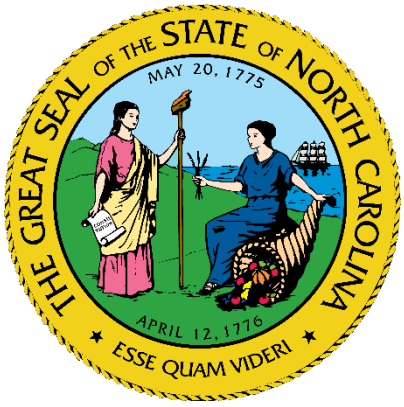


NC Medicaid Managed Care

Requirements for Sharing Claims and Encounters Data to Support Continuity of Care for Beneficiaries Transitioning between NC Medicaid Direct and Health Plans

Change Log		
Version	**Date**	**Updates/Change Made**
2.0	1/22/2020	Initial Publication

3.0	9/18/2020	• Updated Claims Formats
		• Included COBOL Copybooks
		• Added Section for PHP to Tribal Option
		  ○ 834 Trigger Info
		• Added Section for PHP to CCNC
		  ○ 834 Trigger Info

3.1	10/16/2020	Updated Claims Formats to line up with COBOL
4.0	10/1/2021	Updated to include requirements for both Behavioral Health (BH) and Intellectual/Developmental Disability (I/DD) Tailored Plans (TPs) and Standard Plans (SPs) – Referred to as “PHPs” in this document.
5.0	2/1/2022	• Removed embedded documents and replaced with reference to their new file names and paths within PCDU. ○ *Note: Only Standard Plans and Tailored Plans have access to the PCDU* • Minor formatting changes/fixes • Updated page numbers for documents table
5.1	4/11/2022	• Added file extensions to documents table on page 3. • Added reference to Companion Guides found in the EPS
6.0	7/15/2022	Updated document to reflect PIHPs and references to documents in PCDU
7.0	8/31/2023	• Update File Delivery Frequency for ALL • *Replace all instances of ‘PHP’ with ‘Health Plan’* • *Replace all instances of ‘PIHP’ with ‘LME/MCO’*

Below is a list of external references identified in this document and stored/maintained in PCDU

Documents	Section	Page
CL_TOCDPPH_MasterDataElementDictionary_MMDDYYYY.docx	*(1) Department to Health Plans: NC Medicaid Direct Medical & Pharmacy Claims and LME/MCO Encounter data*	6
CL_TOCDPPH_MedicalHeader_MMDDYYYY.xlsx	*(1) Department to Health Plans: NC Medicaid Direct Medical & Pharmacy Claims and LME/MCO Encounter data*	7
CL_TOCDPPH_MedicalLine_MMDDYYYY.xlsx	*(1) Department to Health Plans: NC Medicaid Direct Medical & Pharmacy Claims and LME/MCO Encounters data*	7
CL_TOCDPPH_ClaimsEdit_MMDDYYYY.xlsx	*(1) Department to Health Plans: NC Medicaid Direct Medical & Pharmacy Claims and LME/MCO Encounter data*	7
CL_TOCDPPH_PharmacyHeader_MMDDYYYY.xlsx	*(1) Department to Health Plans: NC Medicaid Direct Medical & Pharmacy Claims and LME/MCO Encounter data*	7
CL_TOCDPPH_PharmacyLine_MMDDYYYY.xlsx	*(1) Department to Health Plans: NC Medicaid Direct Medical & Pharmacy Claims and LME/MCO Encounters data*	7
CL_TOCDPPH_ToCGDITNamingConvention_MMDDYYYY.xlsx	*(1) Department to Health Plans: NC Medicaid Direct (FFS) Medical & Pharmacy Claims and LME-MCO Encounter data*	7
EPS 837I Companion Guide	*Sections (2) – (5) on Sharing* Encounters & Historical Claims data encounters: *Health Plans to Health Plans, LME/MCO to Health Plan/LME/MCO, Health Plan to Tribal Option, Health Plan to CCNC*	9
EPS 837P Companion Guide	*Sections (2) – (5) on Sharing* Encounters & Historical Claims data encounters: *Health Plan to Health Plan, LME/MCO to Health Plan/LME/MCO,*	9

	Health Plan to Tribal Option, Health Plan to CCNC	
EPS NCPDP Companion Guide	*Sections (2) – (5) on Sharing* Encounters & Historical Claims data encounters: *Health Plan to Health Plan, LME/MCO to Health Plan/LME/MCO, Health Plan to Tribal Option, Health Plan to CCNC*	9
COBOL Copybooks		
CL_TOCDPPH_MedicalHeaderCobol_MMDDYYYY.txt	*(1) Department to Health Plans: NC Medicaid Direct Medical & Pharmacy Claims and LME/MCO Encounters data*	7
CL_TOCDPPH_MedicalLineCobol_MMDDYYYY.txt	*(1) Department to Health Plans: NC Medicaid Direct Medical & Pharmacy Claims and LME/MCO Encounter data*	7
CL_TOCDPPH_EditCobol_MMDDYYYY.txt	*(1) Department to Health Plans: NC Medicaid Direct Medical & Pharmacy Claims and LME/MCO Encounter data*	7
CL_TOCDPPH_PharmacyHeaderCobol_MMDDYYYY.txt	*(1) Department to Health Plans: NC Medicaid Direct Medical & Pharmacy Claims and LME/MCO Encounter data*	7
CL_TOCDPPH_PharmacyLineCobol_MMDDYYYY.txt	*(1) Department to Health Plans: NC Medicaid Direct Medical & Pharmacy Claims and LME/MCO Encounter data*	7

