NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Tailored Care Management Provider Manual Updates
October 30, 2026

This document provides a summary of updates in the revised Tailored Care Management (TCM) Provider Manual, which the Department released on Oct. 30, 2026. The requirements in the updated Provider Manual are tentatively effective Dec. 30, 2026. Tailored Plans and LME/MCOs may choose to adopt the updated guidance earlier. TCM providers should follow the implementation timeline provided by the beneficiary's assigned health. The revisions aim to enhance clarity, strengthen guidance, and support consistent implementation across providers and health plans.

Key updates and clarifications are described below:

1. TCM Certification

For several TCM certification cycles, NCQA served as the Department's certification partner. The updates reflect that NCQA is no longer fulfilling this role. The AMH+/CMA assigns Administrative Sites for delivering TCM services with the Tailored Plan or LME/MCO. If a TCM Provider wants to change populations served, adjust Administrative Sites, or update their care management platform, they must notify their contracted Tailored Plan at least 60 days before the change. They must also inform the Department by emailing Medicaid.TailoredCareMgmt@dhhs.nc.gov.

Section III: Overview of the Certification Process p. 9

2. Glidepath "Glide Path" to Provider-based Care Management

We continue to believe that the model of community-based TCM should be maintained and strengthened. It is our intent to provide additional flexibility within the TCM glidepath so that it does not hinder TP/PHIP monitoring, oversight, or actions related to community based TCM performance. To support this refinement, DHB has adjusted the TCM glidepath rates from the original Y3 – 65% and Y4 – 80% to revised rates of Y3 – 55% and Y4 – 55%. To date, the average Plan glidepath achievement is 65%, with the highest Plan assignment to community-based TCM reaching 74%.

Section III: "Glide Path" to Provider-based Care Management p. 10

3. Healthy Opportunities Pilot Program (HOP)

HOP services stopped beginning July 1, 2025. The Department has announced that there is currently work underway to resume operations for HOP with a relaunch in 2027

Section IV: Healthy Opportunities Pilot Program pp. 16-17

4. Member Outreach and Engagement

Care managers should make best effort to initiate contact and receive a member's consent for participating in Tailored Care Management no later than 30 calendar days from the date of assignment to the AMH+/CMA. All outreach attempts should be documented in the care management data system.

Section: V.4.2 Capacity to engage with members through frequent contact p. 22

5. Care Management Comprehensive Reassessments (Annual + Trigger-Based)

Care managers must attempt to complete a care management comprehensive reassessment for members already engaged in care management at least annually, as part of developing the new ISP/Care Plan. Care managers must make "best efforts" to complete the reassessment before the annual due date. Care Managers must make "best efforts" to ensure that the member receives a reassessment within 30 days of when it detects the triggering change or event.

Section: V.4.3 Requirements for Reassessment p. 29

6. Care Plans and Individual Support Plans (ISPs)

Care managers supporting members with co-occurring I/DD, TBI, and behavioral health needs must develop a Care Plan or ISP based on input from the member and/or their legally responsible person. The plan should reflect what matters most to the member and outline coordinated services, including the care manager's role in overall coordination. Care managers are also responsible for submitting the Care Plan or ISP to the Tailored Plan or LME/MCO according to established processes.

Care Plans and ISPs developed under TCM must include, at minimum, the names and contact information of all key individuals involved in the member's care. This includes primary care providers, assigned care management team members (such as the care manager, supervising care manager, and extender), and any parents, caregivers, family members, or natural supports the member chooses to involve. For members in foster care, adoption assistance, or who are former foster youth, the county child welfare worker must also be included. Additional individuals identified by the member or their legally responsible person should be documented as part of the planning and service delivery process.

All Initial, Annual, and Revisions/Updates Care Plans and ISPs must include either a wet or electronic signature. The plan is considered complete on the date it is signed by the member and/or their legally responsible person or guardian.

Initial Care Plan/ISPs

The AMH+ or CMA must make best efforts to complete an initial Care Plan or ISP within 30 days of the completion of the care management comprehensive assessment.

Annual Care Plan/ISPs

Each year, the AMH+ or CMA must ensure the member's Care Plan or ISP is fully updated. This involves the care manager reviewing every component of the existing plan and developing a new version that reflects the member's current goals and needs. This annual update is considered a new Care Plan or ISP and must be signed by the member and/or their legally responsible person or guardian.

For individuals receiving 1915(i) services or enrolled in the 1915(c) Innovations or TBI waivers, the annual Care Plan or ISP must be completed during the member's birth month. The updated plan then becomes effective on the first day of the month following the birth month. Care Plans and ISPs cannot exceed 365 days in duration

(or 366 days in a leap year), meaning the plan's end date is always the last day of the member's birth month. Revisions/Update Care Plan/ISPs during the year do not reset or extend the annual plan cycle.

