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**NC Medicaid Managed Care**

**Data Specifications & Requirements for sharing Patient Risk List to Support Advanced Medical Homes (AMHs)**

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| **Change Log** | | |
| **Version** | **Date** | **Updates/Change Made** |
| 1.0 | 12/31/2020 | Initial Publication |
| 2.0 | 11/1/2021 | 1. Updates required to support Integrated Care for Kids (InCK) Data Specifications and Requirements 2. Clarification on file sharing schedule |
| 3.0 | 1/18/2023 | Additional guidance sections added on PRL submission, Data field instructions/mapping to the BCM051, scenarios and appendix |
| 4.0 | 6/20/2023 | Updating priority populations to include WIC eligibility, SNAP enrollment and eligibility, and Foster Care indicators.  Clarified Date Care Manager Assigned/Care Manager Assignment Date fields. |
| 5.0 | 10/23/2023 | Section C updated with additional guidance on Risk Evidence as it relates to CMARC/CMHRP population. |

*This document is part of a series of policy papers that the Department of Health and Human Services (the Department) to provide additional details to stakeholders regarding the transition of North Carolina Medicaid and NC Health Choice programs to a managed care model. Some topics mentioned in this document may be covered in more detail in other policy papers in the series. For more information on the Department’s proposal, stakeholders are encouraged to review the Amended North Carolina Section 1115 Demonstration Waiver Application and previously released policy papers available at dhhs.gov/nc-medicaid-transformation.*

*While the paper contains information that may be of interest to all those involved in providing care management, the document will be most useful to PHPs, Advanced Medical Homes, information technology vendors, and other entities responsible for receiving and exchanging data.*

*Input is welcome and appreciated. Send comments to* [*Medicaid.Transformation@dhhs.nc.gov.*](mailto:Medicaid.Transformation@dhhs.nc.gov)

# **I. Introduction**

In the previously published resources listed below, the North Carolina Department of Health and Human Services (the Department) outlined the data strategy and specific care management roles, relationships,

and requirements for Prepaid Health Plans (PHPs), Advanced Medical Homes (AMH), and Clinically

Integrated Networks (CINs).

* [Data Strategy to Support the Advanced Medical Home Program in North Carolina](https://files.nc.gov/ncdhhs/AMH-Data-PolicyPaper_FINAL_2018720.pdf), expands on the requirements in the “Data Sharing” section of the Care Management Strategy to provide further information on the data AMH practices will likely need (and the entities responsible for providing it) to perform care coordination and management, population health improvement, and quality management functions for the beneficiaries they serve.
* [Clinically Integrated Networks and Other Partners Support of Advanced Medical Homes Care Management Data Needs](https://files.nc.gov/ncdhhs/documents/CIN-Other_Partners_policy-paper_20190305.pdf), provides updated information on specific data formats, timing, transmission methods, and testing approaches in the following areas: beneficiary assignment, transmission of encounter data, care needs screening, risk stratification, comprehensive assessments, care planning, and coordinating beneficiary care.

To help AMHs and CINs manage their assigned beneficiaries, the Department has established a standardized format and method of sharing Patient Risk information via a Patient Risk List. This document includes the file layouts prescribed by the Department and outlines the transmission protocols and associated requirements that must be followed by the PHPs, AMHs and CINs.

As a general principle, the Department expects PHPs to provide Patient Risk information to AMHs and CINs, on all assigned beneficiaries in a timely, accurate, and complete manner. The Department expects that the information provided will be sufficient to match patients and support the duties required under the AMH program. The Department expects the PHPs to transmit beneficiary information to AMHs, and CINs only the beneficiaries assigned to them.

# **II. PHP to AMH Tier 3/CINs Patient List/Risk Score File**

**File Layout:** To streamline information exchange, and reduce costs and administrative burden for all stakeholders, the Department has developed a flat-file layout for sharing AMH Patient List/Risk Score Data. The PHP Patient List/Risk Score file layout is embedded within this document below.

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**File Data Scope:** Beneficiaries assigned to an AMH Tier 3 or their designated Clinically Integrated Networks (CINs) or Other Partners. These should align with the beneficiaries that the PHPs are sharing through the beneficiary assignment file.

New valid values have been added to the “Priority Population” fields in the Patient Risk File Release 1.0 layout to identify beneficiaries InCK program Service Integration Level (SIL), NICU referral and Healthy Opportunities Pilot designation. PHPs will use the InCK SIL options (009,010, and 011) to identify SIL levels for beneficiaries participating in the InCK program.

PHPs can identify unmet needs of beneficiaries using the “Priority Population” option = “004 – Unmet Resources”. To identify any such beneficiaries that should be enrolled in the Healthy Opportunities pilot, PHPs should instead use “Priority Population” option = “013 – Healthy Opportunities Pilot”.