** MMDDYYYY in file names denotes the most recent date when the file was updated.*

Table of Contents

(1) Department to Health Plans/LME/MCOs: NC Medicaid Direct Medical & Pharmacy Claims and LME/MCO Encounter Data

Scope:

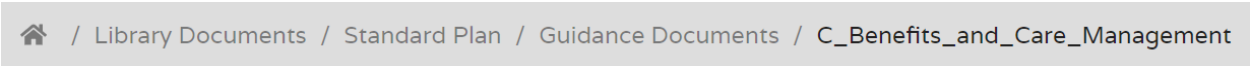
- 24 months of historical Medical & Pharmacy claims and LME/MCO encounter data for beneficiaries transitioning from NC Medicaid Direct to a health plan or LME/MCO.
- For the newly assigned beneficiaries, a daily full file 24 months of historical Medical & Pharmacy claims and LME/MCO encounter data.
- Weekly incremental files generated each Sunday, to include edits/updates of any historical claims and 24 months of historical Medical & Pharmacy claims and LME/MCO encounter data for any newly enrolled beneficiaries.
    - Weekly incremental files are generated on weeks when a Check-write occurs.
    - If there is no Check-write, a daily full file will generate (if there are no claims records to send the file may be empty). Edits/updates to any historical claims or new claims received as NC Medicaid Direct claims in the future due to claims lag will be shared through incremental files.
- All approved and denied claims for carved-in and carved-out services including but not limited to dental claims.
- Weekly incremental files will include ongoing carved-out services claims.
- All LME/MCO claims and encounters payment fields will be zeroed out (Note: LME/MCO claims and encounters will only be for dates of service prior to 04/1/2023).
- To comply with 42 CFR Part 2, these files will not include any records with substance abuse disorder (SUD) detail.

Data Source: NCTracks

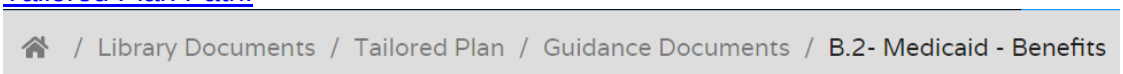
Data Target(s): Health Plans /LME/MCOs

File Layout(s): The Department established file layouts to send Medical & Pharmacy Claims and LME/MCO Encounter data from NCTracks to health plans and LME/MCOs. There are nine interfaces with five associated file layouts and corresponding Copybooks for the Claims and LME/MCO Encounters which are maintained in PCDU at the paths below. Along with the Master Data Element Dictionary (*CL_TOCDPPH_MasterDataElementDictionary_MMDDYYYY.docx)* and the File Naming Convention *(CL_TOCDPPH_ToCGDITNamingConvention_MMDDYYYY.xlsx).*

Standard Plan Path:



Tailored Plan Path:



Interface	Layout	COBOL Copybook
Medical Claims Header	CL_TOCDPPH_MedicalHeader_MMDDYYYY.xlsx	*CL_TOCDPPH_MedicalHeaderCobol_MMDDYYYY.txt*
Medical Claims Line	CL_TOCDPPH_MedicalLine_MMDDYYYY.xlsx	*CL_TOCDPPH_MedicalLineCobol_MMDDYYYY.txt*
Medical Claims Edit	CL_TOCDPPH_ClaimsEdit_MMDDYYYY.xlsx	*CL_TOCDPPH_EditCobol_MMDDYYYY.txt*
Pharmacy Claims Header	CL_TOCDPPH_PharmacyHeader_MMDDYYYY.xlsx	*CL_TOCDPPH_PharmacyHeaderCobol_MMDDYYYY.txt*
Pharmacy Claims Line	CL_TOCDPPH_PharmacyLine_MMDDYYYY.xlsx	*CL_TOCDPPH_PharmacyLineCobol_MMDDYYYY.txt*
Pharmacy Claims Edit	CL_TOCDPPH_ClaimsEdit_MMDDYYYY.xlsx	*CL_TOCDPPH_EditCobol_MMDDYYYY.txt*
LME-MCO Encounters Header	CL_TOCDPPH_MedicalHeader_MMDDYYYY.xlsx	*CL_TOCDPPH_MedicalHeaderCobol_MMDDYYYY.txt*
LME-MCO Encounters Line	CL_TOCDPPH_MedicalLine_MMDDYYYY.xlsx	*CL_TOCDPPH_MedicalLineCobol_MMDDYYYY.txt*
LME-MCO Encounters Edit	CL_TOCDPPH_ClaimsEdit_MMDDYYYY.xlsx	*CL_TOCDPPH_EditCobol_MMDDYYYY.txt*

File Naming Convention: Refer to the document below in PCDU (at the path listed above) for the file naming convention.

File Name: *CL_TOCDPPH_ToCGDITNamingConvention_MMDDYYYY.xlsx*

File Type: Fixed width flat file. All files will be zipped binary files. Once unzipped, the files will be in EBCDIC format.

Transmission Type: Secure File Transfer Protocol (sFTP) on GDIT's MOVEit Site.

File Delivery Frequency: Daily

1. Health plans and LME/MCOs will receive daily full files from NCTracks for newly assigned beneficiaries assigned to a health plan or LME/MCO. This will be followed by weekly incremental files. Incremental files will include new or adjusted claims for beneficiaries with claims history previously sent, along with 24 months of claims history for newly assigned beneficiaries.

