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.