NC Medicaid Managed Care

Requirements for sharing Prior Authorization Data to support Continuity of Care for Beneficiaries transitioning between Medicaid Direct & PHPs

4/27/2022

Change Log		
Version	**Date**	**Updates/Change Made**
2.0		Initial Publication

3.0	11/5/2020	• Pharmacy PA Update
		  ○ Updated default value guidance in Pharmacy PA layout
		  ○ Added section for Pharmacy PAs – NDC/GSN requirement

4.0	2/8/2021	• Updates to the Medical PA and Pharmacy PA Formats • Clarifications on process
5.0	2/18/2021	• Updated LME-MCO PA DED • Correction to Medical PA Format
5.1	3/26/2021	• Updated PHP to Department file naming convention
5.2	5/10/2021	• Updated PHP to Department Medical PA files naming convention
5.3	7/2/2021	• Updated NC Tracks PHP Valid Values
6.0	10/1/2021	• Updating to include requirements for both Standard Plans and Tailored Plans
7.0	1/31/2022	• Removed embedded documents and replaced with reference to their new file names and paths within PCDU • Minor formatting changes/fixes • Updated page numbers for documents table
7.1	4/27/2022	• Added description above documents table on page 3 • Added reference to companion guides to the documents table on page 3 • Updated reference to BCM046 and BCM047 files in documents table on page 3 • Loaded new document to PCDU

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

Documents	Section	Page
PA_TOCDPPH_MedicalFileLayout_MMDDYYYY.doc	*(1) Department of PHPs: Medical Prior Authorization*	5
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" MMDDYYYY" in file names denotes the most recent date when the file was updated.

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Medical Prior Authorizations:

(1) Department to PHPs: Medical Prior Authorizations

Scope:

- All Prior Authorizations approved by the Department and its UM Vendors for beneficiaries who transition from Medicaid Direct to a PHP with a PA end date greater than the PHP Managed Care coverage effective date
- All Prior Authorizations closed within 60 days of the beneficiary's PHP coverage effective date
- Incremental files will include any new, updated or modified prior authorizations for beneficiaries with prior authorizations previously sent, along with any prior authorization data for newly assigned beneficiaries
- In order to comply with 42 CFR Part 2, Prior Authorizations that meet the 42 CFR Part 2 criterion will not be transferred

Data Source: NCTracks

Data Target(s): PHPs and PIHPs

File Layout: The Department has established a file layout to send Medical PA data from NC Tracks to PHPs and a DED supporting the Medical PA file layout. These files are maintained on the PCDU at the paths below.

File Names:
PA_TOCDPPH_MedicalFileLayout_MMDDYYYY.doc
PA_TOCDPPH_MedicalPAFileLayoutDED_MMDDYYYY.xlsx

Standard Plan Path:

/ Library Documents / Standard Plan / Guidance Documents / C_Benefits_and_Care_Management

Tailored Plan Path:

/ Library Documents / Tailored Plan / Guidance Documents / B.2- Medicaid - Benefits

File Naming Convention:

PA_MEDICAL_EXTRACT_DATA_XXXXX-CCYYMMDD-HHMMSS.TXT, with XXXXX being a short name for each PHP. Below are the short names for each PHPs:

PHP Short Name	PHP
CCH	Carolina Complete Health
WELLC	WellCare of North Carolina
UHC	UnitedHealthcare
BCBS	HealthyBlue
AMERI	AmeriHealth Caritas
ALLT	Alliance Health
EAST	Eastpointe
PART	Partners Health Management

SANT	Sandhills Center
TRIT	Trillium Health Resources
VAYT	Vaya Health

File Type: Fixed width flat file

Transmission Type: Secure File Transfer Protocol (sFTP) on GDIT's Move IT Site

File Delivery Frequency & Processing Rules: Daily – with full and incremental data

1. Prior to PHP Managed Care Launch, PHPs will receive an initial full PA file for all beneficiaries that are assigned to them. This will be followed by daily files.
2. PHPs are expected to pick up these files daily, process and load this data for all beneficiaries that are assigned to them, in their respective systems that allows them to meet all the contractual obligations and requirements related to Prior Authorizations that are outlined in the PHP contract. Outlined below are key functions that PHPs are expected to support using this data:
    a. Pay future claims that they will receive from the Providers for the remaining units on these PAs
    b. Support Care Management functions
    c. Support continuity of care for beneficiaries transitioning from Medicaid Direct or subsequently to another PHP or back to Medicaid Direct. The transferring PHP is expected to send all approved PA data to the receiving PHP or Medicaid Direct
    d. Support any data reconciliation efforts related to this data. If the PHP has altered PA data due to their respective operational business rules (i.e., PA effective begin date to align with effective eligibility date), then they should ensure that original source is also stored with them to support any reconciliation efforts and transition of care
3. PHPs will receive updates on existing approved prior authorizations through the daily files. They are expected to update respective prior authorizations within their operational systems with these updates up until the beneficiary's standard plan or tailored plan coverage effective date. After a beneficiary's PHP Effective Date (Medicaid Direct to PHP) the PHP is no longer required to load updates to previously approved PAs from Medicaid Direct into their operational system (i.e., Member TP effective date is 1/1/2023, NC Track sends PA#1 for dos 10/1/2022-12/31/2022 with 2 units and a PA#2 for dos 10/01/2022-2/1/2023 with 2 units. Both PAs are updated to 3 units, the PHP would only be required to update PA#2). They are required to load any newly approved PAs.
4. PHPs will be expected to load prior authorizations even if there are data fields that are not aligned with their operation systems. The following rules have been established for certain data fields:
    a. **Medicaid PA ID:** PHPs should store the reference Medicaid PA ID in their data warehouse if they are unable to load into their operational system.
    b. **Medicaid Recipient ID:** PHPs should store the MID in their data warehouse if they are unable to load into their operational system.
        i. **Merged ID:** PHPs should be able to ingest PA records for beneficiaries with merged IDs
    c. **PA Type Code:** If PHPs are unable to load the PA Type Code into their operation system, then they should be loading into their data warehouse
    d. **Requested Begin Date:** If PHPs are unable to load Requested Begin Date into their operational system, then they should be loading into their data warehouse

e. **Requested End Date:** If PHPs are unable to load Requested End Date into their operational system, then they should be loading into their data warehouse
f. **PA Effective Begin Date:** If the effective begin date is before the Standard Plan or Tailored Plan Eligibility then the PHPs can align the effective begin date in their operation system with the eligibility begin date. PHPs should store the original effective begin date (pre-eligibility) in their warehouse
g. **PA Effective End Date:** If the PA effective End Date is before the Standard Plan or Tailored Plan Effective date then it should be stored in your Warehouse for reference for reauthorization and transferable to a receiving PHP. If the Effective End Date is outside of your management system policy (>365 days) then you should either include the original end date somewhere within your operation system (notes section) or store it in your Data warehouse.
h. **Billing Provider NPI:** If the PHPs are unable to load the Billing Provider, then the PHP should be loading into their data warehouse
i. **Rendering Provider NPI:** PHPs should be loading servicing/rendering provider into their operation system
j. **Blank Rendering NPI:** If there is a blank rendering NPI for a certain PA Type, then the PHP is expected to assign a default code to such field and load into their management system. This is common for PA Type A11 (LTC PA)
k. **Blank Procedure Code:** If there is a blank Procedure code for a certain PA Type, then the PHP is expected to assign a default code to such field and load into their management system.
l. **Scrubbed Prior Authorizations:** Due to 42 CFR Part 2, Prior Authorizations that meet the 42 CFR Part 2 criterion will not be transferred

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 Medicaid Direct 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: PHPs will receive information on beneficiaries assigned to them through the daily 834 files. PHPs are expected to load their beneficiary assignment prior to processing the PA files.
- Member Cross Reference IDs/Merged Member IDs: Beneficiaries can have multiple Member IDs and those values are included in the 834 file – please refer to the 834 Companion Guide for appropriate loop and reference. PHPs are expected to use that data to link beneficiaries with multiple IDs with their active Member ID and properly ingest and map PA data with the appropriate active Member ID.
- Provider Data: PHPs will receive Medicaid Provider data through the PEF Provider file and are expected to load that prior to processing the PA files.

