# InCK Program – PHP FAQs

12/21/2021

| # | Questions and Answers |
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| 1 | **Q: Can the State increase the valid values field for "Phone for Care Manager Assigned"? Healthy Blue's care managers have a 10 digit extension number and there is a 12 digit limit on the report template?**<br><br>A: Yes, this field has been extended to 40 characters in the SIL file. The updated file layout has been shared. |
| 2 | **Q: Can the State confirm what the submission cycle and report due date would be for the new fields on BCM051?**<br><br>A: The new fields on BCM051 will have its first report due date on April 30th 2022. The report will continue its current frequency to be due on or before the last calendar day of the following month. |
| 3 | **Q: What will be the expectation for member incentives related to Care Needs Screener since they are not completing a full screener?**<br><br>A: PHPs are recommended to follow their member incentive policy. |
| 4 | **Q: When can we expect talking points for the InCK program?**<br><br>A: NC InCK talking point will be provided to the PHPs by December 31, 2021. |
| 5 | **Q: Regarding the receipt of quality data. for member level quality data which Plans will use to create provider APM member care gap reports - Plan need the file format by the end of April to prepare data tables to store the data and design/automate GIC provider reports. We also anticipate receiving already produced provider APM scorecards. Plans need more detail on format and size of file in order to plan where to store it.**<br><br>A: The member-level and summary-level templates have been drafted and will be provided to PHPs in the first quarter of 2022. |

**Archive FAQs - 12/6/2021**

| # | Questions and Answers |
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| 1 | **Q: Can the State confirm that the Service Integration Coordinator that works for a PHP will only be assigned to that PHP's members?**<br><br>A: Correct, but they will be assigned to the PHP's members whose lead CM entity is an AMH3. |
| 2 | **Q: Can the State confirm that a PHP's members will only be assigned to that PHP's Service Integration Coordinator?**<br><br>A: Not true – a PHP's members will also be assigned to a range of ICs based on their characteristics including the CIN based ICs and ICs based in other entities. |
| 3 | **Q: Is it the expectation that the Service Integration Coordination will upload the Shared Action Plan and Consent Form to Virtual Health, for all the members assigned to them, including those within an AMH3? If "yes" how will the Shared Action Plan and Consent Form be sent to the PHP?**<br><br>A: Yes, for those who fill out a consent form and/or SAP. There is no requirement that the FN in an AMH 3 sends the SAP or Consent to the PHP, but in some cases if the child is paired with an IC based in a PHP, they may receive the SAP and Consent to upload in VirtualHealth. AMH3s will report on SAP completion on the Patient Risk List. |
| 4 | **Q: For the Shared Action Plan – some PHPs work in a different clinical documentation system and not Virtual Health. Would it be expected that InCK associated staff would have access to VH to place the SAP there OR would they need to configure this in their clinical documentation system, document the SAP there and then they would only be able to share via their portal (which would prevent any edits by external parties).**<br><br>A: InCK associated Integration Consultants based out of Health Plans will receive Shared Action Plans from Family Navigators to upload into the Virtual Health platform. These Integration Consultants at the Health Plans will have access to the VirtualHealth platform. Integration Consultants will be the only staff responsible for uploading SAPs into VirtualHealth.<br>(*Please refer to question #6 from FAQ 11/22/2021 below for more information*) |
| 5 | **Q: Will there be report requests seeking to pull data that may be related to pharmacy encounter level details for example? We are trying to determine the member file flow and ensure InCK identifiers are located where needed for potential granular reporting.**<br><br>A: No, the Department already has access to this level of data via our Data Warehouse. |
| 6 | **Q: Last week, it was presented that InCK expected a particular set of screening questions to be within the Assessment. We had requested samples of those types of questions to ensure we have assessments and screeners that currently align. Could those questions be provided?**<br><br>A: On December 1st the NC InCK team shared example comprehensive assessment elements for the additional InCK domains of educational needs, child welfare needs, and juvenile justice needs. |