Revisions/Updates to the Care Plan or ISP

The care manager collaborates with the member, their legally responsible person or guardian, and the care team to ensure the Care Plan/ISP remains current and accurate. Timely updates help maintain accuracy and ensure that any changes are clearly communicated and documented. Updates or revisions to the Care Plan/ISP must occur within 365 calendar days (or 366 days in leap years) of the annual plan date. The effective date of newly added services should reflect the start date of the service and end on the last day of the member's birth month. In addition to the annual Care Plan/ISP, care managers must update or revise the plan as part of ongoing care management whenever any of the following occurs:

- When the member's circumstances, needs, or health status change significantly
- At the member's request
- Changes in amount, duration or frequency of services and changes in service providers
- Within 30 days of care management comprehensive (re)assessment
- Following a change in the member's foster care placement living arrangement or (as appropriate)
- After triggering events (triggering events defined in Section 4.3. Care Management Comprehensive Assessment)

When Care Plan/ISP Updates Are Not Needed

Plans do not need to be revised for minor interruptions such as short vacations that temporarily pause services. Documentation must still explain why services paused and that no revision is needed.

Roles and Responsibilities for Care Plan/ISP Development and Implementation

Care managers are responsible for:

- Developing and monitoring the implementation of the Care Plan/ISP, working with the member and family to develop the Care Plan/ISP, including developing long-term goals; and supporting the member and/or legally responsible person/guardian to schedule a planning meeting and inviting team members to the meeting at a time and location that is desirable for the member.

Service providers are responsible for:

- Developing intervention strategies, writing short-range goals, and monitoring progress at the service delivery level toward goals identified in the Care Plan/ISP, ensuring that staff are appropriately qualified and trained to deliver the interventions necessary to support the accomplishment of goals; and Clinical supervision of their staff.

Care Plan/ISP and Person-Centered Plan

Many individuals receiving Tailored Care Management may also use enhanced services that require a separate Person-Centered Plan (PCP). As a result, some members will have both a PCP and a Care Plan/ISP. The enhanced service provider is responsible for creating the PCP and, when needed, obtaining service authorization from the Tailored Plan or LME/MCO.

Section: V.4.4 Care Plans and Individual Support Plans (ISPs) pp. 30-33

7. Care Team Documentation

Clear documentation of the assigned care management team members (i.e., care manager, supervising care manager, extender) responsible for delivering care management services to the member is required. If another care manager provides services, the record must clearly indicate who provided the coverage.
Section: V.4.5 Care teams. p. 34

8. 24-Hour Coverage Requirement

AMH+ practices and CMAs, in their role as TCM providers, are not required to serve as first responders during a member's medical emergency or behavioral health crisis. However, they must maintain a process for providing crisis service providers and other entities (such as emergency departments) with necessary information during a crisis or transition of care. For example, if a member is hospitalized and the hospital contacts the TCM provider for guardian information, the AMH+/CMA must be able to respond. Information that may need to be shared includes the Care Plan/ISP and, when applicable, a psychiatric advance directive. Each AMH+/CMA must have a process for responding to such requests 24 hours a day, seven days a week. This may include actions such as checking and responding to voicemail messages on weekends or after hours. Responses to crisis or transition-related requests should occur within 24 hours. A live call center is not required.

This requirement applies at the AMH+/CMA organizational level not the individual care manager level and may be fulfilled by other staff. AMH+ practices and CMAs may leverage existing processes to meet this requirement. For example, outpatient behavioral health providers already maintain 24-hour emergency coverage, and AMH practices are required to ensure 24-hour primary care coverage for services, consultation or referral, and treatment of emergency medical conditions.
Section: V.4.6 Required Components of TCM. p. 35

9. Transitional Care Management

The care manager or care team member must make best efforts to contact the member during their stay in an institution and contact them on the day of discharge (attempts include contact with member, hospital social worker, or other behavioral health provider working with the member).
Section: V.4 Transitional Care Management p. 40

10. Innovations and TBI Waiver Care Coordination

Care managers are responsible for adhering to the Behavioral Health Clinical Coverage Policy 8P for Innovations Waiver Services, which are posted on the NC Medicaid Program Specific Clinical Coverage Policies webpage. If care management guidance conflicts with Clinical Policy 8P, care managers must follow the requirements outlined in clinical policy. Care managers providing TCM to individuals enrolled in the 1915(c) TBI waiver are responsible for adhering to the TBI waiver application and Alliance Health TBI waiver resources posted on the NC Medicaid Traumatic Brain Injury (TBI) Waiver webpage.
Section: V4.9 Innovations and TBI Waiver Care Coordination p.42

11. 1915(i) Care Coordination

There have been important updates to the 1915(i) Care Coordination guidance. Key changes are highlighted below. Please review the full section for complete details.