(2) PHPs to Department: Medical Prior Authorizations

Scope:

- All approved Prior Authorizations for beneficiaries who are transitioning from PHPs to Medicaid Direct after PHP Managed Care go-live date, with PA end date greater than Medicaid Direct coverage effective date
- Services included in the below document (maintained on the PCDU at the paths below) should be used to identify LME-MCO prior authorizations.
  File Name: *PA_TOCPHDP_LMEMCOServiceCodes_MMDDYYYY.pdf*

  Standard Plan Path:

  / Library Documents / Standard Plan / Guidance Documents / C_Benefits_and_Care_Management

  Tailored Plan Path:

  / Library Documents / Tailored Plan / Guidance Documents / B.2- Medicaid - Benefits
- PHPs are required to accept Prior Authorization requests up until 11:59:59pm the night before the Medicaid Direct effective date. The transferring PHP has 14 calendar days after the new Medicaid Direct effective date to adjudicate any open and in process PAs.
- PHPs are not required to send incremental updates after the Medicaid Direct effective date to previously approved PAs. The PHPs should only send newly approved PAs (within 14 days of the Medicaid Direct effective date) with a PA effective date that is after the member's Medicaid Direct effective date. These post-effective date, newly approved PAs constitute the daily file.
- In order to comply with 42 CFR Part 2, PHPs are required to remove PAs that meet the 42 CFR Part 2 criterion unless they have received consent from the beneficiary to share that data and transfer consent form to the receiving entity. PHPs should not send SUD related PAs where consent has not been obtained.

Data Source: PHPs

Data Target(s): NC Tracks

File Layout: The Department has established that the BCM046 file layout for the Medical PA Extract must be used to send Medical PA data from PHPs to NC Tracks. This format will be used to support continuity of care when beneficiaries move from a Standard Plan or Tailored Plan to Medicaid Direct. Rules may differ due to NC Tracks requirements for valid values. This file is maintained on the PCDU at the paths below.
File Name: *BCM046-J Medical Prior Authorization Extract_T_2021_v06.xlsx*

Standard Plan Path:

/ Library Documents / Standard Plan / Report Templates / C_Benefits_and_Care_Management

Tailored Plan Path:

/ Library Documents / Tailored Plan / Report Templates / B.2- Medicaid - Benefits

The Department has also developed a Companion Guide that the PHPs should use to produce valid values for Medicaid Direct to properly ingest. The Companion Guide is a living document and is maintained on PCDU at the paths below.

File Name: *NCMMIS_WPDT_CG_02.14.22_Med PA.pdf*

Standard Plan Path:

/ Library Documents / Standard Plan / Guidance Documents / C_Benefits_and_Care_Management

Tailored Plan Path:

/ Library Documents / Tailored Plan / Guidance Documents / B.2- Medicaid - Benefits

File Naming Convention:

The file naming standard is PA_MEDICAL_EXTRACT_DATA_XXXXXXXX_CCYYMMDD_ HHMMSS.TXT, with XXXXXXXX being the PHP ID for each PHP.
The file name is populated per the following rules:
1. PHP Name varies according to the entity that creates the file and uses the PHP ID in other NCTracks managed care files. Valid values are:

AMESTC00	AmeriHealth Caritas North Carolina
BLUSTC01	HealthyBlue
CARSTP02	Carolina Complete Health
UNISTC03	United Healthcare of North Carolina
WELSTC04	Well Care of North Carolina
ALLTAL00	Alliance Health
EASTAL01	Eastpointe
PARTAL02	Partners Health Management
SANTAL03	Sandhills Center
TRITAL04	Trillium Health Resources
VAYTAL05	Vaya Health

2. CCYYMMDD is the date the file is posted to the NCTracks server.
3. HHMMSS is the file timestamp where midnight is 000000 and noon is 120000.
4. The file extension of TXT is used for all PA files.

Example of files name:

- PA_MEDICAL_EXTRACT_DATA_AMESTC00_20210801_152512.TXT

For test files, EXTRACT is replaced with TEST in the file name.

- PA_MEDICAL_TEST_DATA_WELSTC04_CCYYMMDD_HHMMSS.TXT

File Type: Fixed width flat file

Transmission Type: Secure File Transfer Protocol (sFTP) on GDIT's Move IT Site

File Delivery Frequency & Creation Rules: Daily – Full files followed by daily files

1. PHPs are expected to send a full Medical PA file to the Department the day before the beneficiary's new Medicaid Direct effective date. If the PHP receives a PA request after that initial PA file transfer but before the member disenrolls then the PHP will process according to

standard SLAs (within 14 days of receipt), even if the review extends beyond the member's disenrollment date. If this review results in a newly approved prior authorization after the Medicaid Direct effective date, then the PHP should send the newly approved PA in a daily file. This daily file will not include any updates to Prior Authorizations previously sent. This information will be available in the future eligibility segments in the 834 file and PHPs are expected to use that data to trigger the flow of PA data to the Department.

2. PHPs are not expected to send any data to the Department for any Beneficiaries who will transition into Medicaid Direct prior to PHP Managed Care Launch.
3. PHPs are expected to send approved prior authorizations. If a state approved PA that the PHP received when the beneficiary transitioned from Medicaid Direct to Standard Plan or Tailored Plan is still active and PHPs have updated the PA data, then they are expected to send the updated PA information to the Department. If the PA received from Medicaid Direct does not include a procedure code, it can be omitted in file transfers back to NC Tracks.
4. PHPs are expected to ensure that they do not accept or process any new PAs for the beneficiaries that have transitioned to Medicaid Direct after their Medicaid Direct coverage effective date. For example: Beneficiary moves back into Medicaid Direct with coverage effective date of 8/1/2021. PHPs should not accept PA requests received after 8/1/2021 for this beneficiary and advise the Provider to submit those to Medicaid Direct.

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 Medicaid Direct 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.

Processing Rules

- The Department has worked with NC Tracks to establish guidance on valid values and rules for sending Prior Authorizations to NC Tracks. These rules can be found in the Companion Guide.
- For NC Tracks to ingest PAs, the PHPs must produce a proprietary PA Type field based on the procedure code to PA Type mapping provided by GDIT. This mapping information is located within the Procedure Code to PA Type Crosswalk, which is delivery weekly through the GDIT MoveIT site.
- If there are multiple PA Types for procedure codes at the line level, then the PHPs must split the PA to ensure that there is one unique PA Type at the header level with applicable procedure codes at the line for that particular PA Type.
- If a PA Type cannot be mapped to the procedure code based on the information given, then the PHP should assign a default A00 code
    - For PAs that are assigned an A00 default code there should be only one detail line. A unique PA should be created for each A00 default line

After processing the PHP file, NC Tracks will create a reject file containing the details of all rejected files from the PHP. The file will be posted in the PHP's outbound server folder. The format of this file can be found in the PHP Medical File Companion Guide on the PCDU. Rejected PAs are expected to be reviewed, corrected, and resubmitted on a subsequent daily file within 5 business days of the rejection.