**Archive FAQs - 11/22/2021**

| # | Questions and Answers |
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| 1 | **Q: On 10/25, the State proposed an updated CMARC referral process for SIL 1,2,3 members, where SIL 2 & 3 would be referred to AMH3s for NC InCK services if the AMH3 is participating and referred to CMARC if the AMH3 is not part of a participating CIN. However, on the 11/1 FAQ document (question # 20), we were informed that all CMARC eligible members should only be referred to CMARC. Due to the logic required to ensure these members are referred appropriately, could you please clarify which guidance we should follow?**<br><br>A: CMARC members will not participate in NC InCK. Members should be referred to CMARC using current processes. Those members will not receive additional InCK services via the LHD at this time. |
| 2 | **Q: Can the State provide clarification on expectations reporting file record count? Will this be a new or will it be added to existing report?**<br><br>A: This will be a new report. More guidance will be provided on the new report and process. |
| 3 | **Q: Can the State provide clarification around the process for the SAP upload? Can we do a batch upload into VirtualHealth or do we send NC InCK an extract from our system to upload?**<br><br>A: Integration Consultants will be responsible for uploading the SAP into the VirtualHealth platform. Specific training material around the functionality and process for SAP upload into VirtualHealth will be provided in the coming months. |
| 4 | **Q: Can the State confirm the naming convention for the SIL file? It is listed differently between the layout and the SIL/MFT documents.**<br>**• SIL File: InCK_SIL_BCBSN_mmddyyyy.csv**<br>**• Companion Guide: BLUS_INCK0001_SIL_V01_202107281045.csv**<br><br>A: SIL file naming convention should be according to the NC Medicaid InCK SIL Stratification standard data specification document. Per the example above, 'InCK_SIL_BCBSN_mmddyyyy.csv' is the correct naming convention. The companion guides were updated to reflect the correct naming convention and shared with health plans on 11/12. |
| 5 | **Q: Can the State confirm if there are any VPN issues related to us gaining access to Virtual Health?**<br><br>A: Specific training material around the VirtualHealth platform will be provided in the coming months ahead of the launch of the InCK program. |
| 6 | **Q: If the Health Plans choose to utilize Virtual Health for their Family Navigators to complete the SAP and the Consent, can care plans and comprehensive assessments also be done in Virtual Health, or would this need to be done in the PHP/AMH3s system separately?**<br><br>A: The VirtualHealth platform will not support the completion of the SAP and/or consent form. A PDF version of the SAP will be utilized if not integrated into your CM system. The completed SAP and consent form will be shared with the Integration Consultant for upload into VirtualHealth. |
| 7 | **Q: Can the State provide clarification around what is expected by 1/1? Will we need to provide confirmation that we are complete, or will we be required to deliver items?** |

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| | A: We expect PHPs to be preparing staffing plans and workflows for Integration Consultants and Family Navigators. Integration Consultants should be available to answer questions around integrated care needs. PHP technology teams should be finalizing their ability to ingest the SIL file. |
| **8** | **Q: For January release, we are encouraged to do member outreach. Can the State provide guidance on what kind of outreach is expected, who would be reaching out to and what is most appropriate time to complete this outreach?**<br><br>A: Given the high volume of member communication around the launch of Medicaid Transformation, NC InCK is rethinking its recommended approach to member outreach on the InCK model and does not recommend broad outreach on InCK to all members. PHPs also won't receive their first list of InCK attributed members until February 2022. In December 2021, CINs and PHPs will receive talking points for families on the InCK model for call center, eligibility staff and Family Navigators to support answering inquiries directly from families. NC Medicaid and InCK will revisit any recommendations for direct member outreach in January 2022 and provide recommendations to the PHPs at that time. |
| **9** | **Q: Do we need to retain the SIL level as a member moves from SIL to another SIL level?**<br><br>A: PHPs will receive a monthly SIL file with updated SIL stratifications. The PHPs will then share the updated SILs with AMH providers via the downstream Patient Risk List. |
| **10** | **Q: Do we need to track the changes in SIL level?**<br><br>A: SIL level changes will be tracked on the SIL file, where SIL start/end dates are to be reported.<br><br>PHPs can historically track SIL level internally but will not be required to do so. |
| **11** | **Q: When will the BCM051 Template be finalized?**<br><br>A: The template will be finalized and published by Plan Admin by end of November. |

**Archive FAQs - 11/1/2021**

| # | Questions and Answers |
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| 1 | **Q: If we receive a member that has not been loaded from 834, how should we handle communication with the Department on these members?**<br><br>A: If there are fallouts in the data, you can submit help tickets through the tech ops process. |
| 2 | **Q: 'The reporting period dates are the month the SIL file is effective for.' Will this be for the month we receive the file or for the month following the file? Ex: We receive the SIL file January 19th, will the reporting dates be listed as 1/1/22-1/31/22 or 2/1/22-2/28/22?**<br><br>A: The reporting period dates for the SIL file are for the month before receiving the SIL file. In the example, if receiving the data January 19th, the reporting dates would be listed as 12/1/21 – 12/31/21. |
| 3 | **Q: Can the Department confirm if the SIL will be month by month per question below. For example: SIL level 2 received with reporting period 2/1/22-2/28/22 can the SIL be different like 2/10/22-2/28/22 or should they always match? Also, will the SIL always have an end date listed or can they have an infinity date listed? This will help us identify if we need a term by absence logic in place or if we will always have an end date listed.**<br><br>A: The reporting period will always match for members in the SIL file. Any new members added in the middle of the month will show in the next month's report. The SIL will have a high end-date listed (not infinity date). |
| 4 | **Q: Is there a Header and Trailer in the SIL file?**<br><br>A: There is a header with the column names on the first row of the SIL file as provided in the "File Layout" tab of the SIL file. There is no trailer record included in the SIL file |
| 5 | **Q: Will the SIL .csv file have data enclosed within double quotes?**<br><br>A: No, the SIL .csv file will not have data enclosed within "double quotes". |
| 6 | **Q: Please share the go live schedule or first prod file anticipated on each phase as we now only have the testing schedule but not on prod files.**<br><br>A: An InCK production schedule will be shared during a future weekly InCK PHP/CCNC Technology check in. |
| 7 | **Q: If the members change from a SIL level to another SIL level, will this change occur at the first of the month?**<br><br>A: The change will occur from the first of the following month and will be based on the SIL Effective Date defined in the file. |
| 8 | **Q: In the drawings provided by the Department, we see SIL Inbound/Outbound. Can you confirm that the SIL file will be inbound from DHHS to the PHPs?**<br><br>A: That is correct, the SIL file will be sent from DHHS and received by PHPs. |

