



NC Medicaid Managed Care

Data Specifications & Requirements for sharing Beneficiary Assignment and Pharmacy Lock-in 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	10/11/2021	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
3.1	7/11/2022	Updated Acuity Tier Assignment Date to be an Optional field

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 Data System Guidance](#)
- [Tailored CM Data Strategy FAQ](#)

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 beneficiary and pharmacy lock-in data.

II. Background

The BH I/DD TPs or PIHPs will receive beneficiary enrollment data through the daily 834 files from the Department. Prior to Tailored Plan launch, beneficiaries will have the option to select their Advanced Medical Home (AMH)/Primary Care Provider (PCP) and/or AMH+ practice/CMA during the choice period. If a beneficiary selects their AMH/PCP and/or AMH+ practice/CMA during the choice period, then BH I/DD TPs or PIHPs should assign the beneficiary to their selected AMH/PCP and/or AMH+ practice/CMA. Once assigned and that assignment is validated by the Department, the BH I/DD TPs or PIHPs shall send the full beneficiary roster to the respective AMH+ practice/CMA in the Department's preferred format within seventy-two (72) hours of getting confirmation from the Department that the Tailored CM assignment has been accepted. BH I/DD TPs or PIHPs are also responsible for notifying the

Department of any discrepancies (mismatched information) identified in reconciliation in a format defined by the Department within twenty-four (24) hours.

BH I/DD TP or PIHPs will reconcile AMH/PCP & Tailored CM assignment data with the Department at least monthly using the monthly 834 file and shall be responsible for notifying the Department of any discrepancies (mismatched information) identified in reconciliation in a format defined by the Department.

AMH+ practices/CMAs need accurate, timely and complete information from BH I/DD TP or PIHPs about which members have been assigned to them. This information will serve to:

- Facilitate effective and timely patient outreach and care management
- Determine the level and accuracy of per member per month (PMPM) fees flowing from BH I/DD TP or PIHPs to the practice

III. Beneficiary Assignment File: Data Exchange Protocols

File Layout: To streamline information exchange, and reduce costs and administrative burden for all stakeholders, the Department has developed a flat file layout using the 834 EDI Enrollment standard file format as the baseline. The Department uses the 834 ASC X12 file format to send enrollment information to BH I/DD TP or PIHPs and has published a Companion Guide that outlines each data element, its definition, and valid values. The 834-file layout and Companion Guide are available through the PHP Contract Data Utility (PCDU) and will also be posted on the Department's portal. The beneficiary assignment file layout is attached with this document. The BH I/DD TP or PIHPs are required to share beneficiary data with assigned AMH+ practices/CMAs in this format. The "Data Guidance" section below includes information on custom fields that have been added to this layout that are not referenced in the 834-file Companion Guide.



File Data Scope: Current and future beneficiary managed care eligibility segments, separate record is expected for each eligibility segment. Full file should include the current active/future panel for the File Target. Full file should also include any termination since the previous full file.

- Example: If a member is terminated with an effective date of 8/12/2021, and the BH I/DD TP receives this data on the same date. Then the incremental file should report this termination. The weekly full file for the week of 8/15/2021 should also include this member's termination record.

Member CNDS ID	Start Date	End Date
123456789	7/1/2021	8/12/2021

File Source: BH I/DD TP or PIHPs

File Target(s): Tailored Care Management Agencies – 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: 1st Full file followed by daily incremental files and weekly full files. Weekly full files will ensure that data is reconciled between the source and target every week. The Department will share the production date for the 1st full file through the Deployment schedule. Upon receipt of a beneficiary enrollment information through the 834 files, the BH I/DD TPs or PIHPs shall start sending the beneficiary data to their respective AMH+ practice/CMA up to 30 calendar days prior to their assignment effective date and no later than 7 business days of the assignment effective date.

BH I/DD TPs or PIHPs should continue to send the beneficiary data to their respective AMH+ practice/CMA until beneficiary's assignment end date with the AMH+ practice/CMA.

- The weekly full file should be sent every Sunday between 8:00 PM to 11:59 PM.
- The incremental file should be sent daily between 8:00 PM to 11:59 PM.
- Incremental file should also be sent on the day the full file is sent. The incremental file should be sent before the full file.

Tailored Plan File Naming Convention: BH I/DD TPs are expected to follow the below file naming conventions for full and incremental files.

- Full: NCMT_BeneficiaryAssignmentData_FUL_Rel2.0_<TPShortName>_<AMH+ practice/CMA/CIN Name>_CCYYMMDD-HHMMSS.TXT
- Incremental: NCMT_BeneficiaryAssignmentData_INC_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 conventions for full and incremental files.

- Full: NCMT_BeneficiaryAssignmentData_FUL_Rel1.0_<PIHPShortName>_<AMH+ practice/CMA/CIN Name>_CCYYMMDD-HHMMSS.TXT

- Incremental: NCMT_BeneficiaryAssignmentData_INC_Rel1.0_<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.

If an AMH+ practices, CMAs and/or their affiliated Clinically Integrated Networks (CINs) is looking for historical reconciliation management then, they should work with the BH I/DD TPs or PIHPs to do so.

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.

