STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

JOSH STEIN
GOVERNOR

DEVDUTTA SANGVAI
SECRETARY

March 20, 2025

James Scott, Director
Division of Program Operations
Department of Health & Human Services
Centers for Medicare & Medicaid Services
601 East 12th Street Room 355
Kansas City, Missouri 64106

SUBJECT: State Plan Amendment
Title XIX, Social Security Act
Transmittal #2025-0005

Dear Mr. Scott:

Please find attached an amendment for North Carolina's State Plan under Title XIX of the Social Security Act for the Medical Assistance Program.

This state plan change will extend the $343.97 temporary Health Home payment rate through June 30, 2025, and set $294.86 as the ongoing rate as of July 1, 2025, and set $79.73 as the ongoing add-on payment amount as of July 1, 2025. The proposed effective date for the SPA is January 1, 2025.

Your approval of this state plan amendment is requested. If you have any questions or concerns, please contact me or Ashley Blango at (919) 812-6145.

Sincerely,

DocuSigned by:
Jay Ludlam
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Jay Ludlam
Deputy Secretary

Enclosures

NC - Submission Package - NC2025MS0001O - Health Homes

CMS-10434 OMB 0938-1188

Package Information

Package ID	NC2025MS0001O	**Submission Type**	Official
Program Name	Tailored Care Management	**State**	NC
Version Number	1	**Region**	Atlanta, GA
		Package Status	Pending

Submission - Medicaid State Plan

MEDICAID | Medicaid State Plan | Health Homes | NC2025MS0001O | Tailored Care Management

CMS-10434 OMB 0938-1188

The submission includes the following:

- [ ] Administration
- [ ] Eligibility
- [ ] Benefits and Payments
  - [ ] Health Homes Program

Do not use "Create New Health Homes Program" to amend an existing Health Homes program. Instead, use "Amend existing Health Homes program," below.

- ( ) Create new Health Homes program
- (•) Amend existing Health Homes program
- ( ) Terminate existing Health Homes program

Tailored Care Management

Health Homes SPA - Reviewable Units

Only select Reviewable Units to include in the package which you intend to change.

*

	Reviewable Unit Name	Included in Another Submission Package	Source Type
[ ]	Health Homes Intro	( )	APPROVED
[ ]	Health Homes Geographic Limitations	( )	APPROVED
[ ]	Health Homes Population and Enrollment Criteria	( )	APPROVED
[ ]	Health Homes Providers	( )	APPROVED
[ ]	Health Homes Service Delivery Systems	( )	APPROVED
[ ]	Health Homes Payment Methodologies	( )	APPROVED
[ ]	Health Homes Services	( )	APPROVED
[ ]	Health Homes Monitoring, Quality Measurement and Evaluation	( )	APPROVED

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- [ ] 1945A Health Home Program

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | NC2025MS0001O | Tailored Care Management

Package Header

Package ID	NC2025MS0001O	**SPA ID**	N/A
Submission Type	Official	**Initial Submission Date**	N/A
Approval Date	N/A	**Effective Date**	N/A
Superseded SPA ID	NC-24-0028		
	System-Derived		

Payment Methodology

The State's Health Homes payment methodology will contain the following features

- [ ] Fee for Service
- [ ] PCCM (description included in Service Delivery section)
- [ ] Risk Based Managed Care (description included in Service Delivery section)
- [x] Alternative models of payment, other than Fee for Service or PMPM payments (describe below)
  - [x] Tiered Rates based on
    - [ ] Severity of each individual's chronic conditions
    - [ ] Capabilities of the team of health care professionals, designated provider, or health team
    - [x] Other

Describe below

Please see below

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

Please see below

Provide a comprehensive description of the policies the state will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

As a result of North Carolina's annual review of provider costs and the time spent delivering Health Home services to members, North Carolina will temporarily increase the payment rate from $269.66 to $343.97 starting on February 1, 2024, through June 30, 2025. Starting on July 1, 2025, the ongoing payment rate will be $294.86. North Carolina previously received approval to temporarily increase the add-on payment from $78.94 to $79.73 starting on February 1, 2024, through June 30, 2025; the add-on payment is for individuals with behavioral health, intellectual/developmental disabilities and traumatic brain injury, who are higher acuity and require a greater intensity of care coordination due to the complexity of their needs, as compared to other individuals enrolled in the Health Home program (as defined in the Addendum to this section). Starting on July 1, 2025, this rate increase will no longer be considered temporary and the ongoing add-on payment will be $79.73. The temporary rate increases reflect the level of effort required by providers, based on available data on provider time and effort to date, to implement the Tailored Care Management model. North Carolina is not making any other changes to the payment methodology described below.