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| 9 | **Q: Will a single BCM026 be able to be used for all participating AMH3s under a CIN, or will a file need to be generated for each AMH3 in question?**<br><br>A: There are no anticipated changes to the BCM026 process as part of the InCK launch. |
| 10 | **Q: The naming convention provided by the Department for the BCM026/Care Needs Screening, follows the pattern of a report being sent to a single location, such as DHHS. Examples of this would be BCM047 or MEM013. Files that are routed to AMH3/CINs or are from AMH3/CINs and sent to PHPs typically follow a naming convention that references the sender and the recipient, such as what we see with the claims files and PRL naming convention. Will DHHS be updating the naming convention to better align with the file naming convention typically used between providers and plans. Below are some of the challenges that may occur.**<br>**1. With the current naming convention, when PHP platforms generate BCM026 files for multiple AMH3/CINs they won't be able to be stored in the same folder as each file appears as though it will have the same file name.**<br>**2. Routing tools that route files based on file name won't know where to deliver the files because they will all have the same name.**<br><br>A: There will be no changes to the BCM026 at this time. |
| 11 | **Q: Is there a different BCM051 Report for NC InCK members, or will it be a single BCM051 submission for all reportable members?**<br><br>A: There is only one single BCM051 report for all members. |
| 12 | **Q: The file name for the current version (3a) of the Patient Risk List is NCMT_CareQualityManagement_AMH_PatientListRiskScore_ATRIUM_UHC_20210806-12150 Will the new version (3b) file name be the same or different?**<br><br>A: The file name for the new version (3b) will be called *Patient Risk List Release 2.0* .<br>The naming convention will be:<br>NCMT_CareQualityManagement_AMH_PatientListRiskScore_Rel2.0_<AMH/CIN1>_<PHPShort Name>_CCYYMMDD-HHMMSS.TXT |
| 13 | **Q: We are expecting to receive test files from Duke and CCPN for the Patient Risk List Release 2.0 (for InCK), as UNC has chosen to contract with us as an AMH 2, and not AMH 3. Is this correct? When can we expect to receive them?**<br><br>A: That is correct. You should anticipate receiving your first Patient Risk List Release 2.0 from Tier 3's and CINs in early April. |
| 14 | **Q: Can the SIL file be sent in .txt format instead of .csv? If not, will a header & trailer be sent with the file?**<br><br>A: The SIL file will be available for pickup as a .csv on the MFT landing page. There is a header with the column names on the first row of the SIL file as provided in the "File Layout" tab of the SIL file. There is no trailer record included in the SIL file |
| 15 | **Q: There are 3 tabs in the SIL file example, which tab will have the data?**<br><br>A: The SIL file will have the data populated on the 'File Layout' tab. |

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| **16** | **Q: How do we best prepare our IT, PHP internal CM and AMH3 Care managers for how to trigger and document on CMARC members if different than standard process?**<br><br>A: CMARC will not provide InCK services. |
| **17** | **Q: Will NEW CMARC eligible members be priority assigned to InCK instead of CMARC?**<br><br>A: No. Continue to make referrals to CMARC. |

**Archive FAQs - 10/22/2021**

| # | Questions and Answers |
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| 1 | **Q: Can we use our existing user id and public key associated with that user Id for InCK SIL file – User id: WellCare_NCDHHS?**<br><br>A: The SIL file will be available to be picked up in an MFT. More details on accessing the MFT landing page will be provided in the coming weeks. |
| 2 | **Q: What does the consent look like – can we get a copy?**<br><br>A: Each PHP was sent the form and asked for feedback and we're now reviewing that feedback with Duke's privacy officers and the CINs for a final version. |
| 3 | **Q: Will there be a step-by-step job aide (guidance tool) for the Family Navigator or do the PHPs have to create their own? I would think you all would want standardization but appreciate the willingness to let us be flexible within our own PHP workflows.**<br><br>A: NC InCK is developing a Family Navigator Handbook to provide an overview of InCK requirements for the role, best practices for key components (completing the SAP, quarterly check-ins, identifying a care team) of the model, and templates for outreach to members and care team members. PHPs and AMHs can modify these templates based on their judgment of the best way to support and engage members as long as they continue to adhere to the overall care management requirements for the model. If there are particular templates or job aides that would be helpful, NC InCK is happy to receive those requests and draft them this fall. Send requests to sarah.allin@duke.edu. |
| 4 | **Q: For Initial contact – is there a script that is a quick under 5 minutes "why" they should could consent to having a Family Navigator.**<br><br>A: Yes, a script will be provided to guide member engagement representatives in communicating the benefits of having a Family Navigator and an FAQ will be provided on the InCK consent form. InCK is targeting a date of December 1st to distribute these materials. |
| 5 | **Q: Frequency of outreach – minimum contact with family when they graduate from the program. If they still have needs at the end of the year – they continue to be managed. Does that commit them to another year, or can it be until the need(s) is met?**<br><br>A: The InCK model's goal is to promote a Single Point of Contact for families in SIL 2 and 3 who can be a trusted support in navigating the care needs of their child. All members in SIL 2 and 3 should be assigned a Family Navigator who provides integrated care to the member for 1 calendar year with a minimum of quarterly check-ins. Plans and AMHs can do more frequent check-ins at any time based on member needs. Each January, NC InCK will use its data-informed needs assessment approach to update the stratification of members in SIL 2 and SIL 3 and communicate those new stratifications to the plan.<br><br>Ahead of 2023, NC InCK and NC Medicaid will solicit input from PHPs and AMHs and release additional guidance on ongoing care management for members in SIL 2 and SIL 3. The percentages of members in SIL 2 and SIL 3 will remain consistent across calendar years at ~10% in SIL 2 and 5% in SIL 3. |