**File Source:** PHPs

**File Target(s):** AMH Tier 3s or their designated Clinically Integrated Networks (CINs) or Other Partners

**File Type:** Pipe Delimited, Double Quote Qualified PSV File. Each file layout prescribes maximum field lengths for each field. The source system is expected to use that information to ensure the field lengths do not exceed the maximum filed length while generating the file.

**File Transmission Type:** sFTP. Source and Target entities should work together to establish file exchange through secure file transfer protocol.

**File Delivery Frequency:** At least monthly. 1st Full file followed by incremental monthly files on the 26th of each month.

**File Naming Convention:** PHPs are expected to follow the below file naming convention

NCMT\_CareQualityManagement\_AMH\_PatientListRiskScore\_<PHPShortName>\_<AMH/CIN1>\_CCYYMMDD-HHMMSS.TXT

Below are the short names for each PHPs, use these for <PHPShortName>:

• Carolina Complete Health = CCH

• WellCare of North Carolina = WELLC

• UnitedHealthcare = UHC

• BCBS = BCBS

• AmeriHealth Caritas = AMERI

For < AMH/CIN1>, PHPs should work with their contracted AMH Tier 3s or their designated Clinically Integrated Networks (CINs) or Other Partners to align on a unique name/identifier that they can use.

**File Record Count Validation:** To ensure that target system received and ingested the same count of records that was sent by the source system, both source and target systems are expected to generate systemic notifications:

* Source system is required to generate an automated email notification with the file records totals once they deliver any file, to the target system. Department’s governance team (NCMT.TechOps@dhhs.nc.gov) will be copied on these notifications, their email address will be provided to the source system separately.
* Target system is required to generate an automated email notification with the total records they processed, to the source system. Department’s governance team ([NCMT.TechOps@dhhs.nc.gov](mailto:NCMT.TechOps@dhhs.nc.gov)) will be copied on these notifications, their email address will be provided to the source system separately.

**AMH Tier 3s/CIN Platform Integration & Testing:**

* + The Department expects PHPs to: (1) work with their respective AMH Tier 3s/CIN partners and (2) review the file layout, associated requirements, and implementation timeline and testing expectations to ensure AMH Tier 3s/CIN partners are ready to consume this data per the requirements and implementation timelines shared by the Department.

# **III. AMH Tier 3s/CINs Patient List/Risk Score File to PHP**

**File Layouts:** To streamline information exchange, and reduce costs and administrative burden for all stakeholders, the Department has developed a flat file layout for sharing AMH Patient List/Risk Score Data.

To support the Integrated Care for Kids (InCK) program, the Department has published a new release of the Patient Risk file that will be referred to as Patient Risk file release 2.0. **Release 2.0 will be required to be used only by the AMHs/CINs that will be participating in the InCK program**. At the launch of the InCK program, only three CINs will participate in the InCK program. Other CINs will start participating through a phased approach and the Department and their respective PHPs will work with them to transition to the new version. Until that time, they should continue to use **Release 1** of the Patient Risk file.





**File Data Scope:** AMH Tier 3 or their designated Clinically Integrated Networks (CINs) or Other Partners beneficiary panel. These should align with the beneficiaries that the PHPs are sharing through the beneficiary assignment file.

**File Source:** AMH Tier 3 or their designated Clinically Integrated Networks (CINs) or Other Partners

**File Target(s):** PHPs

**File Type:** Pipe Delimited, Double Quote Qualified PSV File. Each file layout prescribes maximum field lengths for each field. The source system is expected to use that information to ensure the field lengths do not exceed the maximum filed length while generating the file.

**File Transmission Type:** sFTP. Source and Target entities should work together to establish file exchange through secure file transfer protocol.

**File Delivery Frequency:** At least monthly. 1st Full file followed by incremental files on the 7th of each month.

**File Naming Convention:**

1. **Patient Risk File Release 1.0**

AMHs are expected to follow the below file naming convention

NCMT\_CareQualityManagement\_AMH\_PatientListRiskScore\_<AMH/CIN1>\_<PHPShortName>\_CCYYMMDD-HHMMSS.TXT

Below are the short names for each PHPs, use these for <PHPShortName>:

• Carolina Complete Health = CCH

• WellCare of North Carolina = WELLC

• UnitedHealthcare = UHC

• BCBS = BCBS

• AmeriHealth Caritas = AMERI

1. **Patient Risk File Release 2.0**

AMHs are expected to follow the below file naming convention

NCMT\_CareQualityManagement\_AMH\_PatientListRiskScore\_Rel2.0\_<AMH/CIN1>\_<PHPShortName>\_CCYYMMDD-HHMMSS.TXT

Below are the short names for each PHPs, use these for <PHPShortName>:

• Carolina Complete Health = CCH

• WellCare of North Carolina = WELLC

• UnitedHealthcare = UHC

• BCBS = BCBS

• AmeriHealth Caritas = AMERI

For < AMH/CIN1>, PHPs should work with their contracted AMH Tier 3s or their designated Clinically Integrated Networks (CINs) or Other Partners to align on a unique name/identifier that they can use.

