North Carolina Medicaid Update on Care Coordination for High-Risk Pregnant Women and At-Risk Children

Last updated: 10/28/2026

This document applies to NC Medicaid Direct and NC Managed Care Standard Plans and Tailored Plans.

Purpose

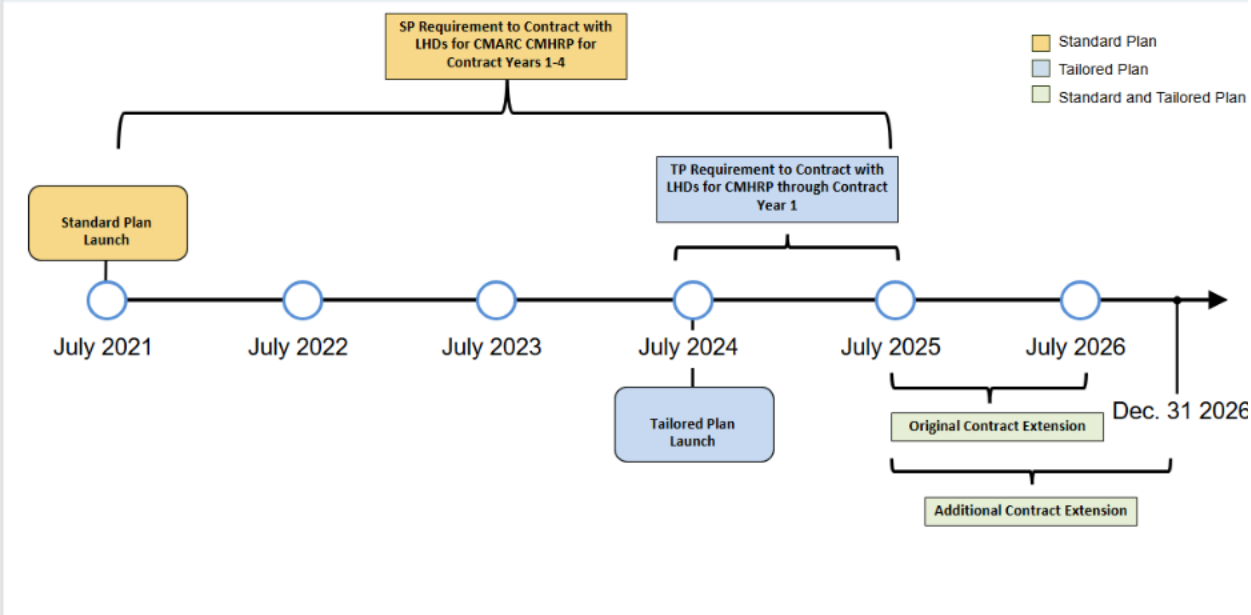
The purpose of this document is to provide updated and clarifying information to Medicaid providers regarding the Department's vision for transitioning members from the Local Health Departments' Care Management for High-Risk Pregnancies and Care Management for At-Risk Children programs. Please note, contract updates between the Department and Standard Plans, Tailored Plans, and Primary Care Case Management (PCCM) entity related to these changes are still in progress and will serve as the definitive expectations for this transition.

Background

North Carolina offers a variety of community-based care management programs targeted to different populations. These include:

- The **Care Management for High-Risk Pregnancies** program is currently the primary vehicle for delivering care management to pregnant women who may be at risk for adverse birth outcomes. This program builds on the legacy model of care management for pregnant women administered by the Local Health Departments (LHDs) since 1988. Through the years, the program name has changed, but the focus on care management services for pregnant Medicaid enrollees has remained the same.
- The **Care Management for At-Risk Children** program offers care management services for at-risk children ages 0 to 5 years. The program coordinates services between health care providers, community programs and supports and family support programs. CMARC is also provided predominantly by LHDs.