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 Medicaid Direct 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 enrollment changes: PHPs will receive information on beneficiary's enrollment changes through the daily 834 files. PHPs are expected to load and use that data to trigger generation of PA files to appropriate target.
- Member Cross Reference IDs/Merged Member IDs: Beneficiaries can have multiple Member IDs and those values are included in the 834 file – please refer to the 834 Companion Guide for appropriate loop and reference. PHPs are expected to use that data to link beneficiaries with multiple IDs with their active Member ID and properly ingest and map PA data with the appropriate active Member ID.

(3) PHPs to PHPs (TPs and SPs): Medical Prior Authorizations

Scope:

- All approved Prior Authorizations for beneficiaries who are transitioning from one PHP to another after PHP Managed Care launch, with PA end date greater than the receiving PHP coverage effective date.
- PHPs are also required to include Prior Authorization History with an end date 60 days prior to the receiving PHP effective date.
- Sending PHPs are required to accept Prior Authorization requests up until 11:59:59pm the night before the Receiving PHP's effective date. The sending PHP has 14 calendar days after the receiving PHP's effective date to approve/deny any open and in process PAs.
- PHPs are not required to send daily updates to PAs after the receiving PHP's effective date, only newly approved PAs (within the 14 days) should be sent in the daily updates.
- In order to comply with 42 CFR Part 2, PHPs are required to remove PAs that meet the 42 CFR Part 2 criterion unless they have received consent from the beneficiary to share that data and transfer consent to the receiving entity. PHPs should not send SUD related PAs where consent has not been obtained.

Data Source: PHPs

Data Target(s): PHPs

File Layout: The Department has established that the BCM046 file layout for the Medical PA Extract must be used to send Medical PA data from PHPs to PHPs. This format will be used to support continuity of care when beneficiaries move between PHPs. Rules may differ due to differing Transition of Care requirements for valid values. This file is maintained on the PCDU at the paths below.
File Name: *BCM046-J Medical Prior Authorization Extract_T_2021_v06.xlsx*

Standard Plan Path:

/ Library Documents / Standard Plan / Report Templates / C_Benefits_and_Care_Management

Tailored Plan Path:

/ Library Documents / Tailored Plan / Report Templates / B.2- Medicaid - Benefits

File Naming Convention:

PA_MEDICAL_EXTRACT_DATA_XXXXX_YYYYY-CCYYMMDD-HHMMSS.TXT, with XXXXX being a short name for each Transferring PHP and YYYYY being a short name for Target PHP. Below are the short names for each PHPs:

PHP Short Name	PHP
CCH	Carolina Complete Health
WELLC	WellCare of North Carolina
UHC	UnitedHealthcare
BCBS	HealthyBlue
AMERI	AmeriHealth Caritas
ALLT	Alliance Health
EAST	Eastpointe
PART	Partners Health Management
SANT	Sandhills Center
TRIT	Trillium Health Resources
VAYT	Vaya Health

File Type: Fixed width flat file

Transmission Type: Secure File Transfer Protocol (sFTP)

File Delivery Frequency, Creation & Processing Rules: Daily – Full files followed by daily files

1. A transferring PHP (PHP 1) is expected to send a full Medical PA file to a receiving PHP (PHP 2) the day before the beneficiary's new PHP 2 Effective date. If PHP 1 receives a PA request after that initial PA file transfer, but before the member disenrolls, PHP 1 will process according to standard SLAs (within 14 days of receipt), even if review extends beyond the member's disenrollment date. If this review results in a newly approved prior authorization after PHP 2's effective date, then PHP 1 should send such newly approved prior authorizations in a daily file. This daily file will not include any updates to Prior Authorizations PHP 1 sent in original PA file. Information on Receiving PHP will be available in the future eligibility segments in the 834 file and PHPs are expected to use that data to trigger this process.
2. Transferring PHPs are not expected to send any data to the Receiving PHP for any Beneficiaries who will transition to another PHP prior to PHP Managed Care Launch.
3. Transferring PHPs are expected to send approved prior authorizations in their system for a beneficiary that will be transitioning to a new PHP.
4. Sending PHPs are not required to send historical PAs from GDIT or LME-MCOs to a receiving PHP.
5. PHPs are expected to ensure that they do not accept or process any new PAs for the beneficiaries that have transitioned to a new PHP after their coverage effective date with the

new PHP. For example: Beneficiary is currently assigned to PHP 1 and moves to PHP 2 with coverage effective date of 8/1/2021. PHP 1 should not accept PA requests for Beneficiary on or after 8/1/2021 and advise the Provider to submit those to the PHP 2.

6. Receiving PHPs are expected to process and load this data for all beneficiaries that are assigned to them, in their respective systems that allows them to meet all the contractual obligations and requirements related to Prior Authorizations that are outlined in the PHP contract. Outlined below are key functions that PHPs are expected to support using this data:
    a. Pay future claims that they will receive from the Providers for the remaining units on these PAs
    b. Support Care management functions
    c. Support continuity of care for beneficiaries transitioning from them to another PHP or Medicaid Direct. The transferring PHP is expected to send all approved PA data to the receiving PHP or to Medicaid Direct
    d. Support any data reconciliation efforts related to this data. If the PHP has altered PA data due to their respective operational business rules (i.e., PA effective begin date to align with effective eligibility date), then they should ensure that original source is also stored with them to support any reconciliation efforts and transition of care
7. Receiving PHPs will be expected to load prior authorizations even if there are data fields that are not aligned with their operation systems.
8. Both Transferring and Receiving systems/entities are expected to report integration monitoring and incident/defect reporting data for this interface based on the requirements of the Department's Technology Operations (TechOps) team.

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.

Dependencies:

- Beneficiary enrollment changes: Both Transferring and Receiving PHPs will receive information on beneficiary's enrollment changes through the daily 834 files. They are expected to load and use that data to trigger generation of PA files to appropriate target. This data will be available through current and future segments in the 834 files.
- Member Cross Reference IDs/Merged Member IDs: Beneficiaries can have multiple Member IDs and those values are included in the 834 file – please refer to the 834 Companion Guide for appropriate loop and reference. PHPs are expected to use that data to link beneficiaries with multiple IDs with their active Member ID and properly ingest and map PA data with the appropriate active Member ID.
- Provider Data: Receiving PHPs will receive Medicaid Provider data through the PDC Provider file and are expected to load that prior to processing the PA files.

Pharmacy Prior Authorizations:

(1) Department to PHPs: Pharmacy Prior Authorizations

Scope:

- All approved Pharmacy Prior Authorizations approved by the Department and its UM Vendors for beneficiaries who are transitioning from Medicaid Direct to a PHP with PA end date greater than PHP Managed Care coverage effective date
- All Prior Authorizations closed within 45 days of the beneficiary's PHP coverage effective date
- Daily files will include any new, updated or modified prior authorizations for beneficiaries with prior authorizations previously sent, along with any prior authorization data for newly assigned beneficiaries. After a beneficiary's Effective Date (Medicaid Direct to PHP) the PHP is no longer required to load updates to previously approved PAs from Medicaid Direct into their operational system. They are required to load any newly approved PAs.
- In order to comply with 42 CFR Part 2, Prior Authorizations that meet the 42 CFR Part 2 SUD criterion will not be transferred.