1915(i) Clinical Coverage Policy

- If care management guidance conflicts with clinical policy, care managers must follow the requirements outlined in the clinical policy. See 1915(i) Provider Resource Frequently Asked Questions (FAQs) | NC Medicaid

for answers to frequently asked questions. Care managers are responsible for adhering to the Behavioral Health Clinical Coverage Polices for 1915(i) services, which are posted here: NC Medicaid Program Specific Clinical Coverage Policies webpage.

Completing the 1915(i) Assessment

The 1915(i) assessment should capture the member's full range of needs, not only the services they express interest in. Care managers must collect thorough information and document all needs. Documenting all identified needs helps prevent unnecessary 1915(i) reassessments, as eligibility is based on the member's needs, not on specific services. After eligibility is established, the member and/or legally responsible person/guardian will select the 1915(i) services to include in the ISP/Care Plan.

1915(i) Timelines

Care managers must document in the care management platform the date the member and/or legally responsible person/guardian expressed interest in 1915(i) services, or the date of notification from the Tailored Plan/LME/MCO of the expressed interest. Care managers must complete the 1915(i) independent assessment in-person or via secure two-way real time video using state-designated tool within ***14 days*** of expressed interest.

The Care Plan or ISP is the 1915(i) service order and a new plan is required annually and must be signed by member and/or legally responsible person/guardian. The Care Plan or ISP is effective for **365 days**, or 366 days in a leap year and Care managers must sign the Care Plan/ISP.

Care managers must submit the 1915(i) Care Plan/ISP to the Tailored Plan/LME/MCO within **45 days** of eligibility determination. All 1915(i) services must be included in the Care Plan/ISP and submitted to the Tailored Plan or LME/MCO. Services requiring prior authorization must also be approved by the Tailored Plan/LME/MCO utilization management team. Care managers should follow the Tailored Plans/LME/MCO's established process for this review. The Tailored Plan/LME/MCO will review the prior authorization request within the required calendar days to complete a utilization review of the service(s).

Immediately Needed 1915(i) Services

Immediately needed 1915(i) services are those required to support timely discharge from inpatient settings, prevent inappropriate or imminent placement outside the current living arrangement, address severe behavioral health or psychiatric risks, or prevent imminent loss of competitive employment. When these situations occur, an interim plan must be completed within 14 days of identifying the need, and a full Care Plan/ISP must be completed within 45 days of the eligibility determination.

Annual 1915(i) Reassessments

Members who receive 1915(i) services must have an independent assessment every year and whenever their needs or circumstances change significantly. Care managers must use the Department's standardized 1915(i) assessment template for both initial and annual reassessments. Annual 1915(i) reassessments must be completed every 12 months and submitted no later than 60 days before the member's current eligibility expires to prevent gaps in services. Care managers are responsible for completing the full NC Medicaid 1915(i) Assessment including ADLs, IADLs, social/work functioning, and cognitive/behavioral needs to ensure an accurate picture of the member's current support needs. Members who discontinue receiving 1915(i) services do not need an annual 1915(i) reassessment. The Care manager must document the member's discontinuation and inform the member that reassessment and eligibility will resume only if they request or re-engage in 1915(i) services in the future.

Monitoring 1915(i) Service Access and Delivery

Care managers are responsible for monitoring how 1915(i) services in the Care Plan/ISP are delivered and resolving or escalating any issues to the Tailored Plan or LME/MCO. Monitoring is documented using the 1915(i) Monitoring Check Sheet and occurs in all service settings on the monitoring schedule outlined in the Care Plan/ISP. The ISP/Care Planning meeting should include discussion of the appropriate monitoring frequency. If concerns are identified, monitoring must occur more frequently to ensure the member's health and safety.

Monitoring frequency for 1915(i) services:

Care managers must follow specific monitoring schedules to ensure that 1915(i) services are delivered appropriately and meet each member's needs. Care managers may increase monitoring when there are concerns about the member's health or safety. These requirements help ensure ongoing service quality, early identification of concerns, and comprehensive support for the member's health, safety, and outcomes.

- Community Living and Supports (CLS) requires **quarterly in-person monitoring**, with monthly **in-person monitoring** when the service is provided by a Relative as Provider.
- Individual Placement and Supports (IPS) and Individual Transitional Supports (ITS) also require **quarterly in-person monitoring**.
- Respite services are monitored through a **quarterly claims review**.
- Supported Employment (SE) requires **quarterly in-person monitoring**. Care manager should not contact the member's employer. Contact should be with the supported employment service provider and member only.
- In months when monitoring activities do not occur, care managers must complete a monthly contact.

