



NC Medicaid Managed Care

Data Specifications & Requirements for sharing Historical and Current Claims & Encounters Data to Support Tailored Care Management for Tailored and Prepaid Inpatient Health Plans

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Change Log		
Version	Date	Updates/Change Made
1.0	10/22/2021	Initial Publication
2.0	3/7/2022	Files Delivery Timing expectations confirmation
3.0	4/19/2022	Updated to include File Naming Conventions to Prepaid Inpatient Health Plans (PIHPs) Program
3.1	8/22/2022	Updated to removed leading pipe from Pipe Delimited File Type examples.
4.0	5/17/2023	Updated Claims Transaction example and populating Claim Frequency Code field in Institutional, Professional, and Dental claims file layouts
5.0	8/21/2023	Updated file naming convention to include TCM Provider/CIN/AMH short names.
6.0	8/24/2023	Updated Claim Header Status Code in the Line file to be an optional field in Institutional, Professional, Pharmacy, and Dental claims file layouts
7.0	2/9/2024	TCM Interfaces consolidation file naming convention update.
8.0	2/14/2025	Updated embedded Institutional, Professional, Dental, and Pharmacy Claims Templates to include Mandatory, Optional, and Situational field designation
9.0	4/27/2026	Updated all claims file layout to central location.

I. Introduction

The Behavioral Health (BH) and Intellectual/Developmental Disability (I/DD) Tailored Plan (TP) Contract and the Prepaid Inpatient Health Plan (PIHP) Contracts are the primary sources for BH I/DD TP, PIHP, and Tailored Care Management (Tailored CM) data exchange and health information technology requirements. The Tailored CM Data Strategy FAQ and Care Management Data System Guidance are also helpful resources that should be referenced by the Tailored Plans in enabling Tailored CM data exchanges to support the Tailored CM requirements.

- [North Carolina's Behavioral Health I/DD Tailored Plan RFA & Contract Documents](#)
- [Tailored CM Care Management Data System Guidance](#)
- [Tailored CM Data Strategy FAQ](#)

BH I/DD TPs PIHPs will be expected to share the following data in a machine-readable format Advanced Medical Home + (AMH+) practices and Care Management Agencies (CMA), or their designated Clinically Integrated Networks (CINs) or Other Partners, for their attributed members to support Tailored CM:

1. **Beneficiary assignment info**, including demographic data and any clinically relevant and available eligibility info.
2. **Pharmacy Lock-in data**
3. **Member claims/encounter data**, including historical physical (PH), behavioral health (BH), and pharmacy (Rx) claims/encounter data with new data delivered monthly (PH/BH) or weekly (Rx).
4. **Acuity tiering and risk stratification data**. BH I/DD TPs or PIHPs will receive an acuity tier (e.g., low, medium, high from the North Carolina Department of Human Services (the Department); BH I/DD TPs or PIHPs required to transmit acuity tier to AMH+ practices/CMAs (and results & methods of any risk stratification they conduct).
5. **Quality measure performance information** at the practice level.
6. **Other data** to support Tailored CM (e.g., previously established care plans, ADT data, historical member clinical info).

To streamline information exchange, and reduce costs and administrative burden for all stakeholders, the Department has developed standard file layouts to assist with exchange of majority of the data required for effective Tailored Care Management. This requirement document outlines the data specifications and requirements for sharing historical and current claims encounters data.

II. Background

The BH I/DD TPs or PIHPs will receive claims resulting from member encounters with providers and will use these claims as a basis for payment according to their respective contracts with providers and guidelines in the BH and I/DD TP Contract. All claims received and adjudicated by the BH I/DD TP will become "encounter data." Encounter data includes both service claim lines paid, and claim lines denied, voided claims, interest paid or recovered, penalties paid or recovered, incentive payments paid or recovered, "zero paid" claim lines, cost settlements, sub-capitated service, third party liability denials, claim line adjustments, and other financial activity associated with payment or recoveries made by the BH I/DD TPs or PIHPs, its delegees or subcontractors.

At crossover, when Medicaid Direct beneficiaries will transition to BH I/DD TPs or PIHPs, they will receive 24 months of historical claims and encounters from the Department. Post launch as

beneficiaries' transition between delivery system, the receiving BH I/DD TPs or PIHPs will receive 24 months of historical claims and encounters from their current Managed Care Organization or the Department.