Data Source: NC Tracks

Data Target(s): PHPs

File Layout: The Department has established a file layout to send Pharmacy Prior Authorization files between NC Tracks and PHPs and a DED supporting the Pharmacy PA file layout. These files are maintained on the PCDU at the paths below.
File Names:
PA_TOCDPPH_PharmPAFileLayout_MMDDYYYY.docx
PA_TOCDPPH_PharmPAFileLayoutDED_MMDDYYYY.xlsx

Standard Plan Path:

/ Library Documents / Standard Plan / Guidance Documents / C_Benefits_and_Care_Management

Tailored Plan Path:

/ Library Documents / Tailored Plan / Guidance Documents / B.2- Medicaid - Benefits

File Naming Convention:

PA_PHARMACY_EXTRACT_DATA_XXXXX-CCYYMMDD-HHMMSS.TXT, with XXXXX being the PHP ID for each PHP. Below are the PHP ID for each PHPs:

PHP ID	PHP FULL NAME
AMESTC00	AmeriHealth Caritas North Carolina
BLUSTC01	Blue Cross and Blue Shield of North Carolina
CARSTP02	Carolina Complete Health
UNISTC03	United Healthcare of North Carolina
WELSTC04	Well Care of North Carolina
ALLTAL00	Alliance Health
EASTAL01	Eastpointe
PARTAL02	Partners Health Management
SANTAL03	Sandhills Center
TRITAL04	Trillium Health Resources

VAYTAL05	Vaya Health

File Type: Fixed width flat file

Transmission Type: Secure File Transfer Protocol (sFTP) on GDIT's Move IT Site

File Delivery Frequency & Processing Rules: Daily - Full files with daily files

1. PHPs will receive an initial full file for all beneficiaries that are assigned to them. This will be followed by daily files
2. PHPs are expected to pick up these files daily, process and load this data for all beneficiaries that are assigned to them, in their respective systems that allows them to meet all the contractual obligations and requirements related to Prior Authorizations that are outlined in the PHP contract. Outlined below are key functions that PHPs are expected to support using this data:
    a. Pay future claims that they will receive from the Providers for the remaining units on these PAs
    b. Support Care management functions
    c. Support continuity of care for beneficiaries transitioning from Medicaid Direct or subsequently to another PHP or back to Medicaid Direct. The transferring PHP is expected to send all approved PA data to the receiving PHP or Medicaid Direct
    d. Support any data reconciliation efforts related to this data. If the PHP has altered PA data due to their respective operational business rules (i.e., PA effective begin date to align with effective eligibility date), then they should ensure that original source is also stored with them to support any reconciliation efforts and transition of care
3. PHPs will receive updates on existing approved prior authorizations through the daily files. They are expected to update respective prior authorizations within their operational systems with these updates up until the beneficiary's PHP Managed Care coverage effective date. After a beneficiary's PHP Managed Care Effective Date (Medicaid Direct to PHP) the PHP is no longer required to load updates to previously approved PAs from Medicaid Direct into their operational system. They are required to load any newly approved PAs.
4. PHPs will be expected to load prior authorizations even if there are data fields that are not easily translated into their operational systems. The following rules have been established for certain data fields:
    a. Medicaid PA ID: PHPs should store the reference Medicaid PA ID in their data warehouse if they are unable to load downstream system. Claim that comes through will likely have the reference ID
    b. Medicaid Recipient ID: PHPs should store the MID in their data warehouse if they are unable to load into their operation system.
    c. Merged ID: PHPs should be able to ingest PA records for beneficiaries with merged IDs
    d. PA Type Code: If PHPs are unable to load the PA Type Code into their operation system, then they should be loading into their data warehouse
    e. Requested Begin Date: If PHPs are unable to load Requested Begin Date into their operational system, then they should be loading into their data warehouse
    f. Requested End Date: If PHPs are unable to load Requested End Date into their operational system, then they should be loading into their data warehouse
    g. PA Effective Begin Date: If the effective begin date is before the Managed Care Eligibility, then the PHPs can align the effective begin date in their operation system

with the eligibility begin date. PHPs should store the original effective begin date (pre-eligibility) in their warehouse

h. **PA Effective End Date:** If the PA effective End Date is before the PHP Managed Care Effective date, then it should be stored in your Warehouse for reference for reauthorization and transferable to a receiving PHP. If the Effective End Date is outside of your management system policy (>365 days) then you should either include the original end date somewhere within your operation system (notes section) or store it in your Datawarehouse. Operational expectation is for the PA to be renewed per the original end date or appeal rights are required.
i. **Billing Provider NPI:** If the PHPs are unable to load the Billing Provider, then the PHP should be loading into their data warehouse
j. **LI-REQ-30-DAY-UNITS:**
k. **FDB-DRUG-CD/DRUG-CD:** If the PHPs are unable to load a prior authorization due to a proprietary GDIT drug name, the PHPs are expected to use the Drug Name to NDC crosswalk file being sent by GDIT to load the prior authorization record.
l. **Scrubbed Prior Authorizations:** Due to 42 CFR Part 2, Prior Authorizations that meet the 42 CFR Part 2 SUD criterion will not be transferred

5. Both Source & Target systems/entities are expected to report integration monitoring and incident/defect reporting data for this interface based on the requirements of the Department's Technology Operations (Tech Ops) team.

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.

Dependencies:

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

(2) PHPs to Department: Pharmacy Prior Authorizations

Scope:

- All approved Prior Authorizations for beneficiaries who are transitioning from PHP to Medicaid Direct after PHP Managed Care go-live date, with PA end date greater than Medicaid Direct coverage effective date.

- PHPs are required to accept Prior Authorization requests up until 11:59:59pm the night before the Medicaid Direct effective date. The sending PHP has 14 calendar days after the new Medicaid Direct effective date to adjudicate any open and in process PAs.
- PHPs are not required to send daily updates after the Medicaid Direct effective date to previously approved PAs. The PHPs should only send newly approved PAs (within 14 days of Medicaid Direct effective date) after Medicaid Direct effective date. These post-effective date, newly approved PAs constitute the daily file.
- In order to comply with 42 CFR Part 2, PHPs are required to remove PAs that meet the 42 CFR Part 2 criterion unless they have received consent from the beneficiary to share that data. PHPs should not send SUD related PAs where consent has not been obtained.

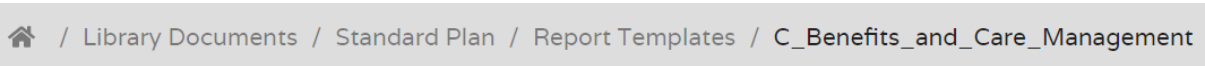
Data Source: PHPs

Data Target(s): NC Tracks

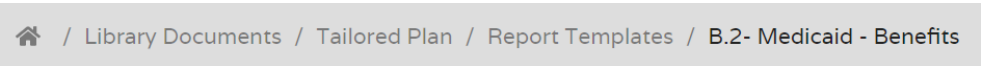
File Layout: The Department has established that the BCM047 file layout for the Pharmacy PA Extract must be used to send Pharmacy PA data from PHPs to NC Tracks. This format will be used to support continuity of care when beneficiaries move from PHPs to Medicaid Direct. Rules may differ due to NC Tracks requirements for valid values. This file is maintained on the PCDU at the paths below.

