North Carolina
Department of Health and Human Services
Division of Medical Assistance
Recipient Services EIS
1985 Umstead Drive – 2512 Mail Service Center - Raleigh, N.C. 27699-2512
Courier Number 56-20-06

Michael F. Easley, Governor
Carmen Hooker Buell, Secretary

Nina M. Yeager, Director
(919) 857-4019

August 10, 2001

Re: Alexander Exit Plan

Dear County Director of Social Services:

This letter is to inform you of progress on the exit plan for "sunset" of the Alexander Consent Order.

Background

A status conference was held on November 17, 1999 with Judge Graham C. Mullen, Chief Judge, United States District Court for the Western District of North Carolina. The Judge directed that the state submit the exit plan to HCFA to determine whether the plan violated federal laws or regulations. (Note: HCFA is now known as the Center for Medicare and Medicaid Services (CMS).)

The plan was forwarded to CMS that responded with concerns that needed to be addressed by the state. The state addressed these concerns after conferring with a county workgroup. The counties that participated were Duplin, Forsyth, Johnston, Martin and Sampson. The plan was ultimately submitted to CMS several times and each time input from the county workgroup was sought. Legal Services also submitted to CMS their objections to the plan. We would like to take this opportunity to thank the members of this group for their invaluable assistance with review and revision of the plan.

CMS Approval

The exit plan was approved by CMS in June 2001. A motion has been filed to terminate the Consent Order. Legal Services requested information regarding the state's compliance with the corrective action requirements of the Consent Order. Legal Services also requested monitor staffing needs for the exit plan. DMA has forwarded the requested information to Legal Services.

Attached to this letter you will find copies of the following:

- Plan to Assure Timely and Quality Services to Applicants for Medicaid
- Addendum - Excluding Days from the Processing Time
- Renewal Motion to Terminate Class Action
- Approval letter from CMS (HCFA)

You can see from the last attachment that the exit plan is now in compliance with all federal regulations. At this time the following action is being taken:

- DMA is reviewing the exit plan to address policy and EIS systems changes needed to implement the provisions of the exit plan, once the court makes its decision.
- Legal Services has until August 15, 2001 to respond to the motion to terminate the litigation. If they object to the motion, the judge will most likely schedule a hearing that will include representatives for the state and the plaintiff.

We will keep you apprised of further developments.

Sincerely,

Nina M. Yeager

Revised Final Version
04/25/01

ALEXANDER V. BRUTON
(C-C-74-183-MU)

EXHIBIT A

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

PLAN TO ASSURE TIMELY AND QUALITY SERVICES TO APPLICANTS FOR MEDICAID

I. INTRODUCTION

Under the mandates and authority of federal and state laws and regulations, this Plan of the Department of Health and Human Services ("Department"), as described herein, establishes a clear and definitive process for assurance of the timely acceptance and processing of Medicaid applications. The Plan shall apply solely to applications for Medicaid coverage that is an entitlement, i.e., all individuals applying who meet the financial and categorical criteria. However, the Plan shall also apply to coverage groups which are not entitlements due to capped federal funding if they are included within Title XIX of the Social Security Act The Plan provides for performance expectations, measurement of expected outcomes, and corrective action measures including provisions for enforcement.

INTAKE

II. (a) Right to Apply

The Department shall continue to assure that all county Departments of Social Services ("DSS's") afford individuals the right to apply for medical assistance ("Medicaid") without delay. 42 C.F.R.§435.906 Specifically, the Department shall assure that DSS's accept applications and do not discourage potential applicants from applying. In all cases, the DSS will require a signed, written application for Medicaid from the applicant and a signed "Notice of a Right to Apply" when application is made at the DSS office or DSS outstation location (See Exhibit A) 42 C.F.R.§435.907

For the purposes of this plan, discouragement by DSS may be presumed if a DSS (a) requires or suggests that the individual wait to apply until other benefits have been applied for or approved

(or denied) or until verification has been obtained; (b) incorrectly states or suggests that the individual is not eligible for Medicaid; or (c) gives materially incorrect or incomplete information about available Medicaid programs or options. The burden of proving the facts constituting discouragement shall be on the individual.

(b) Application Interviews

The DSS shall maintain a daily log of every person who appears at the DSS expressing medical or financial need. The log shall contain the person's name, date of visit, reason for visit and the outcome of the visit. (See Exhibit B)

An individual has the right to apply the same day he comes to the DSS expressing a need for medical assistance. He must be given the opportunity to be interviewed for the purpose of explaining all available Medicaid programs appropriate to his circumstances and completing a signed, written application for Medicaid if appropriate. 42 C.F.R.§ 435.907 An interview shall take place on the first day the individual requests assistance in person unless: (a) the individual arrives at DSS and there is insufficient time to conduct an interview (i.e., within one hour before the end of the work day); (b) the individual voluntarily leaves DSS before he can be interviewed; or (c) the individual makes a request for an appointment on another day.