At the start of North Carolina's transition to Medicaid managed care on July 1, 2021, NC Medicaid embedded care coordination and management into managed care contracts serving the majority of NC Medicaid members. At that point, CMHRP and CMARC were both authorized under the NC Medicaid State Plan as targeted case management services, which continues today. Simultaneously, NC Medicaid instituted a glidepath related to contracting requirements for these programs, which was intended to minimize disruptions for highly vulnerable Medicaid members. Further, it provided a framework to provide Prepaid Health Plans (PHPs) and the Primary Care Case Management (PCCM) entity with additional flexibility to holistically and effectively serve enrollee needs, paired with additional accountability, consistent with the broader goals of Medicaid transformation. The glidepath for these programs has been as follows:



- For the initial years after launch, Standard Plans (for four years after their launch: Contract Years 1 through 4 [July 2021 – June 2025]) and Tailored Plans (for one year after their launch: Contract Year 1 [July 2024 –June 2025]) were required to contract with LHDs to provide CMARC services (Standard Plans only) and CMHRP services (Standard Plans and Tailored Plans). LHDs also provided both CMARC and CMHRP services to Medicaid Direct populations via arrangements with NC Medicaid's PCCM entity.
- During an interim period from July 2025 through June 2026, Standard Plans and Tailored Plans were only required to contract with LHDs that met benchmark specifications against selected process and quality measures in 2024. NC Medicaid aimed to strengthen accountability for program performance and maintain service provision among LHDs meeting performance and quality standards.
- The requirements for Plans to contract with LHDs that met the benchmark specifications were extended through Dec. 31, 2026, and were not extended further. Instead, NC Medicaid will be removing the targeted case management services from the State Plan and integrate care coordination for these populations into the Standard Plan and Tailored Plan responsibilities to supplement the expectations for care management services overseen by those PHPs.

This document provides an overview of changes proposed during this upcoming transition effective Jan. 1, 2027, when the CMARC and CMHRP programs are no longer included in the State Plan, and the PHPs and PCCM entity will have direct responsibility for delivery of specialized care coordination functions for high-risk pregnant women and at-risk children.

Maintaining continued member access to specialized supports for these priority populations aligns with the Department's goal for all Medicaid transformation efforts:

- Improve outcomes for enrollees identified as high-risk;
- Expand the choice of providers delivering the pregnancy-specific and at-risk child-specific functions;
- Increase continuity of care coordination and care management support for enrollees; and

- Integrate care coordination for high-risk enrollees into existing whole-person care approaches.

Currently in 2026

CMHRP provides care management services to pregnant women ages 14-44 enrolled in NC Medicaid and determined to be at high risk for adverse outcomes. CMARC provides care management services for children ages 0 to 5 years enrolled in NC Medicaid and determined to be at risk of adverse outcomes due to specific medical conditions, adverse childhood events, or referral. Table 1 below summarizes the NC Medicaid delivery systems where these programs are currently available.

Table 1. Current CMARC and CMHRP Offering by NC Medicaid Delivery System

NC Medicaid Delivery System	Current CMARC	Current CMHRP
Standard Plan (see program guide)	✓	✓
Tailored Plan (see program guide)		✓
PCCM Entity for Medicaid Direct Enrollees	✓	✓
Children and Families Specialty Plan (CFSP)		

NC Medicaid requires Standard Plans, Tailored Plans, and the PCCM entity (for NC Medicaid Direct enrollees) to pay LHDs no less than or an amount substantially similar to the state plan rate, which is $4.96 Per Member Per Month (PMPM) for CMHRP and $4.56 PMPM for CMARC for all eligible enrollees in the population age range. As discussed in the May 5th Bulletin, NC Medicaid worked with PHPs to maintain CMARC and CMHRP PMPM payments to LHDs providing these services through Dec. 31, 2026.

Currently, Standard Plans (CMARC and CMHRP) and Tailored Plans (CMHRP only) must ensure these targeted case management services continue to be provided in the applicable counties through Dec. 31, 2026. NC Medicaid has developed the existing *Companion Guide for Care Management Termination and Transfer of Services Processes* if an LHD terminates its contract, which outlines roles and responsibilities of LHDs, the Division of Public Health, the Division of Child and Family Wellbeing, Standard Plans, Tailored Plans, and Community Care of NC.

Referrals During the Transition Period

The Department is not prescribing a referral end-date or specific timeframes regarding the transition of these members beyond the Jan. 1, 2027, effective date. The Standard Plans, Tailored Plans, and PCCM entity are responsible for developing and implementing the transition strategies that work best for their respective membership and communicating with providers to make sure they are aware of referral patterns for members.

Looking Ahead to 2027

Beginning Jan. 1, 2027, Standard Plans, Tailored Plans, and the PCCM entity will assume responsibility for delivering care coordination functions for high-risk pregnant women and at-risk children. They will no longer be required to contract with LHDs for targeted case management services that are being removed from the State Plan. NC Medicaid intends to ensure the needs of these priority populations are met by monitoring care coordination functions provided by the Standard Plans, Tailored Plans and their contracted delegates.

