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State/Territory Name: North Carolina

State Plan Amendment (SPA) #: 24-0038

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

March 6, 2025

Mr. Jay Ludlam
Deputy Secretary of Medical Assistance
Division of Medical Assistance
2001 Mail Service Center
1985 Umstead Drive
Raleigh, NC 27699-20014

Re: North Carolina State Plan Amendment (SPA) 24-0038

Dear Mr. Ludlam:

The Centers for Medicare & Medicaid Services (CMS) reviewed the proposed Medicaid Disaster Relief State Plan Amendment (SPA), and accompanying section 1135 waivers submitted in response to Hurricane Helene on September 25, 2024, under transmittal number (TN) 24-0038. This amendment proposes to allow certain flexibilities related to eligibility, including allowing individuals displaced from the state due to Hurricane Helene to continue to be residents of the state; temporarily waive and modify certain requirements related to behavioral health, Long Term Services and Supports (LTSS), and dental benefits; and provide retainer payments for specific 1915(i) services, including Community Living and Supports, Supported Employment, Individual Placement and Supports, and Individual and Transitional Supports. Furthermore, it implements temporary policies, which are different from those policies and procedures otherwise applied under your Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to Hurricane Helene (or any renewals thereof).

On September 29, 2024, the President of the United States issued a proclamation that Hurricane Helene constitutes an emergency by the authorities vested in the President by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (the Act). On September 25, 2024, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services (HHS) declared a public health emergency (PHE), invoking the authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act. During a PHE, the Centers for Medicare and Medicaid Services (CMS) may approve the use of section 1135 authority to help ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in CMS programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of September 28, 2024, with a retroactive effective date of September 25, 2024. The emergency period will terminate, and section 1135 waivers will no longer be available, upon termination of the PHE, including any extensions.

Pursuant to section 1135(b)(5) of the Social Security Act (Act), for the period of the public health emergency, CMS is modifying the requirement at 42 C.F.R. §430.20 that the state submit SPAs related to the declared public health emergency by the final day of the quarter, to obtain a SPA effective date during the quarter, enabling SPAs submitted after the last day of the quarter to have an effective date in a previous quarter, but no earlier than the effective date of the public health emergency

The State of North Carolina requested a waiver to modify the public notice requirements applicable to the SPA submission process. Pursuant to section 1135(b)(5) of the Act, CMS is modifying public notice requirements applicable to the SPA submission process. Public notice for SPAs is required under 42 C.F.R. §447.205 for changes in statewide methods and standards for setting Medicaid payment rates, 42 C.F.R. §447.57 for changes to premiums and cost sharing, and 42 C.F.R. §440.386 for changes to Alternative Benefit Plans (ABPs). Pursuant to section 1135(b)(5) of the Act, CMS is approving the state's request to modify these notice requirements otherwise applicable to SPA submissions.

The State of North Carolina also requested a waiver to modify the tribal consultation timeline applicable to this SPA submission process. Pursuant to section 1135(b)(5) of the Act, CMS is also allowing states to modify the timeframes associated with tribal consultation required under section 1902(a)(73) of the Act, including shortening the number of days before submission or conducting consultation after submission of the SPA.

CMS conducted our review of your submittal according to statutory requirements in Title XIX of the Act and implementing regulations. This letter informs you that North Carolina's Medicaid SPA Transmittal Number 24-0038 is approved effective September 25, 2024. Enclosed is a copy of the CMS-179 summary form and the approved state plan pages.

Please contact Morlan Lannaman at Morlan.Lannaman@cms.hhs.gov if you have any questions about this approval. We appreciate your and your staff's efforts in responding to the needs of the residents and healthcare community of the State of North Carolina.

Sincerely,

[redacted]

Courtney Miller
Director, Medicaid and CHIP Operations Group
Center for Medicaid and CHIP Services

Enclosures

cc: Kathryn Horneffer, NC DHHS
Ashley Blango, NC DHHS

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24 — 0038

2. STATE: NC

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (x) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
September 25, 2024

5. FEDERAL STATUTE/REGULATION CITATION
Title XIX, Section 1135 of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 24 $ 0
b. FFY 25 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
7.4 Medicaid Disaster Relief SPA Template

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
N/A

9. SUBJECT OF AMENDMENT

In response to public health emergency, the state would like to amend the rehab services and behavioral health services and make retainer payments for specific 1915(i) services, including Community Living and Supports, Supported Employment, Individual Placement and Supports, and Individual and Transitional Supports.