File Creation & Processing Rules:

1. Health plans and LME/MCOs should have the capability to unzip the files posted by GDIT and load the records into the appropriate operational environments. In addition, health plans and LME/MCOs are required to share this data downstream as defined by the AMH Data Specification Guidance. T Health plans and LME/MCOs are to use this data to 1) support AMH/PCP auto-assignment and 2) support additional care management functions 3) Tailored Care Management assignment (if applicable).
2. Health plans and LME/MCOs are to ingest all claims records for beneficiaries that have a record in their eligibility system as recorded on the daily 834. Health plans and LME/MCOs should be able to ingest claims records for beneficiaries with merged IDs. See more information on managing merged IDs in the Dependencies section below.
3. For Tailored Plan and LME/MCOs, if LME/MCO encounters are duplicated (i.e., the Tailored Plan already has the records in their system), the duplicate records do not need to be ingested. Duplicate records can be identified using the Transaction Control Number (TCN) unique identifier.
4. Health plans should have the capability to perform duplicate claim checks logic to identify duplicate records as part of their loading and file ingestion of historical and incremental claim files received from NCTracks and other health plans. The processes to identify duplicate records and/or recipients on claims/encounters/pharmacy full files and weekly incremental files should allow health plans to perform these tasks without file processing delays that deviate from their normal file ingestion processes and time.
5. The health plans' duplicate claim check process should prevent duplicate records from being passed to their downstream providers.

File Delivery, Acceptance & Processing Validation: The Department established 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 are 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.

Dependencies:

- Beneficiary assignments: Health plans and LME/MCOs will receive information on beneficiaries assigned to them through the daily 834 file. Health plans and LME/MCOs are to load their beneficiary assignment prior to processing the claims files.
- Member Cross Reference IDs/Merged Member IDs: Beneficiaries can have multiple Member IDs and those values are included in the 834 file – refer to the 834 Companion Guide for appropriate loop and reference. Health plans and LME/MCOs are to use the data to link beneficiaries with multiple IDs with their active Member ID and properly ingest and map claims data with the appropriate active Member ID.
- Provider Data: Health plans and LME/MCOs will receive Medicaid provider data through the Provider Enrollment File (PEF) and are to load prior to processing claims files.

(2) Health Plans to Health Plans (Tailored Plans and Standard Plans): A) NC Medicaid Direct Medical & Pharmacy Claims and LME/MCO (encounters data and B) Medical & Pharmacy Managed Care Encounters Data

Scope:

- 24 months (based on date of claims adjudication) of Medical and Pharmacy claims data for beneficiaries transitioning from one health plan to another after the health plan's managed care go-live date.
- Source health plan will be responsible for identifying 24 months of historical data which can be a combination of both historical NC Medicaid Direct Claims & Encounters and Managed Care Encounters data.
- All approved and denied claims and encounters for carved-in and carved-out services including but not limited to dental claims.
- Edits/updates to any historical claims and encounters.
- Any new claims/encounters received in future due to claims lag within the identified 24-month transition period.
- Ongoing carved-out services claims.
- To comply with 42 CFR Part 2, health plans are required to remove SUD claims and encounters if consent has not otherwise been secured.

Data Source: System: Health Plans

Data Target(s): Health Plans

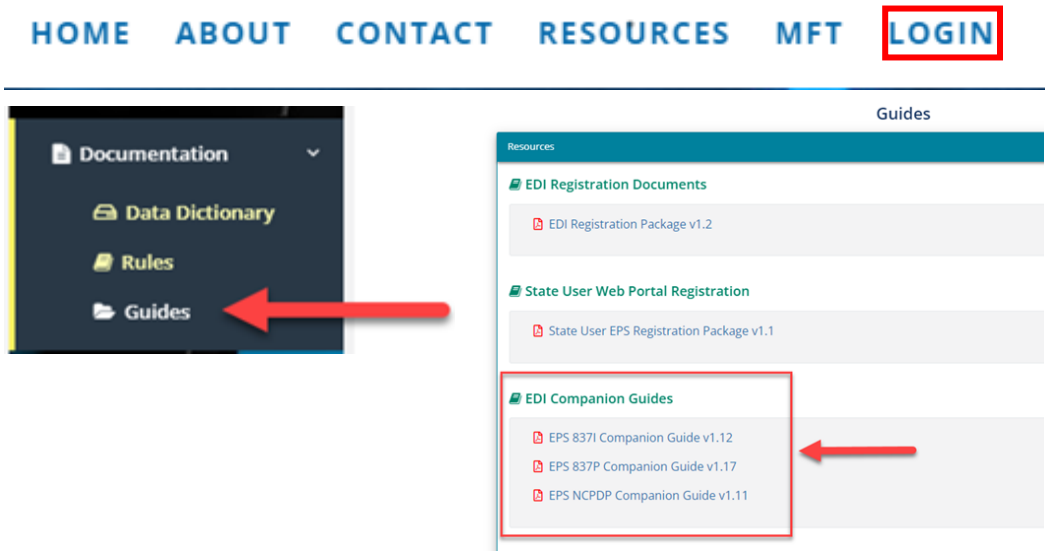
File Layout: Please refer to the latest version of the Advance Medical Home (AMH) and Tailored Care Management for Tailored and Prepaid Inpatient Health Plans Data Specifications requirements document for sharing Encounters & Historical Claims data encounters on the NC Medicaid website. Plans can access Encounter Processing System (EPS) for the most current Companion Guides (see path below). Health plans are to use the same file layouts they will use for sharing this data with AMHs/AMH+/CMA practices and/or their affiliated CINs.