To support their administrative, care management, and population health responsibilities, AMH+ practices and CMAs and/or their affiliated CINs need accurate, timely and complete information on historical and current claims and encounters from BH I/DD TPs or PIHPs related to the beneficiaries that have been assigned to them. Given AMH+ practices and CMAs and/or their affiliated CINs, elevated roles in analytics, care management, and care coordination activities, BH I/DD TPs or PIHPs will be required to share historical and current claims and encounters data on a timely basis with AMH+ practices and CMAs and/or their affiliated CINs subject to applicable data security and privacy requirements as defined in the BH & I/DD TP Contract.

The Department has provided a mapping column in all layouts that maps the historical claims extracts data elements to the Institutional, professional and NCPDP file layouts.

III. Medical Encounters & Historical Claims and Dental Claims: Data Exchange Protocols

File Layout: To streamline information exchange, and reduce costs and administrative burden for all stakeholders, the Department has developed flat file layouts using the standard 837 X12 Professional & Institutional file formats used by healthcare professionals to transit health care claims and encounters, as the baseline. File layouts can be found [here](#) or on the NC Medicaid website by searching for "Care Management Historic and Ongoing Claims and Encounters file layouts".

The Department has published 837 X12 Professional & Institutional Companion Guides that outlines each data element, its definition, and valid values in the 837 X12 Professional & Institutional files. BH I/DD TPs or PIHPs should reference those Companion Guides for understanding the definition and valid values for the file layouts included in this document. Dental and carved out services claims will use a separate file layout and is attached with this document.

The 837 X12 Professional & Institutional Companion Guides are available on the Department Encounter Processing System (EPS). The location is posted in a document in PCDU.

As noted above, at crossover, BH I/DD TPs or PIHPs will receive 24 months of historical claims and encounters from the Department. The Department has provided a mapping column in all layouts that maps the historical claims extracts data elements to the Institutional and professional file layouts.

Claim type for the historical medical claims they will receive from the Department can be identified by checking the values for C-HDR-TY-CD, per below:

- Professional Claims: 'C' 'E' 'L' 'P' 'S' 'T' 'X' '1' '2' '5' '8' 'Y' 'B' 'V' 'O' 'K' '6' '9' 'Y'
- Institutional Claims: 'F' 'G' 'H' 'I' 'N' 'O' '3' 'Z' 'A' 'U' 'Q' 'Z'
- Dental Claims: 'D'

Optional Fields: BH I/DD TPs or PIHPs have the discretion to populate the following financial-related fields at the header and line levels; they can have null values.

Header-level

1. Total Claim Charge Amount

2. Claim allowed Amount
3. Payers Claim Payment Amount

Line-level

1. Line Item Charge Amount
2. Claim allowed amount
3. Payers Claim Payment Amount
4. Claim Header Status Code

Claim Frequency Code: When BH I/DD TPs or PIHPs are populating Claim Frequency Code field in the Professional, Institutional and Dental line claims files they should populate this field based on the value in the header file. Claim Frequency code in the line file should match the header file. Claim Frequency Code field can also be blank in the line file.

File Delivery, Acceptance & Processing Validation: The Department has setup a standard process to validate successful file creation and delivery by the source entity and successful acceptance and ingestion by the target entity. All source and target entities will need to follow these standards and report information to the Department that will allow them to validate successful delivery and ingestion of data through interfaces standardized by the Department. These requirements will be shared with both the source and target entities by the Department's Technology Operations (Tech Ops) team.

AMH+ practices/CMA's Onboarding & Testing: As BH I/DD TPs or PIHPs contract with AMH+ practices and CMA's and/or their affiliated CINs, they are expected to have an onboarding process that supports establishing and enabling the exchange of information between the BH I/DD TPs or PIHPs and these practices. BH I/DD TPs or PIHPs shall review these standard file layouts, associated requirements, testing and implementation expectations with their contracted AMH+ practices, CMA's and/or their affiliated CINs and work with them to enable these data exchanges per the requirements outlined in the BH I/DD TP managed care contract and this requirements document.

A. Medical Encounters

File Data Scope: Paid and Denied Medical encounters. 1st file should include 24 months of historical medical encounters. File data should contain both BH I/DD TP and PIHP members.