10. GOVERNOR'S REVIEW *(Check One)*

( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(•) OTHER, AS SPECIFIED: Secretary

11. SIGNATURE OF STATE AGENCY OFFICIAL [redacted]

12. TYPED NAME
Jay Ludlam

13. TITLE
Deputy Secretary

14. DATE SUBMITTED 12/17/24 | 1:26 PM EST

15. RETURN TO
Office of the Deputy Secretary
Department of Health and Human Services
2001 Mail Service Center
Raleigh, NC 27699-20014

FOR CMS USE ONLY

16. DATE RECEIVED
12/17/2024

17. DATE APPROVED
March 5, 2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
September 25, 2024

19. SIGNATURE [redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Courtney Miller

21. TITLE OF APPROVING OFFICIAL
Director, Center for Medicaid & CHIP Services

22. REMARKS CMS requested pen and ink change to update the CMS 179 with the following:

1/15/24 Box 3 – strike out XX1 and replace with X1X.
1/15/25 Box 5 – delete "Sect. 201/302 National Emergencies Act;" replace with "Title XIX, Section 1135 of the Social Security Act."
1/21/25 Box 9 – delete "consider individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, allow individuals to provide a reasonable explanation of inconsistencies in lieu of requiring a paper application" and replace with the following:

In response to public health emergency, the state would like to amend the rehab services and behavioral health services and make retainer payments for specific 1915(i) services, including Community Living and Supports, Supported Employment, Individual Placement and Supports, and Individual and Transitional Supports.

Section 7 – General Provisions
7. Disaster Relief During a Public Health Emergency or Disaster Period

General Information

1. This Disaster Relief state plan amendment (SPA) is in response to: **2024 Hurricane Helene Public Health Emergency**

2. ☐ This SPA is adding to a previously approved Disaster Relief SPA in effect.

Include previously approved SPA Transmittal Numbers

3. ☐ This SPA is superseding a previously approved Disaster Relief SPA.

Include superseded SPA Transmittal Numbers

4. The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the **2024 Hurricane Helene Public Health Emergency** (or any renewals thereof), or for any shorter period described below:

In response to the public health emergency caused by Hurricane Helene, the state intends to: allow certain flexibilities related to eligibility, including allowing individuals displaced from the state due to Hurricane Helene to continue to be residents of the state; temporarily waive and modify certain requirements related to behavioral health, LTSS, and dental benefits; and provide retainer payments for specific 1915(i) services, including Community Living and Supports, Supported Employment, Individual Placement and Supports, and Individual and Transitional Supports. The state intends to sunset these flexibilities on March 1, 2025.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

5. The agency modifies the following sections during the period of the public health emergency or disaster:
   - ☒ A – Eligibility
   - ☐ B - Enrollment
   - ☐ C - Cost Sharing and Premiums

- ☒ D - Benefits
- ☒ E – Payment
- ☐ F - Post Eligibility Treatment of Income
- ☐ G - Other Policies and Procedures Differing from Approved Medicaid State Plan/Additional Information

Section A – Eligibility

1. ___ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act.

Include name of the optional eligibility group and applicable income and resource standard.

2. ___ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. ___ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

      Income standard: _____

      -or-

   b. ___ Individuals described in the following categorical populations in section 1905(a) of the Act:

      Income standard: _____

3. ___ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

   Less restrictive resource methodologies:

4. __X___ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. ___ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. ____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section D – Benefits

Benefits:

1. ____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. __X___ The agency makes the following adjustments to benefits currently covered in the state plan:

1. Behavioral Health Rehabilitative Services: The state makes the following changes to behavioral health benefits covered under the rehabilitative services benefit.

a. Substance Abuse Comprehensive Outpatient Treatment:
i. Waive initial prior approval process and concurrent reviews.

ii. Waive the requirement for minimum service availability of four hours per day, five days per week; but must provide two hours per day, five days per week.

iii. Waive requirements related to biochemical assays to identify recent drug use (e.g. urine drug screens) for beneficiaries.

iv. Waive beneficiary-to-staff ratio if provided outside of a licensed facility.

b. Diagnostic Assessment:
Waive limit that a beneficiary may receive one diagnostic assessment per year without any additional authorization.

c. Mobile Crisis Management:
i. Waive staff training requirements within 90 days of employment, if unable to be obtained during the state of emergency.

ii. Waive requirement for concurrent review after the first 32 units of service have been rendered.

d. Intensive In-Home Mental Health and Substance Abuse Services:
i. Waive prior approval and reauthorization requirements.

