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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**

**Contents**

1. **Introduction**
2. **Patient Risk Data Sharing by BH I/DD TPs or PIHPs with AMH+ practices, CMAs and/or their affiliated Clinically Integrated Networks (CINs)**
3. **Patient Risk Data Sharing by AMH+ practices, CMAs and/or their affiliated Clinically Integrated Networks (CINs) with BH I/DD TPs or PIHPs**
4. **Submission Guidance**
5. **Instructions for Populating the Patient Risk List Data Fields**
6. **Patient Risk List Field Mapping to the BCM051 Care Management Report**
7. **Scenarios**
8. **Appendix**

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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 |
| 6.0 | 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. |
| 7.0 | 8/21/2023 | Updated file naming convention to include TCM Provider/CIN/AMH short names. |
| s8.0 | 10/23/2023 | Section C updated with additional guidance on Risk Evidence as it relates to CMHRP population. |
| 9.0 | 2/9/2024 | TCM Interfaces consolidation file naming convention update.  Addition of Population Segment data elements in file layout and updated guidance. |
| 10 | 6/3/2024 | Addition guidance defining “reporting month.” |
| 11.0 | 10/23/24 | Addition of following fields to the PRL template: Waiver Services, TCL Member Status, Member Phone Contact, Member Email Contact  Update of Outbound PRL transmission cadence requirement to be sent weekly |

# **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,** including beneficiary’s current pharmacy lock-in assignment, member ID, lock-in dates, lock-in type, NPI of provider or pharmacy.
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 and CMAs. These should align with the beneficiaries that the BH I/DD TPs or PIHPs are sharing through the beneficiary assignment file. File data should contain both BH I/DD TP and PIHP members.

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, PIHPs should instead use “Priority Population” option = “013 – Healthy Opportunities Pilot”.

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

**File Target(s):** AMH+ practices and 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 weekly. 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 every Sunday between 8:00 PM and 11:59 PM.

**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\_PatientListRiskScore\_Rel3.0\_<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

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](https://medicaid.ncdhhs.gov/tailored-care-management/tailored-care-management-data-specifications-guidance).

**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 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 and CMAs. These should align with the beneficiaries that the BH I/DD TPs or PIHPs are sharing through the beneficiary assignment file. File data should contain both BH I/DD TP and PIHP members.

**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. First full file should be sent on the 7th of each month between 8:00 PM and 11:59 PM.

**File Naming Convention:** AMH+ practices, CMAs and/or their affiliated Clinically Integrated Networks (CINs) are expected to follow the below file naming conventions. File naming convention should be utilized for both BH I/DD TPs and PIHPs.

NCMT\_PatientListRiskScore\_Rel3.0\_<AMH+ practice/CIN1/CMA>\_<TP/PIHPShortName>\_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

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](https://medicaid.ncdhhs.gov/tailored-care-management/tailored-care-management-data-specifications-guidance).

**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 and CMAs, 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 BH I/DD TPs and/or PIHPs to provide complete, accurate and timely Patient Risk information to 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.

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

**Reporting Period:** Each submission of the Inbound Patient Risk List (TCM Providers to BH I/DD TPs or PIHP) shall be representative of a “reporting period” of the first through the last calendar day of a given month. Each submission of the Patient Risk List shall by submitted to BH I/DD TPs and/or PIHPs by their applicable AMH+ practices, CMAs and/or their affiliated CINs/Other Data Partners on the 7th day of the second month after the reporting period. For example, a Patient Risk List representing information for the month of March 2024 would be submitted to the BH I/DD TPs and/or PIHPs on May 7th, 2024.

Where applicable as described in the following section, only data that is applicable to the reporting period shall be transmitted on the Patient Risk List to BH I/DD TPs and/or PIHPs by their applicable AMH+ practices, CMAs and/or their affiliated CINs/Other Data Partners.