Data Guidance: Guidance on custom fields not referenced in the 834-file Companion Guide along with additional guidance on few fields that are referenced in the 834-file Companion Guide:

- Field Name: Enrollment Start Date – This is the beneficiary's enrollment begin date with the Medicaid Program.
- Field Name: Enrollment End Date – This is the beneficiary's enrollment end date with the Medicaid Program.
- Field Name: PHP Cross Reference ID – BH I/DD TPs or PIHPs are expected to use these fields to populate their respective beneficiary cross reference IDs, they can populate up to five cross reference IDs
- Field Name: PHP Eligibility Begin Date – This represents the beneficiary's eligibility begin date with the TP
- Field Name: PHP Eligibility End Date – This represents the beneficiary's eligibility end date with the TP
- Field Name: AMH Begin Date – This represents the beneficiary's enrollment start date with the AMH

- Field Name: AMH End Date – This represents the beneficiary’s enrollment end date with the AMH
- Field Name: PCP Begin Date – This represents the beneficiary’s enrollment start date with the PCP
- Field Name: PCP End Date – This represents the beneficiary’s enrollment end date with the PCP
- Field Name: TCM Begin Date – This represents the beneficiary’s enrollment start date with the AMH+ practice/CMA
- Field Name: TCM End Date – This represents the beneficiary’s enrollment end date with the AMH+ practice/CMA
- Field Name: New Eligibility Indicator
 - Acceptable values:
 - “Y” – Yes, represents any new eligibility segment for an existing beneficiary
 - “N” – No, in all other instances use No
- Field Name: Acuity Tier Code
 - Acceptable Values:
 - BH01
 - BH02
 - BH03
 - UN01
 - ID01
 - ID02
 - ID03
- Field Name: Acuity Tier Description
 - Acceptable Values:
 - BH High – Aligns with Acuity Tier Code “BH03”
 - BH Medium – Aligns with Acuity Tier Code “BH02”
 - BH Low – Aligns with Acuity Tier Code “BH01”
 - Undefined – Aligns with Acuity Tier Code “UN01”
 - IDD High – Aligns with Acuity Tier Code “ID03”
 - IDD Medium – Aligns with Acuity Tier Code “ID02”
 - IDD Low – Aligns with Acuity Tier Code “ID01”
- Field Name: Acuity Tier Assignment Date – OPTIONAL. This represents the beneficiary’s assignment date to a specific Acuity Tier. BH I/DD TPs or PIHPs will receive this data from the Department. This is an optional field.
- Field Name: Acuity Tier Effective Date – This represents the beneficiary’s Acuity Tier effective date at the specific tier level. BH I/DD TPs or PIHPs will receive this data from the Department.

- **Field Name: Acuity Tier End Date** – This represents the beneficiary’s Acuity Tier end date at the specific tier level. For active acuity tier assignments this should be populated as a high-end date i.e., 12/31/9999. BH I/DD TP or PIHPs will receive this data from the Department.

Additional Guidance on few fields that are also in the 834-file Companion Guide:

- **Maintenance Type Code**
 - **Acceptable Values:**
 - ‘001’ is sent if there is a change or an update to the Recipient record
 - ‘021’ is sent for new Recipients
 - ‘024’ is sent when a Recipient is terminated – This should be populated if the Beneficiary’s assignment to the AMH/PCP or AMH+ practice/CMA is being end dated and/or the PHP enrollment is being end dated.
- **Field Name: Tribal Option Indicator**
 - **Acceptable Values:**
 - “Y” – Yes represents any beneficiary that is enrolled in tribal option based on the current enrollment segment. This can be identified by a “TRIBAL OP” value in loop 2310 NM106.
 - “N” – No, in all other instances use No
- **Field Name: Indian Health Services Indicator**
 - **Acceptable Values:**
 - “Y” – Yes represents non-Federally Recognized Tribal beneficiaries that are eligible for Indian Health Services. This can be identified by a “Y” in loop 2300 REF02.
 - “N” – No, in all other instances use No

AMH+ practices/CMAs Onboarding & Testing: As BH I/DD TP 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 TP or PIHPs and these practices. BH I/DD TP 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.

IV. Pharmacy Lock-in: Data Exchange Protocols

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 Pharmacy lock-in data. The Department and the BH I/DD TP or PIHPs are using the same format to share Pharmacy lock-in data between themselves. The Pharmacy lock-in file layout is attached with this document.



File Data Scope: Current Pharmacy lock-in assignments

File Source: BH I/DD TP 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.

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

File Delivery Frequency: Weekly. 1st Full file followed by weekly full files. The Department will share the production date for the 1st full file through the Deployment schedule

Upon receipt of a beneficiary enrollment information through the 834 files, the BH I/DD TP or PIHPs shall start sending the Pharmacy lock-in data to their respective AMH+ practice/CMA up to 30 calendar days prior to their assignment effective date and no later than 7 business days of the assignment effective date.

BH I/DD TP or PIHPs should continue to send the Pharmacy lock-in data to their respective AMH+ practice/CMA until beneficiary's assignment end date with the AMH+ practice/CMA.

- The weekly full file should be sent every Sunday between 8:00 PM to 11:59 PM.

Tailored Plan File Naming Convention: BH I/DD TP are expected to follow the below file naming convention.

NCMT_BeneficiaryPharmacyLockInData_<TPShortName>_<AMH+ practice/CMA/CIN Name>_
CCYYMMDD-HHMMSS.TXT

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

NCMT_BeneficiaryPharmacyLockInData_<PIHPShortName>_<AMH+ practice/CMA/CIN Name>_
CCYYMMDD-HHMMSS.TXT

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

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- Trillium Health Resources = TRIB
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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 TP or PIHPs contract with AMH+ practices, 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 TP or PIHPs and these practices. BH I/DD TP 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.