**File Record Count Validation:** To ensure that the target system received and ingested the same count of records that was sent by the source system, both source and target systems are expected to generate systemic notifications:

* The source system is required to generate an automated email notification with the file record totals once they deliver any file to the target system. The Department’s governance team (NCMT.TechOps@dhhs.nc.gov) will be copied on these notifications, and their email address will be provided to the source system separately.
* The target system is required to generate an automated email notification with the total records they’ve processed, to the source system. The Department’s governance team ([NCMT.TechOps@dhhs.nc.gov](mailto:NCMT.TechOps@dhhs.nc.gov)) will be copied on these notifications, and their email address will be provided to the source system separately.

**AMH Tier 3s/CIN Platform Integration & Testing:**

* + The Department expects PHPs to: (1) work with their respective AMH Tier 3s/CIN partners and (2) review the file layout, associated requirements, and implementation timeline and testing expectations to ensure AMH Tier 3s/CIN partners are ready to consume this data per the requirements and implementation timelines shared by the Department.

# **IV. Submission Guidance**

The Department expects SPs, BH I/DD TPs and/or PIHPs to provide complete, accurate and timely Patient Risk information to AMH Tier 3 practices, AMH+ practices, CMAs and/or their affiliated CINs/Other Data Partners for beneficiaries assigned to them. The Department expects that the information provided will be sufficient to match patients and support the duties required under Medicaid Managed Care.

SPs, BH I/DD TPs and/or PIHPs must transmit Patient Risk List data for all their assigned beneficiaries to the applicable AMH Tier 3 practices, AMH+ practices, CMAs and/or their affiliated CINs/Other Data Partners. AMH Tier 3 practices, AMH+ practices, CMAs and/or their affiliated CINs/Other Data Partners should send back the Patient Risk List with all mandatory fields populated, to SPs, BH I/DD TPs or PIHPs as defined in the Data Specifications and Requirements for Sharing Patient Risk List Data.

# **V. Instructions for Populating the Patient Risk List Data Fields**

This section provides additional information on each field in the Patient Risk List file. This section defines which fields are Mandatory (M), Situational (S), or Optional (O) for SPs, BH I/DD TPs and/or PIHPs, as well as AMH Tier 3 practices, AMH+ practices, CMAs, and/or their affiliated CINs/Other Data Partners.

Mandatory fields are required to be populated by the Source system. Situational fields for AMH Tier 3 practices, AMH+ practices, CMAs and/or their affiliated CINs/Other Data Partners should be populated if the corresponding field is populated by the SPs, BH I/DD TPs and/or PIHPs. Optional fields should be populated at the Source system’s discretion.

# **Section A. Header Information**

**Table 1:** Populating the Patient Risk List Header

|  |  |  |  |
| --- | --- | --- | --- |
| Header Information | | | |
| Field Name | M/S/O  Source = SP, BH I/DD TP,  or PIHP | M/S/O  Source = AMH Tier 3, AMH+, CMA, CIN or Other Data Partner | Instructions |
| PHP ID | M | M | SPs, BH I/DD TPs and/or PIHPs should populate this field with their NC Medicaid assigned PHP Identifier.  AMH Tier 3, AMH+, CMA, CIN or Other Partner should populate this field with the PHP ID who is the target for this file and all members included in this file should be assigned to that PHP. The PHP ID should match with the PHP ID that AMH Tier 3/AMH+/CMA/CIN receives from the PHP in their Patient Risk File. |
| PHP Name | M | M | SPs, BH I/DD TPs and/or PIHPs should populate this field with the PHP name.  AMH Tier 3, AMH+, CMA, CIN or Other Partner should populate this field with the PHP Name who is the target for this file and all members included in this file should be assigned to that PHP. The Name should match with the PHP Name that AMH Tier 3/AMH+/CMA/CIN receives from the PHP in their Patient Risk File. |
| Full vs Incremental | M | M | F= Full, I=Incremental  TCM providers will send only full PRL files. AMH 3 practices will send both full and incremental PRL files to SPs. For the PRL going to AMHs 3 practices, SPs are expected to send the PRL at least monthly. 1st Full file followed by incremental monthly files on the 26th of each month.  The incremental file will be any new members that are not a part of the full file load that was sent by the plans to the Care Management entities. The Full fille is all current and future members that are a part of the specific program. |
| File Name | M | M | Please refer to the File Naming Convention Section above |
| File Type | M | M | D = Pipe Delimited, Double Quote Qualified CSV File |
| Version/Release | M | M | Please refer to the Data specifications document |
| Create Date | M | M | Should be the date that the file is transmitted from the source to target systems in YYYYMMDD format |
| Create Time | M | M | Should be the time that the file is transmitted from the source to target systems in HH:MM:SS format |
| Number of Records | M | M | The record count for the outbound and inbound PRLs must match and include all members sent on the PRL outbound from Plans to Provider.  ######### |

