage; the section 9.10 budget claims the program at the enhanced FMAP rate of 80.88%. Not carried is a description of the 457.980 system itself: how claims are identified and separated so that enhanced FMAP is claimed only for the expansion population.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 4.0 (plan pp.62-63), section 3.1 narrative (plan pp.16-18), section 9.10 (plan pp.139-141)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** A description of the claims identification system that separates enhanced FMAP claims for the expansion population from other claims.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Describe the eFMAP claims identification mechanism for the Title XXI program in a filed fiscal record.
>
> **QUESTION:** How does the claims system flag expansion CHIP claims for enhanced FMAP claiming?

CFR-457-070: Professional-advice integrity and physician incentive plan limits

CITATION: 42 CFR 457.985

TOPIC: Professional-advice integrity and physician incentive plan limits

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Per contract

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: The physician incentive plan elements are in the plan's managed care text: section 3.1.2.2 assures that if a contract with an MCO, PAHP or PIHP allows a physician incentive plan, the contract stipulates the entity must comply with 42 CFR 422.208 and 422.210, citing 42 CFR 457.1201(h) cross-referencing 438.3(i); section 3.5 also requires plans to make available, on request, any physician incentive plans in place under 438.3(i). Not carried is the professional advice integrity element of 457.985 running to 42 CFR 422.206(a), and no passage addresses incentive arrangements outside managed care contracts.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 3.1.2.2 (plan p.25) and section 3.5 (plan pp.29-44)

> **SECTION 5D FACE**

UNCOVERED ELEMENT: The 42 CFR 422.206(a) professional advice integrity element of 457.985, and any physician incentive plan limits outside managed care contracts.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: State the 422.206(a) element for CHIP contracting, or confirm no physician incentive plans operate in the CHIP program.

QUESTION: Do any physician incentive plans operate for this population, and where are the 457.985 limits stated?

CFR-457-071: Provider/supplier screening, oversight, and reporting

CITATION: 42 CFR 457.990

TOPIC: Provider/supplier screening, oversight, and reporting

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous provider screening duty

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Two thin carriers exist. The plan adopts 42 CFR Part 455 Subpart B disclosure at section 11.2.1, and section 3.1 narrative states 2011 State legislation mandated standardized requirements for Medicaid and Health Choice provider applications, screenings and enrollment. The only Part 457 pinpoint in the State rules document (H-099, Title 10A NCAC Chapter 22) is an authority citation to 42 CFR 457.990 in the history note to 10A NCAC 22B .0104, which carries no screening substance. The 457.990 elements as such (provider screening under Part 455 Subpart E: risk categorization, site visits, fingerprint-based checks for high risk providers, screening on enrollment and revalidation, and reporting) are not evidenced for the CHIP program in any document read.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 11.2.1 (plan p.142) and section 3.1 narrative (plan pp.16-18); H-099 Title 10A NCAC Chapter 22 (H-099), history note to 10A NCAC 22B .0104 at p.2

SECTION 5D FACE

UNCOVERED ELEMENT: Provider screening, oversight and reporting for CHIP providers under Part 455 Subpart E as imported by 457.990 (risk levels, site visits, revalidation screening).

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: State how Part 455 Subpart E screening applies to CHIP providers, or cross-reference the Medicaid screening record in the Title XXI file.

QUESTION: Are CHIP providers screened under the Medicaid Subpart E process, and where is that stated for Title XXI?

CFR-457-072: Privacy protections for enrollee records

CITATION: 42 CFR 457.1110

TOPIC: Privacy protections for enrollee records

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous privacy duty

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Confidentiality inside managed care contracting is assured in the plan's section 3 text (the reconciliation map places the 457.1110 pinpoint at plan p.44, within the section 3.9 to 3.10 assurances incorporating the Part 438 confidentiality standards for MCOs, PIHPs and PAHPs). The 457.1110 duty runs to the State's own safeguards for information on applicants and enrollees, meeting the standards of 42 CFR Part 431 Subpart F. No passage in the Title XXI plan states the State-side safeguard set (permitted uses and disclosures, safeguards on release, applicant access to records) for the CHIP program; for the expansion population those safeguards operate under the Title XIX framework, which is outside the Part 457 evidence set for this batch.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 3 confidentiality assurances (plan p.44 per the full reconciliation map pinpoint for 457.1110)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** State-side privacy safeguards for CHIP applicant and enrollee information meeting Part 431 Subpart F, stated for the Title XXI program.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** State the privacy safeguards applied to Title XXI applicant and enrollee information in the plan or a filed administrative record.
>
> **QUESTION:** Which published safeguards govern CHIP enrollee information held by DHB and county DSS?

CFR-457-073: Applicant/enrollee review (appeal) process with timeliness standards

CITATION: 42 CFR 457.1120; 457.1130; 457.1140; 457.1150; 457.1160; 457.1170; 457.1180

TOPIC: Applicant/enrollee review (appeal) process with timeliness standards

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Per review request

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: A complete review process narrative is carried. Section 12.1 describes review of eligibility and enrollment matters under N.C.G.S. 108A-70.21(a), 108A-70.26(c), 108A-70.29(a) and 108A-79: written notice of appeal rights on denial and on any subsequent action, and beneficiaries remain enrolled during review of a termination or suspension decision. Section 12.2 describes health services review under N.C.G.S. 108A-70.29 as a two-level process (internal first level review by the DHB Clinical Medical Director or designee, then external second level review by the DHHS Hearing Office), both levels completed within 90 calendar days of the first level request, with request windows of 30 days (first level) and 15 days (second level), hearing rights with representation, written decisions by certified mail, and an expedited track completing each level within 72 hours where the standard timeframe could seriously jeopardize the child's life, health or function, extendable by up to 14 days at the beneficiary's request. Two elements of the cited series are not carried: the plan states in terms that maintenance of services is not provided during the review process, which does not carry the continuation of benefits element of the subpart K series, and the timeliness standards of 457.1130 to 457.1180 are not stated subsection by subsection for eligibility reviews as distinct from health services reviews.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), sections 12.1 and 12.2 (plan pp.142-146)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The continuation of benefits element of the 457.1120 series (the plan states services are not maintained during review), and subsection-level timeliness standards for eligibility and enrollment reviews distinct from health services reviews.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Reconcile the plan section 12 continuation statement with the subpart K continuation element and state the per-subsection timeliness standards for the expansion population, whose reviews now run through Medicaid fair hearings.
>
> **QUESTION:** For expansion children, does the Medicaid fair hearing continuation rule govern instead of the plan section 12 statement that services are not maintained?

