NC Medicaid Provider Operations

Virtual Office Hours
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NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES
Division of Health Benefits

Agenda

1. Welcome & Introduction
2. H.R. 1 Updates
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11. Reminder – Maintain Accurate Provider Record in NCTracks
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H.R. 1 Medical Frailty Overview

Sarah Gregosky
Assistant Secretary & Deputy Medicaid Director

Agenda

- Overview of Medical Frailty and Federal Definitions
- NC Medicaid's Approach for Defining and Verifying Medical Frailty
- Medical Frailty Policy Timeline
- Provider Resources

H.R. 1 Background – Community Engagement Requirements

H.R. 1 Medical Frailty Exclusion

On July 4, 2025, House Reconciliation bill (H.R. 1), was signed into law. The new federal law requires some low-income adults, ages 19 through 64, who are enrolled under Medicaid expansion (MXP), to participate in qualifying activities (e.g., have a monthly income of $580 per month, work, participate in a work training program, go to school or volunteer in the community) for at least 80 hours per month to be eligible for Medicaid health coverage.

An individual who is medically frail or otherwise has special medical needs is excluded from mandatory participation in qualifying activities for community engagement. Medical frailty is defined in H.R. 1 as an individual:

- who is blind or disabled (as defined in section 1614)*
- with a substance use disorder
- with a disabling mental disorder
- with a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living or
- with a serious or complex medical condition

* A determination must be made by Disability Determination Services (DDS) to validate that an individual meets the definition of blind or disabled in section 1614 of the Social Security Act.

Evaluating Community Engagement Exclusions

Step 1: Identify Excluded Population

Individuals must first be identified as an excluded or applicable individual to determine whether assessment for compliance with community engagement requirements can occur.

- Exclusions are evaluated in the current month.
- If an individual meets any of the exclusions below, they are NOT subject to community engagement requirements.

- Medically frail
- Participant in a drug or alcohol treatment and rehabilitation program
- Member of a household receiving SNAP and not exempt from SNAP work requirements
- Meet TANF work requirements
- Pregnant or entitled to postpartum coverage
- Parents, guardians, caretaker relatives or family caregiver of a dependent child under age 14 or a person with a disability
- American Indians, Alaska Natives and IHS eligible
- Veteran with a total disability rating (100%)
- Inmates of a public institution (prison or jail)
- Former foster care youth under age 26

Individuals that meet an exclusion are “Specified Excluded Individuals.” Those who do not meet an exclusion are “Applicable Individuals” and continue to Step 2.

Evaluating Community Engagement Exceptions and Activities

Step 2: Review Prior Months for Applicable Individuals

Qualifying activities and mandatory/short-term hardship exceptions are evaluated during the review period:

- Applicants must meet them in each of the three consecutive months prior to the application month.
- Current beneficiaries must meet them in at least three of the months in the prior certification period.

Qualifying Activities

- At least 80 hours per month of work, community service or participate in a work training program
- Enrolled in an educational program at least half time
- Any combination of the above totaling at least 80 hours per month
- Monthly income of $580 per month (for seasonal workers over a 6-month period)

Short-term Hardship Exceptions

- Reside in a county with a federally declared emergency or disaster
- Reside in a county with a high unemployment rate
- Was in an inpatient hospital, nursing facility, intermediate care for individuals with intellectual disabilities, inpatient psychiatric hospital (or other services of similar acuity)*
- Individual or their dependent must travel outside of their community for an extended period to receive necessary medical services not available within their community of residence*

Mandatory Exceptions

- Children up to age 19
- People who qualify for Medicare
- People who get Supplemental Security Income (SSI) or Social Security Disability Insurance or (SSDI)
- People who were incarcerated (in jail or prison) at some time during the last 3 months

* Must be requested by the applicant or beneficiary.

CMS Interim Final Rule – Medically Frail Definition

CMS Definition of Medically Frail

The CMS interim final rule (IFR), effective July 31, 2026, added important restrictions and requirements to the medically frail exclusion. A “medically frail” individual is defined as someone whose physical, mental or behavioral health condition significantly impairs their ability to comply with the community engagement requirement.