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| 6 | **Q: Does their stratification change engagement frequency – when increasing from SIL 1 to 2 or 3 does that change the frequency of interactions?**<br><br>**A:** Yes, a member's SIL does determine both their assignment of a Family Navigator and model requirements. Members in SIL 1 do not need to receive a Family Navigator, nor do they have requirements for care management, care team convenings or the Shared Action Plan.<br><br>All members in SIL 2 and 3 should receive outreach and assignment of a Family Navigator. Members in SIL 2 and 3 also have similar requirements for identifying a cross sector care team, engaging the care team, and ongoing integrated care support for the member for at least 1 year with a minimum of quarterly check-ins with the member.<br><br>Only members in SIL 3 have a requirement for a comprehensive assessment and outreach for a Shared Action Plan. However, there is a target that 10% of members in SIL 2 should have a Shared Action Plan – the members that the PHPs or AMHs prioritize in SIL 2 for a SAP is at the discretion of the entity. |
| 7 | **Q: By participating in InCK, what is required versus optional?**<br>1. Entry into VH<br>2. Graduation<br>3. Decline<br>4. UTR<br>5. Risk stratification<br>6. Requirements around outreach<br><br>A: Could you please clarify your question? |
| 8 | **Q: Do we send anything out – Is the expectation that we follow standard CM process?**<br>**1. Letters when unable to reach by phone?**<br>**2. Home visits requirements?**<br>**3. UTR letters, program engagement letters, provider letters?**<br><br>A: Any of the items in reference (home visit, follow-up letter, etc.) would be allowed and supported by InCK if AMHs or PHPs feel they would increase engagement, but they are not a requirement of the model at this time. We will review engagement data after year 1 and determine if additional steps are needed to support PHPs and AMHs in engaging InCK members in SIL 2 and 3. |
| 9 | **Q: Reporting: What are expectations for what we report out on?**<br>**1. Completed consent**<br>**2. SAP**<br>**3. The Comprehensive Needs Assessment (CNS)?**<br>**4. Frequency of CNS?**<br>**5. Documentation of changes? VH state platform or PHPs platform?**<br><br>A: You only need to report the data that we ask for on the Risk List (AMH) or BMC051 (health plan). We don't have measurement for every SLA (like sending SAP to IC within 7 days).<br>**1. Completed consent -** FN sends to the IC within 7 days of completion. Not reported out.<br>**2. SAP -** Reported on the BCM051 with data accumulated from Patient Risk Lists.<br>**3. The Comprehensive Needs Assessment (CNS)? -** Reported on the BCM026.<br>**4. Frequency of CNS?** - SIL 1 & 2: Once a year; SIL 3: Once every 6 months |

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| 10 | **Q: We would like to ensure that the CNS will be the standard one currently used by PHPs?**<br><br>A: There are no changes to the CNS domains or required HOP questions. |
| 11 | **Q: Do we need to share the care plans we have in PHP CM platform? Is it separate from SAP?**<br><br>A: The care plan is separate from the SAP. The SAP, which includes elements of the care plan will be the document to be uploaded into Virtual Health and shared with the family and care team. PHPs and AMHs have current requirements for sharing care plans with care team members, including member/family. That is not changed. The SAP requirements are separate and distinct. |
| 12 | **Q: Letters and Customer Service: Are there any special program contact phone numbers?**<br><br>A: There is no specific InCK helpline or contact number; however, in terms of personnel supporting InCK before and after launch, integration consultants and family navigators will be the main point of contact for InCK beneficiaries and PHPs. |
| 13 | **Q: Any special Value-Added benefits in addition to those from PHP?**<br><br>A: No. |
| 14 | **Q: How do we best prepare our IT, PHP internal CM and AMH3 Care managers for how to trigger and document on CMARC members if different than standard process?**<br><br>A: CMARC will not do InCK services. |
| 15 | **Q: Are we to assume that the CMARC members currently managed by CMARC that qualify for NC InCK stay assigned to CMARC?**<br><br>A: Members will still be eligible for CMARC but CMARC will NOT provide InCk services (family navigator, etc.). See response above. |
| 16 | **Q: Will NEW CMARC eligible members be priority assigned to InCK instead of CMARC?**<br><br>A: No. Continue to make referrals to CMARC. |
| 17 | **Q: We understand that existing provider networks will be used for InCK as well and CM will be delegated to AMH for Tier 3– do we need to have any changes with respect to the "Find a provider" web portal for InCK members- We anticipate no changes but please confirm.**<br><br>A: No changes will be necessary for InCK. |
| 18 | **Q: We understand Call Center scripts/FAQs will be shared but wanted to understand if the Call center needs to know if a member is InCK as their regular member support flow will not vary with the member being InCK or non-InCK**<br><br>A: The Call Center will be able to identify InCK members if you allow them the access to do so. We are not requiring member support flows to change or vary for InCK and non-InCK members. |
| 19 | **Q: Please share the go live schedule as we have the testing schedule for the three phases as of now**<br><br>A: We plan to have a full run-through of the Post Launch and Production schedule in the coming weeks with all PHPs and CCNC. |