# **Section B. Patient Identifier**

**Table 2:** Instructions for Populating Patient Identifier

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Identifier | | | |
| Field Name | M/S/O  Source = SP, BH I/DD TP,  or PIHP | M/S/O  Source = AMH Tier 3, AMH+, CMA  , CIN or Other Data Partner | Instructions |
| CNDS ID | M | M | Patient’s Medicaid ID |
| Maintenance Type Code | M | M | ‘001’ is sent if there is a change or an update to an existing patient record  ‘021’ is sent for new patients who are new to the system overall  '000' is sent if existing record with no change |
| Priority Population 1 - 6 | Priority Population 1  is Mandatory  Priority Population  2-6 are Situational | Priority Population 1  is Mandatory  (*Must mirror the SP, BH I/DD TP, Or PIHP’s Entry*)  Priority Population 2-6 are Situational  (*Must mirror the SP, BH I/DD TP, Or PIHP’s Entry*) | The priority care management population that the member falls into based on Plan or The Department’s stratification. Plans can use claims data, or any available data source, including interaction with the member, to identify Priority Population fields. AMH Tier 3, AMH+, CMA, and/or CIN/Other Data Partners are not permitted to change the priority population identifiers.  Valid Values:  000 = Null  001 = CMARC  002 = CMHRP  003 = LTSS  004 = Unmet Resources  005 = Adults and Children with Special Health Care Needs  006 = Rising Risk  007 = Other Priority Population  008 = Transitioning Member  009 = InCK SIL 1  010 = InCK SIL 2  011 = InCK SIL 3  012 = NICU Referral  013 = Healthy Opportunities Pilots  014 = Foster Care  015 = WIC Eligible but Not Enrolled  016 = SNAP Enrolled  017 = SNAP Eligible but Not Enrolled  Additional Guidance:  The priority populations “015”, “016”, and “017” are only applicable to Phase II Nutrition Security Cross-Enrollment (NICE) pilot participants.  If “004” is chosen as a Priority Population, “013” may also be assigned to members in the Pilot participating counties but is not mandatory. Assigning a member “004” will not trigger eligibility determination or enrollment into the Health Opportunities Pilots (HOP) unless “013” is also chosen as a Priority Population. Since the Healthy Opportunities Pilots are only in selected counties, not all members are eligible for HOP. Additional information on HOP can be found in the Appendix of this document.  If “001” is chosen as a Priority Population, “002” cannot be chosen as another Priority Population  If “002” is chosen as a Priority Population, “001” or cannot be chosen as another Priority Population  If “009” is chosen as a Priority Population, “010” or “011” cannot be chosen as another Priority Population  If “010” is chosen as a Priority Population, “009” or “011” cannot be chosen as another Priority Population  If “011” is chosen as a Priority Population, “009” or “010” cannot be chosen as another Priority Population  If “012” is chosen as a Priority Population, “002” cannot be chosen as another Priority Population |

# **Section C. PHP Risk Profile**

**Table 3**: Instructions for Populating PHP Risk Profile

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| --- | --- | --- | --- |
| **PHP Risk Profile** | | | |
| Field Name | M/S/O  Source = SP, BH I/DD TP,  or PIHP | M/S/O  Source = AMH Tier 3, AMH+, CMA, CIN or Other Data Partner | Instructions – The PHP Risk Score Category and PHP Risk Evidence should be completed by SP, BH I/DD TP and/or PIHP only. |
| PHP Risk Score Category | M | S | PHP Risk Score will be populated by the SPs, BH I/DD TPs and/or PIHPs based on their own risk stratification algorithm.  Valid Values:  H = High; M = Medium; L = Low; N = Null  Null should be used when a SP, BH I/DD TP and/or PIHP lacks sufficient data to determine a risk stratification level for a member and no risk stratification level has been assigned to a member. Null should not be used when a SP, BH I/DD TP and/or PIHP determines a member risk stratification has changed. |
| PHP Risk Evidence | O | S | Additional information describing member risk that the Plan wishes to share (i.e., sickle cell, high ED utilization, homelessness). Plans should include risk evidence for risk score of “High”.  Plans should list at least one “Referral Reason” for each member identified as high priority for CMARC and CMHRP services. Plans may include more than one “Referral Reason” as long as the field does not exceed a total of 250 characters. |