ii. Waive staff training requirements within 90 days of employment, if unable to be obtained during the state of emergency.

iii. Waive the two-hour per day minimum service provision and reduce to one-hour per day.

iv. Waive team-to-family ratio requirements.

v. Allow for the 12 contacts required in the first month to be provided via telehealth if the provider is unable to provide the service in person. If the service cannot be provided via telehealth, the service may be provided telephonically.

e. Multisystemic Therapy:
i. Waive prior approval and reauthorization request.

ii. Waive staff introductory and quarterly training requirements if unable to be obtained during the state of emergency.

iii. Waive minimum monthly contacts of 12 in the first month and six contacts in the second and third month.

iv. Waive the three to five-month maximum duration of service.

f. Psychosocial Rehabilitation:
i. Waive initial prior authorization and reauthorization.

ii. Waive requirement for a minimum of five hours per day, five days a week of service availability. Service must be available a minimum of 10 hours per week.

iii. Waive staff ratio of 1:8 only if provided by telehealth or telephonic modalities.

iv. Allow service to be provided outside of the facility by telehealth, telephonically or in-person, including in the person's residence.

g. Child and Adolescent Day Treatment:
i. Waive reauthorization requirements.

ii. Waive minimum of three hours of service per day.

iii. Allow service to be provided outside of the facility by telehealth, telephonically or in-person, including in the person's residence.

h. Partial Hospitalization:
i. Waive prior approval and reauthorization requirements.

ii. Waive requirement of minimum service availability of four hours a day five days per week; but must provide 10 hours of treatment per week.

l. Professional Treatment Services in Facility-Based Crisis Program:
Waive limit that service does not exceed 15 consecutive days and cannot exceed a total of 45 days in a 12-month period.

j. Substance Abuse Intensive Outpatient Program:

i. Waive initial prior approval process and concurrent reviews .

ii. Waive the required minimum service availability of three hours per day but must provide 1.5 hours of treatment per day, three days per week.

iii. Waive beneficiary to staff ratio if provided outside of the facility.

iv. Waive requirements related to biochemical assays to identify recent drug use (e.g. urine drug screens) for beneficiaries.

v. Allow service to be provided outside of the facility by telehealth, telephonically or in-person, including in the person's residence.

k. Substance Abuse Non-Medical Community Residential Treatment:
i. Waive prior authorization and reauthorization requirements.

ii. Allow clinical services/therapies to be provided via telehealth or telephonically by qualified professionals if the qualified professionals are not able to be onsite.

l. Medically Supervised or ADATC Detoxification Crisis Stabilization:
i. Waive initial prior approval process and concurrent reviews

ii. Waive maximum of 30-days of treatment within 12 months.

m. Community Support Team Services (Adults):
i. Waive initial prior approval process and concurrent reviews.

ii. Waive requirement that staff must be dedicated to the team.

iii. Waive requirement that associate licensed professional team lead be fully licensed within 30 months.

iv. Waive maximum of eight units for first and last 30-day period for individuals transitioning to and from other services and allow for 40 units of service to overlap with other state plan services that contain duplicative service components.

n. Assertive Community Treatment:
i. Waive prior authorization and reauthorization request.

ii. Waive requirement for staff to beneficiary ratios.

iii. Waive requirement that team must demonstrate fidelity to the latest tool for Measurement of ACT (TMACT) model of care.

iv. Waive median rate of service frequency.

o. Residential Treatment Services Level IV-Program Type Service:
i. Waive staff training requirement if unable to be obtained during the state of emergency except for sex offender specific training.

ii. Waive requirement to provide opportunity for individual inclusion in community activities.

p. Residential Treatment Services Level II-Program Type Service:
i. Waive staff training requirements if unable to be obtained during the state of emergency, except for sex offender specific training.

ii. Waive prior authorization.

q. Psychotherapy Services :
Waive initial and reauthorization.

r. Rehabilitative Services for Behavioral Health of EPSDT Eligible
The following individualized family service plan (IFSP) services provided on behalf of the Children's Developmental Services Agency may be provided via telehealth: psychological and developmental tests, clinical social work, multidisciplinary evaluations and assessments, and community based rehabilitative services.

s. Substance Abuse Medically Monitored Community Residential Treatment:
i. Waive prior authorization and reauthorization request.

ii. Allow clinical services/therapies to be provided via telehealth or telephonically by qualified professionals if the qualified professionals are not able to be onsite.

t. Medically Monitored Inpatient Withdrawal Management:
i. Allow LCAS and CCS to provide services by telehealth or telephonically.