FLAGS: Conflict NC-5

CFR-457-074: Managed care contract submission and contract requirements

CITATION: 42 CFR 457.1201

TOPIC: Managed care contract submission and contract requirements

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - Per contract; CMS review on submission

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Managed care contract requirements are assured across plan section 3: section 3.1.2 and following incorporate the 457.1201 contract provisions (with the stated carve-outs at section 3.2 for PCCM contracts, which exclude 457.1201(h) and (l)), section 3.1.2.2 carries the physician incentive plan stipulation via 457.1201(h), and the section 3 guidance states contracts must be submitted to the CMS Regional Office for review. The Tailored Plan contracts in the evidence set (H-052, H-053) touch Part 457 only at 457.1203 and are Medicaid contracts, not CHIP contracts of record. Not carried is a CHIP managed care contract of record for the expansion population, or a record of contract submission to CMS for the Title XXI program after the conversion, under which the children are now served through Medicaid Prepaid Health Plan contracts.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 3.1.2 to 3.2 (plan pp.24-28); H-052 and H-053 Tailored Plan contracts (Part 457 pinpoint limited to 457.1203 per the full reconciliation map)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The managed care contract instrument of record for the expansion CHIP population and evidence of its submission to CMS under 457.1201.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Identify the contract instrument covering expansion CHIP children and file its CMS submission record for Title XXI.
>
> **QUESTION:** Under which contract, and which CMS submission, do expansion CHIP children receive managed care services?

CFR-457-075: Network adequacy analysis and annual enrollee survey posting

CITATION: 42 CFR 457.1207; 457.1230

TOPIC: Network adequacy analysis and annual enrollee survey posting

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Annual survey analysis and posting

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (annually) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains

listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Enrollee information and network content is assured in detail at section 3.5 and 3.6: the State assures the enrollee information specified in 42 CFR 457.1207 cross-referencing 438.10 (including information on request, within the 438.10(f) timeframe, in accessible formats and languages), electronic provider directories under 438.10(h)(3), and network adequacy and availability under 457.1230(a) cross-referencing 438.206 and 438.207, including out-of-network cost protections and provider directory accuracy through the website required by 438.10. Section 7.2.3 adds DHB network adequacy requirements for specialty services and an annual access study. Not carried is the annual enrollee experience survey element and public posting of survey results for the CHIP managed care population as such.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), sections 3.5 and 3.6 (plan pp.29-42) and section 7.2.3 (plan pp.123-124)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The annual enrollee experience survey for CHIP managed care enrollees and public posting of its results.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Publish the enrollee experience survey results covering expansion CHIP children in managed care, or state where they are posted.
>
> **QUESTION:** Are expansion CHIP children separately identifiable in the published enrollee survey results?

CFR-457-076: Managed care quality: QAPI, accreditation, ratings, quality strategy

CITATION: 42 CFR 457.1240

TOPIC: Managed care quality: QAPI, accreditation, ratings, quality strategy

OBLIGATED LEVEL: MCO/plan

CADENCE: RECURRING - Strategy drafted/implemented and maintained; QAPI and ratings ongoing

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: Quality strategy and QAPI content is assured in the plan: section 3.12.1.1 assures a written quality strategy for CHIP managed care including State-defined network adequacy standards,

quality metrics and performance targets, performance improvement projects, annual external independent reviews, transition of care policy, health disparities work, intermediate sanctions, and the measures the State will publish annually (42 CFR 457.1240(e) cross-referencing 438.340); section 3.12.2.1.1 and 3.12.2.1.2 assure MCO, PIHP and PAHP quality assessment and performance improvement programs with performance improvement projects designed for significant, sustained improvement (457.1240(b) cross-referencing 438.330); section 7.1.4 states Medicaid health plans and PCCM entities must perform two or more clinical quality improvement projects each year, one always focused on children including children in the CHIP program, supported and monitored by Medicaid or its EQRO; the current EQR technical report (NL-05) reviews the managed care program including CHIP plans. Not carried are the accreditation and public quality ratings elements of 457.1240 (plan accreditation status review and the quality rating system) as applied to CHIP plans.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), sections 3.12.1 and 3.12.2 (plan pp.53-59) and section 7.1.4 (plan p.123); NL-05 NC Medicaid Annual Technical Report, April 2026 (EQR technical report)

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** Accreditation review and public quality ratings for CHIP managed care plans under 457.1240.
>
> **OWNER LEVEL:** EQRO
>
> **ACTION:** Publish accreditation status and quality ratings for the plans serving expansion CHIP children, or state where they are posted.
>
> **QUESTION:** Where are accreditation results and quality ratings for the plans serving these children published?

CFR-457-077: External quality review of CHIP MCOs/PIHPs/PAHPs

CITATION: 42 CFR 457.1250

TOPIC: External quality review of CHIP MCOs/PIHPs/PAHPs

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Per EQR cycle

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: External quality review is both assured in the plan and evidenced in a current report. Plan section 3.12.5.1.1 assures the State contracts with at least one external quality review organization, section 3.12.5.1.2 addresses EQRO qualifications, and section 3.12.5.2 assures the mandatory EQR-related activities described in 42 CFR 457.1250(a) are conducted. The current EQR technical report of record (NL-05, NC Medicaid Annual Technical Report, April 2026, prepared by the EQRO) covers the NC managed care program including Medicaid and CHIP health plans, conducts the mandatory

activities (validation of performance improvement projects, performance measure validation, compliance monitoring review under CMS Protocol 3 for compliance with Medicaid and CHIP managed care regulations, and validation of network adequacy), and its standards table applies 42 CFR 457.1250(a), cross-referenced through 438.358(b)(1), to the reviewed program.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), sections 3.12.5 to 3.12.5.2 (plan pp.61-64); NL-05 NC Medicaid Annual Technical Report, April 2026, executive summary and compliance standards table (457.1250 pinpoint at report p.223 per the full reconciliation map)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 457.1250: the State must conduct, or contract with an EQRO to conduct, annual external quality review of each CHIP MCO, PIHP and PAHP, including the mandatory EQR activities, and produce an annual technical report.