File Name: *BCM047-J PharmPALayout_T_2021_v05.xlsx*

Standard Plan Path:

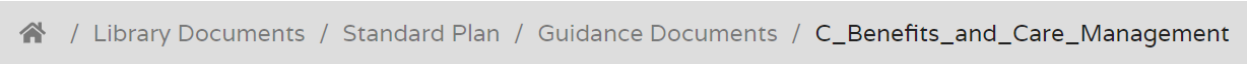


Tailored Plan Path:

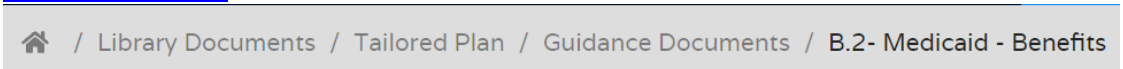


NC Tracks has also developed a Companion Guide that the PHPs should be using to ensure the proper values are sent to NC Tracks. This file is maintained on the PCDU at the paths below.
File Name: *NCMMIS_WPDT_CG_02.14.22_Med PA.pdf*

Standard Plan Path:



Tailored Plan Path:



File Naming Convention:

The format of the file name is as follows:

<File Identifier>_ <PHP Name>_<Date>_<Time>.txt

Each segment of the file name is populated according to the following rules:

- File Identifier is the constant value 'PA_PHARMACY_INPUT' which refers to Pharmacy PA

- PHP Name varies according to the entity that creates the file. Valid values are BLUSTC01, CARSTP02, UNISTC03, WELSTC04, AMESTC00, ALLTAL00, EASTAL01, PARTAL02, SANTAL03, TRITAL04, VAYTAL05
- Date represents the date the file is sent, in CCYYMMDD format
- Time represents the time the file is sent, in HHMMSS format, where midnight is 000000 and noon is 120000
- The file extension, 'TXT', will be used for all file names.

Examples of files names are provided below:

- PA_PHARMACY_INPUT_BLUSTC01_20210704_000000.TXT

File Type: Fixed width flat file

Transmission Type: Secure File Transfer Protocol (sFTP) on GDIT's Move IT Site

File Delivery Frequency & Creation Rules: Daily – Full files followed by daily files

1. PHPs are expected to send a full Pharmacy PA file to the Department the day before the beneficiary's new Medicaid Direct effective date. If the PHP receives a PA request after that initial PA file transfer but before the member disenrolls then the PHP will process according to standard SLAs (within 14 days of receipt), even if the review extends beyond the member's disenrollment date. If this review results in a newly approved prior authorization after the Medicaid Direct effective date, then the PHP should send the newly approved PA in a daily file. This daily file will not include any updates to Prior Authorizations previously sent.
2. PHPs are not expected to send any data to Medicaid Direct for any Beneficiaries who will transition into Medicaid Direct prior to PHP Managed Care Launch.
3. PHPs are expected to send all approved prior authorizations. If a state approved PA that the PHP received when the beneficiary transitioned from Medicaid Direct to Managed Care is still active and PHPs have updated the PA data, then they are expected to send the updated PA information to the Medicaid Direct.
4. PHPs are expected to ensure that they do not accept or process any new PAs for the beneficiaries that have transitioned to Medicaid Direct after their Medicaid Direct coverage effective date. For example: Beneficiary moves back into Medicaid Direct with coverage effective date of 8/1/2021. PHPs should not be accepting PA requests received after 8/1/2021 for this beneficiary and advise the Provider to submit those to Medicaid Direct.
5. Both Sending and Receiving systems/entities are expected to report integration monitoring and incident/defect reporting data for this interface based on the requirements of the Department's Technology Operations (Tech Ops) team.

Processing Rules:

1. PHPs are expected to send Pharmacy Prior Authorizations at the NDC level – NC Tracks does not process GPI. PHPs are requested to populate the PA using one valid NDC (preferably based on

most recent claim) based on the GPI 14-character level. There should only be one NDC per PA sent from the PHP.

2. PHPs are expected to populate prior authorization quantity with a default value of all 9's for all reason codes.
3. PHPs are Expected to populated prior authorization quantity accumulated with a default value of all 9's
4. After processing the PHP file, NC Tracks will create a reject file containing the details of all rejected files from the PHP. The file will be posted in the PHP's outbound server folder. Rejected PAs are expected to be reviewed, corrected, and resubmitted on a subsequent daily file within 5 business days of the rejection. The format of this file can be found in the Companion Guide on the PCDU at the paths below.
   File Name: *WPDT_CG_03.10.21_NCPDP PA.pdf*

   Standard Plan Path:

   / Library Documents / Standard Plan / Guidance Documents / C_Benefits_and_Care_Management

   Tailored Plan Path:

   / Library Documents / Tailored Plan / Guidance Documents / B.2- Medicaid - Benefits

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 Medicaid Direct 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 enrollment changes: PHPs will receive information on beneficiary's enrollment changes through the daily 834 files. PHPs are expected to load and use that data to trigger generation of PA files to appropriate target.
- Member Cross Reference IDs/Merged Member IDs: Beneficiaries can have multiple Member IDs and those values are included in the 834 file – please refer to the 834 Companion Guide for appropriate loop and reference. PHPs are expected to use that data to link beneficiaries with multiple IDs with their active Member ID and properly ingest and map PA data with the appropriate active Member ID.

(3) PHPs (TPs and SPs) to PHPs (TPs and SPs) and PHPs (TPs and SPs to PIHPs): Pharmacy Prior Authorizations

Scope:

- All approved Prior Authorizations for beneficiaries who are transitioning from one PHP to another PHP after PHP Managed Care launch, with PA end date greater than new PHP coverage effective date
- PHPs are also required to include Prior Authorization History with an end date 45 days prior to the receiving PHP effective date.

- Sending PHPs are required to accept Prior Authorization requests up until 11:59:59pm the night before the Receiving PHP's effective date. The sending PHP has 14 calendar days after the receiving PHP's effective date to approve/deny any open and in process PAs.
- PHPs are not required to send daily updates to PAs after the receiving PHP's effective date, only newly approved PAs (within the 14 days) should be sent in the daily updates.
- In order to comply with 42 CFR Part 2, PHPs are required remove PAs that meet the 42 CFR Part 2 SUD criterion unless they have received consent from the beneficiary to share that data. PHPs should not send SUD related PAs where consent has not been obtained.

Data Source: PHPs

Data Target(s): PHPs

File Layout: The Department has established that the BCM047 file layout for the Pharmacy PA Extract must be used to send Pharmacy PA data from PHPs to PHPs. This format will be used to support continuity of care when beneficiaries move between PHPs. Rules may differ due to differing Transition of Care requirements for valid values. This file is maintained on the PCDU at the paths below.