**ARCHIVE FAQs – 10/6/2021**

| # | Questions and Answers |
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| 1 | **Q: Patient Risk file: PHPs send a separate Patient risk file today to LHDs for CMARC. Is there any impact to that CMARC patient risk file in mapping SIL level?**<br>A: No, there is no impact to mapping SIL level from the CMARC patient risk file. If a child is in the InCK program, they would not be impacted by CMARC and vice versa. |
| 2 | **Q: There has been confirmation of no change to ID card logo but a mention of InCK logo in communications - is it optional & can PHPs use only the NC Medicaid logo with members?**<br>A: We are putting together talking points and recommendations for member outreach. We will have more conversations around this in the future. |
| 3 | **Q: Will InCK data be visible to Call Center agents? If so, at what level? Will knowing the beneficiary as an active InCK member suffice? Will there be any specific script needed for the agents regarding InCK members?**<br>A: Call Center agents should be able to respond to any program that PHPs offer. Will send out an FAQs for Call Center reps around InCK program. |
| 4 | **Q: As per Quality workgroup meeting minutes, tech specs are expected for Quality from 1/1/2022. Is there a different go live date for Quality measures?**<br>A: The NC InCK Quality Technical Specifications will be finalized by 1/1/2022. APM measures, and the first interim report for these measures, will be 7/1/22. The measurement year follows the calendar year for all measures except the Kindergarten Readiness Measure from the Department of Public Instruction. |
| 5 | **Q: Can DHHS verify the valid values for the Location Code in the Patient Risk List file?**<br>A: The Location Code should be specific to the Care Management Entity. |
| 6 | **Q: Is there any requirement for InCK to find a provider as it is going to use the same Medicaid provider network?**<br>A: All children in InCk at enrolled in a PCP, majority of which are AMH Tier 3s. We don't understand the question about a provider network. |
| 7 | **Q: System Generated SIL vs SIL_IND field in the supplemental file – how & where does the InCK consultant update that value?**<br>A: InCK consultants do not update either value. SIL indicators (both fields) are system generated. System Generated SIL is not applicable for PHPs, so this will be omitted from the file sent to PHPs. Updated layout will be shared this week. |
| 8 | **Q: When can PHPs anticipate the sample supplemental file from State as it is needed for development?**<br>A: The most recent SIL Stratification file layout has already been sent to PHPs (on 9/17) along with a companion guide (on 8/26) to assist development. Dummy SIL file is planned to be sent to PHPs in early November to assist with testing. |
| 9 | **Q: Is AMH Risk profile field in the BCM051 layout the same as SIL level?**<br>A: No, it is not. The SIL level has to be provided through the "priority population" fields on the InCK Risk List. The AMH Risk Profile field will be removed from the final template version we share with PHPs. Updated layout will be shared this week. |
| 10 | **Q: Is the layout for the Care Needs Screening to AMHs changing, or is it only data mapping?**<br>A: The layout for Care Needs Screening will change to include a few additional fields. The Department plans to share this in the next PHP meeting on 10/12. |