CFR-457-078: Managed care grievance and appeal system

CITATION: 42 CFR 457.1260

TOPIC: Managed care grievance and appeal system

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Continuous grievance/appeal duty

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Division of Health Benefits — NC Health Choice (Title XXI)

HOME BASIS: NC Health Choice is administered within DHB ('programs remained NC Medicaid and NC Health Choice' under the combined division — Lane A §1.2); its Title XXI State Plan remains listed on the State Plan Public Notices page (Conflict C-5). No separate CHIP unit was published in sources reached.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat E)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a Medicaid expansion CHIP under Title XXI

BASIS: The grievance and appeal system is described for both delivery forms. For managed care members, plan section 12.2 states the PHP shall establish and maintain a grievance and appeals system including a grievance process, a plan level appeal process and access to a State fair hearing under 42 CFR Part 438 Subpart F, with reasonable assistance in completing forms and procedural steps including interpreter services and toll-free TTY/TDD capability (438.406(a)), decision-maker independence and clinical expertise rules (438.406(b)(2)), authorized representative filing (438.402(c)), Department-developed notice templates meeting 438.10(c)(4)(ii), and definitions per 438.400; plan sections 3.6 to 3.8 carry the corresponding State assurances under 457.1260 cross-referencing 438.228 and related provisions. For all other beneficiaries, section 12.2 carries the two-level State review with expedited handling. Since April 1, 2023 the expansion children are served inside this same Medicaid managed care grievance system, so the system described is the operative one for the population.

RECORD LOCATION: H-013 CHIP SPAs NC-23-0008 and NC-23-0010 packet (H-013), section 12.2 (plan pp.142-146) and sections 3.6 to 3.8 (plan pp.36-48)

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 457.1260: a State with CHIP MCOs, PIHPs or PAHPs must ensure each entity maintains a grievance and appeal system meeting 42 CFR Part 438 Subpart F, including grievance and appeal processes, expedited appeals, notices, enrollee assistance and access to a State fair hearing.

FLAGS: Conflict NC-5

CFR-460-001: State assurance on PACE organization applications and expansions

CITATION: 42 CFR 460.12(b)

TOPIC: State assurance on PACE organization applications and expansions

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Per PACE application or expansion request

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as the state administering agency for PACE

BASIS: The PACE manual (H-115, Adult Medicaid Manual MA-2275) establishes NC's PACE administration: the program is regulated through a three-party agreement among CMS, NCDHHS through DHB and the PACE organization, and eligibility turns on the individual living in the approved geographic area of the PACE organization and meeting the state's nursing home level of care criteria. What the manual does not carry is the state assurance step at 460.12(b): NC's assurance to CMS, on a PACE organization's application or expansion, that the organization can meet the requirements. Note on evidence quality: the baseline map carried Part 460 for this document from the haul citation only, and the cure's own text pass found no CFR citation in the manual's text; this grade rests on the manual's substantive passages actually read, not on any citation.

RECORD LOCATION: H-115 (H-115), Adult Medicaid Manual MA-2275, sections A-C

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The state assurance to CMS on PACE organization applications and service area expansions (42 CFR 460.12(b)); the held manual describes the operating program, not the assurance NC gives CMS on an application.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce a state assurance letter or the PACE application file showing NC's assurance to CMS for an approved organization or expansion.
>
> **QUESTION:** Where is NC's 460.12(b) assurance documented when a PACE organization applies or expands?

SEARCHES RECORDED: H-115 read in full (18 pages): no assurance, application approval or expansion passage found; enforcement and application terms searched with no hits. Full map: no other document carries Part 460.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 460.12(b) text as carried in the register requirement of record

FLAGS: Evidence basis corrected in this cure: H-115's Part 460 mapping was haul-only in the baseline and the cure text pass found no CFR citation in the document. Grade rests on text read, per the task instruction.

CFR-460-002: State signs PACE program agreement with CMS and PACE org

CITATION: 42 CFR 460.30

TOPIC: State signs PACE program agreement with CMS and PACE org

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Per PACE program agreement execution

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC as a party to each PACE program agreement

BASIS: The PACE manual (H-115) states the agreement element directly: the PACE program is regulated through a three-party agreement among the Centers for Medicare and Medicaid Services (CMS), the North Carolina Department of Health and Human Services (DHHS) through the Division of Health Benefits (DHB), and the PACE organization, and the manual's enrollment sections operate on that agreement (the Participant Enrollment Agreement, enrollment effective the first day of the month after signature). That is the 460.30 structure as written: CMS, the state administering agency and the PACE organization as parties to one program agreement.

RECORD LOCATION: H-115 (H-115), Adult Medicaid Manual MA-2275, section A.1 and enrollment sections

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 460.30 text as carried in the register requirement of record

FLAGS: Same evidence note as CFR-460-001: the manual carries no CFR citation in its text (cure text pass); the grade rests on the substantive three-party agreement passage read.

CFR-460-003: PACE agreement content: Medicaid rate, service area, data requirements

CITATION: 42 CFR 460.32

TOPIC: PACE agreement content: Medicaid rate, service area, data requirements

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Per agreement negotiation/amendment

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC PACE program agreements and Medicaid payment

BASIS: Two of the three content elements are carried in the manual (H-115): on payment, the state establishes and pays the Medicaid capitation, CMS establishes and pays the Medicare capitation, and the PACE organization receives a capitated payment per beneficiary and assumes full financial risk without limits on amount, duration or scope; on service area, enrollment requires living in the approved geographic area of the PACE organization, and county caseworkers refer individuals to the PACE organization covering the service area where they reside (DHB-5106 referral process). The third element, the agreement's data and reporting requirements on the PACE organization, is not stated anywhere in the manual: searches for reporting and data submission duties owed by the organization to the state returned nothing.

RECORD LOCATION: H-115 (H-115), Adult Medicaid Manual MA-2275, sections A-B and referral process

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The data and reporting requirements element of the PACE agreement content (42 CFR 460.32): what the PACE organization must report to the state and CMS is not stated in held evidence. The Medicaid rate is carried only as state-paid capitation, with no rate amount or rate-setting term.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce a PACE program agreement showing the rate, service area and data requirement terms together.
>
> **QUESTION:** What data and reporting does NC's PACE agreement require of PACE organizations?

SEARCHES RECORDED: H-115 read in full; searched for report, data and submit terms owed by the PACE organization (no hits). Full map: no other Part 460 document.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 460.32 text as carried in the register requirement of record

CFR-460-004: State enforcement: CAP, payment withholding, termination of PACE agreement

CITATION: 42 CFR 460.48; 460.50

TOPIC: State enforcement: CAP, payment withholding, termination of PACE agreement

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - As warranted by noncompliance

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: Managed care supervision is a published responsibility of the Deputy Secretary for NC Medicaid (Apr. 21, 2026 announcement — Lane A §1.3), and the PHP/Tailored Plan contract

apparatus is DHB's (Lane A §2.2). No separately named managed care section was published in sources reached; the home is the division's managed care oversight function.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC enforcement against PACE organizations

BASIS: No NC evidence for state enforcement under 42 CFR 460.48 and 460.50 was found. The PACE manual (H-115), the only Part 460 document in the corpus, was read in full and contains no corrective action plan, payment withholding, suspension or agreement termination provision for PACE organizations; its remedies language concerns individual enrollment and placement only. No other held document addresses PACE enforcement.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The entire provision: corrective action, sanctions, payment withholding and termination of the PACE agreement (42 CFR 460.48 and 460.50) are not addressed in held evidence.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce the enforcement article of a NC PACE program agreement or the PACE monitoring and sanctions procedure.
>
> **QUESTION:** What enforcement tools does NC hold against a PACE organization, and where are they written?