File Source: BH I/DD TPs or PIHPs

File Target(s): Tailored Care Management Agencies – AMH+ practices, CMA's and/or their affiliated CINs

File Type: Pipe Delimited, Double Quote Qualified File. The 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 field length while generating the file.

The following coding method is preferred: Pipe.double quote.data.double quote.pipe. Data examples are included below:

"ABCD"|"2019-12-01"|".....

The empty fields are expected to be |""| in this format - "ABCD"|"2019-12-01"|" |".....

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. The Department will share the production date for the 1st full file through Deployment schedule.

- 1st full and ongoing incremental files should be sent between 8:00 PM and 11:59 PM every Sunday. Weekly frequency files should be sent every Sunday. Monthly frequency files should be sent on 1st Sunday of the month.
1. BH I/DD TPs or PIHPs should share the first Medical Encounter file with AMH+ practices, CMAs and/or their affiliated CINs upon 834 confirmation of assignment for that beneficiary.
 - Upon receipt of a beneficiary the BH I/DD TP should start sending the Medical Encounters file to the AMH+ practices, CMAs and/or their affiliated CINs up to 30 calendar days prior to the effective begin date and sent no later than 7 business days of the effective date.
 - BH I/DD TPs or PIHPs should continue to send the Medical Encounter File to the AMH+ practices, CMAs and/or their affiliated CINs up until the AMH's effective end date
 2. BH I/DD TPs or PIHPs should ensure that all new and updated transactions are picked up as part of Incremental file generation. If an encounter goes through multiple adjustments since the creation of last file, all those transactions should be included in the next file.
 3. BH I/DD TPs or PIHPs are required to submit all managed care encounters to the Department EPS system. If BH I/DD TPs or PIHPs make any changes to their encounters to resolve any exceptions reported by the EPS system. Those updated encounter records are required to be included in the incremental files that BH I/DD TPs or PIHPs will be sending to the AMH+ practices, CMAs and/or their affiliated CINs this will ensure data integrity across systems.
 4. AMH+ practices, CMAs and/or their affiliated CINs can separately request BH I/DD TPs or PIHPs for a full file for reconciliation purposes, as needed. BH I/DD TPs or PIHPs are required to work with AMH+ practices, CMAs and/or their affiliated CINs to ensure data integrity between both systems.

File Naming Convention: BH I/DD TPs and PIHPs are expected to follow the below file naming convention. File naming convention should be utilized by both BH I/DD TPs and PIHPs.

NCMT_<MedicalEncounterClaimData>_<TP/PIHPShortName>_<AMH+ practice/CMA/CIN Name>_CCYYMMDD-HHMMSS.TXT

Below are the short names for each BH I/DD TPs/PIHPs, use these for <TP/PIHPShortName>:

- Alliance Health = ALLB
- Partners Health Management = PARB
- Trillium Health Resources = TRIB

- Vaya Health = VAYB

Below are the values for Medical Encounter Claim Data, use these for <MedicalEncounterClaimData>:

- Medical Encounter Claim Professional Header = MEDENCCLMPHD
- Medical Encounter Claim Professional Line = MEDENCCLMPLN
- Medical Encounter Claim Institutional Header = MEDENCCLMIHD
- Medical Encounter Claim Institutional Line = MEDENCCLMILN

For < AMH+ practice/CMA/CIN Name>, BH I/DD TPs or PIHPs should reference the document titled “Data Specifications & Requirements for Sharing Tailored Care Management Entity Short Names to Support Tailored Care Management for Tailored Plans and Prepaid Inpatient Health Plans” on the NC Medicaid portal here – [Link](#).

B. Historical Fee-for-service (FFS) Medical Claims

File Data Scope: 24 months of historical paid and denied Medical FFS Claims. PIHPs will continue to receive physical health claims from the Department, their scope will include sending those as well to the AMH+ practices, CMAs and/or their affiliated CINs. File data should contain both BH I/DD TP and PIHP members.

File Source: BH I/DD TPs or PIHPs

File Target(s): Tailored Care Management Agencies – AMH+ practices, CMAs and/or their affiliated CINs

File Type: Historical Fee-for-service (FFS) Medical claims will use the same file layout and naming convention that will be used for Medical Encounters, please refer to the file type guidance and naming convention under Medical encounters above. The Department will be sending historical FFS medical claims to the BH I/DD TPs or PIHPs in a different format; hence, please refer to Column H, labeled as “NC Tracks Field”, for respective field mapping in the embedded layouts.