The DSS must explain all available Medicaid programs and options appropriate to the individual's circumstances and discuss the advantages and disadvantages of each program or option for which a potential applicant may qualify. 42 C.F.R. §435.404 The Department will assure that all inquires and withdrawals are clearly documented by DSS and written notice of the reason for inquiry/withdrawal and right to appeal given or mailed to the applicant. (See Exhibit C) Inquiries or withdrawals subsequently determined to have been improper are subject to corrective action defined in Section IV.(b)(4). below.

Every applicant shall be furnished written and oral information about Medicaid eligibility requirements, available Medicaid services and rights and responsibilities of the applicant. 42 C.F.R.§435.905

III. PROCESSING

(a) Time Standards

The Department and the DSS shall assure that Medicaid applications are processed within the following time standards except as provided otherwise herein:

(1) Forty-five (45) days for Medicaid applications not based on disability ("Other Medicaid applications"). *This includes* the Medicaid benefit for Work First ("TANF") applicants.

(2) Ninety (90) days for all Medicaid applications based on disability ("MAD");

42 C.F.R. §435.911

(3) Seventy (70) days for the Disability Determination Section ("DDS") to process their portion of Medicaid applications requiring a determination of disability.

For these applications, the time standards established pursuant to federal regulations are computed from the date the application is signed to the date a written notice of decision is mailed or given to the applicant (except that when an application is taken by mail, the date a signed, completed application is received by the DSS is considered the date of application). 42 C.F.R. §435.911. When the 45th or 90th day falls on a weekend, holiday or on other days the DSS or DDS is closed because of unforeseen or exceptional circumstances (e.g. adverse weather conditions, office relocation), the 45th or 90th day shall be deemed to be the next work day. Where an individual applies for full Medicaid benefits, that application continues to pend while any deductible ("spenddown")is unmet and after "MQB" benefits are approved. Applications for prospective and retroactive Medicaid coverage are to be processed separately.

(b) Internal Processing Compliance Thresholds.

In each Medicaid program category compliance with the requirement to process applications within the legal time standard shall be measured each month for each county and recorded on an "Internal Report Card". The Internal Report Card shall contain only those categories identified in Section III (a)(1)(2) and (3). In each Report Card program category, compliance will be measured against a "processing compliance threshold" consisting of the Average Processing Time ("APT") and the Percentage of Cases Processed Timely ("PPT"). The purpose of the thresholds is to take appropriate corrective action, if necessary, consistent with the provisions of Section V, when a DSS or the DDS fails to meet the processing compliance standards of Section III (a).

(1) The processing compliance threshold for Other Medicaid applications shall be 90% for Level II and III DSS's and 85% for Level I DSS's (i.e., 90% or 85% of all applications shall be processed by the forty-fifth (45th) day, and the average processing time shall be no more than 45 days).

(2) The processing compliance threshold for all Medicaid applications based on disability shall be 90% for Level II and III DSS's and 85% for Level I DSS's (i.e., 90% or 85% of all applications shall be processed by the ninetieth (90th) day, and the average processing time shall be no more than 90 days).

(3) The processing compliance threshold for the DDS shall be 90% for Level II and III DSS's and 85% for Level I DSS's (i.e., 90% or 85% of all disability applications completed statewide in a month shall be processed by the seventieth (70th) day).

For purposes of measuring the internal processing compliance thresholds and taking appropriate corrective action if necessary, delays not within the control of a DSS or the DDS shall be excluded from the processing time. Such delays shall include the days for which the application pends solely for verification of sufficient medical expenses to meet a Medicaid deductible ("spenddown"), an approved FL-2 determination for level of care for a CAP or long term care applicant or medical determination of dates of emergency care for an undocumented alien or delays in obtaining medical evidence or results of a consultative examination for a disabled applicant.

(c) Mandated Processing Standards and Monitoring of Inconsistent Compliance Reports

The Department recognizes that the time standards for processing Medicaid applications must cover the period from the date of application to the date a notice of decision is mailed to the applicant and will take measures to insure that the applicable time standards for processing Medicaid applications are complied with. 42 C.F.R. § 435.911. An "Actual Time Report Card" shall be developed each month for every DSS and the DDS which will be identical to the Internal Report Card with the exception that it will not record any exclusions of time.

When a DSS or the DDS is in compliance with the applicable processing threshold in a Report Card program category as reflected on the Internal Report Card but is out of compliance in that program category for the same time period as reflected on the Actual Time Report Card for three (3) consecutive months or five (5) out of twelve (12) months, staff of the Division of Medicaid Assistance ("DMA") shall substantiate the accuracy and correctness of the excluded time. The DSS or DDS will take appropriate corrective action as directed by the DMA.