Companion Guide File Names: *EPS 837I Companion Guide*

EPS 837P Companion Guide

EPS NCPDP Companion Guide

EPS Path:



File Naming Convention: Health Plans are expected to follow the file naming convention below. NCMT_<ClaimFileType>_<SourcePHPShortName>_< TargetPHPShortName >_ CCYYMMDD-HHMMSS.TXT

Below are the short names for each Health Plan and LME-MCO, use these for < SourcePHPShortName > & <TargetPHPShortName>:

- AmeriHealth = AMERI
- Healthy Blue = BCBS
- Carolina Complete Health = CCH
- United Health Care = UHC
- WellCare = WELLC
- Alliance Health = ALLIA
- Eastpointe = EASTP
- Partners Health Management = PARTN
- Sandhills Center = SANDH
- Trillium Health Resources = TRILL
- Vaya Health = VAYAH
- Alliance Health LME-MCO = ALLB
- Eastpointe LME-MCO= EASB
- Partners Health Management LME-MCO= PARB
- Sandhills Center LME-MCO= SANB
- Trillium Health Resources LME-MCO= TRIB

- Vaya Health LME-MCO= VAYB

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

- Medical Encounter Claim Professional Header = MEDENCCLMPHD
- Medical Encounter Claim Professional Line = MEDENCCLMPLN
- Medical Encounter Claim Institutional Header = MEDENCCLMIHD
- Medical Encounter Claim Institutional Line = MEDENCCLMILN
- Pharmacy Header = RXENCHD
- Pharmacy Line = RXENCLN
- Dental Header = DENCLMHD
- Dental Professional Line = DENCLMLN

Transmission Type: Secure File Transfer Protocol (sFTP)

File Delivery Frequency: Weekly (Saturday at midnight) - Full files for newly transitioned members within five days of new enrollment then followed by weekly incrementals

File Creation & Processing Rules:

1. Transferring health plans will receive information on disenrollment from them and enrollment with new health plans through the 834 files, which should trigger the creation of these files. Transferring health plans will have five days to send the new health plan 24 months of historical claims and encounters data followed by weekly incremental updates.
2. Receiving health plans should have the capability to load this data into the appropriate operational environments. In addition, health plans are required to share this data downstream as defined by the AMH Data Specification Guidance. The expectation is for health plans to use this data to 1) Support AMH/PCP Auto-assignment 2) Support additional care management functions 3) Tailored Care Management Assignment (if applicable).
3. Health plans are expected to ingest all claims records for beneficiaries that they have a record for in their eligibility system as recorded on the daily 834s. Health plans should be able to ingest claims records for beneficiaries with merged IDs. See more information on managing merged IDs in the Dependencies section below.
4. Health plans are expected to report any errors/exceptions to the Department following the process defined by the Department's technology operations team.
5. **Health plans should have the capability to perform duplicate claim checks logic to identify duplicate records as part of their loading and file ingestion of historical and incremental claim files received from NCTracks and other health plans.** The processes to identify duplicate records and/or recipients on claims/encounters/pharmacy full files and weekly incremental files should allow the health plans to perform these tasks without file processing delays that deviate from their normal file ingestion processes and time.
6. The health plan's duplicate claim check process should prevent duplicate records from being passed to their downstream providers.

File Delivery, Acceptance & Processing Validation: The Department established 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.

(3) *LME/MCOs to Health Plans or LME/MCOs: Behavioral Health Medical Claims*

Scope:

- 24 months (based on date of claims adjudication) of Behavioral Health Claims data, which includes claims adjudicated and claims received from a Standard Plan, Tailored Plan or another LME/MCO, for beneficiaries transitioning from an LME/MCO to a health plan or LME/MCO, after the health plan's managed care go-live date.
- NCTracks will send 24 months of Medical and Pharmacy claims and encounter data. Incremental weekly updates will be sent.
- Edits/updates to any historical claims and encounters.
- Any new encounters received in future due to claims lag.
- To comply with 42 CFR Part 2, health plans and LME/MCOs are required to remove SUD encounters if consent has not otherwise been secured.

Data Source: LME/MCOs

Data Target(s): Health Plans and LME/MCOs

File Layout: Refer to the latest version of the Advance Medical Home (AMH) and Tailored Care Management for Tailored and Prepaid Inpatient Health Plans Data Specifications requirements document for sharing Encounters & Historical Claims data encounters on the NC Medicaid website. Plans can access Encounter Processing System (EPS) for the most current Companion Guides (see path below). LME/MCOs are to use the same file layouts that they will use for sharing data with AMHs/AMH+/CMA practices and/or their affiliated CINs.

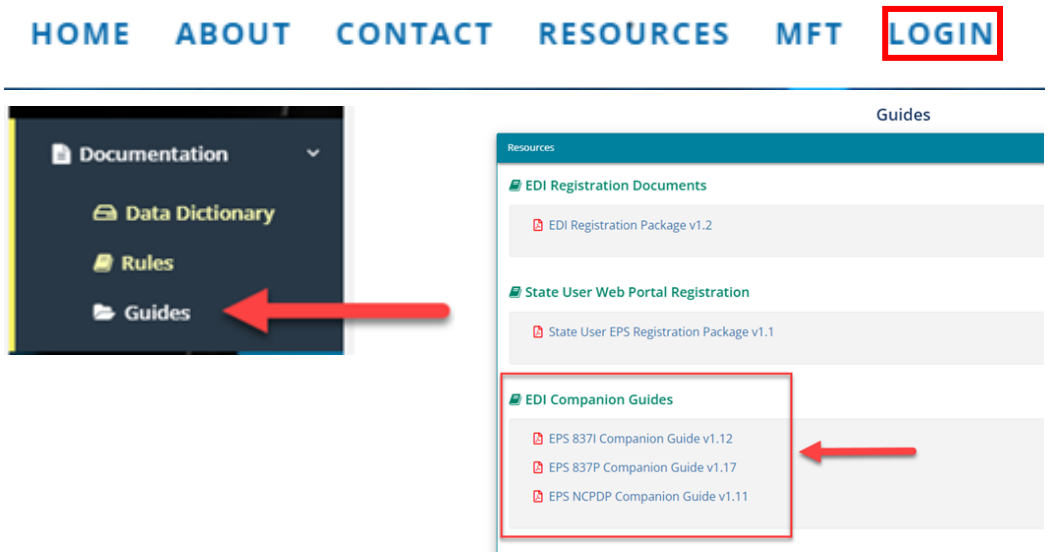
Companion Guide File Names:

EPS 837I Companion Guide

EPS 837P Companion Guide

EPS NCPDP Companion Guide

EPS Path:



File Naming Convention: LME-MCOs are expected to follow the below file naming convention. NCMT_<ClaimFileType>_<SourcePHPShortName>_< TargetPHPShortName >_ CCYYMMDD-HHMMSS.TXT

Below are the short names for each health Plan and LME/MCO, use these for < SourcePHPShortName > & <TargetPHPShortName>:

- AmeriHealth = AMERI
- Healthy Blue = BCBS
- Carolina Complete Health = CCH
- United Health Care = UHC
- WellCare = WELLC
- Alliance Health = ALLIA
- Eastpointe = EASTP
- Partners Health Management = PARTN
- Sandhills Center = SANDH
- Trillium Health Resources = TRILL
- Vaya Health = VAYAH
- Alliance Health LME-MCO = ALLB
- Eastpointe LME-MCO= EASB
- Partners Health Management LME-MCO = PARB
- Sandhills Center LME-MCO = SANB
- Trillium Health Resources LME-MCO= TRIB
- Vaya Health LME-MCO = VAYB

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

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

Transmission Type: Secure File Transfer Protocol (sFTP)

File Delivery Frequency: Weekly (Saturday at midnight) - Full files for newly transitioned members within five days that is new then weekly incremental.

File Creation & Processing Rules:

1. Transferring LME/MCOs receive information on disenrollment from them and enrollment with new receiving entity through the 834 files, this should trigger the creation of the files. Transferring LME/MCOs have five days to send the receiving entity 24 months of historical behavioral health claims and encounters data followed by weekly incremental updates.
2. The receiving entity should have the capability to load this data into the appropriate operational environments. In addition, health plans are required to share this data downstream as defined by the AMH Data Specification Guidance. Health plans are to use this data to 1) support AMH/PCP auto-assignment 2) support additional care management functions 3) Tailored Care Management assignment (if applicable).
3. Receiving entities are to ingest all claims records for beneficiaries they have a record for in their eligibility system as recorded on the daily 834. Health plans should be able to ingest claims records for beneficiaries with merged IDs. See more information on managing merged IDs in the Dependencies section below.
4. Health plans and LME/MCOs are to report any errors/exceptions to the Department following the process defined by the Department's technology operations team.
5. **Health plans should have the capability to perform duplicate claim checks logic to identify duplicate records as part of their loading and file ingestion of historical and incremental claim files received from NCTracks and other health plans.** The processes to identify duplicate records and/or recipients on claims/encounters/pharmacy full files and weekly incremental files should allow the health plan to perform these tasks without file processing delays that deviate from their normal file ingestion processes and time.
6. The health plan's duplicate claim check process should prevent duplicate records from being passed to their downstream providers.

File Delivery, Acceptance & Processing Validation: The Department established 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.

(4) Health Plans to LME/MCOs: A) NC Medicaid Direct Medical & Pharmacy Claims and LME/MCO (encounters data and B) Medical & Pharmacy Managed Care Encounters Data

Scope:

- 24 months (based on date of claims adjudication) of Medical & Pharmacy claims data for beneficiaries transitioning from a health plan to an LME/MCO after the health plan's managed care go-live date.
- Source health plan is responsible for identifying 24 months of historical data, this can be a combination of both historical NC Medicaid Direct Claims & Encounters and Managed Care Encounters data.
- All approved and denied claims and encounters for carved-in and carved-out services including but not limited to dental claims.
- Edits/updates to any historical claims and encounters.
- Any new claims/encounters t received in the future due to claims lag within the identified 24-month transition period.
- Ongoing carved-out services claims.
- To comply with 42 CFR Part 2, health plans are required to remove SUD claims and encounters if consent has not otherwise been secured.

Data Source: System: Health Plans

Data Target(s): LME/MCOs

File Layout: Refer to the latest version of the Advance Medical Home (AMH) and Tailored Care Management for Tailored and Prepaid Inpatient Health Plans Data Specifications requirements document for sharing Encounters & Historical Claims data encounters on the NC Medicaid website. Plans can access Encounter Processing System (EPS) for the most current Companion Guides (see path below). Health plans are to use the same file layouts they will use for sharing this data with AMHs/AMH+/CMA practices and/or their affiliated CINs.