- Functional Impairment: Diagnosis alone is not sufficient, the condition’s severity and impact on function are critical. States need to establish standards linking the severity of a particular condition to an individual’s ability to work.
- No State Expansion: States cannot add additional categories to the definition for community engagement purposes beyond those listed in H.R. 1.
- Lists and Processes: States must develop auditable and justifiable lists of qualifying diseases, diagnoses, disorders and other health conditions (e.g., using ICD-10 codes) and update them regularly. If a condition is not on the list, individuals must have a process to request consideration for the exclusion.
- Limits on Use of Attestation: The IFR allows states to use attestation for medical frailty (in the absence of electronic data) in year one, with limits on the use of attestation beginning in 2028.

Note: HB 696 has further limitations on attestation

Tiered Approach for Defining Medical Frailty

NC Medicaid Definition of Medically Frail

As suggested by CMS, NC Medicaid is using a tiered approach to defining medical frailty. The Department's team of clinical experts have defined each tier and the codes to include.

Tier 1

- *Standalone* diagnoses and services that indicate the condition significantly impairs an individual's ability to work. Automatic detection using this tier begins Jan. 1, 2027.
- Beneficiaries who are Behavioral Health and Intellectual/Developmental Disabilities Tailored Plans eligible are automatically included in this tier.

Tier 2

- A *combination* of diagnoses, services, medications and/or durable medical equipment (DME) that together indicate the condition significantly impairs an individual's ability to comply with the community engagement requirements.
- Beginning Jan. 1, 2027, if an individual has a Tier 2 code, documentation from the beneficiary (completed by their provider) confirming that the individual has a condition that impairs their ability to work or otherwise meet the community engagement requirement must be submitted to their local Department of Social Services (DSS).
- Finalized criteria for Tier 2 and the ability to detect Tier 2 eligibility automatically through claims data and Electronic Health Records (EHR) will be implemented later in 2027.

NC Medicaid Definition of Medical Frailty – Tier 1

Medically Frail Tier 1 Diagnoses/Services by Category

Tailored Plan Eligible

Already defined. Includes those enrolled in a Tailored Plan and those eligible for, but not enrolled in, a Tailored Plan (including individuals in a Standard Plan or NC Medicaid Direct).

Blind or Disabled

Already defined. Based on a determination made by Disability Determination Services (DDS) to validate an individual meets the definition of blind or disabled in section 1614 of the Social Security Act.

Disabling Mental Disorder

- Major depressive disorders – moderate to severe
- Bipolar disorders
- Schizophrenia and other chronic psychotic disorders
- Anorexia/bulimia nervosa – moderate to extreme
- Post-traumatic stress disorder
- Agoraphobia
- Enhanced Assertive Community Treatment (ACT) and inpatient treatment services

NC Medicaid Definition of Medical Frailty – Tier 1 (Continued)

Medically Frail Tier 1 Diagnoses/Services by Category

Substance Use Disorder

- Alcohol or drug dependence (e.g., opioid, cannabis, stimulants, other psychoactive substances, excluding tobacco-related)
- Certain conditions arising due to withdrawal or chronic alcohol/substance abuse or dependence (e.g., seizures, dementia, psychosis)
- Withdrawal management, Opioid Treatment Program (OTP), Substance Abuse Intensive Outpatient Program (SAIOP), Substance Abuse Comprehensive Outpatient Treatment (SACOT), residential and inpatient substance use disorder treatment services

Physical, Intellectual or Developmental Disability

- Age-related cognitive decline
- Cerebral palsy
- Chromosomal abnormalities
- Central nervous system diseases/disorders and spinal cord injuries
- Certain fractures, surgeries or other injuries (e.g., spine, head, leg)
- Use of certain medical equipment (e.g., wheelchair)

NC Medicaid Definition of Medical Frailty – Tier 1 (Continued)

Medically Frail Tier 1 Diagnoses/Services by Category

Serious or Complex Medical Condition

- Cancer, malignant neoplasms, chemotherapy/radiation treatments
- End-stage renal disease, failure/disease of kidney, heart, etc.
- Organ transplants, removals, and other major surgeries
- Diabetes (Type 1 and Type 2) with complications
- Heart failure with complications
- Use of certain medical equipment (e.g., insulin pump, oxygen)
- Infections, diseases and viruses (e.g., tuberculosis, sepsis, HIV)
- Dementias

Note: These are examples of some diagnoses/services included in Tier 1 for each category of medical frailty. This list is NOT comprehensive.

Verifying Medical Frailty

Verification Process

Information provided in Medicaid applications and recertifications must be verified prior to making an eligibility determination. Local DSS will follow the same approach for verifying medical frailty as they do with other information.