SEARCHES RECORDED: H-115 full text searched for enforcement, corrective action, withholding, sanctions and termination of agreement (no hits). Full map: H-115 is the only Part 460 document; corpus-wide PACE search returns H-115 only.

GUIDANCE READINGS (DETERMINATIONS FILE): 42 CFR 460.48 and 460.50 text as carried in the register requirement of record

CFR-162-001: Health plan must use provider NPIs on standard transactions

CITATION: 45 CFR 162.412

TOPIC: Health plan must use provider NPIs on standard transactions

OBLIGATED LEVEL: bureau/section

CADENCE: RECURRING - continuous — every standard transaction

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Systems — NCTracks (GDIT, fiscal agent) under the Division of Health Benefits

HOME BASIS: NCTracks is NC's multi-payer MMIS, operated by GDIT as the State's fiscal-agent contractor under DHB (Lane A §1.4, §4). HIPAA standard transactions and code sets execute in the MMIS/fiscal-agent layer.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC health plans conducting standard transactions

BASIS: No NC evidence for the health plan NPI use duty at 45 CFR 162.412 was found. The corpus carries NPIs in a different duty: plan section 4.46 requires the ordering or referring professional's NPI on claims under 42 CFR 455.440, which is a Medicaid enrollment and claims rule, not the

HIPAA standard transaction rule that a health plan must use NPIs in standard transactions. No held document cites 162.412 or states the transaction-level duty for NC's plans or for NCTracks.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The entire provision: no held document states that a health plan must use provider NPIs in standard transactions (45 CFR 162.412).
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce an NCTracks or PHP companion guide or trading partner term stating NPI use in standard transactions.
>
> **QUESTION:** Where is the 162.412 NPI duty stated for NC's EDI operations?

SEARCHES RECORDED: Full map: no document carries a 162.412 pinpoint. Corpus searched for the section number and for NPI use in transactions (455.440 passages only, read and distinguished). No NC EDI companion guide is in the held corpus.

GUIDANCE READINGS (DETERMINATIONS FILE): 45 CFR 162.412 text as carried in the register requirement of record

CFR-162-002: Must conduct transactions as standard transactions on request

CITATION: 45 CFR 162.925(a)

TOPIC: Must conduct transactions as standard transactions on request

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - on trading-partner request

EVIDENCE CLASS: GOVERNING

NC HOME: Systems — NCTracks (GDIT, fiscal agent) under the Division of Health Benefits

HOME BASIS: NCTracks is NC's multi-payer MMIS, operated by GDIT as the State's fiscal-agent contractor under DHB (Lane A §1.4, §4). HIPAA standard transactions and code sets execute in the MMIS/fiscal-agent layer.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC covered entities conducting electronic transactions

BASIS: No NC evidence for the conduct duty at 45 CFR 162.925(a), conducting a transaction as a standard transaction on request, was found. Held contracts require plans to submit encounters and claims in standard formats (for example ASC X12 837 and 275 attachment transactions in H-046, H-052 and H-053), which governs format, not the on-request conduct duty, and no held document states that a transaction requested as standard must be conducted as standard.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The entire provision: the on-request standard transaction conduct duty (45 CFR 162.925(a)) is not stated in held evidence.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)

ACTION: Produce the EDI operations policy or trading partner agreement stating the standard transaction conduct duties.

QUESTION: Where are NC's standard transaction conduct duties documented for its EDI operations?

SEARCHES RECORDED: Full map: no 162.925 pinpoint in any document. Corpus searched for standard transaction conduct and on request language (format requirements in plan contracts only, read and distinguished).

GUIDANCE READINGS (DETERMINATIONS FILE): 45 CFR 162.925(a) text as carried in the register requirement of record

CFR-162-003: Standard electronic health care transactions

CITATION: 45 CFR 162 Subparts K–R (162.1102, 162.1202, 162.1302, 162.1402, 162.1502, 162.1602, 162.1702, 162.1802)

TOPIC: Standard electronic health care transactions

OBLIGATED LEVEL: agency

CADENCE: RECURRING - continuous — all electronic transactions

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Systems — NCTracks (GDIT, fiscal agent) under the Division of Health Benefits

HOME BASIS: NCTracks is NC's multi-payer MMIS, operated by GDIT as the State's fiscal-agent contractor under DHB (Lane A §1.4, §4). HIPAA standard transactions and code sets execute in the MMIS/fiscal-agent layer.

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC electronic health care transactions with providers and plans

BASIS: Several named standard transactions are carried in operation. The NCTracks checkwrite schedule (H-140) runs the weekly cycle on the 835 (remittance advice), 820 and 277P transactions, with RAs and 835s delivered by 8 a.m. Wednesday. Plan contracts require standard ASC X12 HIPAA transactions: H-052 and H-053 require providers to submit claim attachments through the standard ASC X12 275 transaction or an attachment indication in an 837, and H-046 requires PHP encounter submission under the Department's companion guides for 837I, 837P and NCPDP. What is not carried is the full adopted set across Subparts K-R (eligibility 270/271, claim status 276/277, referral 278, enrollment 834, premium payment 820 as a plan transaction, and the pharmacy subpart transactions as standards), stated as NC's standard transaction set; the evidence is transaction-by-transaction use, not the set.

RECORD LOCATION: H-140 (H-140), 2026 checkwrite schedule; H-052 (H-052) and H-053 (H-053), claim attachment terms; H-046 (H-046), encounter submission terms

SECTION 5D FACE

UNCOVERED ELEMENT: The complete adopted standard transaction set of 45 CFR Part 162 Subparts K-R as NC's set; held evidence shows individual transactions in use (837, 835, 820, 277P, 275, NCPDP) without the full set or the remaining subparts.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Produce the NCTracks companion guide set or EDI manual listing the standard transactions NC conducts.

QUESTION: Where is NC's full standard transaction set published for trading partners?

SEARCHES RECORDED: Full map: no Part 162 pinpoint in any document. Corpus searched for standard transaction and ASC X12 across contracts, manuals and NCTracks documents (hits listed in basis). No companion guide document is held.