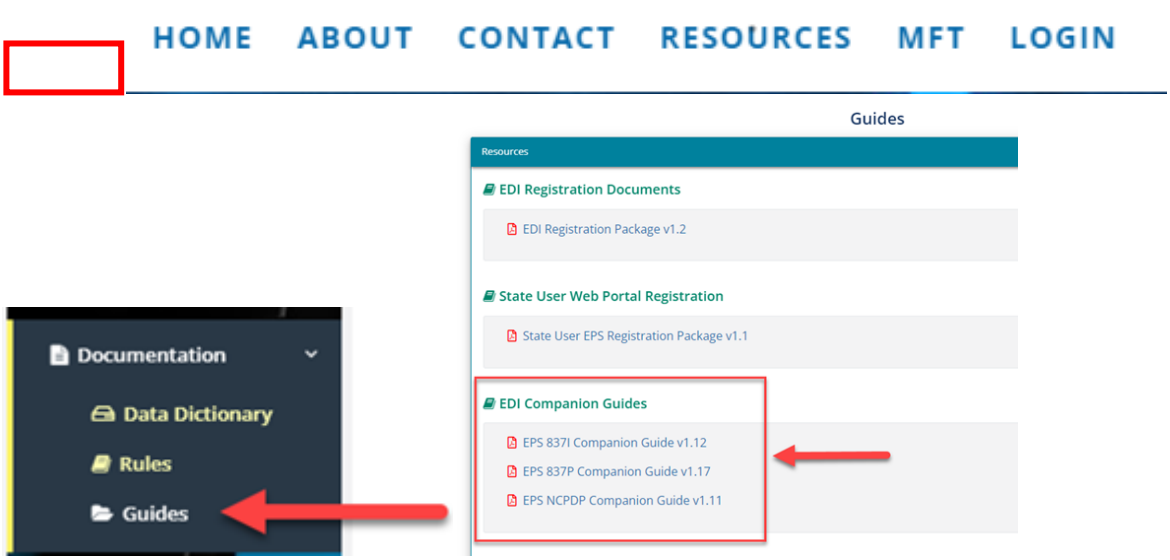
Companion Guide File Names:

EPS 837I Companion Guide

EPS 837P Companion Guide

EPS NCPDP Companion Guide

EPS Path:



File Naming Convention: Health plans are to follow the file naming convention below. NCMT_<ClaimFileType>_<SourcePHPShortName>_< TargetPHPShortName >_ CCYYMMDD-HHMMSS.TXT

Below are the short names for each health plan and LME/MCO, use these for < SourcePHPShortName > & <TargetPHPShortName>:

- AmeriHealth = AMERI
- Healthy Blue = BCBS
- Carolina Complete Health = CCH
- United Health Care = UHC
- WellCare = WELLC
- Alliance Health = ALLIA
- Eastpointe = EASTP
- Partners Health Management = PARTN
- Sandhills Center = SANDH
- Trillium Health Resources = TRILL
- Vaya Health = VAYAH
- Alliance Health LME-MCO = ALLB
- Eastpointe LME-MCO = EASB
- Partners Health Management LME-MCO = PARB
- Sandhills Center LME-MCO = SANB
- Trillium Health Resources LME-MCO = TRIB
- Vaya Health LME-MCO = VAYB

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

- Medical Encounter Claim Professional Header = MEDENCCLMPHD
- Medical Encounter Claim Professional Line = MEDENCCLMPLN
- Medical Encounter Claim Institutional Header = MEDENCCLMIHD
- Medical Encounter Claim Institutional Line = MEDENCCLMILN
- Pharmacy Header = RXENCHD
- Pharmacy Line = RXENCLN
- Dental Header = DENCLMHD
- Dental Professional Line = DENCLMLN

Transmission Type: Secure File Transfer Protocol (sFTP)

File Delivery Frequency: Weekly (Saturday at midnight) - Full files for newly transitioned members within five days of new enrollment then followed by the weekly incremental.

File Creation & Processing Rules:

1. Transferring health plans receive information on disenrollment from them and enrollment with new health plans through the 834 files, which should trigger the creation of these files. Transferring health plans have five days to send the new health plan 24 months of historical claims and encounters data followed by weekly incremental updates.
2. Receiving health plans should have the capability to load this data into the appropriate operational environments. In addition, health plans are required to share this data downstream as defined by the AMH Data Specification Guidance. The health plans are to use this data to 1) support AMH/PCP auto-assignment 2) support additional care management functions 3) Tailored Care Management assignment (if applicable).
3. Health plans are to ingest all claims records for beneficiaries they have a record for in their eligibility system as recorded on the daily 834. Health plans should be able to ingest claims records for beneficiaries with merged IDs. See more information on managing merged IDs in the Dependencies section below.
4. Health plans are to report any errors/exceptions to the Department following the process defined by the Department's technology operations team.
5. **Health plans should have the capability to perform duplicate claim checks logic to identify duplicate records as part of their loading and file ingestion of historical and incremental claim files received from NCTracks and other health plans.** The processes to identify duplicate records and/or recipients on claims/encounters/pharmacy full files and weekly incremental files should allow the health plans to perform these tasks without file processing delays that deviate from their normal file ingestion processes and time.
6. The health plans' duplicate claim check process should prevent duplicate records from being passed to their downstream providers.

File Delivery, Acceptance & Processing Validation: The Department established 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 need to follow these standards and report information to the Department to 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.

(5) Health Plans to Tribal Option: Medical & Pharmacy Managed Care Encounters data

Scope:

- 24 months (based on date of claims adjudication) of Medical & Pharmacy Encounter data for beneficiaries transitioning from a health plan to the Tribal Option after their managed care go-live date.
- All approved and denied encounters for carved in services.
- Edits/updates to any encounters.
- Any new encounters received in the future due to claims lag.
- To comply with 42 CFR Part 2, health plans are required to remove SUD encounters if consent has not otherwise been secured.

Data Source: Health Plans

Data Target(s): Tribal Option

File Layout: Refer to the latest version of the Advance Medical Home (AMH) and Tailored Care Management for Tailored and Prepaid Inpatient Health Plans Data Specifications requirements document for sharing Encounters & Historical Claims data encounters on the NC Medicaid website. Plans can access Encounter Processing System (EPS) for the most current Companion Guides (see path below). Health plans are to use the same file layouts they will use for sharing data with AMHs/AMH+/CMA practices and/or their affiliated CINs.