Key Requirements Effective Jan. 1, 2027, for Pregnant Women Identified as High Risk

To accomplish the above goals, NC Medicaid will revise pregnancy-specific care coordination functions as requirements in the Standard Plan, Tailored Plan, and the PCCM entity contracts to be effective on Jan. 1, 2027. Key terms are defined below:

- Pregnancy-Specific Care Coordination
    - Specialized care coordination functions for high-risk pregnancies during pregnancy and up to 84 days postpartum
    - Pregnancy-specific care coordination activities include identifying high-risk pregnancies, engaging the Member, pregnancy risk assessment completion, pregnancy-specific care goals, and attempted and completed interactions
    - Includes three outreach attempts or complete patient-centered interactions with the Member every 30 calendar days
    - If the Member remains Medicaid enrolled after 84 days postpartum and has other postpartum support needs, the PHP will coordinate with AMH Tier 3 or PHP care manager for ongoing support
    - Plans will submit a Pregnancy Care Coordination Report to facilitate Department monitoring.
- For enrollees receiving concurrent care coordination functions and care management services (including care management delivered by an AMH Tier 3, Plan-based care managers or Tailored Care Management provider), the Standard Plan or Tailored Plan shall ensure non-duplication of care if there is an existing care manager and an additional care coordinator supporting the member.

<u>Specialized Care Coordination Functions</u>

Required specialized care coordination functions will include:

1. *Population Identification and Engagement*

The Standard Plan, Tailored Plan, or PCCM entity will identify each enrollee's level of pregnancy risk and needs, which could include leveraging referral information from the Pregnancy Risk Screening (PRS) completed by providers and other screening or assessment information (e.g., risk stratification) to evaluate service needs tied to high-risk pregnancy. DHHS will update and distribute the PRS form by Jan. 1, 2027, and providers will submit PRS forms directly to PHPs/PCCMs. Although the Department's Pregnancy Management Program Policy is sunsetting with this transition, the incentive payment for completion of the Pregnancy Risk Screening form will remain.

The Department defines High-Risk Pregnant Women as including, but not limited to, females ages 14 to 44 who are pregnant who have a history or are at risk of:

1) Pre-term birth (<37 completed weeks)
2) At least one spontaneous preterm labor and/or rupture of the membranes
3) Low birth weight (<2500g)
4) Fetal death > 20 weeks

5) Neonatal death (within first 28 days of life)
6) Second trimester pregnancy loss
7) Three or more first trimester pregnancy losses
8) Cervical insufficiency
9) Gestational diabetes
10) Postpartum depression
11) Hypertensive disorders of pregnancy: Eclampsia, Preeclampsia, Gestational hypertension, Hemolysis, Elevated Liver enzymes, Low Platelet count (HELLP) syndrome
12) Multifetal gestation
13) Fetal complications: Fetal anomaly, Fetal chromosomal abnormality, Intrauterine growth restriction (IUGR), Oligohydramnios, Polyhydramnios
14) Chronic conditions which may complicate pregnancy: Diabetes, Hypertensions, Asthma, Mental illness, HIV, Seizure disorder, Renal disease, Systemic lupus erythematosus
15) Current use of drugs or alcohol/recent drug use or heavy alcohol use in the month prior to learning of pregnancy
16) Late entry into prenatal care (>14 weeks)
17) Hospital utilization in the antepartum period
18) Missed 2+ prenatal appointments
19) Cervical insufficiency
20) Vaginal bleeding in 2nd trimester
21) Short interpregnancy interval (<12 months between last live birth and current pregnancy)
22) Current sexually transmitted infection
23) Recurrency urinary tract infections (>2 in past 6 months, >5 in past 2 years)
24) Non-English speaking
25) Positive depression screen

Enrollees identified as candidates for pregnancy-related care coordination may be referred for care coordination through multiple pathways, including:

- PHP internal risk stratification,
- PRS form received from a referring provider
- Community referral sources (such as Division of Social Services [DSS] or Women, Infants, and Children [WIC] programs), or
- Enrollee self-referral

Pregnancy-specific care coordination functions will involve a patient-centered, collaborative partnership approach to build capacity toward improved self-care and foster self-management skill building. Face-to-face interactions (e.g., home visit, primary care office visit, hospital visit, community visit, video conferencing) should be prioritized over telephone interactions for enrollees whenever possible.