GUIDANCE READINGS (DETERMINATIONS FILE): 45 CFR Part 162 Subparts K-R text as carried in the register requirement of record

CFR-162-004: Standard medical code sets

CITATION: 45 CFR 162.1002 (Subpart J)

TOPIC: Standard medical code sets

OBLIGATED LEVEL: agency

CADENCE: RECURRING - continuous — all standard transactions

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — frequency stated (recurring) but no calendar anchor date is stated in the source text; not calendared.

NC HOME: Systems — NCTracks (GDIT, fiscal agent) under the Division of Health Benefits

HOME BASIS: NCTracks is NC's multi-payer MMIS, operated by GDIT as the State's fiscal-agent contractor under DHB (Lane A §1.4, §4). HIPAA standard transactions and code sets execute in the MMIS/fiscal-agent layer.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): Applies to NC claims and encounter data using standard code sets

BASIS: No NC evidence for adoption of the standard medical code sets at 45 CFR 162.1002 (Subpart J) was found as a stated requirement. Code sets are used throughout the corpus in practice (CPT and ICD coding in clinical coverage policies and billing guides, for example H-078), but no held document states the HIPAA code set adoption duty or cites 162.1002, and use in practice documents does not carry the provision as a requirement on NC's transactions.

RECORD LOCATION:

SECTION 5D FACE

UNCOVERED ELEMENT: The entire provision: the standard medical code set requirement (45 CFR 162.1002, Subpart J) is not stated in held evidence.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Produce the companion guide or policy language adopting the standard code sets for NC transactions.

QUESTION: Where does NC state the standard code set requirement for its electronic transactions?

SEARCHES RECORDED: Full map: no 162.1002 or Subpart J pinpoint in any document. Corpus searched for the section number and code set adoption language (coding usage passages only).

GUIDANCE READINGS (DETERMINATIONS FILE): 45 CFR 162.1002 text as carried in the register requirement of record

NC-001: Medicaid Bulletin issuance and Monthly Bulletin Digest compilation

CITATION: NC Medicaid Bulletin Digests page; bulletin renovation note (articles added weekly in blog format)

TOPIC: Medicaid Bulletin issuance and Monthly Bulletin Digest compilation

OBLIGATED LEVEL: bureau/section

CADENCE: RECURRING - Bulletin articles post as approved in a weekly blog flow; the Monthly Bulletin Digest compiles each month's bulletins and special bulletins; archive retained to 1997

EVIDENCE CLASS: GOVERNING

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Medicaid Communications is the published contact for bulletin retrieval (Lane A §1.4); bulletin issuance is a division act.

CURE DETERMINATION: **GAP-DETERMINED** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): State program row: NC Medicaid bulletin practice

BASIS: No NC evidence for Medicaid Bulletin issuance and Monthly Bulletin Digest compilation as a documented practice was found. Bulletins are referenced throughout the corpus as guidance providers must follow (provider manuals and clinical policies cite Medicaid bulletins and special bulletins), and NCTracks announcement pages are held (H-156, H-166), but no held document is or describes the Bulletin Digest, a digest compilation, or a bulletin issuance procedure in blog format with weekly articles.

RECORD LOCATION:

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The entire row: bulletin issuance procedure and Monthly Bulletin Digest compilation are not documented in held evidence.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce a Monthly Bulletin Digest issue or the bulletin issuance procedure page.
>
> **QUESTION:** Where is the Bulletin Digest compiled and published, and under what issuance procedure?

SEARCHES RECORDED: Corpus searched for bulletin digest, Monthly Bulletin and Medicaid Bulletin (references to bulletins as authority only, in H-069, H-072, H-075, H-078 and others, read and distinguished). Full map: no document is a bulletin digest. REGISTER-COVERAGE lists no held evidence for this row.

GUIDANCE READINGS (DETERMINATIONS FILE): Register record of evidence for the row (Medicaid Bulletin Digests page and bulletin renovation note)

NC-002: State Plan Amendment — 10-day public posting before CMS submission

CITATION: Medicaid State Plan Public Notices page ('Ten-Day Posting for Submission to CMS')

TOPIC: State Plan Amendment — 10-day public posting before CMS submission

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - Per SPA: a 10-day public notice posts, followed by the 'Proposed Amendments Sent to CMS' listing

EVIDENCE CLASS: GOVERNING

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: SPA notices issue from DHB; a DHB SPA Coordinator function is named in NC's own SPA correspondence (Lane A §6 R-2).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): State law row: G.S. 108A-54.1A ten-day SPA posting

BASIS: The practice is carried in current operation. The Medicaid State Plan Public Notices page (H-002) lists the 2026 ten-day postings for submission to CMS with dates: SPA 26-0001 10-Day Public Notice (Hospital Program Readmission Review), Jan. 14, 2026; SPA 26-0002, Feb. 13, 2026; SPA 26-0003 and later 2026 postings through SPA 26-0008 (Sept. 18, 2026), with previous ten-day posting archives for 2021-2025 on the same page. The statutory basis is described in the CHIP state plan documents (H-013, H-022): N.C.G.S. 108A-54.1A requires the 10-day posting of the State Plan Amendment to the Department's web page prior to CMS submission, with no separate public comment period.

RECORD LOCATION: H-002 (H-002__6f49fb86.html), Medicaid State Plan Public Notices page, 2026 ten-day posting list; H-013 (H-013) and H-022 (H-022), G.S. 108A-54.1A passage

GUIDANCE READINGS (DETERMINATIONS FILE): Register citation for the row (Medicaid State Plan Public Notices page, Ten-Day Posting for Submission to CMS)

NC-003: Medical coverage policy change procedure — 45-day publication and comment; 15-day re-notice if modified

CITATION: N.C.G.S. §108A-54.2

TOPIC: Medical coverage policy change procedure — 45-day publication and comment; 15-day re-notice if modified

OBLIGATED LEVEL: agency

CADENCE: EVENT-TRIGGERED - At least 45 days before adoption: publish the proposed policy, notify all Medicaid and NC Health Choice providers, accept comments; if the policy is modified, re-publish at least 15 days before adoption; consultation with the Physician Advisory Group and affected provider societies during development

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Coverage Policy Function (formal section label not published)

HOME BASIS: The statute assigns the procedure to the Department; coverage policy is DHB's published function (Lane A §6 R-3).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): State law row: N.C.G.S. 108A-54.2 medical coverage policy procedure

BASIS: The full procedure is carried in the CHIP state plan documents (H-013, H-022), which state the process mandated by N.C.G.S. 108A-54.2: the Department must consult with and seek the advice of the Physician Advisory Group and other organizations the Secretary deems appropriate, and consult officials of professional societies representing affected providers; at least 45 days prior to

adoption of a new or amended policy the Department must publish the policy on its website and notify all providers; during the 45-day period it must accept oral and written public comments; if the policy is modified after the comment period, it must notify providers and, on request, provide notice of the amendments for at least 15 days prior to posting the new or amended policy; and shorter 30 and 10 day posting periods apply where a change is necessitated by an act of the General Assembly or a change in federal law.