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| **11** | **Q: What are the following details regarding testing expectations?**<br>**• Defined scope**<br>**• Expected number of integration files and partner organizations**<br>**• Testing data and environment requirements**<br>**Can testing be completed with the PHPs and AMHs using modified mock files with an attestation for completion?**<br>A: The Department's E2E testing team is working on finalizing the testing approach. At a high level, we plan to focus on integration testing the new SIL interface, ability for PHPs to generate the patient risk that includes SIL beneficiaries and ability for them to ingest the new version of the patient risk file that they will receive from CINs that are participating InCK program. |
| **12** | **Q: It is noted that the Monthly Patient Risk File is to be sent to the AMH 3s/ CINS on/by the 26th of each month. Our internal risk stratification does not run until the first week of the following month and we currently send the Risk File to AMHs/CINs during the first week of the month. Is there flexibility around the date of the 26th (can we continue with the current timing, which has worked well), or is the 26th a new, hard and fast date? If this is a hard date, what is the guidance on risk stratification logic which does not run on this cycle?**<br>A: The objective of using a defined schedule is to ensure that all AMHs/CINs are able to receive these files within the defined schedule. We did factor other dependencies as well as part of aligning on this schedule. We will be working with individual PHPs on a larger standardization of files and data sharing. |
| **13** | **Q: Can you please clarify if PHPs will be sending two versions (exiting layout and new layout) of the Monthly Patient Risk File to AMHs?**<br>A: PHPs will be using the existing layout of the patient risk file. No change in layout from what PHPs will be sending to AMHs/CINs. The only change is the addition of new valid values for the existing "priority population" fields that will allow you to share SIL information. |
| **14** | **Q: Can you please clarify the factor that determines which version of the Patient Risk List an AMH/CIN receives – is it geography (inside versus outside of InCK region) or InCK member attribution (if an AMH has even one InCK attributed member they get the new version of the Risk File)?**<br>A: PHPs will be sending existing layout. For InCK attributed members, AMHs/CINs will include their SIL indicator in the "priority population" fields. A limited number of AMH T3s/CINs will have a different version of the Patient Risk File, InCK Child Risk List, which will be generated by the AMH T3 and CINs. Impacted CINs are Duke, UNC, and CCPN for InCK launch. |
| **15** | **Q: It is sometimes the case that we send data to the CINs who contract with the AMHs, and not the AMHs directly. Given this, it seems likely that a CIN may have a contract with one AMH with InCK attributed members and another AMH without InCK attributed members. In this scenario, are we expected to send only the new layout of the Risk List file to the CIN? How would you expect us to report the InCK attributed members and non-InCK attributed members in 1 file to the CIN/T3 AMH.**<br>A: See responses to #13 and #14 |
| **16** | **Q: What would happen if an InCK-attributed member is assigned to a T3 AMH who never had a InCK member before. Are they expected to flip to the new layout of the Risk List file instantaneously?**<br>A: A limited amount of AMH T3s/CINs will have a different version of the Patient Risk File. Impacted CINs are Duke, UNC, CCPN for InCK launch. |
| **17** | **Q: If we are only to send one file version (the new layout), is it anticipated that those AMHs with a mix of InCK and non-InCK patients will ignore the new fields and values? Given the scenarios outlined in #5 above, our recommendation is that we adopt the new file layout (v2) and leave the additional fields as blank for non-InCK beneficiaries and populate those fields with values only for InCK beneficiaries. The same would hold for the files being reported back to the PHPs by the CINs.**<br>A: The SIL information will be sent in an existing field. AMHs/CINs are expected to review all the values they are receiving in the "priority population" fields. |

**ARCHIVE FAQs – 9/21/2021**

**Questions from PHPs on behalf of Care/Quality NCAHP group**

| # | Questions and Answers |
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| 1 | **Q: Concerning the practice levels/tiers of the InCK region providers, is there an expectation to differentiate on referrals, care management process or Alternative Payment Model (APM) incentives for various level tiers?**<br>A: The responsible care management entity and requirements should follow the specifications for tiers under Medicaid Transformation (i.e., care management provided by AMH Tier 3 and PHP in AMH Tier 2). APM incentives are required to be offered to AMH Tier 3 practices and optional but encouraged for AMH Tier 2 practices. |
| 2 | **Q: Questions about Patient Risk List (PRL) sent to AMHs: We understand from the recent Technology calls that there will be one PRL sent to the AMHs. How will we differentiate the providers?**<br>A: PRL only goes to AMH Tier 3 providers. Plans will provide care management and InCK services for members in AMH Tiers 1 & 2. |
| 3 | **Q: Will the PRL file need to be modified? Will there be differing risk scores for this membership, PHP risk level and Service Integration Level (SIL) risk level?**<br>A: The PRL will be modified as specified in the NC InCK technical specifications, including the SIL added as a new priority population. SIL could affect the risk category (high/medium/low) you assign members, but it does not need too. InCK has required care management (i.e., family navigator) interventions for members in SIL 1, 2, 3-regardless of any addition high/medium/low risk the Plan may assign to that member. The priority population (SIL 1, 2, 3) drives the interventions. |
| 4 | **Q: Are quality measure layouts needed?**<br>A: DHB will be calculating the quality measures. A draft of the format will be shared that will be used to send quality measure rates. It is not yet developed because the other data exchanges are higher priority at present. |
| 5 | **Q: Will there be any logo and/or branding in ID card and/or correspondence?**<br>A: There will be no logo or branding on any Medicaid ID card. Communications (letter to families, etc.) about NC InCK may include the NC InCK logo. |
| 6 | **Q: Are there any provider network changes? Will we be required to contract with InCK providers out of network?**<br>A: No, there is no requirement to contract with InCK providers out of network. InCK eligible people in PHP counties should already be assigned a primary care provider (PCP) in network. That PCP, if a Tier 3, is required to provide the additional care management (i.e., family navigator) services for members assigned to that AMH. |
| 7 | **Q: Regarding the Shared Action Plan (SAP) – who is responsible for initiating and maintaining the plan? Will it be managed through InCK/VH care management platform?**<br>A: The beneficiary's designated Family Navigator is responsible for initiating and maintaining the SAP. That family navigator may be at a PHP (for members assigned to PCPs, AMH Tiers 1 & 2) or at a Tier 3/CIN (for members assigned to a Tier 3 practice). With signed consent, the SAP will be sent to the Integration Consultant or can be uploaded into NC InCK's Virtual Health Platform within 7 days of completion. NC InCK will release best practice guidance for completing and updating the SAP for distribution to PHPs and AMHs. Contract guidance will also specify that the Family Navigator is responsible for posting the SAP in a manner that is accessible to both the care team listed on the consent and guardian. NC InCK also encourages plans to maintain the SAP and share with care teams via their own platforms to increase uptake (just like PHPs and AMH Tier 3s are required to post care plans in an accessible way for members/families). |