Once a member is identified as high-risk and pregnant or referred for pregnancy-specific care coordination, the pregnancy-specific care coordinator should outreach the member and facilitate a prompt and thorough assessment and determination of level of need for pregnancy-specific care coordination support. Assessments may draw from, but are not limited to: prior assessment history and prior care management documentation (for example, from the enrollee's interactions with care

managers associated with Advanced Medical Homes (AMH), Tailored Care Management or other services), information from claims data/history, medical record(s), enrollee/family interview(s), and information from obstetric care provider and referral source. Assessment findings will be up-to-date and documented appropriately in the system of record. If the enrollee also is receiving care management, the pregnancy-specific care coordinator will coordinate with the care manager on the pregnancy-specific assessment approach to ensure non-duplication and share pregnancy-specific assessment findings to inform the enrollee's overall comprehensive assessment managed by the care manager.

2. *Pregnancy-Specific Plan Development*

For enrollees identified as having a high-risk pregnancy, the Standard Plan, Tailored Plan, or the PCCM entity (or subcontracted entity) will develop pregnancy-specific goals and actions to address the identified level of obstetric risk and needs throughout the pregnancy and monitor progress, revising the plan as needed. The pregnancy-specific goals will include the use of condition-specific pathways and interventions that are most effective in meeting their needs and achieving their goals. The pregnancy-specific goals shall include information and/or education to meet identified needs and encourage self-management, using materials that meet literacy standards, and titrate the level of care coordination services based upon the level of need as determined through evaluation of the pregnancy-specific goals and ongoing assessment. If the enrollee also is receiving other care management, the care coordinator will coordinate with their care manager to share the pregnancy-specific goals and receive the enrollee's overall comprehensive care plan and ensure non-duplication.

3. *Coordination and Linkage to Pregnancy Care*

For those enrollees identified as having a high-risk pregnancy, the PHP or the PCCM entity will coordinate with and link enrollees to care, including referring and connecting the enrollee to any needed prenatal, postpartum, preventive and primary care services, specialist services and community resources.

4. *Transition at End of Eligibility for Pregnancy-Specific Care Coordination*

The enrollee will be eligible for high-risk pregnancy care coordination up to 84 days postpartum. If the enrollee remains Medicaid enrolled at the end of eligibility for pregnancy-specific care coordination, the Standard Plan, Tailored Plan, or the PCCM should coordinate with any existing care manager or, if no previous care manager was involved with the member, connect the individual to care management if they have further support needs.

<u>Additional Programmatic Requirements</u>

Training

The Standard Plan, Tailored Plan, or the PCCM entity will ensure pregnancy-specific care coordinators and their supervisors complete orientation and programmatic trainings on a one-time basis as well as ongoing training annually on high-risk prenatal and postpartum care to ensure staff are appropriately trained to serve enrollees.

Monitoring and Oversight

NC Medicaid will closely monitor care coordination to ensure high-risk pregnant members receive access to pregnancy care coordination. Monitoring will address utilization of care coordination functions to ensure they are meeting their intended goals. Furthermore, Standard Plans, Tailored Plans, and PCCM shall develop a high-risk pregnancy care coordination policy that outlines their organization's approach to meet contractual requirements.

Payment and Contracting

Beginning Jan. 1, 2027, the cost of pregnancy-specific care coordination functions will be included in the capitation payment for Standard Plans and Tailored Plans and will be part of the PCCM entity's fees. Standard Plans and Tailored Plans may opt to subcontract pregnancy-specific care coordination functions to subcontractors. As applicable, subcontractors will be responsible for directly negotiating payment with the Standard Plans and Tailored Plans. All referrals for high-risk pregnancy care coordination must be received directly by the Standard Plans and Tailored Plans. The subcontractor should receive key information from the Standard Plan, Tailored Plan, or PCCM entity on the enrollee (e.g., enrollee ID, risk stratification, referral source, existing care manager information, prior medical or care management documentation, claims/encounter or quality measure data history). Subcontractors must meet contractual requirements related to qualifications of pregnancy-specific care coordinators and functions.