RECORD LOCATION: H-013 (H-013) and H-022 (H-022), medical policy process passage citing N.C.G.S. 108A-54.2

GUIDANCE READINGS (DETERMINATIONS FILE): Register citation for the row (N.C.G.S. 108A-54.2)

NC-004: Provider reverification (revalidation) — five-year cycle; monthly reverification due-date report

CITATION: NCTracks Provider Recredentialing pages; NC Medicaid reverification notices (42 CFR 455.414 as cited by NC)

TOPIC: Provider reverification (revalidation) — five-year cycle; monthly reverification due-date report

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Each actively enrolled provider reverifies at least every 5 years through NCTracks; notifications begin 70 days before the due date; the Active Provider Reverification Report refreshes monthly with 12 months of due dates

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — the State's report refresh is monthly with no day of month published; provider due dates are per-provider. Not calendared to a single date.

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Reverification policy is NC Medicaid's; the process runs in NCTracks (Lane A §4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): State program row: NCTracks provider reverification, five year cycle with monthly due-date report

BASIS: All elements are carried. Plan section 4.46 (H-001, p.186) assures revalidation at least every five years under 42 CFR 455.414. The NCTracks recredentialing page (H-147) states the reverification report is updated monthly and offers reverification due dates over a period of twelve months, that providers receive notice through the NCTracks message center and by mail, and that the reverification must be completed, with fees paid, by 5 p.m. on the due date or the record is suspended and claims pend. The announcements (H-148, May 10, 2024, and H-089) confirm the five year mandate and the 70-day completion window.

RECORD LOCATION: H-001 (H-001), NC Title XIX State Plan p.186; H-147 (H-147__3ba9511d.html); H-148 (H-148__6e253df5.html); H-089 (H-089__9ef5cdae.html)

GUIDANCE READINGS (DETERMINATIONS FILE): Register citation for the row (NCTracks provider recredentialing pages and reverification notices, citing 42 CFR 455.414)

NC-005: Provider enrollment and recredentialing application fee

CITATION: N.C.G.S. §108C-2.1(a)–(b) (as quoted in the NCTracks recredentialing FAQ)

TOPIC: Provider enrollment and recredentialing application fee

OBLIGATED LEVEL: provider

CADENCE: EVENT-TRIGGERED - Application fee equal to the federally required amount plus $100, charged at enrollment and again at recredentialing every five years

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Provider Enrollment (NCTracks provider portal)

HOME BASIS: Fee collection rides the NCTracks enrollment/recredentialing process (Lane A §4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): State law row: N.C.G.S. 108C-2.1 provider enrollment and recredentialing application fee

BASIS: The fee is carried in the NCTracks recredentialing record the register cites: the recredentialing page (H-147) states providers submitting enrollment, re-enrollment or revalidation/reverification applications will be assessed the $100 NC Medicaid Provider Application Fee, in addition to the federal fee imposed for specified taxonomies, with amounts by year in the published State and Federal Fee Amounts spreadsheet; the behavioral health enrollment FAQs (H-146) state the same $100 North Carolina fee structure and point to the Federal Fee and NC Application Fee FAQs. The grade is on the fee as quoted and operated in NCTracks; the statutory text of G.S. 108C-2.1 itself is not in the held corpus, which is flagged.

RECORD LOCATION: H-147 (H-147__3ba9511d.html), fee passage; H-146 (H-146__d776b32a.html), fee passage

GUIDANCE READINGS (DETERMINATIONS FILE): Register citation for the row (N.C.G.S. 108C-2.1(a)-(b) as quoted in the NCTracks recredentialing FAQ)

FLAGS: The $100 state fee and the federal fee structure are carried by NCTracks pages read in this cure; the text of G.S. 108C-2.1 was not itself held or read. If the desk requires the statute's face, this row should be re-opened as Partial.

NC-006: NCTracks weekly checkwrite cycle

CITATION: NCTracks Checkwrite Schedule (DHHS/DHB annual schedule PDFs, 2025–2027)

TOPIC: NCTracks weekly checkwrite cycle

OBLIGATED LEVEL: bureau/section

CADENCE: RECURRING - Weekly: claims cutoff Thursday (portal 11:59 p.m.; batch 6:00 p.m.); checkwrite normally the following Tuesday (the State approves and releases funds; the date on the Remittance Advice); EFT effective Wednesday, shifting to the next business day on the published holiday/quarter/year-end rule

EVIDENCE CLASS: GOVERNING

NC HOME: Systems — NCTracks (GDIT, fiscal agent) under the Division of Health Benefits

HOME BASIS: The checkwrite is the fiscal agent's operating cycle under DHB; the State releases funds on the checkwrite date (Lane A §4).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): State program row: NCTracks weekly checkwrite cycle

BASIS: The 2026 Provider Checkwrite Schedule (H-140) carries the cycle in full: batch claims submitted by 6 p.m. Thursday are processed through the checkwrite cycle on Friday, portal and POS pharmacy claims successfully processed by 11:59 p.m. Friday; remittance advices and 835s, 820s and 277Ps are received by 8 a.m. Wednesday, electronic payments Wednesday or Thursday, checks within a week of the Wednesday mailing; NCTracks issues 50 checkwrites per fiscal year on a

weekly cycle, exceptions being the last week of June (end of state fiscal year) and the last week of the calendar year; the schedule defines the cutoff date and the other cycle terms.

RECORD LOCATION: H-140 (H-140), 2026 Provider Checkwrite Schedule, p.1

GUIDANCE READINGS (DETERMINATIONS FILE): Register citation for the row (NCTracks Checkwrite Schedule, DHHS/DHB annual schedule PDFs)

NC-007: NC Medicaid Annual Report and Annual Report Tables (state fiscal year)

CITATION: Medicaid Annual Reports and Tables page (Finance Section contact)

TOPIC: NC Medicaid Annual Report and Annual Report Tables (state fiscal year)

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Annual publication by state fiscal year (July 1–June 30); SFY 2025 is the latest as reached

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — annual by SFY; no publication month/day is printed on the index page reached. Not calendared to a date.

