NC Standard Plan Capitation Rates – Care Management Assumptions
State Fiscal Year 2026 (July 1, 2025-June 30, 2026)

Updated May 27, 2025

This bulletin applies to NC Medicaid Managed Care Standard Plans.

Introduction

This document provides information about the assumptions underlying the care management component of capitation payments to NC Medicaid Managed Care Standard Plan Prepaid Health Plans (Standard Plans). North Carolina Department of Health and Human Services (the Department) is providing this information to ensure that the care management fees being agreed upon by Standard Plans and Advanced Medical Home Tier 3 delegated care management providers are adequate to support the amount and quality of care management services the Department expects of all care management providers, including AMH Tier 3 practices and Standard Plans. The Standard Plan capitation rates developed by the Department's actuary, Mercer Government, reflect the Department's belief that investment in robust community-based care management will drive improvements in care outcomes and achieve greater value from the state's Medicaid dollar. **The Department has not established minimum care management fees and maintains the expectation that Standard Plans and providers will arrive at mutually agreeable rates that are commensurate with the intensity and breadth of the care management being provided.**

This document provides assumptions for the Standard Plan managed care capitation rates for State Fiscal Year 2026 (July 1, 2025-June 30, 2026). Similar to the methodology for State Fiscal Year 2025, the care management component of the capitation rates is developed in aggregate across the non-Expansion and Expansion populations.

Under the Advanced Medical Home (AMH) Tier 3 program, Standard Plans must delegate certain care management functions and responsibilities to certified practices that meet the program's requirements. Where such delegation occurs, Standard Plans are expected to pay care management fees sufficient to support the delegated activities and in alignment with Standard Plan contractual requirements. AMH Tier 3 practices are expected to comply with the requirements outlined in the Department's Advanced Medical Home Manual.

By providing additional information on the assumptions the Department used to develop components of the rate, Standard Plans and AMH Tier 3 practices will be better positioned to enter into care management contracts that enable all parties to meet the Department's expectations in the execution of care management responsibilities and achievement of improved health outcomes.

Care Management Component of Standard Plan Capitation Rates

The Standard Plan capitation rates include funding for care management. In the State Fiscal Year 2026 capitation rates, $10.86 PMPM is built in for care management staffing needs in accordance with the

Department's requirements and assumed average care management need levels within the Standard Plan populations. This figure is agnostic to the entity responsible for the delivery of care management and represents the expected cost to either a Standard Plan or an AMH Tier 3 practice of delivering care management. **The buildup is based on a set of assumptions about care manager staffing ratios by care management need level and qualifications, which should be understood as averages rather than policies about how each care team must be constructed.** The $10.86 PMPM is an expected average cost for whole-person care management activities in accordance with the Department's requirements and assumed average care management need levels within the Standard Plan populations. The table below describes the buildup of the $10.86 PMPM care management component for the Standard Plan populations. In reality, care teams will vary in how they are staffed according to the needs of individual members and assigned panels.

For State Fiscal Year 2026, the Department assumes approximately 23 percent of beneficiaries will receive care management, and the need level will vary by population. The estimate is an average across all populations - non-Expansion and Expansion - with a higher care management need expected for Expansion adults.

Component	Share of Members	Staffing Ratio	Staff Qualifications	Average Compensation per FTE	Cost ($PMPM) *
Low-Needs Care Management	Non-Expansion: 11.5% Expansion: 13.2%	250 members per FTE	Community Health Worker (CHW)/Licensed Practical Nurse (LPN)/Medical Assistance (MA)/Social Worker (SW)	$82,994	$3.30
Moderate-Needs Care Management	Non-Expansion: 8.5% Expansion: 9.8%	150 members per FTE	CHW/LPN/MA/Registered Nurse (RN)	$89,291	$4.38
High-Needs Care Management	Non-Expansion: 2.0% Expansion: 2.3%	75 members per FTE	RN	$110,719	$2.55
Staff Supervisor	NA	20 members per FTE		$110,719	$0.62
Total					**$10.86**

***The Per Member Per Month (PMPM) represents the total expected costs of care management for the Standard Population spread across all expected members, rather than only those members actively engaged in care management as listed above. Note that the sum of the components may not match the illustrated total due to rounding.*

Additionally, given DHHS' care management strategy and specific requirements outlined in the contract, the capitation rates also include considerations in the care management assumption for the care coordination for beneficiaries utilizing Long-Term Services and Supports, responsibilities of Local Health Departments, AMH contracting and payment requirements, and additional costs for requirements related to opportunities for health initiatives for all populations. Base payments for AMH, Care Management for At-Risk Children and Care Management for High-Risk Pregnancies are included in the service portion of the capitation rates. These items are not relevant to AMH Tier 3 care management contracting and thus have not been summarized in this document.