# **Section D. CM Entity Risk Profile & Interactions**

**Table 4**: Instructions for Populating CM Entity Risk Profile and Interactions

|  |  |  |  |
| --- | --- | --- | --- |
| CM Entity Risk Profile & Interactions | | | |
| Field Name | M/S/O  Source = SPs, BH I/DD TP,  or PIHP | M/S/O  Source = AMH Tier 3, AMH+, CMA, CIN or Other Data Partner | Instructions – The CM Entity Risk Score Category should be completed by the AMH Tier 3, AMH+, CMA, CIN or Other Data Partner only. |
| CM Entity Risk Score Category | O | Optional for TCM Providers (AMH+ and CMAs)  Mandatory for AMH Providers | The risk level that the member falls into (high, medium, low) based on theAMH Tier 3, AMH+, CMA, CIN or Other Partner risk algorithm.  Valid Values:  H = High; M = Medium; L = Low; N = Null  This field is populated by the AMH Tier 3/AMH+/CMA/CIN or Other Partner and are expected to use their own risk stratification algorithm. It is acceptable to have the risk category differ from that assigned by the PHP. |
| Assigned CM Entity | O | M | Assigned Entity performing CM services. This should match with the NPI in the State Provider System (NC Tracks).  The Provider Directory Listing and Affiliation Report can be found on the NC Medicaid Portal (link in Appendix). |
| Number of CM Interactions | O | M | Total number of beneficiary CM interactions completed in the reporting month. Please see the scenarios below for what constitutes a CM interaction. |
| Number of Face-to-Face Encounter | O | M | Total number of face-to-face beneficiary interactions completed in the reporting month. Please see the scenarios below for what is considered a Face-to-Face encounter. For more information, please refer to “section VII” below, as well as the [AMH Program Manual](https://medicaid.ncdhhs.gov/media/10916/download?attachment) and [Tailored CM Program Manual](https://medicaid.ncdhhs.gov/media/11859/download?attachment) for guidance on what is counted as a face-to-face encounter. |
| Date Comprehensive Assessment Completed | O | M | The date that a Comprehensive Assessment was completed for a beneficiary. Report should include the most recent date for each member within the reporting period.  YYYYMMDD |
| Care Plan Created (Y/N)  (Only applicable to the PRL 2.0) | O | M | Identifies if a Care Plan has or has not yet been created in the reporting period. If a member has only a Shared Action Plan for InCK, it should be documented in the Shared Action Plan field and N should be indicated in this field. |
| Date Care Plan Created | O | M | The date that Care Plan was completed for a beneficiary. If the Care Plan Created field is a ‘N’, this field should be left blank. If a Care Plan Created field is a ‘Y’, the date should be populated. This field should only include the date the Care Plan was created if it was created in the reporting period. YYYYMMDD. |
| Date Care Plan Updated | O | M | The date that a Care Plan was most recently updated for a beneficiary within the reporting period. If the Care Plan was never updated or if a Care Plan was never created, this field can be left blank. YYYYMMDD. |
| Date Care Plan Closed | O | M | The date that a Care Management episode was closed for a beneficiary within the reporting period. This should align with end-dating a care plan. YYYYMMDD |
| Date Care Manager Assigned  (Only applicable to the PRL 2.0) | O | M | The date that a beneficiary's last/current Care Manager was assigned. This field is intended to capture the date that the last/current Care Manager was assigned even if that date is prior to the reporting month but not after the reporting month. YYYYMMDD |
| Initial Care Manager Outreach Date  (Only applicable to the PRL 2.0) | O | M | The date that a Care Manager first attempted outreach to a beneficiary. This includes attempted outreach where a member declines.  YYYYMMDD |
| Name of Care Manager Assigned  (Only applicable to the PRL 2.0) | O | M for InCK beneficiaries only | The name of the last/current Care Manager assigned to a beneficiary during the reporting month. This field is mandatory for InCK beneficiaries. |
| Phone Number for Care Manager Assigned  (Only applicable to the PRL 2.0) | O | M for InCK beneficiaries only | The phone number of a beneficiary's last/current Care Manager. This field is mandatory for only InCK beneficiaries. XXX-XXX-XXXX |
| Email for Care Manager Assigned  (Only applicable to the PRL 2.0) | O | M for InCK beneficiaries only | The email address of a beneficiary's last/current Care Manager. This field is mandatory only for InCK beneficiaries. |
| Date Shared Action Plan Created  (Only applicable to the PRL 2.0) | O | M for InCK beneficiaries only | The date that a Shared Action Plan was created for an SIL 3 InCK beneficiary. This field is applicable and mandatory for InCK beneficiaries only.  YYYYMMDD |
| Assigned CM Entity Location Code  (Only applicable to the PRL 2.0) | O | M | The location code of the AMH that performed the care management. Each AMH site has an NPI + location code. Only applicable to AMH Tier 3s and AMH+s. When populated, this should match with the State’s Provider System (NC Tracks) NPI.  Example NPI + Location Code  1234567891\_003 |

# **VI. Patient Risk List Field Mapping to the BCM051 Care Management Report**

SPs, BH I/DD TPs, and PIHPs report to The Department care management activities for their members monthly. Information in the Patient Risk List is used to populate the care management activities for the BCM051 Care Management Interaction Beneficiary report that plans submit to The Department. Table 5 identifies the fields from the Patient Risk List that directly correlate to the fields in the .txt data file for the BCM051 Care Management Report.

