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**NC Medicaid Managed Care**

**Data Specifications & Requirements for sharing Patient Risk 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 | 11/15/2021 | Initial Document |
| 2.0 | 3/7/2022 | Files Delivery Timing expectations confirmation and additional guidance |
| 3.0 | 4/19/2022 | Updated to include File Naming Conventions to Prepaid Inpatient Health Plans (PIHPs) Program |
| 4.0 | 1/18/2023 | Additional guidance sections added on PRL submission, Data field instructions/mapping to the BCM051, scenarios and appendix |
| 5.0 | 1/30/2023 | Clarifying definition of Face-to-face encounter |

# **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](https://medicaid.ncdhhs.gov/providers/programs-and-services/behavioral-health-idd/behavioral-health-idd-tailored-plan)
* [Tailored CM Data System Guidance](https://medicaid.ncdhhs.gov/tailored-care-management-data-system-guidance/)
* [Tailored CM Data Strategy FAQ](https://medicaid.ncdhhs.gov/documents/tailored-care-management-data-strategy-questions-and-answers/)

BH I/DD TPs or PIHPs will be expected to share the following data in a machine-readable format with 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, 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 the exchange of most of the data required for effective Tailored Care Management. This requirement document outlines the data specifications and requirements for sharing Patient risk data.

As a general principle, the Department expects BH I/DD TPs or PIHPs to provide Patient Risk information to AMH+ practices, CMAs and/or their affiliated Clinically Integrated Networks (CINs) for beneficiaries assigned to them 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 Tailored CM program.

# **II. Patient Risk Data Sharing by BH I/DD TPs or PIHPs with AMH+ practices, CMAs and/or their affiliated Clinically Integrated Networks (CINs)**

**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 Patient List/Risk Score Data. The BH I/DD TPs or PIHPs Patient List/Risk Score file layout is embedded within this document below. Please review information where source is “Tailored Plan” in the file layout (Columns E & F), to understand the specific requirements related to the data that needs to be populated by BH I/DD TPs or PIHPs.



**File Data Scope:** Beneficiaries assigned to AMH+ practices, CMAs and/or their affiliated Clinically Integrated Networks (CINs). These should align with the beneficiaries that the BH I/DD TPs or PIHPs are sharing through the beneficiary assignment file.

BH I/DD TPs or PIHPs can identify that a beneficiary has unmet resource needs using the “Priority Population” option = “004 – Unmet Resources”. To identify any such beneficiaries that are enrolled in the Healthy Opportunities pilot, BH I/DD TPs or PIHPs should instead use “Priority Population” option = “013 – Healthy Opportunities Pilot”.

**File Source:** BH I/DD TPs or PIHPs

**File Target(s):** AMH+ practices, CMAs and/or their affiliated Clinically Integrated Networks (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.

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

**File Delivery Frequency:** At least monthly. The file should include all currently active and future assignment date beneficiaries with the respective AMH+ practices, CMAs and/or their affiliated Clinically Integrated Networks (CINs). The file should be sent on the 26th of each month between 8:00 PM and 11:59 PM. In case, BH I/DD TPs or PIHPs are sending these weekly, then they should send the file every Sunday between 8:00 PM to 11:59 PM.

**Tailored Plan File Naming Convention:** BH I/DDTPs are expected to follow the below file naming convention:

NCMT\_PatientListRiskScore\_Rel2.0\_<TPShortName>\_< AMH+ practice/CMA/CIN Name >\_CCYYMMDD-HHMMSS.TXT

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

* Alliance Health = ALLT
* Eastpointe = EAST
* Partners Health Management = PART
* Sandhills Center = SANT
* Trillium Health Resources = TRIT
* Vaya Health = VAYT

**Prepaid Inpatient Health Plan File Naming Convention:** PIHPs are expected to follow the below file naming convention:

NCMT\_PatientListRiskScore\_Rel2.0\_<PIHPShortName>\_< AMH+ practice/CMA/CIN Name >\_CCYYMMDD-HHMMSS.TXT

Below are the short names for each PIHPs, use these for <PIHPShortName>:

• Alliance Health = ALLB

• Eastpointe = EASB

• Partners Health Management = PARB

• Sandhills Center = SANB

• Trillium Health Resources = TRIB

• Vaya Health = VAYB

For < AMH+ practice/CMA/CIN Name>, BH I/DD TPs or PIHPs should work with the AMH+ practices, CMAs and/or their affiliated Clinically Integrated Networks (CINs) to align on a unique name/identifier that they can use.