File Name: *BCM047-J PharmPALayout_T_2021_v05.xlsx*

Standard Plan Path:

/ Library Documents / Standard Plan / Report Templates / C_Benefits_and_Care_Management

Tailored Plan Path:

/ Library Documents / Tailored Plan / Report Templates / B.2- Medicaid - Benefits

File Naming Convention:

PA_PHARMACY_EXTRACT_DATA_XXXXX_YYYYY-CCYYMMDD-HHMMSS.TXT, with XXXXX being a short name for each Transferring PHP and YYYYY being a short name for Target PHP. Below are the short names for each PHPs:

PHP Short Name	PHP
CCH	Carolina Complete Health
WELLC	WellCare of North Carolina
UHC	UnitedHealthcare
BCBS	HealthyBlue
AMERI	AmeriHealth Caritas
ALLT	Alliance Health
EAST	Eastpointe
PART	Partners Health Management
SANT	Sandhills Center
TRIT	Trillium Health Resources
VAYT	Vaya Health
ALLB	Alliance Health
EASB	Eastpointe

PARB	Partners Health Management
SANB	Sandhills Center
TRIB	Trillium Health Resources
VAYB	Vaya Health

File Type: Fixed width flat file

Transmission Type: Secure File Transfer Protocol (sFTP)

File Delivery Frequency, Creation & Processing Rules: Daily – Full files followed by daily incremental files

1. A transferring PHP (PHP 1) is expected to send full Pharmacy PA file to a receiving PHP (PHP 2) the day before the beneficiary's new PHP 2 Effective date. If PHP1 receives a PA request after that initial PA file transfer, but before the member disenrolls, PHP 1 will process according to standard SLAs (within 14 days of receipt), even if review extends beyond member's disenrollment date. If this review results in a newly approved prior authorization after PHP 2's effective date, then PHP 1 should send such newly approved prior authorizations in a daily file. This daily file will not include any updates to Prior Authorizations PHP1 sent in original PA file. Information on Receiving PHP will be available in the future eligibility segments in the 834 file and PHPs are expected to use that data to trigger this process.
2. Transferring PHPs are not expected to send any data to the Receiving PHP for any Beneficiaries who will transition to another PHP prior to PHP Managed Care Launch.
3. Transferring PHPs are expected to send all approved prior authorizations in their system for a beneficiary that will be transitioning to a new PHP.
4. Sending PHPs are not required to send historical PAs (from GDIT) to a receiving PHP.
5. PHPs are expected to ensure that they do not accept or process any new PAs for the beneficiaries that have transitioned to a new PHP after their coverage effective date with the new PHP. For example: Beneficiary is currently assigned to PHP 1 and moves to PHP 2 with coverage effective date of 4/1/2020. PHP 1 should not be accepting PA requests for beneficiary on or after 4/1/2020 and advise the Provider to submit those to the PHP 2.
6. Receiving PHPs are expected to process and load this data for all beneficiaries that are assigned to them, in their respective systems that allows them to meet all the contractual obligations and requirements related to Prior Authorizations that are outlined in the PHP contract. Outlined below are key functions that PHPs are expected to support using this data:
    a. Pay future claims that they will receive from the Providers for the remaining units on these PAs
    b. Support Care management functions
    c. Support continuity of care for beneficiaries transitioning from them to another PHP or Medicaid Direct. The transferring PHP is expected to send all approved PA data to the receiving PHP or Medicaid Direct
    d. Support any data reconciliation efforts related to this data. If the PHP has altered PA data due to their respective operational business rules (i.e., PA effective begin date to align with effective eligibility date), then they should ensure that original source is also stored with them to support any reconciliation efforts and transition of care
7. Receiving PHPs will be expected to load prior authorizations even if there are data fields that are not easily translated into their operational systems.

8. Both Source & Target systems/entities are expected to report integration monitoring and incident/defect reporting data for this interface based on the requirements of the Department's Technology Operations (Tech Ops) team.

Dependencies:

- Beneficiary enrollment changes: Both Source and Receiving PHPs will receive information on beneficiary's enrollment changes through the daily 834 files. They are expected to load and use that data to trigger generation of PA files to appropriate target. This data will be available through current and future segments in the 834 files.
- Member Cross Reference IDs/Merged Member IDs: Beneficiaries can have multiple Member IDs and those values are included in the 834 file – please refer to the 834 Companion Guide for appropriate loop and reference. PHPs are expected to use that data to link beneficiaries with multiple IDs with their active Member ID and properly ingest and map PA data with the appropriate active Member ID.
- Provider Data: Receiving PHPs will receive Medicaid Provider data through the PDC Provider file and are expected to load that prior to processing the PA files.

Behavioral Health Prior Authorizations:

(1) LME-MCOs (PIHP) to PHPs: Behavioral Health Prior Authorizations

Scope:

- All approved Behavior Health Prior Authorizations approved by LME-MCOs, including carved out services, and transferred to PHP for beneficiaries who are transitioning from Medicaid Direct to PHP Managed Care with PA end date greater than managed care coverage effective date
    - At PHP Managed Care go-live, Outpatient Behavioral Health Service PAs provided by Directly Enrolled Providers are excluded from the transfer
- All Prior Authorizations closed within 60 days of the beneficiary's PHP Managed Care coverage effective date
- Future full files will include any new, updated or modified prior authorizations for beneficiaries with prior authorizations previously sent, along with any prior authorization data for newly assigned beneficiaries
- In order to comply with 42 CFR Part 2, LME-MCO will remove PAs that meet the 42 CFR Part 2 criterion where member consent is not secured. LME-MCOs are not required to send SUD related PAs where a consent would be required to send such PA. For PAs not submitted by LME-MCOs, PHPs are expected to work with Providers to accept PAs directly from the Provider.

Data Source: LME-MCOs

Data Target(s): PHPs

File Layout: The Department has established a file layout to send Behavior Health PA data from LME-MCOs to PHPs and a DED supporting the file layout. They are zipped file that will be sent between LME-MCOs and PHPs for Behavioral Health Prior Authorizations. Within the zipped file there will be a flat file containing Prior Authorizations from LME-MCOs.
These file layouts are maintained on the PCDU at the paths below.

File Names:
PA_TOCPHBH_PAFileLayoutLMEMCO_MMDDYYYY.xlsx
PA_TOCLMEMCOPH_PADED_MMDDYYYY.xlsx

Standard Plan Path:

/ Library Documents / Standard Plan / Guidance Documents / C_Benefits_and_Care_Management

Tailored Plan Path:

/ Library Documents / Tailored Plan / Guidance Documents / B.2- Medicaid - Benefits

Documents Supplementing the PA File: In addition to the Prior Authorization flat file identified above, the LME-MCOs will include corresponding Consent Forms, if consent is secured to share a PA within the scope of 42 CFR Part 2. Also, a consent spreadsheet should be included with each Prior Authorization submission to identify members where consent was gained. If no PAs being sent meet the 42 CFR Part 2 criterion, consent forms and the consent ID spreadsheet do not need to be included. These files are maintained on the PCDU at the paths below.

File Names:
PA_TOCLMEMCOPH_COPriorAuthFileTransfer_MMDDYYYY.xlsx
PA_TOCLMEMCOPH_42CFRPart2TOCConsentPHP_MMDDYYYY.docx

Standard Plan Path:

/ Library Documents / Standard Plan / Guidance Documents / C_Benefits_and_Care_Management

Tailored Plan Path:

/ Library Documents / Tailored Plan / Guidance Documents / B.2- Medicaid - Benefits

File Naming Convention:

PHPs will receive the Prior Authorization full files along with the consent spreadsheet using the naming conventions detailed in the following document, on the PCDU.