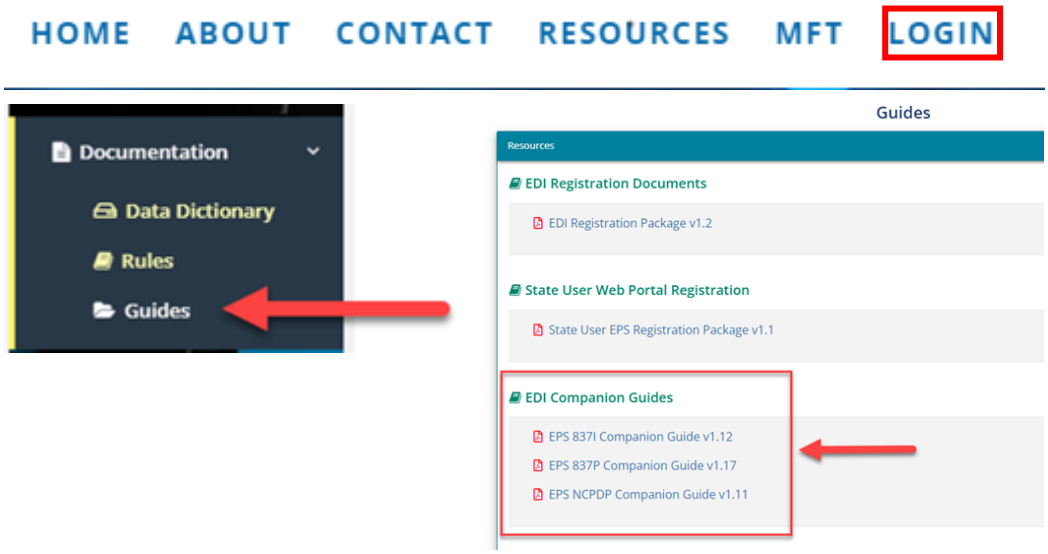
Companion Guide File Names:

EPS 837I Companion Guide

EPS 837P Companion Guide

EPS NCPDP Companion Guide

EPS Path:



File Naming Convention: Health plans are to follow the file naming convention below.

NCMT_<MedicalEncounterClaimData>_<PHPShortName>_<TribalEntity>_ CCYYMMDD-HHMMSS.TXT

Below are the short names for each health plan:

- Carolina Complete Health = CCH
- WellCare of North Carolina = WELLC
- UnitedHealthcare = UHC
- Healthy Blue = BCBS
- AmeriHealth Caritas = AMERI
- Alliance Health - ALLIA
- Eastpointe = EASTP
- Partners Health Management = PARTN
- Sandhills Center = SANDH
- Trillium Health Resources = TRILL
- Vaya Health = VAYAH
- Alliance Health LME/MCO = ALLB
- Eastpointe LME/MCO = EASB
- Partners Health Management LME/MCO = PARB
- Sandhills Center LME/MCO = SANB
- Trillium Health Resources LME/MCO = TRIB
- Vaya Health LME/MCO = VAYB

Note: LME/MCO to Tribal is not in the in scope of this document.

Below are the current short names for Tribal Option when sending claims and encounters:

- AmeriHealth = EBCI_TRIBAL
- Carolina Complete Health = CIHA
- Healthy Blue = TRIBALOPTION
- UnitedHealthCare = TRIBAL OP

WellCare of North Carolina = Tribal Below is the short name for the Tribal entity that future entities must use:

EBCI Tribal Option = TBOP

Below are the values that need to be used for Medical Encounter Claim Data:

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

Full and incremental files will use the same file naming convention. The file layout includes a data field “Full vs. Incremental” that needs to be appropriately populated to allow the target to identify the difference.

Transmission Type: Tribal Option Secure File Transfer Protocol (sFTP)

File Delivery Frequency: Weekly (Saturday at midnight) - Full files for newly transitioned members within five days that is new, then weekly incremental.

File Creation & Processing Rules:

1. Transferring health plans receive information on disenrollment from them and enrollment with the Tribal Option through the 834 files, this should trigger the creation of these files. Transferring health plans have five days to send the Tribal Option 24 months of encounters data followed by weekly incremental updates.
2. The Tribal Option should have the capability to load this data into the appropriate operational environments.
3. The Tribal Option is to use this data to support additional care management functions.
4. The Tribal Option is to ingest all claims records for beneficiaries that have a record for in their eligibility system as recorded on the daily 834. The Tribal Option should be able to ingest encounter records for beneficiaries with merged IDs.
5. Health plans and the Tribal Option are to report any errors/exceptions to the Department following the process defined by the Department’s Technology Operations (Tech Ops) team.
6. **Health plans should have the capability to perform duplicate claim checks logic to identify duplicate records as part of their loading and file ingestion of historical and incremental claim**

files received from NCTracks and other health plans. The process to identify duplicate records and/or recipients on claims/encounters/pharmacy full files and weekly incremental files should allow the health plans to perform these tasks without file processing delays that deviate from their normal file ingestion processes and time.

7. The health plan's duplicate claim check process should prevent duplicate records from being passed to their downstream providers.

Dependencies:

Beneficiary assignments: Health plans will receive information on beneficiaries assigned to them through the daily 834 files. Health plans are to load their beneficiary assignment prior to processing the claims files. Beneficiaries identified as Tribal Option will be reflected in the 834 2310 Loop (NM106). When the beneficiary is enrolled in the Tribal Option, "TRIBAL OP" will be returned on the 834.

