AGENTIC ARMOR LLC

NORTH CAROLINA · MEDICAID

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.

Determination	Citation	Verdict	Section	Page
CFR-430-001	42 CFR 430.10, 430.12	Verified	Appendix only	147
CFR-430-002	42 CFR 430.16	Partial	Section 2 · Partial compliance	92
CFR-430-003	42 CFR 430.25	Partial	Section 2 · Partial compliance	21
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
CFR-430-008	42 CFR 430.42	GAP-DETERMINED	Section 3 · Missing outright	125
CFR-430-009	42 CFR 430.48	GAP-DETERMINED	Section 3 · Missing outright	125
CFR-430-010	42 CFR 430.49	GAP-DETERMINED	Section 3 · Missing outright	125
CFR-431-001	42 CFR 431.10, 431.11	Verified	Appendix only	147
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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
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NC-008	Session Law 2023-134, §9E.20	Verified	Appendix only	165
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NC-010	Quality Management and Improvement page (EQR Technical Reports, 2020-2021 through 2024-2025)	Verified	Appendix only	165
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