File Name: *PA_TOCLMEMCOPH_CQLMEFileNamingConnvention_MMDDYYYY.xlsx*

Standard Plan Path:

/ Library Documents / Standard Plan / Guidance Documents / C_Benefits_and_Care_Management

Tailored Plan Path:

/ Library Documents / Tailored Plan / Guidance Documents / B.2- Medicaid - Benefits

File Type: Tilde delimited flat file

Transmission Type: Secure File Transfer Protocol (sFTP) through NC Managed File Transfer (MFT)

MFT Connection and Attestation Process: With each file receipt from the NC MFT, the PHPs should expect a zipped file from each LME-MCO.

Structure of the receipt should be as follows from each LME-MCO folder location:

- PHP 1 Zip
    - PA .txt File
    - Consent Forms*
    - Consent ID Spreadsheet*

*Only include these files if the .txt file contains PAs that meet the 42 CFR Part 2 criterion.

File Delivery Frequency & Processing Rules: Daily files

1. PHPs will receive an initial full file for all beneficiaries that are assigned to them. This will be followed by daily files up until the beneficiary's Managed Care Effective Date
2. PHPs are expected to pick up these files daily, process and load this data for all beneficiaries that are assigned to them, in their respective systems that allows them to meet all the contractual obligations and requirements related to Prior Authorizations that are outlined in the PHP contract. Outlined below are key functions that PHPs are expected to support using this data:
    a. Pay future claims that they will receive from the Providers for the remaining units on these PAs for services covered under the PHP.
    b. Support Care management functions
    c. Support continuity of care for beneficiaries transitioning from them to another PHP or Medicaid Direct. The transferring PHP is expected to send all approved PA data to the receiving PHP or the Department
    d. Support any data reconciliation efforts related to this data. If the PHP has altered PA data due to their respective operational business rules (i.e., PA effective begin date to align with effective eligibility date), then they should ensure that original source is also stored with them to support any reconciliation efforts and transition of care
3. The LME-MCOs will send prior authorization to the PHPs up until 11:59:59pm the night before the PHP Managed Care effective date. PHPs are expected to update respective prior authorizations within their operational systems with these updates up until the beneficiary's PHP coverage effective date.
4. PHPs will be expected to load prior authorizations even if there are data fields that are not easily translated into their operational systems. The following rules have been established for certain data fields:
    a. **Medicaid PA ID:** PHPs should store the reference LME-MCO PA ID in their data warehouse if they are unable to load in their downstream system. Claim that comes through will likely have the reference ID
    b. **Medicaid Recipient ID:** PHPs should store the MID in their data warehouse if they are unable to load into their operation system.
    c. **Merged ID:** PHPs should be able to ingest claims records for beneficiaries with merged IDs
    d. **PA Type Code:** If PHPs are unable to load the PA Type Code into their operation system, then they should be loading into their data warehouse
    e. **Requested Begin Date:** If PHPs are unable to load Requested Begin Date into their operational system, then they should be loading into their data warehouse

f. **Requested End Date:** If PHPs are unable to load Requested End Date into their operational system, then they should be loading into their data warehouse
g. **PA Effective Begin Date:** If the effective begin date is before the PHP Eligibility, then the PHPs can align the effective begin date in their operation system with the eligibility begin date. PHPs should store the original effective begin date (pre-eligibility) in their warehouse
h. **PA Effective End Date:** If the PA effective End Date is before the PHP Effective date, then it should be stored in your Warehouse for reference for reauthorization and transferable to a receiving PHP. If the Effective End Date is outside of your management system policy (>365 days) then you should either include the original end date somewhere within your operation system (notes section) or store it in your Datawarehouse. Operational expectation is for the PA to be renewed per the original end date or appeal rights are required.
i. **Rendering Provider NPI:** LME-MCOs will not be sending rendering NPIs on their prior authorizations. The direction is for the PHPs to assign a default code in order to ingest these PAs.
j. **Blank Procedure Code:** If there is a blank Procedure code for a certain PA Type, then the PHP is expected to assign a default code to such field and load into their management system.

5. For the LME-MCO Prior Authorizations PHPs should expect incomplete data. If PHPs are not able to load Prior Authorization data into their operational systems, then they are expected to store the prior authorizations in their Data Warehouse for reference. The expectation is that PHPs will use this reference data to adjudicate future claims which will have the reference IDs. If the PHP requires additional information to pay a claim, then the PHP should reach out to the LME-MCO or provider to obtain additional information

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 Medicaid Direct 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: PHPs will receive information on beneficiaries assigned to them through the daily 834 files. PHPs are expected to load their beneficiary assignment prior to processing the PA files.
- Member Cross Reference IDs/Merged Member IDs: Beneficiaries can have multiple Member IDs and those values are included in the 834 file – please refer to the 834 Companion Guide for appropriate loop and reference. PHPs are expected to use that data to link beneficiaries with multiple IDs with their active Member ID and properly ingest and map PA data with the appropriate active Member ID.
- Provider Data: PHPs will receive Medicaid Provider data through the PEF Provider file and are expected to load that prior to processing the PA files.

(2) PHPs to LME-MCOs: Behavioral Health Prior Authorizations

Scope:

- All approved Behavioral Health Prior Authorizations approved by the PHPs or previously transferred by LME-MCOs for beneficiaries who are transitioning from PHPs to Medicaid Direct after Managed Care go-live date, with PA end date greater than Medicaid Direct coverage effective date
- Services included in the below document (maintained on PCDU at the paths below) should be used to identify out LME-MCO prior authorizations. If PHPs identify additional services that are not on this list, and they believe should be sent to LME-MCOs then the PHPs are encouraged to send such PAs.
  File Name: *PA_TOCPHLMEMCO_LMEMCOServiceCodes_MMDDYYYY.pdf*

  Standard Plan Path:

  / Library Documents / Standard Plan / Guidance Documents / C_Benefits_and_Care_Management

  Tailored Plan Path:

  / Library Documents / Tailored Plan / Guidance Documents / B.2- Medicaid - Benefits

- PHPs are required to accept Prior Authorization requests up until 11:59:59pm the night before the Medicaid Direct effective date. The sending PHP has 14 calendar days after the new Medicaid Direct effective date to adjudicate any open and in process PAs.
- PHPs are not required to send daily updates to PAs after the Medicaid Direct effective date, only newly approved PAs (within the 14 days) should be sent in the daily updates.
- In order to comply with 42 CFR Part 2, PHPs are required to remove PAs that meet the 42 CFR Part 2 criterion unless they have received consent from the beneficiary to share that data. PHPs should not send SUD related PAs where consent has not been obtained.
- If a member is moving from a TP to an LME-MCO that are the same organization, the TP should determine what information is required for the transitioning member.

Data Source: PHPs

Data Target(s): LME-MCOs

File Layout: The Department has established that the BCM046 file layout for the Medical PA Extract must be used to send Behavioral Health PA data from PHPs to LME-MCOs. This format will be used to support continuity of care when beneficiaries move from a PHP to Medicaid Direct. Rules may differ due to differing Transition of Care requirements for valid values. This file is maintained on the PCDU at the paths below.