**Table 5**: DATA\_CM\_Reason tab

|  |  |  |
| --- | --- | --- |
| DATA\_CM\_Reason tab | | |
| BCM051 Field Name | Patient Risk List Field Name | Additional Guidance |
| Service Center ID | PHP ID | BCM051 and PRL fields are identical. |
| Plan Name | PHP Name | BCM051 and PRL fields are identical. |
| Monthly Report Period Start Date | N/A | This should correspond to the current reporting period. Please ensure this date matches the date of submission upload page in PCDU. |
| Monthly Report Period End Date | N/A | This should correspond to the current reporting period. Please ensure this date matches the date of submission upload page in PCDU. |
| Plan Region ID | N/A | The Plan Region ID maps to the member’s administrative county. |
| Member County ID | N/A | The Member County ID is 1-102 in alphabetical order for the counties (there is a list in the valid values of the BCM051 report template). |
| County Name | N/A | County Name corresponds with the Member County ID |
| Medicaid ID | CNDS ID | BCM051 and PRL fields are identical. |
| Plan/PCCM Risk Profile | PHP Risk Score Category | BCM051 and PRL fields are identical. |
| Priority Population 1 | Priority Population 1 | BCM051 and PRL fields are identical. |
| Priority Population 2 | Priority Population 2 | BCM051 and PRL fields are identical. |
| Priority Population 3 | Priority Population 3 | BCM051 and PRL fields are identical. |
| Priority Population 4 | Priority Population 4 | BCM051 and PRL fields are identical. |
| Priority Population 5 | Priority Population 5 | BCM051 and PRL fields are identical. |
| Priority Population 6 | Priority Population 6 | BCM051 and PRL fields are identical. |
| Care Management Entity | Assigned CM Entity | BCM051 and PRL fields are identical. |
| Comprehensive Assessment Completion Date | Date Comprehensive Assessment Completed | BCM051 and PRL fields are identical. Report should include the most recent date for each member even if it is outside of the reporting period. |
| Number of Beneficiary Interactions | Number of CM Interactions | BCM051 and PRL fields are identical. |
| Number of Face-To-Face Beneficiary Interactions | Number of Face-To-Face Encounters | BCM051 and PRL fields are identical. |
| Care Plan Creation Date | Date Care Plan Created | BCM051 and PRL fields are identical. Report should include the most recent date for each member even if it is outside of the reporting period. |
| Date Care Plan Updated | Date Care Plan Updated | BCM051 and PRL fields are identical. Report should include the most recent date for each member even if it is outside of the reporting period. |
| Date Care Plan Closed | Date Care Plan Closed | BCM051 and PRL fields are identical. Report should include the most recent date for each member even if it is outside of the reporting period. |
| Shared Action Plan Creation Date | Date Shared Action Plan Created | BCM051 and PRL 2.0 fields are identical. Report should include the most recent date for each member even if it is outside of the reporting period. |
| Name of Care Manager Assigned | Name of Care Manager Assigned | BCM051 and PRL 2.0 fields are identical. |
| Care Manager Assignment Date | Date Care Manager Assigned | BCM051 and PRL 2.0 fields are identical. Report should include the most recent date for each member even if it is outside of the reporting period. This field is intended to capture the date that the last/current Care Manager was assigned even if that date is prior to the reporting month but not after the reporting month. |
| Phone for Care Manager Assigned | Phone Number for Care Manager Assigned | BCM051 and PRL 2.0 fields are identical. |
| Email for Care Manager Currently Assigned | Email for Care Manager Assigned | BCM051 and PRL 2.0 fields are identical. |
| Initial Care Manager Outreach Date | Initial Care Manager Outreach Date | BCM051 and PRL 2.0 fields are identical. Report should include the most recent date for each member inside the reporting period. |

# **VII. Scenarios**

# **How should the Comprehensive Assessment be reported by Providers on the PRL?**

AMH Tier 3, AMH+, CMA, CIN or Other Partners should report all interactions that have occurred only during the reporting month. If the interactions occur multiple times during the reporting month, these should be recorded as a cumulative count.

**For Standard Plans an interaction is defined as**:

* Face-to-face (including virtual) visit with care manager; could include delivery of Comprehensive Assessment, development of Care Plan or other discussion of patient’s health-related needs.
* Phone call or active email/text exchange between member of care team and Member (must include active participation by both parties; unreturned emails/text messages do NOT count).
* Phone call or active email/text exchange between member of care team and Member discussing Care Plan or other health-related needs.