(d) Obtaining Information

During the interview for a face-to-face application and upon assessment of a mail-in application, the DSS shall identify information necessary to determine eligibility and will negotiate with the applicant during the interview, or by telephone for mail-in applications, to determine who can most readily obtain the necessary information. The DSS will be responsible for obtaining information in the following circumstances: (1) when there is a fee for obtaining the information; (2) when it is available within the agency; (3) when the applicant requests assistance; or (4) DSS is required by federal law or regulation or administrative rules to assist or to use inter and intra agency verification aids. Additionally, the DSS will be responsible for obtaining information when the applicant is mentally, physically, or otherwise incapable (e.g., unable to speak English, unable to read and write, housebound, hospitalized, institutionalized, or otherwise clearly unable to obtain the requested verification without assistance), except where an able family member or other client representative accepts responsibility for obtaining verification and has not requested assistance. 42 C.F.R.§435.908

The applicant and any third party shall be given written notice of the information he is requested to provide and a reasonable time to provide the information of at least 12 days (which includes mail time) after the date the written request is mailed or is given to the applicant or third party. If the information requested from the applicant or third party is not returned by the requested date, or is returned incomplete, the DSS shall make a second written request for the missing information and, in the case of the applicant, offer assistance and additional time if needed. A reasonable time of at least 12 days (which includes mail time) after the request is mailed shall be allowed for the applicant or third party to provide the requested information.

If the applicant or a third party contacts the DSS to request additional time, the DSS shall allow additional time of least 12 days (which includes mail time).

If additional information or action is needed from the applicant to process a disability determination, the DDS shall contact the applicant by telephone or in writing and allow a reasonable time of at least 12 days (which includes mail time) for the applicant to supply the information or take the requested action. **20 C.F.R. §§ 416.901-998.**

If a disabled applicant fails to provide DDS with the requested information or take the requested action within the time allotted and has alleged a mental impairment, the DDS shall make a follow-up contact to again request the information or action and allow at least 12 days (which includes mail time) for the applicant to act. The DDS shall apply policies employed for Titles II and XVI claims to determine if special circumstances warrant exception when an applicant refuses or fails to attend a scheduled consultative examination or if good cause for failure to cooperate may be involved.

(e) Decision

An application may be denied at any time it is established and documented in the DSS case record that (1) the applicant is not eligible under any Medicaid program or category; (2) the applicant has voluntarily withdrawn his application; (3) the applicant cannot be located; (4) the applicant refuses or fails to cooperate (including failure to keep appointments or take required actions) or information necessary to establish eligibility is not provided; or (5) if it is established that the applicant does not have sufficient predicted medical expenses to meet the deductible ("spenddown") obligation. The notice of denial shall specify the precise reasons for the denial, the regulatory basis therefor and the right to a hearing if the applicant disagrees with the action to deny his application or the reasons for denial pursuant to N.C.G.S. §108A-79 and administrative rules governing appeal rights. The case record shall document the facts to support the DSS or DDS decision and indicate that the DSS or the DDS sent a notice confirming that an application was withdrawn voluntarily, that the applicant can not be located or that the applicant has failed or refused to cooperate. **42 C.F.R.§§435.912 & 435.913.**

IV. INTERNAL MONITORING PERFORMANCE

(a) The Department shall continue to employ a sufficient number of trained individuals to act as monitors for the purpose of monitoring the compliance of each DSS and the DDS as set forth below. However, the Department, through its Medicaid Program Representatives ("MPR"), shall at all times provide technical assistance, training and/or consultation to any DSS requiring or requesting same.

(b) Performance Measures and Schedule

(1) Acceptance without Delay

Subject to a county's schedule for monitoring for timeliness of processing, each county shall be monitored to assure that acceptance of and dispositions of applications are correct under this Plan and federal regulations.

(2) Timeliness of Processing by DSS

(i) Any county that meets the internal processing compliance threshold for each month in each Medicaid category as determined in the month in which this Plan is approved for the preceding twelve (12) months and thereafter in January of each year, shall be monitored no less frequently than every other year.

(ii) Any county that fails the internal processing compliance threshold in the MAD category only for any month or months solely because of delay by the DDS shall be monitored no less frequently than every other year.

(iii) Any county that fails the internal processing compliance threshold for one or two months in any Medicaid category shall be monitored on an annual basis, except that the chief monitor in his sole discretion may waive annual monitoring if the DSS submits a request for waiver because the failure was beyond the control of the agency. The DSS must supply clear and convincing evidence that it took all steps reasonably possible to timely process all applications in the category and months of failure.

(iv) Any county that fails the internal processing compliance threshold for three or more months in any Medicaid category shall be monitored on an annual basis.

(3) Timeliness of Processing by DDS

(i) If the DDS meets the DDS internal processing compliance threshold for processing disability determinations statewide for each month as determined in the month in which this Plan is approved for the preceding twelve (12) months and thereafter in January of each year, it shall be monitored no less frequently than every other year.

(ii) If the DDS fails to meet the internal processing compliance threshold

for processing disability determinations statewide for one or two months, it shall be monitored on an annual basis except that the chief monitor may in his sole discretion waive annual monitoring if the DDS failure was beyond its control. The DDS must request a waiver and supply clear and convincing evidence that it took all steps reasonably possible to timely process all disability determinations for that month.

(iii) If the DDS fails to meet the DDS internal processing compliance threshold for three or more months, it shall be monitored on an annual basis.