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. The Department will share the production date for the 1st full file through Deployment schedule.

- 1st full and ongoing incremental files should be sent between 8:00 PM and 11:59 PM every Sunday. Weekly frequency files should be sent every Sunday. Monthly frequency files should be sent on 1st Sunday of the month.
1. BH I/DD TPs or PIHPs should share the first Historical FFS Medical Claims file with AMH+ practices, CMAs and/or their affiliated CINs upon 834 confirmation of assignment for that beneficiary.
 - Upon receipt of a beneficiary the BH I/DD TP should start sending the Medical Claims file to the AMH+ practices, CMAs and/or their affiliated CINs up to 30

- calendar days prior to the effective begin date and sent no later than 7 business days of the effective date.
- BH I/DD TPs or PIHPs should continue to send the Medical Claims File to the AMH+ practices, CMAs and/or their affiliated CINs up until the AMH's effective end date
- 2. BH I/DD TPs or PIHPs should ensure that all new and updated transactions are picked up as part of Incremental file generation.
- 3. AMH+ practices, CMAs and/or their affiliated CINs can separately request BH I/DD TPs or PIHPs for a full file for reconciliation purposes, as needed. BH I/DD TPs or PIHPs are required to work with AMH+ practices, CMAs and/or their affiliated CINs to ensure data integrity between both systems.

File Naming Convention: Refer to information under Medical encounters above

C. Historical & Ongoing Fee-for-service (FFS) Dental Claims

File Data Scope: 24 months of paid and denied Medical FFS Dental Claims. File data should contain both BH I/DD TP and PIHP members.

File Source: BH I/DD TPs or PIHPs

File Target(s): Tailored Care Management Agencies – AMH+ practices, CMAs and/or their affiliated CINs

File Type: Historical and ongoing Dental Claims will use the Dental file layout - Pipe Delimited, Double Quote Qualified File. The 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 field length while generating the file.

The following coding method is preferred: Pipe.double quote.data.double quote.pipe. Data examples are included below:

"ABCD"|"2019-12-01"|".....

The empty fields are expected to be |""| in this format - "ABCD"|"2019-12-01"|"""|".....

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. The Department will share the production date for the 1st full file through Deployment schedule.

- 1st full and ongoing incremental files should be sent between 8:00 PM and 11:59 PM every Sunday. Weekly frequency files should be sent every Sunday. Monthly frequency files should be sent on 1st Sunday of the month.
- 1. BH I/DD TPs or PIHPs should share the first Dental file with AMH+ practices, CMAs and/or their affiliated CINs upon 834 confirmation of assignment for that beneficiary.

- Upon receipt of a beneficiary the BH I/DD TP should start sending the Medical Encounters file to the AMH+ practices, CMAs and/or their affiliated CINs up to 30 calendar days prior to the effective begin date and sent no later than 7 business days of the effective date.
 - BH I/DD TPs or PIHPs should continue to send the Dental File to the AMH+ practices, CMAs and/or their affiliated CINs up until the AMH's effective end date
2. BH I/DD TPs or PIHPs should ensure that all new and updated transactions are picked up as part of Incremental file generation.
 3. AMH+ practices, CMAs and/or their affiliated CINs can separately request BH I/DD TPs or PIHPs for a full file for reconciliation purposes, as needed. BH I/DD TPs or PIHPs are required to work with AMH+ practices, CMAs and/or their affiliated CINs to ensure data integrity between both systems.

File Naming Convention: BH I/DD TPs and PIHPs are expected to follow the below file naming convention. File naming convention should be utilized by both BH I/DD TPs and PIHPs.

NCMT_<DentalClaimsData>_<TP/PIHPShortName>_<AMH+ practice/CMA/CIN Name>_CCYYMMDD-HHMMSS.TXT

Below are the short names for each BH I/DD TPs/PIHPs, use these for <TP/PIHPShortName>:

- Alliance Health = ALLB
- Partners Health Management = PARB
- Trillium Health Resources = TRIB
- Vaya Health = VAYB

Below are the values for Dental Claims Data, use these for <DentalClaimsData>:

- Dental Header = DENCLMHD
- Professional Line = DENCLMLN

IV. Pharmacy Encounters and Claims: Data Exchange Protocols

File Layout: To streamline information exchange, and reduce costs and administrative burden for all stakeholders, the Department has developed flat file layouts using the standard National Council for Prescription Drug Programs (NCPDP) file format used by healthcare professionals to transmit health care claims and encounters, as the baseline. File layouts can be found [here](#) or on the NC Medicaid website by searching for "Care Management Historic and Ongoing Claims and Encounters file layouts".