**The following should not be reported as care management encounters in the risk reporting template:**

* Care Management for At Risk Children (CMARC) and Care Management for High Risk Pregnancy (CMHRP) encounters.
* Care manager leaves a voicemail with Member or sends unreturned email/text message.
* Health Plan/care manager sends mailer to Member.
* Phone calls between Member and practice front desk staff for scheduling purposes.
* Scheduled in-person visit to which the Member fails to show up.

**For Tailored Care Management (TCM), the minimum contact requirements will be as follows:**

* Care manager contacts for members with behavioral health needs:
  + **High Acuity**: At least four care manager-to-member contacts per month, including at least one in-person contact with the member.
  + **Moderate Acuity**: At least three care manager-to-member contacts per month and at least one in-person contact with the member quarterly (includes care management comprehensive assessment if it was conducted in- person).
  + **Low Acuity**: At least two care manager-to-member contacts per month and at least two in-person contacts with the member per year, approximately six months apart (includes the care management comprehensive assessment if it was conducted in-person).
* Care manager contacts for members with an I/DD or a TBI:
  + High Acuity: At least three care manager-to-member contacts per month, including two in-person contacts and one telephonic contact with the member.
  + Moderate Acuity: At least three care manager-to-member contacts per month and at least one in-person contact with the member quarterly. o Low Acuity: At least one telephonic contact per month and at least two in person care manager-to-member contacts per year, approximately six months apart.
  + Low Acuity: At least one telephonic contact per month and at least two in person care manager-to-member contacts per year, approximately six months apart.
    - * For more information on Tailored Care Management Interactions, see the [Tailored CM Provider Manual](https://medicaid.ncdhhs.gov/media/11859/download?attachment)

# **How should the Comprehensive Assessment be reported by Providers on the PRL?**

If a Comprehensive Assessment is complete, the most recent Comprehensive Assessment completion date within the reporting period should always be populated within the PRL submission. This field should be left blank by the provider if a Comprehensive Assessment has never been completed or still in progress. If a Comprehensive Assessment was complete in the previous reporting period, or any reporting period prior, the field should be left blank.

# **How do providers populate the “Date Care Plan Created” field?**

Providers should populate this field in each PRL submission to the plan and report the date on which the Care Plan was last created within the reporting period. Please note that providers should align on their response to Care Plan Created (Y/N) field. If the Care Plan Created field is a Y, the Care Plan Created field should have a valid date in the format requested. If the Care Plan Created field is a N, the Date Care Plan Created should be left blank.

# **How do providers populate the “Date Care Plan Updated” field?**

Providers should populate this field in each PRL submission to the plan and report the most recent date on which the Care Plan was completed or updated within the reporting month. If the Care Plan was never updated or if a Care Plan was never created, this field can be left blank.

# **How do Plans populate PHP Risk Score Category when there are discrepancies between plans and providers risk stratification?**

There may be instances in which a AMH Tier 3’s, AMH+’s, CMA’s risk score categorization for an individual varies from a PHP’s, BH I/DD TP’s, or PIHP’s risk score categorization. Although the PHPs, BH I/DD TPs, or PIHPs may resolve discrepancies based on their internal processes, The Department expects each PHP, BH I/DD TP, or PIHP to describe and document their approach to resolving risk level categorization discrepancies in the Comprehensive Assessment. The PHP, BH I/DD TP, or PIHP and the AMH Tier 3’s, AMH+’s, CMA’s do not have to automatically equate high risk with a priority population identifier.

# **VIII. Appendix**

# **Helpful links:**

* [Tailored Care Management Data Specifications Guidance](https://medicaid.ncdhhs.gov/tailored-care-management/tailored-care-management-data-specifications-guidance)
* [CMHRP/CMARC Data Specifications Guidance](https://medicaid.ncdhhs.gov/care-management/care-management-high-risk-pregnancies-cmhrp)
* [Advanced Medical Home Data Specifications Guidance](https://medicaid.ncdhhs.gov/transformation/advanced-medical-home/advanced-medical-home-data-specification-guidance%22%20HYPERLINK%20%22https://medicaid.ncdhhs.gov/transformation/advanced-medical-home/advanced-medical-home-data-specification-guidance)
* Provider Directory Listing and Affiliation Report
* [Healthy Opportunities Pilots](https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots)
* [Tailored CM Provider Manual](https://medicaid.ncdhhs.gov/tailored-care-management-provider-manual-update-aug-29-2022/download?attachment)

# **Maintenance Code**

The Maintenance Type code comes from the member 834 file that Plans receive.