(4) Other Monitoring

The Department may require monitoring of any DSS or the DDS at any time creditable allegations are made indicating failure of a DSS or the DDS to comply with this Plan and program policies for accepting and processing applications in the Medicaid categories subject to this Plan.

(c) Process and Content of Monitoring

(1) Subject to the provisions stated in (a) and (b) of this section, monitoring may be conducted onsite at the DSS or the DDS or at a central location. The DSS's and the DDS shall be notified upon determination under (b) (2) and (3) of this Section whether or not it is subject to be monitored in that calendar year. However, the monitoring calendar shall be unannounced. Upon notification to the DSS or the DDS of the sample of cases to be monitored, the DSS or the DDS shall within three (3) work days prepare the requested work space and files in the possession of the DSS or DDS selected for monitoring or transmit the original files and documents to the monitoring unit. Upon such notification, no alteration of the files shall be allowed. However, the monitors shall have discretion to request additional documentation or explanation from the agency if it appears that documentation is missing.

(2) The chief monitor and his staff shall develop monitoring instruments to document their review and findings for the expected and desired outcomes consistent with this Plan. Application processes may be monitored as a means to assure that applicants are not denied benefits to which they are entitled. However, errors that are discovered and corrected prior to a case being monitored, or inadequate documentation, shall not be cause for failure of any standard or outcome if the applicant is not harmed by such improper action, omission or inadequacy. Staff in the Department and in the Division of Medical Assistance ("DMA") shall have the opportunity to review the proposed instruments and provide comments for consideration by the chief monitor. The chief monitor shall resolve any disputed issues in consultation with the Department attorney and the Attorney General's Office.

(3) In monitoring for acceptance without delay, the monitors shall review all relevant documentation in the DSS file which supports the agency's actions and decisions including consideration of eligibility for dates prior to the applicant's request to withdraw, notice of inquiry

or withdrawal and for inquiries only, notice of the right to apply. The monitors shall have discretion to review the agency's application logs and contact applicants to corroborate the agency's actions and decisions.

(4) In monitoring the DSS for timeliness of processing, the monitors shall review the following in a sample of applications approved and denied, including dispositions resulting from appeal reversals and court orders:

(i) Computation of days excluded from the processing time solely due to delays for medical bills to establish when a Medicaid deductible ("spenddown") is met; awaiting an approved FL-2 determination for level of care for a CAP or long term care applicant; awaiting a decision of dates of emergency care for an undocumented alien;

(ii) Discussion of relevant Medicaid options appropriate to the applicant's circumstances;

(iii) Appropriate requests made for missing information and follow-up;

(iv) Appropriate offers of assistance in obtaining necessary information; and

(v) Correct entry of dates in EIS for application date, disposition and category of assistance.

(5) In monitoring the DDS for timeliness of processing disability determinations, the monitors shall review the following for each case in the sample that had a disability determination:

(i) Computation of days excluded from DDS processing time solely due to applicant failure to keep an appointment for a consultative examination or failure or delay in providing necessary information requested by the DDS; and

(ii) Correct entry of dates in EIS for receipt of case for disability determination and decision.

(6) The findings of the monitors may be disputed by a DSS or by the DDS only for accuracy of the days excluded or included in determining timely processing or the application of a process or standard that is not expressly included in this Plan.

(d) Sample Size and Selection

(1) The sample size shall vary according to the classification of the DSS as levels I through III as follows:

Level I	25 approvals,	30 denials,	10 withdrawals,	10 inquiries
Level II	40 approvals,	45 denials,	20 withdrawals,	20 inquiries
Level III	60 approvals,	65 denials,	30 withdrawals,	30 inquiries

(2) The sample shall be drawn from applicant dispositions made by that DSS during the 12 months immediately preceding the month in which monitoring is conducted, regardles of whether the monitoring is annual or biennial. Twenty-five percent (25%) of the sample of approvals and denials shall be from the DSS's "MAD" category and 75% from the DSS's "Other Medicaid" category.

(3) The monitors shall also select a sample of QI2 applications each year solely t determine if they were accepted and processed in compliance with the provisions of this Plan and applicable federal regulations.

(e) Notification of Monitoring Findings

The finding from a DSS's monitoring and required or recommended corrective actions shall be sent by certified mail to the DSS within 10 business days after completior of the monitoring. The DSS may dispute findings pursuant to (c)(6) of this Section within 10 business days after receipt of the findings and must provide written documentation to support its reason for dispute. Disputes on matters not expressly allowed by this Plan shall be denied. The findings shall become final if no dispute is filed or upon the response of the chief monitor to the disputed finding(s). The DSS shall take required corrective actions no later than 30 calendar days after the finding(s) is final.

The DDS shall be notified of the findings of disability cases reviewed at the same time as a DSS is notified and shall have the same rights, requirements and time frames for dispute.