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| 8 | **Q: Will care plans need to be on both the InCK site and PHP platforms? There are concerns about working on multiple platforms, can we have more context on this for PHP care managers?**<br>A: The SAP (with consent) is the only plan required to be uploaded on to the Virtual Health platform. The NC InCK Integration Consultants are available to upload the plan on to the platform for any Family Navigator. NC InCK also encourages plans to maintain the SAP and share with care teams via their own platforms to increase uptake and use provided they have the appropriate consent. |
| 9 | **Q: Will PHPs be responsible for the Tier 1 and Tier 2 care management coordination for InCK or is there another plan?**<br>A: PHPs are responsible for care management, inclusive of InCK requirements for members in Tier 1 and 2 practices. |
| 10 | **Q: Staffing: We understand that a full-time SIC is required. What will be the PHP's role with the FNs? Do the positions have to be clinical? Who is hiring/managing the SICs/FNs? Will additional interviews be needed for SICs if replaced by new PHP staff? Some of the PHPs anticipate that there will be a shift in staff when the SIC goes full time.**<br>A: The Family Navigator can be an existing or new member (if needed) of the care management team within the PHP or Advanced Medical Home. Current PHP and AMH requirements allow for a care team approach for a variety of levels of staff on care managements teams. So, for InCK there is flexibility in staffing the FN role (e.g., Care Manager, RN, BSW, LPN, MSW, CHW, pop health specialist).<br><br>All 5 PHPs already have an Integration Consultant (IC) staffed, and InCK encourages continuity in the Integration Consultant team ahead of launch if possible. However, in the event that another 0.5 FTE or full-time Integration Consultant needs to be identified, PHPs will externally or internally identify at least 2 candidates for new/replacement IC role and participate in a collaborative interview process with the InCK Managing Director and Operations and Strategy Director to identify the file candidate to fill the role. ICs must have clinical experience and licensure, such as a registered nurse or licensed clinical social worker. The management, hiring and oversight structure will follow the path previously used to identify the part-time consultant with the PHP. DHB will be funding 1 FTE Integration Consultant as part of PHP capitation as of January 1, 2022. |
| 11 | **Q: ID stratification criteria has not yet been shared. PHPs will need to identify which members are already being care managed. How to best blend the roles and goals of various CPs or service plans.**<br>A: That's true, but this isn't different than the current system. Plans use their own risk methodology to ID members in care management and send those to AMH Tier 3s. Tier 3s also do their own risk stratification and incorporate the PHP stratification lists in their work. SIL stratification lists is one more risk stratification input for PHPs and AMH Tier 3s to do. Risk lists will be shared with Medicaid ID so PHPs and AMHs can ID those beneficiaries, some of which may already be in care management currently. All care management encounters for any patient (regardless of priority pop, risk stratification method, etc.) should be captured in PHPs or AMHs care management systems and encounters should be shared on BCM051 and the PRL respectively. |
| 12 | **Q: Will data feeds flow from State to PHPs? How often? Are there any new data needs?**<br>A: The SIL file will be sent monthly. Required data elements will be in the finalized SIL file provided to PHPs. This is the only new file at the moment. PHPs need to use that SIL to populate the PRL for AMH Tier 3s. |
| 13 | **Q: Care Needs Screener (CNS) – Is there a license requirement for the screener? What is the extent of the screening? Are the AMHs asking the same questions as the PHP for the incentives?**<br>A: PHPs continue to conduct the CNS inclusive of the SDOH standardized questions for each member according to contract requirements. PHPs are still required to send those results to AMH Tier 3s in a standardized format (BMC026; more information coming). The AMH Tier 3s are ONLY required to ask the standardized SDOH questions for InCK members for whom the PHP didn't capture a screen and share that info back to the PHP using BMC026 (more info coming). No one asking the required SDOH questions is required to have a license or certification. |

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| 14 | **Q: How will CMARC be involved in the five InCK counties? If referrals are not going to the LHDs for CMARC, will the PRL file change? Will LHD CMARC payment structures be modified?**<br>A: LHD population based PMPMs will remain the same. At this time, we are not asking LHDs to participate in the pilot. CMARC will still receive referrals for members according to current protocols. New SIL 1, 2,3 members who would otherwise meet CMARC criteria should be referred to the AMH Tier 3 (if the member has one) or maintained for care management at the PHP (if the member is in a Tier 1 or 2). We will talk more about this at a future date.<br><br>In addition, we need to talk through impact to AMH Tier 3s who are NOT part of CCPN, Duke, or UNC CIN. We are going to phase those smaller AMH Tier 3s in at a later time. Let's have a dedicated conversation about this the week of our Pop Health meeting on 9/27. |