Tailored Care Management rates are separate from the health plans' risk-based managed care capitation rates. Health Home providers—LME-MCOs, AMH+ practices, and CMAs—will be paid a monthly rate for each member enrolled in Tailored Care Management that obtained a qualifying Health Home contact in the month. A qualifying Health Home contact is defined as an interaction that includes the member (or guardian, as indicated) that fulfills one or more of the six core health home services. The state will add an additional payment to the monthly rates for individuals who are higher acuity

and require a greater intensity of care coordination, as described above and defined in the Addendum to this section. For members receiving provider-based Tailored Care Management, LME-MCOs will be required to pass the full amount of the monthly payment down to the provider delivering Tailored Care Management.

In order to access the payment for any given member, the LME-MCO must demonstrate that one core Health Home service was delivered to the member during the previous month. For members obtaining Health Home services through AMH+ practices and CMAs, LME-MCOs will make payments to their providers for those months when a core Health Home service was delivered, passing down 100% of the payments. For each member assigned to them who has received a qualifying Health Home service that month, AMH+ practices and CMAs will be required to submit a single claim to the LME-MCO demonstrating that they delivered a at least one Health Home core service. LME-MCOs may retain the entirety of the payment for members receiving Health Home services through a plan-based care manager.

North Carolina's payment model encourages the provision of high-quality care and ensures members are receiving the right care, at the right place, at the right time by providing Health Home providers with robust standards for what Tailored Care Management entails. It will also ensure that LME-MCOs and AMH+ practices and CMAs are only reimbursed in months in which Health Home services are delivered.

Rates were developed with input from clinical experts on the average amount of time and effort Health Home providers are expected to spend on any given member who receives a qualifying Health Home contact in a month. Rates were based on care manager, care manager extender, and supervising care manager labor costs (including salary, fringe benefits, and vacation/sick time) combined with expected caseloads and adding costs associated with administration/overhead, program expenses and required clinical consultant time. Salaries were derived from state-specific wage data from the Bureau of Labor Statistics. Expected caseloads were developed based on the estimated time needed to deliver meaningful, in-person and telephonic/virtual contacts on a monthly basis to a member that receives a qualifying Health Home contact, time needed for travel and other non-member facing time (e.g., coordination with providers), and the annual productive time for each care manager. The rates will be paid on a per member per month (PMPM) basis for members who received a qualifying Health Home contact in the month.

North Carolina will review rates at least annually and review the provider costs (salary, fringe benefits, and administration/overhead) and the time spent delivering Health Home services to members when determining the appropriateness of the rates.

Effective Date: 1/1/2025
Website where rates are displayed: https://medicaid.ncdhhs.gov/revised-tcm-rate-guidance/download?attachment

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | NC2025MS0001O | Tailored Care Management

Package Header

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Superseded SPA ID	NC-24-0028 System-Derived		

Assurances

☐ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved

In order to avoid the duplication of payment for similar services, the state analyzed programs and settings that offer beneficiaries services similar to Health Home services. Through this analysis, North Carolina determined that the following services are duplicative of Tailored Care Management:
- Case management provided through Assertive Community Treatment.
- Case management provided through Intermediate Care Facilities for Individuals with Intellectual Disabilities.
- Case management provided through nursing facilities for individuals who have resided in, or are likely to reside there, for a period of 90 days or longer.
- Case management provided through the Community Alternatives Program for Children (CAP/C).
- Case management provided through the Community Alternatives Program for Disabled Adults (CAP/DA).
- Care management provided through the High-Fidelity Wraparound program.
- Care management provided through the EBCI Tribal Option.
- Care management provided through the Program of All-Inclusive Care for the Elderly.
- Care management provided by the state's PCCM vendor.
- Care Management for At-Risk Children (program offered by North Carolina Medicaid and administered by the state's local health departments providing care management services for at-risk children ages zero to five).

Tailored Care Management may be provided for one month if a beneficiary is transitioning to or from ACT, a long-stay in a nursing facility, or ICF-IID to or from Tailored Care Management.

As the Department reviews and approves new in lieu of services (ILOS) and State Plan services, the Department will monitor whether these new services are duplicative of Tailored Care Management and will perform the activities below to prevent duplication.

Individuals who opt out or are not engaged in Tailored Care Management will receive care coordination through the PIHP or Tailored Plan. North Carolina will not claim the enhanced Health Home match for these individuals.

North Carolina has developed multiple strategies to ensure members do not receive services that are duplicative of Tailored Care Management, including through LME-MCO oversight and systems requirements and quarterly reporting/monitoring requirements:

- LME-MCO Oversight/Reporting Obligations. LME-MCOs are contractually obligated to ensure that members do not receive a duplicative service and must submit, for state review and approval, their policies and procedures for ensuring members do not receive duplicative care management from multiple sources.

- Audits. The Department will audit LME-MCOs to verify that LME-MCOs are not making payments to AMH+ practices and CMAs for both Tailored Care Management and a duplicative service for the same beneficiary in a single month except for months in which a member is transitioning services. LME-MCOs are responsible for ensuring that they do not submit a claim to the Department for Tailored Care Management in a month that a provider delivered a duplicative service to a beneficiary.

☐ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☐ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☐ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
Addendum to Payment Methodology Section_Q1 2025	1/17/2025 4:09 PM EST	

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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