CORRECTIVE ACTION

V. (a) GENERAL CORRECTIVE ACTION.

The Department is required to have methods to keep itself currently informed of the adherence of DSS's to the Medicaid State Plan provisions and the DSS's procedures for determining eligibility. Additionally, the Department must take corrective action to ensure DSS adherence. 42 C.F.R. §435.903 Accordingly, any DSS which fails to meet any processing compliance threshold of Section III (b) of this Plan for any month shall be the subject of attention by the MPR. The level of attention will be determined by the MPR based upon the degree of noncompliance and the compliance experience of the DSS. If the DDS fails its internal compliance threshold for any month, the DDS and the Division of Medical Assistance ("DMA") shall evaluate the cause(s) for delay and

determine what corrective action is appropriate. If the DDS fails its internal compliance threshold for three (3) consecutive or five (5) out of twelve (12) months, it shall be referred to the State Corrective Action Team.

(b) Reopening Final Determination of Eligibility

(1) In the event of a county or State appeal decision in favor of an applicant, the DSS shall reopen the application and request any necessary information within five (5) work days from the date the final appeal decision is received by the DSS. The application shall be processed within five (5) work days after the date the last piece of necessary information is received by the DSS. If eligible, the applicant shall be entitled to benefits retroactive to the date of application. 42 C.F.R.§431.246.

(2) The DSS shall reopen an application as an administrative reopen retroactive to the date of application upon order of a court of competent jurisdiction that overturns an agency decision of denial or an order to reconsider eligibility based on new or additional information. The DSS shall request any necessary information within five (5) work days after receipt of a court order and shall process the application within (5) work days after receipt of the last piece of necessary information. If eligibility is established, the applicant shall be entitled to benefits retroactive to the date of the initial application. 42 C.F.R.§§ 435.903 & 447.47.

(3) A Medicaid application which was denied on the basis of a Social Security denial (e.g, Title II) which is subsequently reversed upon appeal through the Social Security Administration processes will be processed as a new application under the compliance threshold for MAD applications. (See Section III. (a)(2)). Under this requirement, the processing time shall commence on the date the DSS learns of the reversal. 42 C.F.R.§§ 435.903 & 447.47. The Medicaid benefit will be retroactive to the date of the original Medicaid application if the applicant is otherwise eligible.

(4) Any Medicaid inquiry, withdrawal, or denial that is subsequently determined to be improper by the DSS or monitors shall be reopened retroactive to the date of the initial application or inquiry. If eligible, the application shall be approved for benefits retroactive to the date of application or inquiry. 42 C.F.R.§§ 435.903 & 447.47.

(c) Corrective Action by the Local Corrective Action Team

(1) Each DSS that fails to take corrective action required as a result of monitoring or fails to meet any processing compliance threshold in Section III. (b) of this Plan for three successive months or five out of any twelve months will be required to participate in a local corrective action team unless it is clear that the reason(s) for the noncompliance has been or is being corrected by the DSS. This determination will be made by the MPR and the Assistant Director for Recipient and Provider Services of the Division of Medical Assistance.

The local corrective action team will be convened by the Assistant Director for Recipient and Provider services or his designee (who shall act as Chair) within (10) days of notice that a DSS is subject to this subsection. The team will include:

-- the MPR and any additional state staff identified by the Assistant Director;

-- the DSS director and any additional staff identified by the DSS director;

-- the county manager or the chair of the county board of commissioners;

-- a member of the general public who is concerned about health care availability for low income citizens;

-- the social services board chairman or other board member;

-- an independent management consultant at the option and expense of the county.

(2) The local corrective action team may design any remedy reasonable and necessary to bring a DSS into compliance with this Plan, including but not limited to the following: employing additional staff, altering office procedures (such procedures must be consistent with federal and state regulations, laws and Department rules and policies), purchasing office equipment, retaining private consultants, and reopening of cases and ordering retroactive relief (subject to the provisions of (b) of this subsection) to applicants harmed by practices violative of this Plan. A corrective action plan will be established by the team within forty days of notice that a local corrective action team was required, and a date for compliance with the Plan shall be set. The date by which the Compliance thresholds shall be met will be based upon the extent of the problem; however, compliance must be achieved within three months after the date the compliance plan was required by this subsection to be established.

(3) Failure to take corrective actions required under the provisions of (b) of this subsection or failure to meet the compliance thresholds by the date established by the local corrective action team will result in referral to the State Corrective Action Team unless an extension of time, not to exceed three months, is granted by the State Corrective Action Team.

(d) Corrective Action by State Corrective Action Team

(1) A permanent State Corrective Action Team shall be convened by the Secretary of the Department and will include the following members:

- A representative of the Department of Health and Human Services, appointed by the Secretary;

- A representative of the NC Association of County Commissioners;

- Two representatives of county DSS's appointed by the Presidents of the following associations: North Carolina Social Services Association; North Carolina Association of County Directors of Social Services, and the North Carolina Association of County Boards of Social Services; however, in the event of a conflict of interest, an alternate representative shall be appointed;

- The Chairman of the Board of Legal Services of North Carolina or his designee;

- A recipient of Medicaid, appointed by the Secretary; and

- A representative of the Institute of Government

The Secretary of the Department shall designate a Chairperson. Upon the resignation of any member, the appointing authority shall select a replacement.