The Department has published the NCPDP Companion Guide that outlines each data element, its definition, and valid values in the NCPDP file layout. BH I/DD TPs or PIHPs should reference those Companion Guides for understanding the definition and valid values for the file layouts included in this document.

The NCPDP Companion Guide is available on the Department Encounter Processing System (EPS). The location is posted in a document in PCDU.

As noted above, at crossover, BH I/DD TPs or PIHPs will receive 24 months of historical pharmacy claims and encounters from the Department. The Department has provided a mapping column in all layouts that maps the historical claims extracts data elements to the Institutional and professional file layouts.

Claim type for historical pharmacy claims can be identified by checking the values for C-HDR-TY-CD, per below:

- Pharmacy Claims: 'R'

Optional Fields:

- BH I/DD TPs or PIHPs have the discretion to populate the following financial-related fields at the header and line levels; they can have null values.

Header-level

1. Total Claim Charge Amount
2. Claim allowed Amount
3. Payers Claim Payment Amount

Line-level

1. Line Item Charge Amount
2. Claim allowed amount
3. Payers Claim Payment Amount
4. Claim Header Status Code

- All fields under section 7.7 in NCPDP Companion guide are optional and not required, they can have null values.

File Delivery, Acceptance & Processing Validation: The Department has setup a standard process to validate successful file creation and delivery by the source entity and successful acceptance and ingestion by the target entity. All source and target entities will need to follow these standards and report information to the Department that will allow them to validate successful delivery and ingestion of data through interfaces standardized by the Department. These requirements will be shared with both the source and target entities by the Department's Technology Operations (Tech Ops) team.

AMH+ practices/CMA's Onboarding & Testing: As BH I/DD TPs or PIHPs contract with AMH+ practices and CMA's and/or their affiliated CINs, they are expected to have an onboarding process that supports establishing and enabling the exchange of information between the BH I/DD TPs or PIHPs and these practices. BH I/DD TPs or PIHPs shall review these standard file layouts, associated requirements, testing and implementation expectations with their contracted AMH+ practices, CMA's and/or their affiliated CINs and work with them to enable these data exchanges per the requirements outlined in the BH I/DD TP managed care contract and this requirements document.

A. Pharmacy Encounters

File Data Scope: Paid and Denied Pharmacy encounters. File data should contain both BH I/DD TP and PIHP members.

File Source: BH I/DD TPs or PIHPs

File Target(s): Tailored Care Management Agencies – AMH+ practices, CMAs and/or their affiliated CINs

File Type: Pipe Delimited, Double Quote Qualified File. The 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 field length while generating the file.

The following coding method is preferred: Pipe.double quote.data.double quote.pipe. Data examples are included below:

"ABCD"|"2019-12-01"|".....

The empty fields are expected to be |""| in this format - "ABCD"|"2019-12-01"|" ""|".....

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. The Department will share the production date for the 1st full file through Deployment schedule.

- 1st full and ongoing incremental files should be sent between 8:00 PM and 11:59 PM every Sunday. Weekly frequency files should be sent every Sunday. Monthly frequency files should be sent on 1st Sunday of the month.
1. BH I/DD TPs or PIHPs should share the first Pharmacy Encounter file with AMH+ practices, CMAs and/or their affiliated CINs upon 834 confirmation of assignment for that beneficiary.
 - Upon receipt of a beneficiary the BH I/DD TP should start sending the Medical Encounters file to the AMH+ practices, CMAs and/or their affiliated CINs up to 30 calendar days prior to the effective begin date and sent no later than 7 business days of the effective date.
 - BH I/DD TPs or PIHPs should continue to send the Pharmacy Encounter File to the AMH+ practices, CMAs and/or their affiliated CINs up until the AMH's effective end date
 2. BH I/DD TPs or PIHPs should ensure that all new and updated transactions are picked up as part of Incremental file generation. If an encounter goes through multiple adjustments since the creation of last file, all those transactions should be included in the next file.
 3. BH I/DD TPs or PIHPs are required to submit all managed care encounters to the Department EPS system. If BH I/DD TPs or PIHPs make any changes to their encounters to resolve any exceptions reported by the EPS system. Those updated encounter records are required to be included in the incremental files that BH I/DD TPs or PIHPs will be sending to the AMH+ practices, CMAs and/or their affiliated CINs this will ensure data integrity across systems.
 4. AMH+ practices, CMAs and/or their affiliated CINs can separately request BH I/DD TPs or PIHPs for a full file for reconciliation purposes, as needed. BH I/DD TPs or PIHPs are