NC HOME: Division of Health Benefits — Finance Section

HOME BASIS: The Finance Section is the published contact/owner for the Annual Reports and Tables (Lane A §1.4, §3).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): State program row: NC Medicaid Annual Report and Annual Report Tables by state fiscal year

BASIS: The Annual Report itself is held and current: the NC Medicaid Annual Report for State Fiscal Year 2025 (H-126, July 1, 2024 to June 30, 2025) is an overview of financial outcomes and investment summaries for programs administered by DHB, with expenditure exhibits comparing SFY2024 and SFY2025 ($35.8 billion SFY2025 expenditures) and messages from the Secretary and the Deputy Secretary for NC Medicaid. The companion element of the row, the Annual Report Tables as a published companion (the register ties the row to the Annual Reports and Tables page and a Finance Section contact), is not in the held corpus: no tables document was acquired, and H-126's contents do not present a separate tables volume.

RECORD LOCATION: H-126 (H-126), NC Medicaid Annual Report SFY2025, pp.1-6 and exhibits list

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The Annual Report Tables companion publication; held evidence carries the Annual Report narrative and exhibits only.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce the current Annual Report Tables document or the page section that publishes it.
>
> **QUESTION:** Where are the Annual Report Tables published for the current fiscal year?

SEARCHES RECORDED: Full map searched for annual report documents (H-126 is the only annual report; H-124 is an access monitoring plan citing the SFY2022 report). Corpus searched for Annual Report Tables (no document found).

GUIDANCE READINGS (DETERMINATIONS FILE): Register record of evidence for the row (Medicaid Annual Reports and Tables page)

NC-008: PHP Performance Metrics — annual report to the General Assembly

CITATION: Session Law 2023-134, §9E.20

TOPIC: PHP Performance Metrics — annual report to the General Assembly

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Annual report on each PHP's performance against the Department's claims-payment performance standards and metrics; latest as reached covers SFY 2025, dated April 6, 2026

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — annual on an SFY basis; the observed publication (April 6, 2026) is a pattern, not a printed due date in sources reached.

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: The report measures the prepaid health plans DHB oversees (Lane A §3).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): State law row: Session Law 2023-134, section 9E.20 PHP performance metrics reporting

BASIS: The report required by the session law is held in its current cycle: the Prepaid Health Plan Performance Metrics Report (H-062), Session Law 2023-134, Section 9E.20, from NCDHHS to the Joint Legislative Oversight Committee on Medicaid and the Fiscal Research Division, dated April 6, 2026, covering July 1, 2024 to June 30, 2025, states at p.3 that as required in section 9E.20 the Department shall report to those two legislative recipients, and carries the metrics content (claims payment and timeliness metrics, CAHPS results, and medical loss ratio reporting including notice of a plan's FY2024 MLR adjustment).

RECORD LOCATION: H-062 (H-062), PHP Performance Metrics Report, cover and pp.2-8

GUIDANCE READINGS (DETERMINATIONS FILE): Register citation for the row (Session Law 2023-134, section 9E.20)

NC-009: PHP medical loss ratio — 88 percent minimum; annual reporting aligned to the rating year

CITATION: N.C.G.S. §108D-65; PHP Contract MLR provisions

TOPIC: PHP medical loss ratio — 88 percent minimum; annual reporting aligned to the rating year

OBLIGATED LEVEL: MCO/plan

CADENCE: RECURRING - Each PHP's MLR for health care services must be at least 88 percent; PHPs calculate and report aggregate MLR annually, aligned to the rating year; the Department publishes CMS-defined and Department-defined MLR

EVIDENCE CLASS: GOVERNING

NC HOME: Division of Health Benefits — Managed Care Oversight (Deputy Secretary for NC Medicaid)

HOME BASIS: MLR oversight is part of DHB's managed care supervision (Lane A §3).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): State law and contract row: PHP medical loss ratio, 88 percent minimum

BASIS: The contract machinery around the 88 percent figure is carried, the statute is not. The PHP rate books held (H-046, H-049) print contractual minimum MLR thresholds by rating group with the Total Standard Plan threshold at 88.0 percent (rating groups range from 85.8 to 92.0 percent), the PHP contract (H-046) sets liquidated damages of $2,000 per calendar day for failure to timely and accurately submit the Medical Loss Ratio Report under Section V.I.2 and Attachment J, and the 9E.20 performance report (H-062) reports MLR in the annual cycle including a plan's FY2024 MLR adjustment notice. No held document carries the text of N.C.G.S. 108D-65 itself, so the statutory minimum and its annual reporting alignment to the rating year are graded on contract and report evidence only.

RECORD LOCATION: H-046 (H-046), MLR report damages term and Standard Plan Rate Book thresholds; H-049 (H-049), rate book threshold tables; H-062 (H-062), MLR reporting passages

> **SECTION 5D FACE**
>
> **UNCOVERED ELEMENT:** The text of N.C.G.S. 108D-65 (the statutory 88 percent minimum and the annual reporting duty aligned to the rating year); held evidence is contract thresholds and reports, which vary by rating group around the 88.0 percent total.
>
> **OWNER LEVEL:** Division of Health Benefits (DHB)
>
> **ACTION:** Produce the text of G.S. 108D-65 as applied, or the MLR report template that ties plan reporting to the statutory rating year.
>
> **QUESTION:** Where is the statutory 88 percent MLR standard, as distinct from the contract thresholds, documented in NC's public record?

SEARCHES RECORDED: Corpus searched for 108D-65 and medical loss ratio: statute text not held; contract and rate book passages in H-046, H-049, H-052 and H-053 and the H-062 report read at pinpoint.

GUIDANCE READINGS (DETERMINATIONS FILE): Register citation for the row (N.C.G.S. 108D-65 and PHP contract MLR provisions)

FLAGS: Contract thresholds are not uniformly 88 percent: rating groups run 85.8 to 92.0 percent with the total at 88.0 percent. The register's 88 percent minimum is the total figure; flagged so the row is not read as a flat floor for every group.

NC-010: External Quality Review — annual EQR Technical Report (EQRO: HSAG)

CITATION: Quality Management and Improvement page (EQR Technical Reports, 2020-2021 through 2024-2025)

TOPIC: External Quality Review — annual EQR Technical Report (EQRO: HSAG)

OBLIGATED LEVEL: agency

CADENCE: RECURRING - Annual program-wide EQR Technical Report across all PHPs, produced by the EQRO (Health Services Advisory Group, Inc.) and published by the division; Encounter Data Validation reports publish with it

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — publication observed in March/April in the years listed; no NC-printed due date was established in sources reached.

NC HOME: Division of Health Benefits — Quality Management and Improvement

HOME BASIS: EQR reporting publishes from Quality Management and Improvement (Lane A §1.4, §3).