**Questions from IT**: Any type of IT build will need to allow time for testing.

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| 1 | **Q: Do we need to display member identification in Web portals for delegated care managers – we believe they use their own systems but wanted to clarify and confirm Web portals as out of scope?**<br>A: That's correct. You send member info on the PRL to AMH Tier 3s. |
| 2 | **Q: Are there any new claims payments to providers, new billing codes, or are the new codes only for quality measures? This will help identify where we will ingest the file. We are trying to identify if claims are impacted or not.**<br>A: The only claims change is the new billable code 1003F for the Kindergarten Readiness Bundle Measure. The code does not need separate reimbursement and will be used as a marker to track K-readiness activities, rather than service as a reimbursable code. This code is active in NC Tracks and further guidance provided in the NC InCK Quality Measure Technical Specifications. A NC Medicaid Bulletin will be posted later this fall as well. |
| 3 | **Q: Any changes or addition to the existing payment model – pertaining to the above question on claims configuration request needs?**<br>A: Please clarify the question. |
| 4 | **Q: Will there be an impact to utilization management and the authorization process?**<br>A: There will be no change to utilization management or the authorization process. |
| 5 | **Q: Will there be any changes to internal care manager assignment matrix (which is currently assigned based on patient risk stratification today)?**<br>A: That is up to your entity. |
| 6 | **Q: When there is no entry in the supplemental file, will that signal that the beneficiary is not part of the InCK program for that month?**<br>A: Yes, that is correct. |
| 7 | **Q: Will there be impact on transition of care dis-enrollment processes?**<br>A: No, all transition will follow current TOC protocols. |
| 8 | **Q: Are there any changes in 834 segments for InCK?**<br>A: No, PHPs will get separate InCK SIL file. There are no changes to the 834 or BA file. |
| 9 | **Q: We see the BCM026 CNS layout is not changing with this program – will we have these members flow through the BCM026 report as well?**<br>A: We are currently updating the BCM026 to include more data elements. InCK members will flow through the BCM026. PHPs will continue to conduct the CNS inclusive of the SDOH standardized questions for each member according to contract requirements. PHPs are still required to send those results to AMH Tier 3s but will require sharing using a standardized format (BMC026; more info coming). The AMH Tier 3s are ONLY required to ask the standardized SDOH questions for InCK members for whom the PHP didn't capture a screen and share that info back to the PHP using BMC026 (more info coming). |

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| 10 | **Q: Is BCM026 going to be a combination of what we receive from AMHs to DHHS plus our own care management managed members?**<br>A: Yes. There are changes expected for the BCM026 CNS layout. This information will be shared in the coming weeks. |
| 11 | **Q: Currently the CNS is not consistent between AMH/PHPs. Will there be changes in questions and layout of CNS files?**<br>A: PHPs continue to conduct the CNS inclusive of the SDOH standardized questions for each member according to contract requirements. PHPs are still required to send those results to AMH Tier 3s. We will require sharing using a standardized format (BMC026; more info coming). The AMH Tier 3s are ONLY required to ask the standardized SDOH questions for InCK members for whom the PHP didn't capture a screen and share that info back to the PHP using BMC026 (more info coming). |
| 12 | **Q: Are there any changes anticipated for PHP care management platforms as part of this process – understand the InCK care managers will be using InCK/Virtual Health platform. Should members be ID'd in PHP care management platform in anyway other than to know that these members are part of InCK program- any other specific items needed?**<br>A: It is up to each entity on how to use the InCK member enrollment and SIL information provided. NC InCK needs PHPs to perform required functions based on the data. NC InCK also encourages plans to maintain the SAP and share with care teams via their own platforms to increase uptake (just like PHPs and AMH Tier 3s are required to post care plans in an accessible way for members/families). InCK Integration Consultants will view member attribution for InCK in InCK's instance of Virtual Health, but your care management teams may need record of both a member's InCK membership and Service Integration Level for Family Navigator assignment. |

### Questions from Pop Health Calls

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| 1 | **Q: Will we send out SIL File layout to AMHs for Tier 1s and 2s? How does this work with the APM?**<br>A: No, PHPs won't sent out SIL files to anyone. PHPs must take information on the SIL file to populate the Patient Risk List sent to Tier 3s only. |
| 2 | **Q: Will there be an impact or a change in LHD payment arrangements?**<br>A: LHD population based PMPMs will remain the same. At this time, we are not asking LHDs to participate in the pilot. CMARC will still receive referrals for members according to current protocols. New SIL 1, 2,3 members who would otherwise meet CMARC criteria should be referred to the AMH Tier 3 (if the member has one) or maintained for care management at the PHP (if the member is in a Tier 1 or 2). We will talk more about this at a later date.<br>In addition, we need to talk through impact to AMH Tier 3s who are NOT part of CCPN, Duke, or UNC CIN. We are going to phase those smaller AMH Tier 3s in at a later time. We will have a dedicated conversation about this the week of the Pop Health meeting on 9/27. |
| 3 | **Q: Does the care manager date/assignment need to capture the current care manager assignment or is there a need to show who care managers were over time (i.e., if the care manager assignment changed) and what is the timing for this?**<br>A: Care manager assignment should be the most recent/current care manager for the reporting period. NC InCK will populate this information in their Virtual Health platform and use it for proactive Integration Consultant outreach to offer support to the assigned care team member. |