Step 1: Check Online Data Sources

- Applications: Information provided in an application will be validated against all available online data sources and verified automatically, when applicable.
- Recertifications: When possible, recertifications (renewals) will be completed ex parté. Online data sources will be used to validate the beneficiary is still eligible without contact from their local DSS caseworker.

Step 2: Request Manual Documentation

- Applications and Recertifications: For information that may impact an applicant or beneficiary's Medicaid eligibility that cannot be verified via online sources, caseworkers will send a Request for Information form by mail (followed by a text/email reminder) to obtain manual documentation.
- Beneficiaries can return the required documentation by mail, drop it off at their local DSS or upload in an enhanced ePASS account. This documentation can include the completed Provider Attestation form.

Verifying Medical Frailty (Continued)

Verification Process

Step 3: Accept Applicant/Beneficiary Attestation

- Applications: Answers to questions on the signed application (attestation) may be used as verification in the event the applicant cannot reasonably provide manual documentation.*
- Recertifications: Information provided on the recertification form (attestation) may be used as verification in the event the beneficiary cannot reasonably provide manual documentation.*

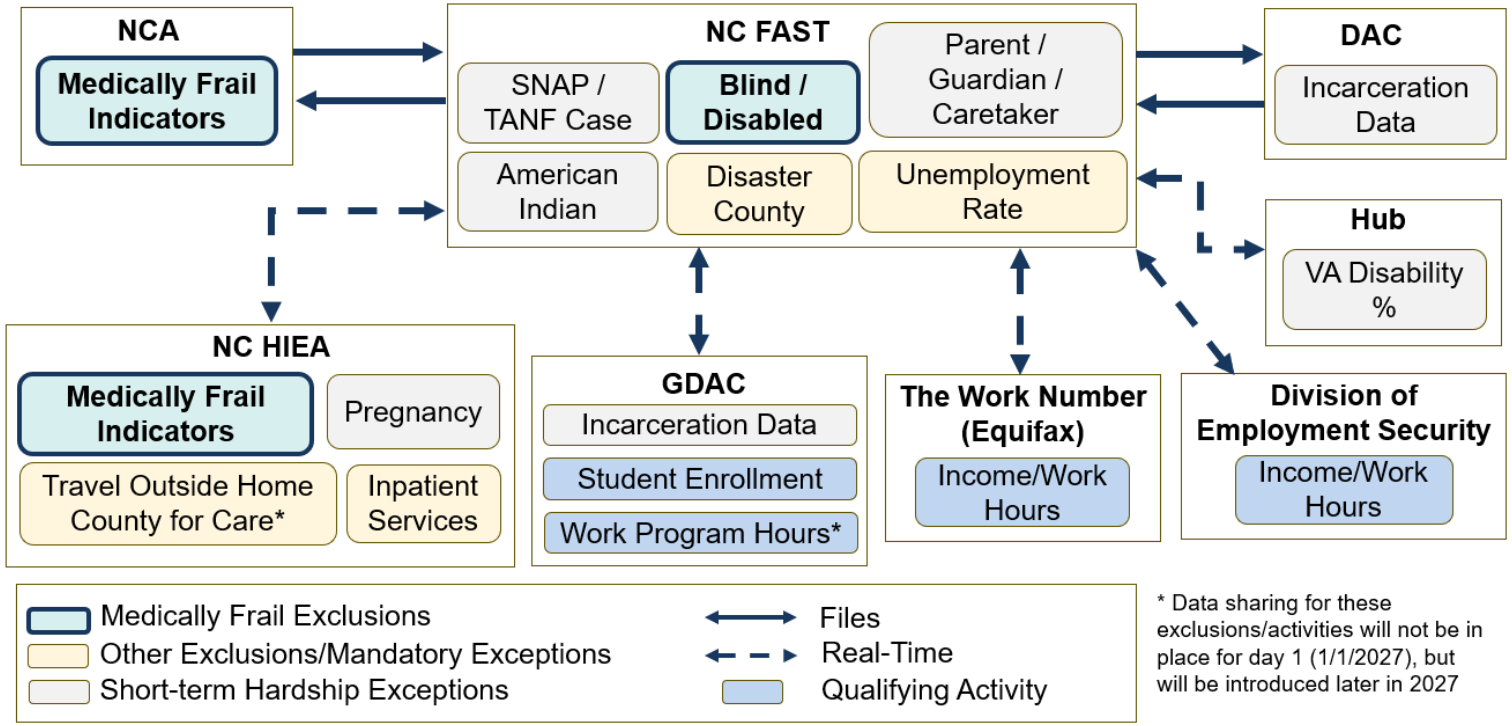
* Individuals who do not respond to a Request for Information or recertification form may be determined ineligible due to failure to respond to the request.