(2) The State Corrective Action Team may design any remedy reasonable and necessary to bring a DSS or the DDS into compliance with this Plan, including but not limited to the following: proposing employing additional staff, altering office procedures (consistent with federal and state laws, regulations and administrative rules and policies of the Department), purchasing equipment, retaining private consultants, reopening of cases and ordering retroactive relief to applicants harmed by practices violative of this Plan (subject to the provisions of (b) of this subsection), and recommending that the Department assist in the operation of a DSS.

(3) The State Corrective Action Team shall establish a corrective action plan within forty-five days of convening to address a noncomplying DSS or the DDS, and a date for compliance with the plan shall be set.

VI. LOCAL GOVERNMENT COMMISSION

In the event that a county and the State Corrective Action team are unable to resolve problems of DSS non-compliance, the Local Government Commission established pursuant to N.C.G.S.§159-3 may be requested to review the county budget and its fiscal condition in relation to the proposed corrective action and may assess and determine the capacity of the county to expend resources to bring the county into compliance. The Local Government Commission may take enforcement action pursuant to Chapter 159 of the General Statutes as appropriate. To assist in this review, the Local Government Commission shall have at its disposal the expertise of the various state agencies.

VII. ACCESS TO RECORDS AND DISPOSITION

All records made or received pursuant to this Plan shall be available to the public pursuant to Chapter 132 of the General Statutes, subject to protection of the applicant's rights to confidentiality as provided under N.C.G.S. 108A-80 and Title 10, Chapter 50, Section .0400 of the North Carolina Administrative Code as well Section 1902 (a) (7) of the Social Security Act [42 U.S.C. 1396a (a) (7)]. The records available under this Plan include report cards for each DSS and DDS; monitoring reports and recommended corrective actions; disputes of monitoring findings; waiver of annual monitoring; local and state corrective action plans.

The results of each DSS and DDS monitoring, including disputed findings and resolutions, shall be retained for a period of 36 months, then shredded pursuant to records disposition policies.

VIII. IMPLEMENTATION

IX. This Plan shall be implemented upon termination of the 1992 Consent Order in Alexander v. Bruton (United States District Court, Western District of North Carolina, Charlotte Division, File Number C-C-74-183-M).

NOTICE OF YOUR RIGHT TO APPLY FOR MEDICAID BENEFITS
(This is NOT the application form)

** You have the legal right to apply for Medicaid TODAY.

** You must sign an official application form to start the application process.

** Unless you sign an official application and complete an eligibility interview, you cannot receive benefits.

** If possible, you should wait to talk with a caseworker before signing an application. The caseworker can give you more information about the programs for which you may be eligible.

** If you are unable to stay to see a caseworker today, tell the receptionist immediately. Explain that you must leave but that you want to sign an application. The receptionist will schedule an appointment for you to complete the application. You will be told the appointment date and time and every effort will be made to be cooperative. However, repeated failures to keep interview appointments may result in your application being denied.

YOUR APPEAL RIGHTS

You have the right to appeal when:

- You are discouraged in any way from signing an application today.
- You are refused the right to sign an application.

To find out how to appeal, ask a Medicaid caseworker or call the state toll-free number at 1-800-662-7030.

Explanation provided by: Applicant/Representative Signature:

_____ _____

County:_____ Date: _____

Exhibit A

ALEXANDER EXIT PLAN

Excluding Days from the Processing Time (Rev. 5-29-01)

I. Principle

A. County Exclusion of Days

1. Counties will be allowed to have days excluded for more reasons than presently allowed under the Consent Order. However, the county will only be able to have one type of exclusion per application. That exclusion will only pertain to the last item needed to determine eligibility for an application. The exclusions will be for:

    a. Medical bills to meet a deductible,
    b. Receipt of the DDS disability determination decision provided that is the last item needed to determine eligibility
    c. Request for medical records for emergency dates for non-qualified aliens,
    d. Receipt of FL2/MR2,
    e. Receipt of CAP Plan of Care.

2. Counties must document in the record the reason for the exclusion of days. They will also document at what point the exclusion of days should stop.

3. Counties will use a revised date screen to document exclusion of days.

B. DDS Exclusion of Days

DDS will be allowed to exclude days due to certain client delays in determining disability. The exclusion of time will begin when an appointment for a consultative examination has been scheduled and has had to be rescheduled to a later time at the client's request, or rescheduled to a later time because the client failed to attend the scheduled examination or cancelled because of failure to attend the examination. Days will stop being excluded when the results of the examination are received or the decision is made to not reschedule the appointment.

The DDS exclusion can be used to calculate the county report card only when the disability determination is the last piece of information needed by the county. If the county has not established all other points of

eligibility prior to receipt of the DDS decision then any DDS excluded time will not be used to calculate the county report card.

C. Combination of Excluded Days for Counties and DDS

The county will always document its dates to be excluded on the EIS Date Screen while the dates on the DD Screen will always be used in calculating the DDS Report Card.