1915(i) Monitoring methods include face-to-face (in-person or virtual) contact with the member, telephonic check ins, observing the service provider during service delivery, and reviewing the provider's paid claims or service documentation when available. When monitoring takes place via telephone or virtual platforms, adhere to CCP 1-H: Telehealth, Virtual Patient Communications, and Remote Patient Monitoring.

1915(i) Telephone Contacts

Care managers must call the member and/or their legally responsible person or guardian in any month without a face-to-face 1915(i) monitoring contact to check for any issues with services. All contact attempts must be documented. A 1915(i) telephone contact is met when the care manager verifies that services match the Care Plan/ISP, the member can access services, any access issues are addressed, services meet the member's needs, provider choice is offered, the member is satisfied with services, and any non 1915(i) needs are addressed. Care managers should review the monitoring activity against the TCM qualifying contact definition to determine whether it is billable.

Monitoring Restrictive Interventions

Care managers must conduct quarterly monitoring for members with restrictive interventions to ensure that all such interventions including any protective devices used for behavioral support are documented in the Care Plan/ISP and, when applicable, in the Positive Behavior Support Plan. Care Mangers are also responsible for ensuring compliance with required reviews for the removal of restrictions.

HCBS Settings Compliance Monitoring

Care managers must use the designated HCBS Setting Compliance Monitoring Checklist to assess HCBS compliance for members receiving services in provider-owned and provider-operated settings. This includes 1915(i) services such as IDD Supported Employment and Individual Transitional Supports delivered in group homes. For IDD Supported Employment, the checklist is required when the 1915(i) provider both employs the

member and delivers their HCBS services. The HCBS Setting Compliance Monitoring Checklist is *not* used for services delivered in private homes.

1915(i) Monitoring Policies and Procedures

TCM providers must have policies and procedures for escalating any concerns identified during 1915(i) service monitoring or HCBS compliance visits to the Tailored Plan or LME/MCO. Care managers must document both the concerns and the resolution in the care management platform.
Section V 4.10, 1915(i) Care Coordination pp. 44-50

12. Risk Stratification

Risk stratification is no longer required at the TCM provider level.
Section: V.5: Health IT p. 61

13. Training Requirements

The AMH+ or CMA must ensure that care managers, care manager extenders, and supervisors complete six hours of annual refresher training (i.e., if a care manager's deployment date is October 2022, the care manager would begin refresher training in November 2023 and would need to complete the refresher training by October 2024). TCM staff can partner with their supervisors to create an education plan that is tailored to the care managers' needs and populations they serve. Available courses include a curated list of elective courses, chronic disease management and Learning Collaborative courses.
Section: V.7 Training p. 65

14. TCM Monitoring and Oversight

Initial monitoring of Tailored Plans/LME/MCOs, AMH+s and CMAs primarily focuses on providing technical assistance for out of compliance findings. However, egregious and/or systemic noncompliance issues (e.g., concerns related to member health and safety, patterns of noncompliance findings) may result in further review and/or corrective action. The determination of corrective action for AMH+s and CMAs will be at the discretion of the Tailored Plan/LME/MCO conducting the monitoring.
Section: VII Oversight Model after TCM Launch p. 67

15. Documentation of Member Rights

Care managers should document as part of the care management comprehensive assessment or development of the Care Plan/ISP that the individual's rights were explained to the member/legally responsible person/guardian and made available. The approved forms of documentation are the individual and/or legally responsible person/guardian providing an electronic or wet signature, or the care manager attesting that they explained the individual's rights and provided the member with a written summary of their rights.
Section: IX. Documentation Guidance p. 71

16. Requesting Prior Authorization

Health Plans may determine whether the care manager or the 1915(i) service provider should submit the prior authorization request (SAR or TAR). Therefore, the following language that requires the submission of the authorization request by the care manager was removed from STDs.
Appendix 3: Additional Standard Terms and Conditions (STDs) for Tailored Plan/LME/MCO Contracts with AMH+ Practices or CMAs Certified to Provide TCM to Members Obtaining 1915(i) Services p. 69

17. Standard Terms and Conditions

The Standard Terms and Conditions appendixes have been updated to include the latest guidance from the TCM Provider Manual.

APPENDIX 1: Standard Terms and Conditions for Tailored Plan/LME/MCO Contracts with AMH+ Practices or CMAs pp. 74-94

Appendix 3: Additional Standard Terms and Conditions (STDs) for Tailored Plan/LME/MCO Contracts with AMH+ Practices or CMAs Certified to Provide TCM to Members Obtaining 1915(i) Services pp. 98-104

APPENDIX 5: Required Annual TCM Refresher Trainings for Care Managers, Care Manager Extenders, and Supervisors pp. 109-110