(6) Health Plans to Community Care of North Carolina (CCNC): Medical & Pharmacy Managed Care Encounters data

Scope:

- 24 months (based on date of claims adjudication) of Medical & Pharmacy Encounter data for beneficiaries transitioning from a health plan to CCNC after the health plan's managed care go-live date.
- All approved and denied encounters for carved in services.
- Edits/updates to any encounters.
- Any new encounters received in future due to claims lag.
- To comply with 42 CFR Part 2, health plans are required to remove SUD encounters if consent has not otherwise been secured.

Data Source: Health Plans

Data Target(s): CCNC

File Layout: Refer to the latest version of the Advance Medical Home (AMH) & Tailored Care Management for Tailored and Prepaid Inpatient Health Plans Data Specifications requirements document for sharing Encounters & Historical Claims data encounters on the NC Medicaid website. Plans can access Encounter Processing System (EPS) for the most current Companion Guides (see path below). Health plans are to use the same file layouts they will use for sharing this data with AMHs/AMH+/CMA practices and/or their affiliated CINs.

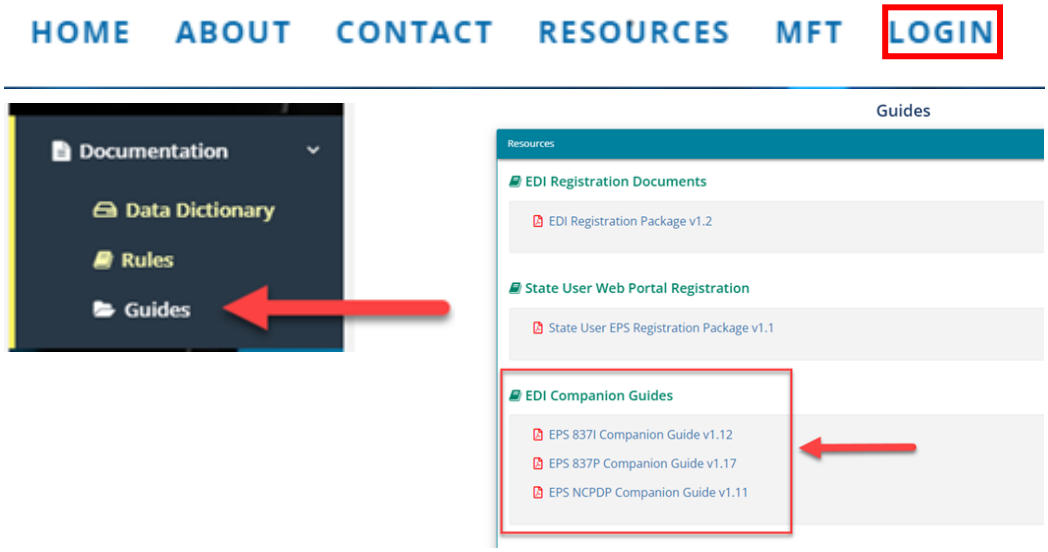
Companion Guide File Names:

EPS 837I Companion Guide

EPS 837P Companion Guide

EPS NCPDP Companion Guide

EPS Path:



File Naming Convention: Health plans are to follow the file naming convention below:

NCMT_<MedicalEncounterClaimData>_<PHPShortName>_<N3CN>_ CCYYMMDD-HHMMSS.TXT

Below are the short names for each Health Plan:

- Carolina Complete Health = CCH
- WellCare of North Carolina = WELLC
- UnitedHealthcare = UHC
- Healthy Blue = BCBS
- AmeriHealth Caritas = AMERI
- Alliance Health = ALLIA
- Eastpointe = EASTP
- Partners Health Management = PARTN
- Sandhills Center = SANDH
- Trillium Health Resources = TRILL
- Vaya Health = VAYAH

Below are the values to use for Medical Encounter Claim Data:

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

- Pharmacy Line = RXENCLN

Full and incremental files will use the same file naming convention. The file layout includes a data field "Full vs Incremental" that needs to be appropriately populated to allow the target to identify the difference.

Transmission Type: CCNC Secure File Transfer Protocol (sFTP)

File Delivery Frequency: Weekly (Saturday at midnight) - Full files for newly transitioned members within five days that is new then weekly incremental.

File Creation & Processing Rules:

1. Transferring health plans receive information on disenrollment from them and enrollment with NC Medicaid Direct (CCNC) through the 834 files, this should trigger the creation of these files. Transferring health plans will have five days to send CCNC 24 months of encounters data followed by weekly incremental updates.
2. CCNC should have the capability to load this data into the appropriate operational environments.
3. CCNC is to use this data to support additional care management functions.
4. CCNC is to ingest all claims records for beneficiaries that have a record for in their eligibility system as recorded on the daily 834. CCNC should be able to ingest encounter records for beneficiaries with merged IDs.
5. Health plans and CCNC are to report any errors/exceptions to the Department following the process defined by the Department's technology operations team.
6. **Health Plans should have the capability to perform duplicate claim checks logic to identify duplicate records as part of their loading and file ingestion of historical and incremental claim files received from NCTracks and other health plans.** The processes to identify duplicate records and/or recipients on claims/encounters/pharmacy full files and weekly incremental files should allow the health plans to perform these tasks without file processing delays that deviate from their normal file ingestion processes and time.
7. The health plans duplicate claim check process should prevent duplicate records from being passed to their downstream providers.

File Delivery, Acceptance & Processing Validation: The Department established 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 to 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.

Dependencies:

Beneficiary assignments: Health plans receive information on beneficiaries assigned to them through the daily 834 files. Health plans are to load their beneficiary assignment prior to processing the claims files. Beneficiaries identified as CCNC will be reflected in the 834 2310 Loop (NM106). When the recipient is assigned to CCNC, "CCNC" will be returned on the 834.