EXAMPLE: Application is taken April 2 and requires a disability decision. County determines all points of eligibility are met except for the disability decision on May 3. On that date a notice will be sent to the client that all points of eligibility have been determined except for the disability decision.

DDS began processing the disability application on April 6. On April 18, a consultative examination is scheduled for April 27. On April 27, the client calls and asks for a rescheduled consultative examination. DDS schedules the next consultative examination for May 9. DDS begins excluding days April 28. DDS receives the results of the rescheduled examination on May 15. DDS makes its decision on disability on May 18.

The days to be excluded for the DDS report card are from April 28 to May 14. The county disposes the application on May 18. The days to be excluded for the county are May 4 to May 17. These dates will be entered on the EIS Date Screen.

II. Medical Bills to Meet a Deductible

Processing time can be adjusted by excluding days that would otherwise be counted when the application is pending the medical bills to meet a deductible and the following documentary procedures have been followed.

A. All points of eligibility have been established except for receipt of medical bills to meet a deductible, and

B. The DMA-5025, "Notice of Binding Decision" is sent notifying the applicant of the deductible amount. This form cannot be sent until all other points of eligibility have been established, and

C. All medical bills received by the agency are date-stamped upon receipt. If the bills are not date-stamped, it will be assumed that the deductible was met on the date the DMA-5025 was mailed or the date the last medical bill was date-stamped, which ever is later.

Exclusion of processing time begins on the day after the DMA-5025 is mailed and ends on the day medical bills sufficient to meet a deductible are received.

This procedure follows current policy as outlined in MA-3303, IV. and MA-2303, IV.

III. Applicant Delays in Disability Determinations

A. DDS

Exclusion of the processing time will be keyed in the DD screen.

1. In the case of a rescheduled appointment at the client's request the exclusion of processing time begins on the date of the original appointment to the date the results of the rescheduled appointment are received by DDS.

2. In the case of no-shows involving rescheduling, the exclusion of days begins on the date of the missed appointment and ends with the date the results of the rescheduled examination are received by DDS.

4. In the case of no-shows in which a decision was made not to reschedule the appointment, the exclusion of days begins on the date of the missed appointment and ends on the date that it is determined that the appointment(s) will not be rescheduled.

B. County

1. Exclusion of the processing time begins on the date that all points of eligibility have been established except for determination of disability, and

2. Ends on the date that the disability decision is received by the county from DDS.

3. The county will use the EIS Date Screen to document its days to be excluded while DDS will use the DD Screen.

IV. Undocumented/non-qualified Alien Emergency Care

Excluded time will be for delays in obtaining medical evidence in the cases of undocumented/non-qualified aliens.

This exclusion of time will also apply to the qualified aliens who are here during their first five years and are only eligible for emergency care during those 5 years.

A. All points of eligibility have been established except for determining dates of emergency care, and

B. Medical records required to determine emergency days have been requested twice from the provider at least 12 days apart using MA-2504/MA-3404, Figure 4.

Exclusion of the processing time begins on the date that all other eligibility factors are met and the medical records have been requested from the provider twice and the second 12 days are finished. Exclusion of the processing time ends when the medical records are received from the provider and are date stamped.

If incomplete medical records are received from the provider, processing time can be excluded each time the complete records are requested from the provider after the first two requests at least 12 days apart have occurred.

V. Receipt of Approved FL2/MR2

A. All points of eligibility have been established except for receipt of an approved FL2/MR2, and

B. A notice is sent to the applicant that all points of eligibility have been determined except for receipt of the approved FL2/MR2, and

C. The approved FL2/MR2 is date stamped upon receipt. If the item is not date stamped, it will be assumed that the approved FL2/MR2 was received on the date that the notice was mailed to the applicant.

D. If the client is eligible as Private Living Arrangement, then procedures in II. above would apply.

VI. Receipt of Approved CAP Plan of Care

A. All points of eligibility have been established except for receipt of an approved CAP Plan of Care, and

B. A notice is sent to the applicant that all points of eligibility have been determined except for receipt of the approved CAP Plan of Care, and

C. The approved CAP Plan of Care is date stamped upon receipt. If the approved CAP Plan of Care is not date stamped, it will be assumed that the approved CAP Plan of Care was received on the date that the notice was mailed to the applicant.

D. If the client is eligible as Private Living Arrangement, then procedures in II. above would apply.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION
FILE NO. C-C-74-183-M

CLARA ALEXANDER, et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	**RENEWAL MOTION TO TERMINATE CLASS ACTION PURSUANT TO FED. R. CIV. P. 60(b)**
	)	
	)	
DAVID BRUTON, et al.	)	
	)	
Defendants.	)	

NOW COME the Defendants and respectfully renew their Motion to Terminate Class Action Pursuant to Fed. R. Civ. P. 60(b) originally filed herein on March 20, 1998.