required to work with AMH+ practices, CMAs and/or their affiliated CINs to ensure data integrity between both systems.

File Naming Convention: BH I/DD TPs and PIHPs are expected to follow the below file naming convention. File naming convention should be utilized by both BH I/DD TPs and PIHPs.

NCMT_<PharmacyEncounterClaimData>_<TP/PIHPShortName>_<AMH+ practice/CMA/CIN Name>_CCYMMDD-HHMMSS.TXT

Below are the short names for each BH I/DD TPs/PIHPs, use these for <TP/PIHPShortName>:

- Alliance Health = ALLB
- Partners Health Management = PARB
- Trillium Health Resources = TRIB
- Vaya Health = VAYB

Below are the Pharmacy Encounter Claim Data values, use these for <PharmacyEncounterClaimData>:

- Pharmacy Header = RXENCHD
- Pharmacy Line = RXENCLN

For < AMH+ practice/CMA/CIN Name>, BH I/DD TPs or PIHPs should reference the document titled “Data Specifications & Requirements for Sharing Tailored Care Management Entity Short Names to Support Tailored Care Management for Tailored Plans and Prepaid Inpatient Health Plans” on the NC Medicaid portal here – [Link](#).

B. Historical Fee-for-service (FFS) Pharmacy Claims

File Data Scope: 24 months of historical paid and denied Pharmacy FFS claims. PIHPs will continue to receive pharmacy claims from the Department, their scope will include sending those as well to the AMH+ practices, CMAs and/or their affiliated CINs. File data should contain both BH I/DD TP and PIHP members.

File Source: BH I/DD TPs or PIHPs

File Target(s): Tailored Care Management Agencies – AMH+ practices, CMAs and/or their affiliated CINs

File Type: Historical Fee-for-service (FFS) Pharmacy claims will use the same file layout and naming convention that will be used for Pharmacy Encounters, please refer to the file type guidance and naming convention under Pharmacy encounters above. The Department will be sending historical FFS Pharmacy claims to the BH I/DD TPs or PIHPs in a different format; hence, please refer to Column H, labeled as “NC Tracks Field”, for respective field mapping in the embedded layouts.

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. The Department will share the production date for the 1st full file through Deployment schedule.

- 1st full and ongoing incremental files should be sent between 8:00 PM and 11:59 PM every Sunday. Weekly frequency files should be sent every Sunday. Monthly frequency files should be sent on 1st Sunday of the month.
1. BH I/DD TPs or PIHPs should share the first Historical Fee-for-service (FFS) Pharmacy file with AMH+ practices, CMAs and/or their affiliated CINs upon 834 confirmation of assignment for that beneficiary.
 - Upon receipt of a beneficiary the BH I/DD TP should start sending the Pharmacy file to the AMH+ practices, CMAs and/or their affiliated CINs up to 30 calendar days prior to the effective begin date and sent no later than 7 business days of the effective date.
 - BH I/DD TPs or PIHPs should continue to send the Pharmacy File to the AMH+ practices, CMAs and/or their affiliated CINs up until the AMH's effective end date
 2. BH I/DD TPs or PIHPs should ensure that all new and updated transactions are picked up as part of Incremental file generation.
 3. AMH+ practices, CMAs and/or their affiliated CINs can separately request BH I/DD TPs or PIHPs for a full file for reconciliation purposes, as needed. BH I/DD TPs or PIHPs are required to work with AMH+ practices, CMAs and/or their affiliated CINs to ensure data integrity between both systems.

File Naming Convention: Refer to information under Medical encounters above