Key Requirements Effective Jan. 1, 2027 for Children Identified as High Risk

NC Medicaid believes that a whole-person centered approach to care can help to improve maternal, birth and early childhood health outcomes across North Carolina and is committed to access to high-quality care coordination inclusive of specialized functions for these priority populations. NC Medicaid will add at-risk child-specific care coordination functions as requirements in the Standard Plan and the PCCM entity contracts to be effective on Jan. 1, 2027, to provide these populations with more intensive, longitudinal support.

- At-Risk Child-Specific Care Coordination – specialized care coordination functions for at-risk children who are eligible ages 0 to 5 years
- Interactions with existing care management programs are noted in the "Understanding the Interaction of these Specialized Care Coordination Functions with Other Existing Care Management / Care Coordination Requirements in NC Medicaid" section below.

<u>At-Risk Child-Specific Care Coordination Functions</u>

These at-risk child-specific care coordination functions will include:

1. *Population Identification and Engagement*

The Standard Plan and the PCCM entity will identify each enrollee's level of childhood risk and needs, which could include leveraging referral information and other screening or assessment information (e.g., risk stratification) to determine eligibility and evaluate service needs tied to childhood risk. The Standard Plan and the PCCM entity also will build and maintain strong relationships with local medical homes

serving children ages 0 to 5 years, regularly engaging with other possible referral sources, including but not limited to hospitals, social service agencies (e.g., DSS, WIC), and ad hoc community events.

Enrollees may be referred through multiple pathways, including:

- Standard Plan/PCCM internal risk stratification
- Referrals or screenings from the medical home provider, health system, or other providers
- Community referral sources (such as DSS or WIC programs)
- Family or enrollee self-referral

Once a member is identified as an at-risk child or referred for care management and care coordination, the PHP will complete an encounter or three or more attempted encounters within seven business days of referral or identification as an at-risk child. Referral criteria include, but are not limited to:

- Child with Special Health Care Needs, defined as a child at increased risk for a chronic physical, developmental, behavioral, or emotional condition that has lasted or is expected to last at least 12 months and who requires health and related services of a type or amount beyond that required by children generally.
- Infant in Neonatal Intensive Care Unit (NICU)
- Child experienced adverse childhood events including, but not limited to:
    - Child in foster care
    - History of abuse and neglect
    - Caregiver unable to meet infant's health and safety needs/neglect
    - Parent(s) has history of parental rights termination
    - Parental/caregiver/household substance abuse, neonatal exposure to substances
    - Child Protective Services Plan of Safe Care referral for "Substance Affected Infant"
    - Child exposed to family/domestic violence
    - Unsafe where child lives /environmental hazards or violence
    - Incarcerated family or household member
    - Parent/guardian suffers from depression or other mental health condition, maternal postpartum depression
    - Homeless or living in a shelter/Unstable housing

2. Enhanced Care Coordination Requirements for At-Risk Children Ages 0 to 5

At-risk child-specific care coordination functions will require more intensive outreach and engagement than traditional Standard Plan and AMH Tier 3 care management. For those enrollees identified as at-risk children, the Standard Plan or the PCCM entity (or subcontracted entity) will coordinate with and link the enrollee to care, including referring and connecting the child and family to needed medical, developmental, specialist, preventive and primary care services, and community resources. This process will require a higher volume and intensity of interactions than would be expected in a typical care management engagement.

For those enrollees identified as at-risk children ages 0 to 5, the Standard Plan or PCCM entity will attempt or complete patient-centered encounters with the enrollee every 30 calendar days for at least six months and then ongoing as needed for Care Plan goals, unless the parent or guardian declines the frequency of encounters. At-risk child-specific enhanced care coordination functions should aim to

involve the parent or caregiver in all decision-making processes through a patient-centered, collaborative partnership approach to build the family's capacity toward improved self-care and foster self-management skill building. Face-to-face family encounters (e.g., home visit, primary care office visit, hospital visit, community visit, video conferencing) should aim to be prioritized over telephone encounters for at-risk children, whenever possible.