1. **‘001’ is sent if there is a change or an update to the Recipient record**

* **Additional details:** When Plans receive “001” in the first BA full file, do not consider something has changed from the previous PRL file. It is coming from the State’s system and Plans should use it as is.

1. **‘021’ is sent for new Recipients**

* **Additional details:** If a new member is enrolled into a Medicaid program, the 834 file will show “021” as the maintenance type code and this will be pulled into the first full BA file and eventually the PRL sent to the providers.

1. **‘024’ is sent when a Recipient is terminated**

* **Additional details:** This should be populated if the Beneficiary’s assignment to the provider is being end dated and/or the PHP enrollment is being end dated.

# **Suggested CMARC/CMHRP Referral Reason**

The below embedded document contains suggested PHP Referral Reasons/ Risk Evidence values. PHPs can share more than one Referral Reason; however, the free text field may not contain more than 250 characters.



# **Priority Population Eligibility Criteria**

|  |  |  |  |
| --- | --- | --- | --- |
| **Code** | **Description** | **Definition** | **Source** |
| **000** | Null | N/A | N/A |
| **001** | Care Management for At-Risk Children (CMARC) | Eligibility | [CMARC & CMHRP Program Guide](https://files.nc.gov/ncdma/Program-Guide-for-Care-Management-of-High--Risk-Pregnancies-and-At-Risk-Children-in-Managed-Care-5.12.pdf)  [For TPs: Management of High Risk Pregnancies in Tailored Plan](https://medicaid.ncdhhs.gov/program-guide-management-high-risk-pregnancies-tailored-plan/download?attachment) |
| **002** | Care Management for High-Risk Pregnancies (CMHRP) | Eligibility |
| **003** | Long-Term Services and Supports | Eligibility | [LTSS Program Guide](https://medicaid.ncdhhs.gov/documents/reports/transformation/caremanagement/ltss-program-guide-edited-final/download) |
| **004** | Unmet Resources | PHP Screening | [DHHS-Standard Plan Contract](https://files.nc.gov/ncdma/Contract--30-190029-DHB-PHP-Amendment-2--CCH-3--model.pdf) Amendment 2/3 |
| **005** | Adults and Children with Special Health Care Needs | Eligibility | [DHHS-Standard Plan Contract](https://medicaid.ncdhhs.gov/media/11034/download?attachment) Amendment 8/9 |
| **006** | Rising Risk | PHP Risk Stratification | [DHHS-Standard Plan Contract](https://files.nc.gov/ncdma/Contract--30-190029-DHB-PHP-Amendment-2--CCH-3--model.pdf) Amendment 2/3 |
| **007** | Other Priority Population | PHP Screening | [PHP](https://medicaid.ncdhhs.gov/media/11034/download?attachment) - Other priority populations as determined by the PHP (i.e., Members with complex conditions like HIV, Hepatitis C, or Sickle Cell) |
| **008** | Transitioning Member | Eligibility | [NC Medicaid Managed Care Transition of Care Policy](https://medicaid.ncdhhs.gov/media/8498/download?attachment) |
| **009** | InCK SIL 1 | DHHS Risk Stratification | [NC InCK Playbook for Health Care Providers](https://ncinck.org/wp-content/uploads/2022/04/F_Provider-Guide_Merged_2.17.2022.pdf) |
| **010** | InCK SIL 2 |
| **011** | InCK SIL 3 |
| **012** | NICU Referral | Eligibility | [Medicaid and Health Choice Clinical Coverage Policy No: 1A-7](https://files.nc.gov/ncdma/documents/files/1A-7_0.pdf) |
| **013** | Healthy Opportunities Pilots | Eligibility | [Healthy Opportunities Pilots FAQ Document](https://www.ncdhhs.gov/media/12642/download?attachment) |
| **014** | Foster Care | Eligibility | [NCMT Fact Sheet Managed Care Populations and Enrollment Notices](https://medicaid.ncdhhs.gov/ncmt-fact-sheet-managed-care-populations-and-enrollment-noticespdf/open) |
| **015** | WIC Eligible but Not Enrolled | Eligibility | [Requirements for Sharing Data to Support NICE](https://medicaid.ncdhhs.gov/advanced-medical-home-data-specification-guidance) |
| **016** | SNAP Enrolled |
| **017** | SNAP Eligible but Not Enrolled |

**Unmet Resources for TCM definition:** Non-medical needs of individuals that foundationally influence health, including but not limited to needs related to housing, food, transportation and addressing interpersonal violence/toxic stress.

**Adults and Children with Special Health Care Needs definition for TPs:** Populations who have or are at increased risk of having a chronic illness and/or a physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that usually expected for individuals of similar age. This includes but is not limited to individuals with: HIV/AIDS; an SMI, I/DD or SUD diagnosis; Chronic Pain; Opioid Addiction; or receiving Innovations or TBI waiver services.