2. Long Term Services and Supports:
a. Home Health:
Home Health providers can begin services with verbal orders from the physician or as per CMS Interim Final Rule 42 CFR 440.70, Licensed Practitioners, as defined by CMS. Physician assistants and nurse practitioners can order home health services for any individual in any setting.

b. Private Duty Nursing:
Lift prior authorization requirement for short-term increase in private duty nursing (PDN) hours (up to 4 weeks) for any PDN beneficiary that has a current PDN PA certification.

c. Staff Training:
Waive staff training requirements if unable to be obtained during the State of Emergency.

3. **Dental:**

a. Overrides:

i. Allow an override of the five-year limit for panoramic radiographic images by submitting a retroactive prior approval request with documentation about previous radiographs lost in Hurricane Helene.

ii. Allow override of the 8-year limit on partial dentures and the 10-year limit on complete dentures for appliances lost in Hurricane Helene with documentation from the Federal Emergency Management Agency (FEMA), the American Red Cross, or a homeowners insurance claim indicating loss of possessions, or information by any authority which documents loss of possessions due to the natural disaster

3. __X___ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. __X___ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

   a. __X___ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

   b. _____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. ____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. ___ Newly added benefits described in Section D are paid using the following methodology:

   a. _____ Published fee schedules –

      Effective date (enter date of change): _____

      Location (list published location): _____

   b. _____ Other:

      Describe methodology here.

Increases to state plan payment methodologies:

2. _____ The agency increases payment rates for the following services:

   Please list all that apply.

   a. _____ Payment increases are targeted based on the following criteria:

      Please describe criteria.

   b. Payments are increased through:

      i. _____ A supplemental payment or add-on within applicable upper payment limits:

         Please describe.

      ii. _____ An increase to rates as described below.

         Rates are increased:

         _____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

   a. _____ Are not otherwise paid under the Medicaid state plan;

   b. _____ Differ from payments for the same services when provided face to face;

   c. _____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

   d. _____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

      i. _____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

      ii. _____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. __X__ Other payment changes:

Retainer Payments for 1915(i) services. The State will make retainer payments for specific 1915(i) services, including Community Living and Supports, Supported Employment, Individual Placement and Supports, and Individual and Transitional Supports. Providers who are unable to deliver services due to the emergency may bill for services they would have otherwise delivered to Medicaid enrollees. They will be reimbursed for such services at the normal Medicaid rate. Retainer payments are limited to a period of up to 30 days.

Retainer payments are time-limited and cannot exceed one (1) 30 billable day period.

The state confirms that retainer payments are for direct care providers who normally provide services that include habilitation and personal care but are currently unable to due to barriers caused by the impact of the hurricane.

The state has a distinguishable process to monitor payments to avoid duplication of billing, which includes the following listed requirements:

a. Individual workers or nurses are required to sign an attestation prior to claiming retainer payments, in which they must attest to the items listed below:

b. The employee who receives retainer payments will not be eligible for unemployment as to hours covered by the retainer payment

c. To retain their availability to the specified waiver participant when the impacts of Hurricane Helene that prevented the delivery of services to the waiver participant have abated.

d. To report any retainer payments billed, sought, or received in submitting any unemployment insurance claim during the period in which retainer payment is received.

e. To receive the maximum reimbursement rate or wages per the planned pay period for approved hours/units in an active service plan approved before the retainer agreement was initiated.

f. Retainer payments are for primary staff that provide regularly scheduled services and are unable to deliver services.

g. Staff members identified as back up staff are not eligible for retainer payments.

h. To agree to receive a maximum of one retainer agreement for one specified waiver participant.

i. Due to the impacts of Hurricane Helene, the waiver participant is not able to receive waiver services in the usual amount, frequency and duration from their current provider.

Provider organizations that accept a retainer payment agreement for a specified worker cannot receive duplicative payments and must adhere to the following requirements listed below:

a. The provider agency cannot bill retainer payments on behalf of staff who are laid off.

b. The provider agency's retainer payment claims must be adjusted to account for any layoffs if staff are laid off.

Provider Agencies must also attest that they have not received funding from other sources that would exceed their revenue for the last full quarter prior to the emergency event or that retainer payments would not result in them exceeding their prior revenue.

If a provider has not already received revenues in excess of the pre-PHE level but receipt of the retainer payment in addition to those prior sources of funding results in the provider exceeding the pre-PHE level, any retainer payment amounts in excess will be recouped. If a provider had already received revenues in excess of the pre-PHE level, retainer payments are not available.