Infants referred for Plan of Safe Care will be served by the mother's Medicaid plan until the infant is enrolled with a Medicaid plan at which time the assigned PHP will be responsible for the infant's care coordination, including connecting the family to or completing:

- Evidence-based parenting programs
- Mental health providers
- Home visiting programs
- Identification of appropriate childcare
- Screening for referral to the NC Infant-Toddler Program through intervention for infants with diagnosis of Neonatal Abstinence Syndrome or for infants with developmental concerns

3. Transition at End of Eligibility for At-Risk Child Care Coordination

Enrollees ages 0 to 5 years will be eligible for at-risk child-specific care coordination intensity and duration requirements until the at-risk child is assessed to no longer need continued support. Standard Plans and the PCCM entity will monitor children who have been determined to be no longer in need of the at-risk child-specific care coordination functions, and re-establish at-risk child-specific care coordination if their level of risk is determined to have changed before their sixth birthday. Interactions with existing care management programs are noted in the section "Understanding the Interaction of these Specialized Care Coordination Functions with Other Existing Care Management Programs in NC Medicaid" below.

<u>Additional Programmatic Requirements</u>

Monitoring and Oversight

NC Medicaid will closely monitor the intensity and duration of these specialized functions during and after the period of transition to ensure enrollees continue to receive high-quality support. Monitoring will address both utilization and duration of care coordination functions to determine if they are meeting their intended goals and requirements.

Contracting

Standard Plans and the PCCM entity may opt to subcontract to provide at-risk child-specific care coordination functions, and subcontractors will be responsible for directly negotiating payment with the Standard Plans and the PCCM entity. All referrals for at-risk child care coordination should be sent to the Standard Plan or PCCM entity directly. Subcontractors must meet all contractual requirements, including requirements related to qualifications of at-risk child care coordination functions. In determining whether to subcontract, PHPs and the PCCM entity should consider enrollees' needs and particularly the need to minimize the risk of fragmentation of care.

Understanding the Interaction of these Specialized Care Coordination Functions with Other Existing Care Management / Care Coordination Requirements in NC Medicaid

These care coordination functions are complementary (i.e., additive) to existing care management programs like Standard Plan/AMH Tier 3 care management and Tailored Care Management. While AMH Tier 3 and Tailored Care Management entities may be contracted to provide care management, if they do not have specialized pregnancy care coordination expertise, it will be appropriate to have a separate care coordinator who addresses enrollees' high-risk pregnancy-related needs.

- **For Standard Plan enrollees receiving care management from an AMH Tier 3 practice or Standard Plan:**
    - The care manager and pregnancy- specific care coordinator will closely collaborate and share information to address the enrollee's whole person care needs.
- **For Tailored Plan enrollees receiving care management from a Tailored Care Management provider** (e.g., AMH+, Care Management Agency, or Tailored Plan):
    - The care manager and pregnancy-specific care coordinator will closely collaborate and share information to address the enrollee's whole person care needs.
- **For Tailored Plan enrollees who have opted out of receiving Tailored Care Management, but are receiving care coordination for 1915(i) services, Innovations Waiver services, or Traumatic Brain Injury waiver services, or other Tailored Plan care coordination**:
    - The existing Tailored Plan care coordinator and pregnancy-specific care coordinator will closely collaborate and share information to address the enrollee's whole person care needs.
- **For Medicaid Direct enrollees who are receiving care management from the PCCM entity:**
    - The Medicaid Direct care manager and pregnancy- specific care coordinator will closely collaborate and share information to address the enrollee's whole person care needs.

In cases where an enrollee has a pregnancy- specific care coordinator for those specialized functions *and* an additional care coordinator or care manager, the two individuals will share information throughout (e.g., assessments, pregnancy-specific and at-risk child-specific goals, coordination to services) during the specialized care coordination period to ensure collaboration and non-duplication. For example, the pregnancy-specific goals should be added to an enrollee's comprehensive care plan. In addition, collaboration between staff is integral to ensure enrollees are not repeating information and/or receiving conflicting information on connections to care so that enrollee experience is considered.

Throughout and at the end of the specialized care coordination period, the Standard Plan, Tailored Plan, or the PCCM entity continues to be responsible for assessing enrollee needs for other care management (e.g., through AMH, Tailored Care Management) or other care coordination services (e.g., 1915(i)). At the end of the specialized care coordination period, the pregnancy- specific care coordinator will transfer information back to Standard Plan, Tailored Plan, or the PCCM entity care manager or other care coordinator.

See Appendix for graphics illustrating these requirements.