In support of this Motion the Defendants say and aver that:

1. On November 17, 1999 this Court orally directed the Defendants to submit their "Plan to Assure Timely and Quality Services to Applicants for Medicaid (hereinafter referred to as the "Exit Plan") to the Health Care Financing Administration of the United States Department of Health and Human Services (hereinafter referred to as "HCFA" although recently renamed the "Centers for Medicare & Medicaid Services") for a determination of whether the Exit Plan meets all applicable federal laws and regulations.

2. On December 1, 1999 the Defendants submitted the Exit Plan to HCFA for review.

3. In response to the comments and concerns of HCFA the Defendants revised the Exit Plan on three (3) occasions.

4. On May 31, 2001 HCFA wrote the Director of the Division of Medical Assistance of the North Carolina Department of Health and Human Services that "the Exit Plan now meets all federal statutory and regulatory requirements" and "is now in compliance with all federal laws

and regulations." See Exhibit "A" attached hereto.

5. On June 6, 2001 counsel for the Plaintiffs wrote HCFA renewing their request to comment on the revised Exit Plan, which request HCFA granted.

6. On June 18, 2001 counsel for the Plaintiffs faxed and mailed their comments to HCFA.

7. On June 20, 2001 HCFA wrote counsel for the Plaintiffs as follows:

We will advise the State that our May 31, 2001, letter stating that the Exit Plan meets all statutory and regulatory requirements stands.

See Exhibit "B" attached hereto.

WHEREFORE, having complied with this Court's directive and secured the approval of the Exit Plan by HCFA, the Defendants renew their Motion to Terminate Class Action Pursuant to Fed. R. Civ. P. 60(b). The Defendants hereby incorporate herein by reference their Memorandum of Law in support of their original Motion to Terminate Class Action.

Respectfully submitted this 29th day of June, 2001.

THE EDMISTEN & WEBB LAW FIRM

By: _____

WILLIAM WOODWARD WEBB
P.O. Box 1509
Raleigh, NC 27602
State Bar #4624

NORTH CAROLINA DEPARTMENT OF JUSTICE

By: _____ (by ehk)

ROBERT J. BLUM
Special Deputy Attorney General
PO Box 629
Raleigh, NC 27602
State Bar#5115

CERTIFICATE OF SERVICE

This is to certify that the undersigned attorney has served a copy of the foregoing ***Renewal Motion to Terminate Class Action Pursuant to Fed. R. Civ. P. 60(b)*** by depositing a copy of same in a postpaid wrapper in a post office or official depository under the exclusive care and custody of the United States Post Office, properly addressed as follows:

William D. Rowe, Esquire
North Carolina Justice
& Community Development Center
224 South Dawson Street
P.O. Box 28068
Raleigh, NC 27611

Douglas Sea
Attorney at Law
1930 Mecklenburg Avenue
Charlotte, NC 28205

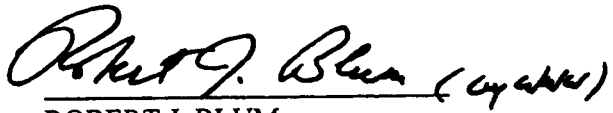
This the 29th day of June, 2001.

THE EDMISTEN & WEBB LAW FIRM

By: 

WILLIAM WOODWARD WEBB
P.O. Box 1509
Raleigh, NC 27602
State Bar #4624

NORTH CAROLINA DEPARTMENT OF JUSTICE

By: 

ROBERT J. BLUM
Special Deputy Attorney General
PO Box 629
Raleigh, NC 27602
State Bar#5115

EXHIBIT "A"

MEDICARE • MEDICAID
Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration – Region IV

Sam Nunn Atlanta Federal Center
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303 - 8909

May 31, 2001

Mr. Paul R. Perruzzi, Director
Division of Medical Assistance
Department of Health and Human Services
1985 Umstead Drive
2517 Mail Service Center
Raleigh, NC 27699-2517

Dear Mr. Perruzzi:

Thank you for your continued efforts to develop an Exit Plan that will allow resolution of the Alexander v. Bruton law suit, while establishing a clear and definitive process for the assurance of the timely acceptance and processing of Medicaid applications. We are pleased to tell you that, with the latest modification to the Plan, the Exit Plan now meets all federal statutory and regulatory requirements.

We reviewed your modifications to the Plan dated May 3, 2001, in response to our January 22, 2001, letter. Our only concern with the May 3, 2001 Plan modifications was the exclusion of the days in which the Division of Medical Assistance (DMA) was making the decision on "emergency services" for undocumented aliens as specified on page 4 of the document "Excluding Days from the Processing Time". We believe it is not appropriate to exclude these days as they are within the control of DMA. On May 29, 2001, you resubmitted the document omitting the section that excluded the days for the determination of emergency services by DMA. The Alexander Exit Plan is now in compliance with all federal laws and regulations.

If you have any questions, please contact Michael McDaniel at (404) 562-7413 or e-mail mmcdaniel2@hcfa.gov.

Sincerely,

Eugene A. Grasser
Associate Regional Administrator
Division of Medicaid and State Operations

CC: Bob Tomlinson, HCFA
William Woodward Webb
Robert J. Blum
William D. Rowe