Verifying Medical Frailty (Continued)

Online Data Sources

NC Medicaid will first try to identify people that meet the medically frail exclusion automatically using health information it already has (claims and encounters data from NCAnalytics (NCA) and electronic health records from NC Health Information Exchange Authority (HIEA).

Data for other exclusions, mandatory exceptions, short-term hardship exceptions and qualifying activities will come from information already in NC FAST (e.g., parents/guardians), from existing data sharing processes (e.g., GDAC/DAC, The Work Number) or from new data sources (e.g., HIEA).



Verifying Medical Frailty (Continued)

Provider Attestation Form

NC Medicaid worked with the NC Division of Child and Well-being to update an existing form used by SNAP to serve as provider attestation of medical frailty for Medicaid when electronic data are not available or a condition is not on the medically frail code list.

DSS-8209 Medical Report - Work Requirement Exclusions and Exemptions

- Collects information related to pregnancy, substance use disorder (SUD) treatment program participation and medical frailty.
- Signed by the provider, the form will confirm the individual has a condition or diagnosis that impacts their ability to work.
- Includes instructions for the individual, provider and local DSS caseworker.
- Will be sent with a request for information form at application or recertification, if applicable.
- Can serve as verification for 12 months.

Timeline for Medical Frailty Policy

NC Medical Frailty Clinical Coverage Policy (CCP)

NC Medicaid's new medical frailty CCP outlines NC Medicaid's approach, criteria and documentation process to be used to determine medical frailty exclusions from community engagement requirements beginning Jan. 1, 2027.

- Aug. 6, 2026 – NC Medicaid shared the draft medical frailty CCP with the Physicians Advisory Group (PAG) for feedback.
- Oct. 6, 2026 – The draft medical frailty CCP, Tier 1 and Tier 2 code lists, and the draft provider attestation form were posted for a 30-day public comment period.
- Nov. 5, 2026 – Public comment period ends.
- Dec. 1, 2026 – The final CCP, Tier 1 and Tier 2 code lists and provider form will be posted
- Jan. 1, 2027 – Effective date of the medical frailty CCP and code lists.

Materials are posted for public comment on medicaid.ncdhhs.gov/meetings-notices/proposed-medicaid-policies.

Final materials will be posted here on Dec. 1, 2026, medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies.

Provider Resources

H.R. 1 Resources

- Visit NC Medicaid's provider-specific H.R. 1 webpage to learn more about the requirements medicaid.ncdhhs.gov/providers/federal-medicaid-changes-what-providers-need-know.
- General information about the community engagement requirements can be found at Medicaid.nc.gov/changes.
- NC Medicaid will post additional information to the Provider Playbook in the coming weeks, including H.R. 1-related FAQs.
- Join us for the quarterly Back Porch Chat Thursday, Nov. 19, from noon to 1 p.m. – you can register to attend here Register.

Unannounced Site Visits Effective Oct. 1, 2026

- Providers subject to site visits on or after Oct. 1, 2026, should expect to receive notification
- **Site visits:**
  - **Will not** be scheduled for a specific date or time
  - Must be allowed during normal hours of operation
- Failure to grant access will be treated as a failed site visit



Provider Enrollment FAQs (reference question #6)
Unannounced Site Visits bulletin

DEA Certification Required for Prescribing Controlled Substances



As of Nov. 1, 2026, Pharmacy Claims for controlled substances will be denied without an active certification

- NC Medicaid prescribers are required to report DEA certification during enrollment or utilize the DEA Designation Form
- As of Nov. 1, 2026, pharmacy claims **for controlled substances** will be denied if the prescriber does not have an active DEA certification on file in NCTracks (based on claim's date of service)
- Providers with active DEA certification are not required to take action
- Providers that used the DEA Designation Form process during enrollment **must act** to add DEA certification to their record
- Failure to add an active DEA certification will result in denied claims **for controlled-substance** prescriptions beginning with dates of service on or after Nov. 1, 2026