Next Steps and Conclusion

To facilitate a safe and smooth transition, Standard Plan, Tailored Plan, and the PCCM will initiate the process of transitioning care plans for currently-engaged enrollees no later than during the month of December 2026 or in alignment with the *Companion Guide for Care Management Termination and Transfer of Services Processes* where an LHD ends CMAR/CMRHP services prior to the end of December 2026. In addition, NC Medicaid expects Standard Plans, Tailored Plans, and the PCCM entity to implement safe and effective transitions of care and encourages them to use the CMARC and CMHRP terminations and transitions policy as a guide. NC Medicaid expects that Standard Plans, Tailored Plans, and the PCCM entity will have necessary capacity to transition all currently-engaged enrollees effective Jan. 1, 2027.

The Department will actively monitor the transition to ensure enrolled members are appropriately transitioned by Dec. 31, 2026. Additionally, the Department is engaging with each PHP regarding their transition approaches and timelines and will share more detailed implementation guidance with provider, as appropriate.

North Carolina is committed to ensuring the continued delivery of high-quality care coordination services for pregnant enrollees who are at high-risk for adverse birth outcomes and for at-risk children. These changes are intended to further integrate these specialized care coordination functions with other services provided via Medicaid managed care to strengthen critical supports for enrollees in need across the state. NC Medicaid looks forward to working with the leadership of Standard Plans, Tailored Plans, the PCCM entity, LHDs, other providers, and community partners to maintain quality care for enrollees during this transition.