CURE DETERMINATION: **Verified** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): State program row: annual External Quality Review technical report by the EQRO (HSAG)

BASIS: The current annual EQR technical report is held as a cure acquisition: NL-05 is the 2025 External Quality Review Technical Report for North Carolina Medicaid, prepared for NCDHHS DHB by Health Services Advisory Group, Inc. (HSAG), the Department's EQRO (report NC2025_EQR-Technical Report_F2_0426, April 2026). Its executive summary states 42 CFR 438.364 requires states to use an EQRO to prepare an annual, independent technical report aggregating and analyzing the data from all EQR activities under 438.358, and the report carries the mandatory activities (performance improvement project validation, performance measure validation, compliance monitoring, network adequacy validation) and statewide comparative results. Earlier years in the register's range are evidenced in the corpus by the Alliance EQR reports (H-129, 2019-2020) and the Sandhills EQR report (H-130).

RECORD LOCATION: NL-05 (NL-05), 2025 EQR Technical Report, executive summary and contents; H-129 (H-129); H-130, Sandhills EQR report

GUIDANCE READINGS (DETERMINATIONS FILE): Register record of evidence for the row (Quality Management and Improvement page, EQR Technical Reports 2020-2021 through 2024-2025)

NC-011: Section 1115 Demonstration — quarterly monitoring reports

CITATION: NC Medicaid 1115 Demonstration (11-W-00313/4) monitoring, as published on the Quality page

TOPIC: Section 1115 Demonstration — quarterly monitoring reports

OBLIGATED LEVEL: federal-facing state report

CADENCE: RECURRING - Quarterly monitoring reports for the Managed Care / Healthy Opportunities Pilots and SUD portions of the demonstration, plus an annual monitoring report by Demonstration Year; the renewed demonstration runs December 10, 2024 – December 9, 2029

EVIDENCE CLASS: GOVERNING

NC HOME: NC DHHS / Division of Health Benefits — agency level (obligation sits above any single unit)

HOME BASIS: Demonstration monitoring is a division-level CMS-facing act (Lane A §2.3, §3).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): State program row: Section 1115 demonstration quarterly monitoring reports (11-W-00313/4)

BASIS: The monitoring duty is carried in the demonstration's approval terms: the 1115 extension approval package (H-025) lists quarterly monitoring reports, including implementation updates, as deliverables due 60 calendar days after the end of each quarter (30 calendar days for the fourth quarter) under STCs 15.6 and 15.10, and requires quarterly and annual expenditure reporting for the demonstration populations. The demonstration itself (NC Medicaid Reform Section 1115, 11-W-00313/4) is approved December 10, 2024 through December 9, 2029 in the same document. No actual filed quarterly monitoring report is in the held corpus; the evidence is the CMS-imposed requirement and schedule, not a produced report.

RECORD LOCATION: H-025 (H-025), 1115 extension approval package, deliverables table (STC 15.6 and 15.10) and approval period

> **SECTION 5D FACE**

UNCOVERED ELEMENT: A filed quarterly monitoring report for the demonstration; held evidence carries the STC requirement and due dates only.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Produce the most recent filed quarterly monitoring report for 11-W-00313/4.

QUESTION: Where are the filed quarterly monitoring reports for the current demonstration published?

SEARCHES RECORDED: Corpus searched for quarterly monitoring report and 1115 monitoring (H-025 STC passages only). Full map: no document is a filed 1115 monitoring report.

GUIDANCE READINGS (DETERMINATIONS FILE): Register record of evidence for the row (NC Medicaid 1115 Demonstration 11-W-00313/4 monitoring as published on the Quality page)

NC-012: Medicaid Managed Care Quality Strategy — maintenance, and the Annual Quality Report against it

CITATION: NC Medicaid Managed Care Quality Strategy (first published 2018; updated 2023); Annual Quality Report

TOPIC: Medicaid Managed Care Quality Strategy — maintenance, and the Annual Quality Report against it

OBLIGATED LEVEL: agency

CADENCE: RECURRING - The Quality Strategy is a maintained division document (2018; updated 2023); the Annual Quality Report assesses performance against its aims and goals (2021–2023 report, June 2025)

EVIDENCE CLASS: GOVERNING / Anchor: UNRESOLVED — no fixed NC-printed update interval for the Strategy was established in sources reached; not calendared as a triennial duty.

NC HOME: Division of Health Benefits — Quality Management and Improvement

HOME BASIS: Both documents publish from Quality Management and Improvement (Lane A §3).

CURE DETERMINATION: **Partial** (determiner: NC Cure grading seat F)

APPLICABILITY (DETERMINATIONS FILE): State program row: Medicaid Managed Care Quality Strategy maintenance and Annual Quality Report

BASIS: The Quality Strategy's existence and currency through 2023 are carried: the Access Monitoring Review Plan (H-124) states the Quality Strategy was first published in 2018 and most recently updated in 2023, details NC Medicaid Managed Care's aims, goals and objectives for quality management and improvement, and names the Department's priority quality improvement initiatives, and the 2025 EQR technical report (NL-05) includes a Quality Strategy section in its program overview. The cure's document search (NL-06) then found the current version is not producible from the public record: a July 1, 2025 bulletin states CMS approved the 2025 Quality Strategy and that NCDHHS published it on the Quality Management and Improvement page, but that page carries no Quality Strategy document link and the 2025 document was not found on any host searched. No document held is an Annual Quality Report against the strategy; the quality measure performance tables held (H-125) are performance and target tables, not the named annual report.

RECORD LOCATION: H-124, Access Monitoring Review Plan, p.8 (Quality Strategy passage); NL-05 (NL-05), Quality Strategy section; NL-06 cure search record (NOT-FOUND-AFTER-SEARCH)

SECTION 5D FACE

UNCOVERED ELEMENT: The current (2025) Quality Strategy document itself, and the Annual Quality Report against the strategy; held evidence carries the strategy's history through the 2023 update and a bulletin claim of a 2025 approval that the publication page does not support.

OWNER LEVEL: Division of Health Benefits (DHB)

ACTION: Publish or produce the CMS-approved 2025 Quality Strategy document and the current Annual Quality Report.

QUESTION: Where is the 2025 Quality Strategy document that the July 1, 2025 bulletin says was published?

SEARCHES RECORDED: Cure document-axis search NL-06 read in full (bulletin located, document not posted, hosts searched). Corpus searched for Quality Strategy and Annual Quality Report (H-124, H-125 and NL-05 passages read; no annual quality report document found).

GUIDANCE READINGS (DETERMINATIONS FILE): Register record of evidence for the row (NC Medicaid Managed Care Quality Strategy, first published 2018, updated 2023; Annual Quality Report)

FLAGS: Conflict: the July 1, 2025 bulletin (per NL-06) says the 2025 Quality Strategy was published on the Quality Management and Improvement page; the page carries no such document. Graded on the stronger evidence (the document is not producible) and flagged.