NCTracks DEA Certification FAQs
How to Address the DEA Certification Requirement if You Do Not Have a DEA Certification

End of Year License Renewals

Providers with licenses that expire annually are strongly encouraged to submit license renewal requests in a timely manner to avoid expirations

- It is the provider's responsibility to ensure licenses are renewed and updated by date of expiration
- Providers should be attentive to end of year licensure expirations and act accordingly

Risk Level Adjustment

The Credentialing Committee is responsible for reviewing provider files that contain flagged items for disposition of their enrollment, reenrollment and recredentialing applications

Clean Files	**Approved** by Credentialing Committee Medical Director
Low Risk	
Medium Risk	Findings that are significant but have either occurred in the distant past or have been fully resolved
High Risk	Findings that reflect serious or unresolved adverse actions where the State has discretionary authority, prior adverse licensure actions that are now resolved, substantial malpractice settlements, significant criminal findings

Risk Level Adjustment

Approved Credentialing files with the following findings are bumped up:

- A provider, owner(s), managing employee(s) that have been excluded from OIG, Medicare, SAM or any other Federal Health Care Program within the past 10 years
- A provider, owner(s), managing employee(s) with criminal convictions of offenses within NCGS 108c-4 occurring less than 10 years ago

Bump Up Process

- Fingerprinting
- Site Visit (if not already completed)
- Revalidation within two years of credentialing committee approval

Verifying a Provider's Legal Name

NCTracks requires providers to use their full legal name

Your legal name must match:

- NPPES (National Plan and Provider Enumeration System)
- Accreditation, certification, and licensure agencies
  For DEA records, only first and last name must match
- Employer Identification Number (EIN) / Taxpayer Identification Number (TIN)

Verifying a Provider's Legal Name (Continued)

Why this matters:

Matching names across systems allows NCTracks to complete credentialing and background checks successfully.

How providers can verify their legal name:

- Log into NCTracks and review the name displayed on your Provider Record
- Compare it to your government-issued ID, NPPES profile, DEA certification, and any licensing or accreditation documents
- Confirm all systems show the same full legal name

If the name in NCTracks is incorrect:

- Email NCTracksProvider@nctracks.com with supporting documentation
- Update NPPES, DEA or licensure records directly if the name on file does not match your legal ID

Provider Reverification Application Reminders

- Reverification occurs **every *five years* as required by 42 CFR 455.414.**
- **Notifications** are delivered through the secure NCTracks Provider Portal.
- **Credentials and qualifications** must remain valid and cannot expire within 30 days of the application submission date.
- During this process, **background checks** are performed (for everyone listed on the application).
- Providers are encouraged to **respond promptly** to avoid processing delays or adverse determinations.
- ***Failure to complete reverification may result in termination from NC Medicaid***

nctracks.nc.gov/content/public/providers/provider-recredentialing.html

Additions/Updates to Services under 251S

- The deadline for organizational providers enrolled under the **251S00000X (Community/Behavioral Health)** taxonomy that did not have an active service on record was **October 1, 2026**
- Organizations were required to add at least one approved service for each location associated with the 251S taxonomy or have a pending **Manage Change Request (MCR)** or revalidation application submitted by **November 6, 2026**
- Any organization that did not meet these requirements by November 6, 2026, had its **251S taxonomy terminated**
- To remain compliant, providers must submit an MCR in NCTracks to add at least one approved service type and service, as outlined in the **Provider Permission Matrix (PPM)**
- Failure to add an approved service type and service before the November 6, 2026 deadline may result in termination of the 251S taxonomy
- Termination of the 251S taxonomy can also lead to termination of the associated service location and, potentially, the provider record.

Additions/Updates to Services under 251S

- CIS Services: Updates and Additions to CIS Services

The following CIS Services are being updated to require national accreditation "within one year of enrollment in new service" (current: every three years):

- Substance Abuse Intensive Outpatient Program (SAIOP)
- Substance Abuse Comprehensive Outpatient Treatment (SACOT)
- Substance Abuse Non-Medical Community Residential Treatment
- Substance Abuse Medically Monitored Community Residential Treatment

The following CIS Services and their associated requirements are being added to the PPM:

- **Clinically Managed Residential Withdrawal Management Services:** requires a DHSR Mental Health license and national accreditation within one year of enrollment in new Service (accepted accrediting bodies are CARF, JCAHO, COA and CQL)
- **Clinically Managed Low-intensity Residential Treatment Services:** requires a DHSR Mental Health license and national accreditation within one year of enrollment in new Service (accepted accrediting bodies are CARF, JCAHO, COA and CQL)
- **Clinically Managed Population Specific High-intensity Residential Program:** requires a DHSR Mental Health license and national accreditation within one year of enrollment in new Service (accepted accrediting bodies are CARF, JCAHO, COA and CQL)

Additions/Updates to Services under 251S

- 251S is High Categorical Risk except for Nationally Accredited Providers

Per 108C-3(g)(2), the 251S00000X Community/Behavioral Health taxonomy is deemed a High Categorical Risk, which will trigger fingerprinting, the federal ACA fee and a site visit. Providers who are nationally accredited are excluded from the High Categorical Risk Screening and will be screened a Limited Categorical Risk

A pending change in NCTracks will allow nationally accredited to upload their accreditation and bypass the High Categorical Risk screening questions during the application process (for initial enrollment, reenrollment, revalidation and MCR applications) and be screened as Limited Risk. Until then, a manual process in place for providers who are nationally accredited. Contact the Provider Ombudsman at Medicaid.providerombudsman@dhhs.nc.gov 866-304-7062

(g) High Categorical Risk Provider Types – All of the following provider types are designated as high categorical risk:

(2) Agencies providing behavioral health services, excluding (i) behavioral health and intellectual and developmental disability provider agencies that are nationally accredited by an entity approved by the Secretary and (ii) licensed outpatient behavioral health providers

Maintaining An Accurate Provider Record in NCTracks

Participating providers are contractually obligated to maintain and update their NCTracks record

(Providers have 30 days to report any changes within their record)

The Provider's Role

Verify Information Regularly

- Confirm all details in NCTracks
- Review listings in the Health Plan Lookup Tool
- Ensure Office Administrator (OA) information is accurate

Maintain Accurate Provider Data

- Confirm active taxonomies
- End-date owners and managing employees no longer associated with the organization
- End-date unused service locations

Prevent Delays and Disruptions

- Correct outdated information that may cause processing delays or service disruptions
- Confirm that License/Accreditation/Certification (LAC) dates are valid and not expiring

Submit Required Documentation Timely

- Provide all requested supporting documents on time
- Follow Change of Ownership (CHOW) protocol when applicable

Reminder: Mandatory Disclosure of Sanctions & Expungements

NC Medicaid providers must answer all Exclusion Sanction questions accurately on every application (initial enrollment, reverification, reenrollment) and on all Manage Change Requests.

Enrolled providers are required to report any board-issued or legal sanctions to NCTracks within 30 days of the decision.

Expungement definition

An expungement is a court-ordered process that removes criminal history information from public access. Although records are generally sealed, certain government agencies may still access information about expunged records.

- Providers must disclose all board sanctions and court orders, including expungements.
- If an expungement is granted, the court issues a certified Final Order.
- Submit the Final Order with the enrollment application as proof of expungement.

Please note that an affirmative response does not automatically disqualify an applicant. However, failing to disclose required information will result in termination or denial.

Links & Resources

- The Impact of HR1 and Federal Changes to Medicaid
- Unannounced Site Visits Effective October 1, 2026
- Drug Enforcement Administration Certification Required for Prescribing Controlled Substances
- NCTracks DEA Certification FAQs
- How to Address the DEA Certification Requirement if You Do Not Have a DEA Certification
- How to Add or Update Credentials: NCTracks User Guides & Fact Sheets
- Provider Categorical Risk Level Adjustment
- Provider Reverification Application Reminders
- Termination of Taxonomy 251S00000X for Records Without a Service Effective Nov. 2, 2026
- Providers: Risks of Not Accurately Reporting on Your NCTracks Provider Record
- Reminders About Required Provider Disclosures
- Confirming Medicaid Coverage for Beneficiaries
- Provider Enrollment FAQs
- Extreme Weather Webinar Series
- Behavioral Health | NC Medicaid
- NC Medicaid Provider Ombudsman: Medicaid.providerombudsman@dhhs.nc.gov
- GDIT Call Center: 1-800-688-6696
- NC Medicaid Bulletins

Questions & Answers



Thank you for joining us!

Join us in December for our final session in the 2026 Summer/ Fall Webinar Series