# **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 BH I/DD TPs and/or PIHPs, as well as 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+ practices, CMAs and/or their affiliated CINs/Other Data Partners should be populated if the corresponding field is populated by the 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 = BH I/DD TP,  or PIHP | M/S/O  Source = AMH+, CMA, CIN or Other Data Partner | Instructions |
| PHP ID | M | M | BH I/DD TPs and/or PIHPs should populate this field with their NC Medicaid assigned PHP Identifier.  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+/CMA/CIN receives from the PHP in their Patient Risk File. |
| PHP Name | M | M | BH I/DD TPs and/or PIHPs should populate this field with the PHP name.  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+/CMA/CIN receives from the PHP in their Patient Risk File. “PHP” refers to any Prepaid Health Plan. |
| Full vs Incremental | M | M | F= Full, I=Incremental  TCM providers will send only full Patient Risk List (PRL) files. 1st Full file followed by full monthly files on the 26th of each month.  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. Truncate file name to fit maximum field length. |
| 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 = BH I/DD TP,  or PIHP | M/S/O  Source = 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 |
| Population Segment | M | O | Aligns with a TCM member’s Population Segment as defined by the LME/MCO’s or Tailored Plan’s Tailored Care Management (TCM) Auto Assignment (AA) Algorithm. This field may not be blank or differ from the valid values below. The LME/MCO shall update the “Population Segment” data element if any member’s population segment is updated outside of the LME/MCOs TCM Auto Assignment algorithm.  **Valid Values:**  TBI Waiver  Innovations Waiver  MH/SUD Child  I/DD  TBI Services  Co-Occurring Adult  Co-Occurring Child  MH/SUD Adult |
| Population Segment Effective Date | M | O | The LME/MCO or Tailored Plan shall populate the “Population Segment Effective Date” field with the date in which a TCM member’s population segment is applied. This date should be either equal to or after the member’s TCM Begin Date.  YYYYMMDD |
| Priority Population 1 - 6 | Priority Population 1  is Mandatory  Priority Population  2-6 are Optional | Priority Population 1  is Mandatory  (*Must mirror the BH I/DD TP, Or PIHP’s Entry*)  Priority Population 2-6 are Optional  (*Must mirror the 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+, 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 Pilot  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 |
| Waiver Services | M | M | 01 = No Waiver Service currently received​  02 = 1915(i) currently received​  03 = Innovations Waiver currently received​  04 = TBI Waiver currently received |
| TCL Member Status | M | M | Y/N – indicating Y if member is currently TCL status and N if not |

# **Section C. PHP Risk Profile**

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

|  |  |  |  |
| --- | --- | --- | --- |
| **PHP Risk Profile** | | | |
| Field Name | M/S/O  Source = BH I/DD TP,  or PIHP | M/S/O  Source = AMH+, CMA, CIN or Other Data Partner | Instructions – The PHP Risk Score Category and PHP Risk Evidence should be completed by BH I/DD TP and/or PIHP only. |
| PHP Risk Score Category | O | O | PHP Risk Score will be populated by the 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 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 BH I/DD TP and/or PIHP determines a member risk stratification has changed. |
| PHP Risk Evidence | O | O | 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 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 = BH I/DD TP,  or PIHP | M/S/O  Source = AMH+, CMA, CIN or Other Data Partner | Instructions – The CM Entity Risk Score Category should be completed by the 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+, CMA, CIN or Other Partner risk algorithm.  Valid Values:  H = High; M = Medium; L = Low; N = Null  This field is populated by the 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 [Tailored CM Program Manual](https://medicaid.ncdhhs.gov/documents/providers/playbook/tcm-provider-manual-20240209/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) | O | M | Identifies if a Care Plan has or has not yet been created in the reporting period. |
| 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 Care Management was terminated for a beneficiary within the reporting period for any reason. This should align with the date that a member opts out of TCM or disenrolls with a BH I/DD TP or PIHP. YYYYMMDD |
| Date Care Manager Assigned | 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 | 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 | O | M | The name of the last/current Care Manager assigned to a beneficiary during the reporting month. |
| Phone Number for Care Manager Assigned | O | M | The phone number of a beneficiary's last/current Care Manager. XXX-XXX-XXXX |
| Email for Care Manager Assigned | O | M | The email address of a beneficiary's last/current Care Manager. |
| Date Shared Action Plan Created | O | N/A | Not applicable for Tailored Care Management. |
| Assigned CM Entity Location Code | O | M | The NPI + location code of the AMH+ or CMA that performed care management. Each TCM Provider has an administrative site NPI + location code. When populated, this should match with the State’s Provider System (NC Tracks) NPI.  Example NPI + Location Code  1234567891\_003 |
| Member Phone Contact​ | S | S | Phone number for the member. If member has a person who is legally responsible for them, then the LRP's contact number is provided |
| Member Email Contact​ | S | S | Email address for the member. If member has a person who is legally responsible for them, then the LRP's contact number is provided |

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

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 3.0 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 3.0 fields are identical. |
| Care Manager Assignment Date | Date Care Manager Assigned | BCM051 and PRL 3.0 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 3.0 fields are identical. |
| Email for Care Manager Currently Assigned | Email for Care Manager Assigned | BCM051 and PRL 3.0 fields are identical. |
| Initial Care Manager Outreach Date | Initial Care Manager Outreach Date | BCM051 and PRL 3.0 fields are identical. Report should include the most recent date for each member inside the reporting period. |

# **VII. Scenarios**

# **How should interaction data be reported by Providers on the PRL?**

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.

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

* Care manager leaves a voicemail with Member or sends unreturned e-mail/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.

As a reminder, a qualifying Tailored Care Management contact is defined as an interaction that includes the member and/or legally responsible person/guardian that fulfills one or more of the six core Health Home services. For more information on Tailored Care Management Interactions, see the [Tailored CM Provider Manual](https://medicaid.ncdhhs.gov/documents/providers/playbook/tcm-provider-manual-20240209/download?attachment) (see Section V.4.2. Capacity to Engage with Members Through Frequent Contact).

# **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 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.

# **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/documents/providers/playbook/tcm-provider-manual-20240209/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 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.