Appendix: Illustrative Delivery System Graphic: High-Risk Pregnancy

Figure 1. Understanding Future State for Standard Plan Enrollees

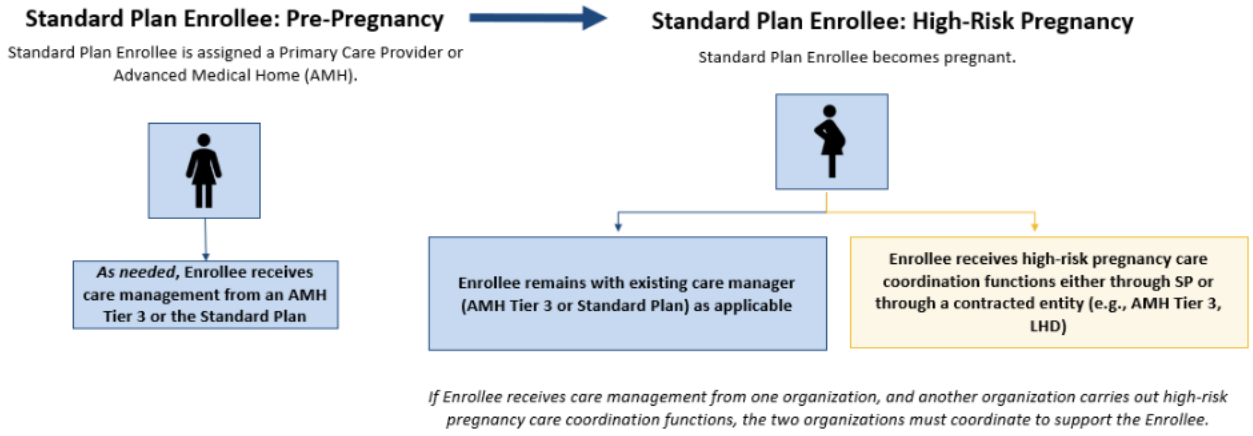


Figure 2. Understanding Future Changes for Tailored Plan Enrollees

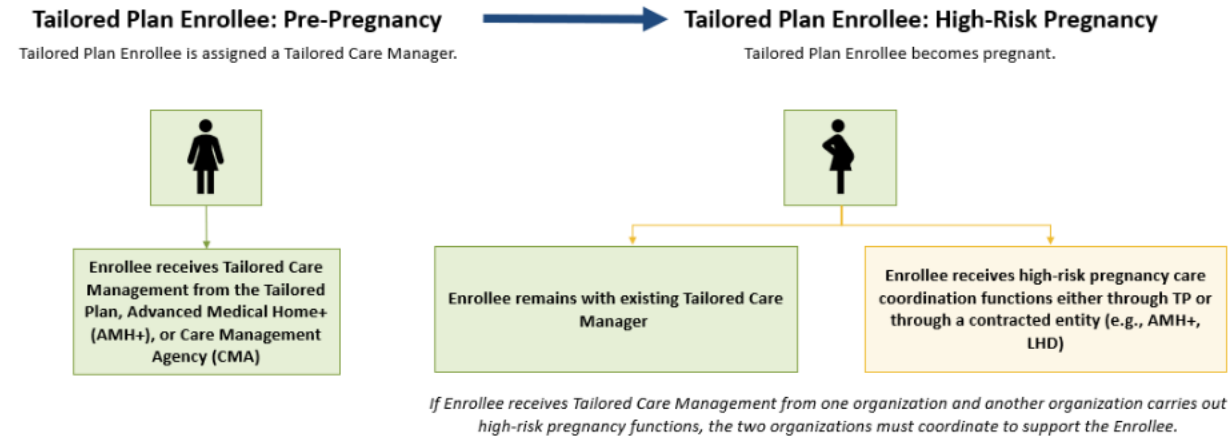
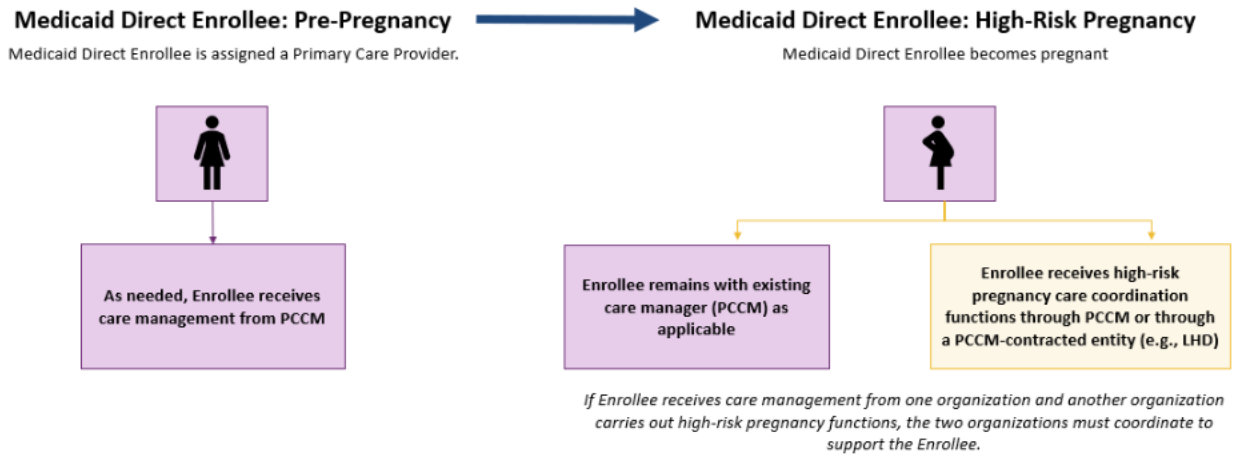


Figure 3. Understanding Future Changes for Medicaid Direct Enrollees



Appendix: Illustrative Delivery System Graphic: At-Risk Children

Figure 4. Understanding Future Changes for Standard Plan Enrollees

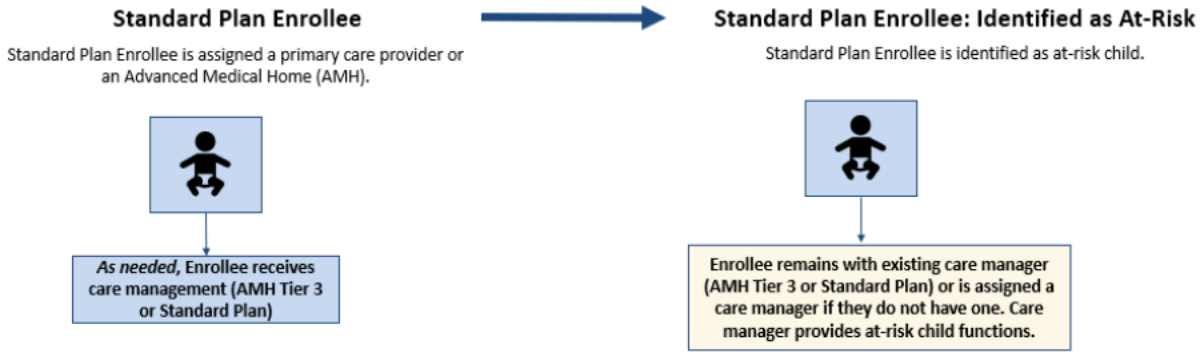


Figure 5. Understanding Future Changes for Medicaid Direct Enrollees