**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/CMAs Onboarding & Testing:** As BH I/DD TPs or PIHPs contract with AMH+ practices and CMAs 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, CMAs and/or their affiliated CINs and work with them to enable these data exchanges per the requirements outlined in the TP managed care contract and this requirements document.

# **III. Patient Risk Data Sharing by AMH+ practices, CMAs and/or their affiliated Clinically Integrated Networks (CINs) with BH I/DD TPs or PIHPs**

**File Layout:** Same layout that BH I/DD TPs or PIHPs will share with AMH+ practices, CMAs and/or their affiliated Clinically Integrated Networks (CINs). Please review information where source is “AMH+ practices, CMAs and/or their affiliated Clinically Integrated Networks (CINs)” in the file layout (Columns G & H), to understand the specific requirements related to the data that needs to be populated by AMH+ practices, CMAs and/or their affiliated Clinically Integrated Networks (CINs).



**File Data Scope:** Beneficiary panel of AMH+ practices, CMAs and/or their affiliated Clinically Integrated Networks (CINs) beneficiary panel. These should align with the beneficiaries that the BH I/DD TPs or PIHPs are sharing through the beneficiary assignment file.

**File Source:** AMH+ practices, CMAs and/or their affiliated Clinically Integrated Networks (CINs)

**File Target(s):** BH I/DD TPs or PIHPs

**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.

**File Transmission Type:** Secure File Transfer Protocol (sFTP). Source and target entities should work together to establish file exchange through secure file transfer protocol.

**File Delivery Frequency:** Monthly. 1st Full file should be sent on the 7th of each month between 8:00 PM and 11:59 PM.

**Tailored Plan File Naming Convention:** AMH+ practices, CMAs and/or their affiliated Clinically Integrated Networks (CINs) are expected to follow the below file naming conventions.

NCMT\_PatientListRiskScore\_Rel2.0\_<AMH+ practice/CIN1/CMA>\_<TPShortName>\_CCYYMMDD-HHMMSS.TXT

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

* Alliance Health = ALLT
* Eastpointe = EAST
* Partners Health Management = PART
* Sandhills Center = SANT
* Trillium Health Resources = TRIT
* Vaya Health = VAYT

**Prepaid Inpatient Health Plan File Naming Convention:** AMH+ practices, CMAs and/or their affiliated Clinically Integrated Networks (CINs) are expected to follow the below file naming conventions.

NCMT\_PatientListRiskScore\_Rel2.0\_<AMH+ practice/CIN1/CMA>\_<PIHPShortName>\_CCYYMMDD-HHMMSS.TXT

Below are the short names for each PIHPs, use these for <PIHPShortName>:

• Alliance Health = ALLB

• Eastpointe = EASB

• Partners Health Management = PARB

• Sandhills Center = SANB

• Trillium Health Resources = TRIB

• Vaya Health = VAYB

For < AMH+ practice/CMA/CIN Name>, BH I/DD TPs or PIHPs should work with the AMH+ practices, CMAs and/or their affiliated Clinically Integrated Networks (CINs) to align on a unique name/identifier that they can use.

**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 AMH+ practices, CMAs and/or their affiliated Clinically Integrated Networks (CINs) by BH I/DD TPs or PIHPs.

**AMH+ practices/CMAs Onboarding & Testing:** As BH I/DD TPs or PIHPs contract with AMH+ practices, CMAs and/or their affiliated Clinically Integrated Networks (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. AMH+ practices, CMAs and/or their affiliated Clinically Integrated Networks (CINs) should work with their respective BH I/DD TPs or PIHPs to review these standard file layouts, associated requirements, testing and implementation expectations to effectively enable these data exchanges.

# **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 Patient Risk List (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 Optional | Priority Population 1  is Mandatory  (*Must mirror the SP, BH I/DD TP, Or PIHP’s Entry*)  Priority Population 2-6 are Optional  (*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  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”. |

# **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 the AMH 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 designated for 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.  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. |
| 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.

# **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 |
|  | 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) |

**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.