File Name: *BCM046-J Medical Prior Authorization Extract_T_2021_v06.xlsx*

Standard Plan Path:

/ Library Documents / Standard Plan / Report Templates / C_Benefits_and_Care_Management

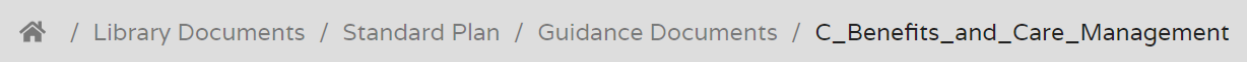
Tailored Plan Path:

/ Library Documents / Tailored Plan / Report Templates / B.2- Medicaid - Benefits

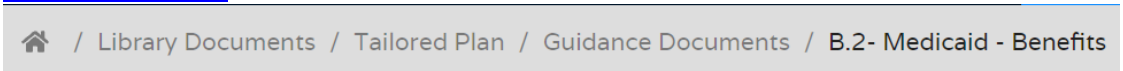
Documents Supplementing the PA File: In addition to the Prior Authorization flat file identified above, the PHPs will include corresponding Consent Forms for PAs impacted by 42 CFR Part 2, if member consent is secured to share a PA with SUD detail. Also, a consent spreadsheet should be included with each Prior Authorization submission to identify beneficiaries where consent was gained. If no PAs being sent meet the 42 CFR Part 2 criterion, consent forms and the consent ID spreadsheet do not need to be included. PHPs should not send SUD related PAs where consent has not been obtained. These files are maintained on PCDU at the paths below.

File Names:
PA_TOCPHLMEMCO_PHPPriorAuthorizationTrans_MMDDYYYY.xlsx
PA_TOCPHLMEMCO_ConsentForm_MMDDYYYY.docx

Standard Plan Path:



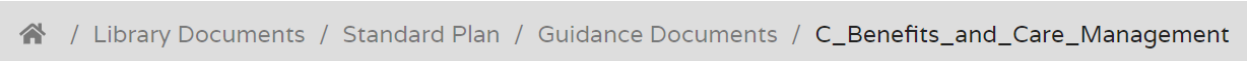
Tailored Plan Path:



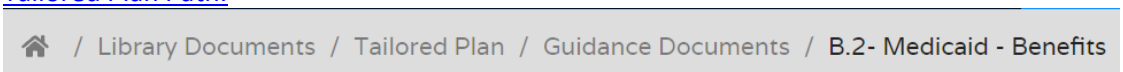
File Naming Convention: PHPs will send Behavioral Health Prior Authorization files using the following naming conventions detailed in the following document, on the PCDU.

File Name: *PA_TOCPHLMEMCO_CQPHPBHFileNamingConvention_MMDDYYYY.xlsx*

Standard Plan Path:



Tailored Plan Path:



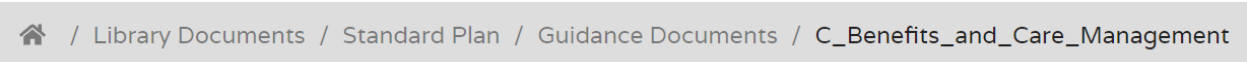
File Type: Fixed width flat file

Transmission Type: Secure File Transfer Protocol (sFTP) through the NC MFT

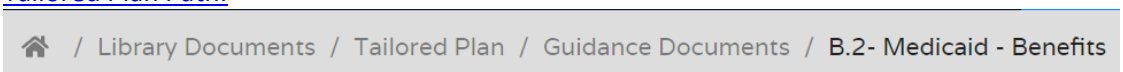
MFT Connection and Attestation Process: With each daily submission to NC MFT, the PHPs should zip all 7 LME-MCO zips (as applicable) along with a .JSON attestation form and submit to NC MFT. The User Manual for connecting the NC MFT and the Attestation process can be found on the PCDU at the paths below.

File Name: *PA_TOCPHLMEMCO_ContractorVendorUserGuideforPCDU_MMDDYYYY.docx*

Standard Plan Path:



Tailored Plan Path:



Structure of the Daily Submissions Should Be as Follows:

- Wrapper Zip File for Daily Submission
    a. JSON Attestation Form for the Daily Submission
    b. LME-MCO 1 Zip
        i. PA .txt File
        ii. Consent Forms*
        iii. Consent ID Spreadsheet*
    c. LME-MCO 2 Zip
        i. PA .txt File
        ii. Consent Forms*
        iii. Consent ID Spreadsheet*
    d. LME-MCO 3 Zip
        i. PA .txt File
        ii. Consent Forms*
        iii. Consent ID Spreadsheet*
    e. LME-MCO 4 Zip
        i. PA .txt File
        ii. Consent Forms*
        iii. Consent ID Spreadsheet*
    f. LME-MCO 5 Zip
        i. PA .txt File
        ii. Consent Forms*
        iii. Consent ID Spreadsheet*
    g. LME-MCO 6 Zip
        i. PA .txt File
        ii. Consent Forms*
        iii. Consent ID Spreadsheet*
    h. LME-MCO 7 Zip
        i. PA .txt File
        ii. Consent Forms*
        iii. Consent ID Spreadsheet*

*Only include these files if the .txt file contains PAs that meet the 42 CFR Part 2 criterion.

File Delivery Frequency & Creation Rules: Daily – Full files followed by daily files

1. PHPs are expected to send a full Behavioral Health PA file to the LME-MCO the day before the beneficiary's new Medicaid Direct effective date. If the PHP receives a PA request after that initial PA file transfer but before the member disenrolls then the PHP will process according to standard SLAs (within 14 days of receipt), even if the review extends beyond the member's disenrollment date. If this review results in a newly approved prior authorization after the Medicaid Direct effective date, then the PHP should send the newly approved PA in a daily file. This daily file will not include any updates to Prior Authorizations previously sent.
2. PHPs are not expected to send any data to the LME-MCOs for any Beneficiaries who will transition into Medicaid Direct prior to PHP Managed Care Launch.
3. PHPs are expected to send all approved prior authorizations. If an LME-MCO approved PA that the PHP received when the beneficiary transitioned from Medicaid Direct to PHP is still active

and PHPs have updated the PA data, then they are expected to send the updated PA information to the LME-MCO.

4. PHPs are expected to ensure that they do not accept or process any new PAs for the beneficiaries that have transitioned to Medicaid Direct after their Medicaid Direct coverage effective date. For example: Beneficiary moves back into Medicaid Direct with coverage effective date of 8/1/2021. PHPs should not be accepting PA requests received after 8/1/2021 for this beneficiary and advise the Provider to submit those to Medicaid Direct.

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 Medicaid Direct 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 enrollment changes: PHPs will receive information on beneficiary's enrollment changes through the daily 834 files. PHPs are expected to load and use that data to trigger generation of PA files to appropriate target.
    - PHPs will be able to identify the proper LME-MCO to send Prior Authorizations to using the benefit plan for the active period that replaced theirs on the 834. The following loop should be used:

HD*001**HMO*PHPB*IND~
DTP*348*D8*20190401~
DTP*349*D8*20191031~
REF*M7*MICNN~
REF*ZZ*LA 10~
REF*ZZ*ELIGSTAT A~
REF*ZX*RESCO 013~
REF*ZZ*ADMCO 013~
LX*1~
NM1*Y2*1*CARDINAL INNOVATIONS HEALTHCARE SOLUTIONS***LME MCO*003*XX*1265573745*72~
N3*550 S CALDWELL ST*STE 1500~
N4*CHARLOTTE*NC*282023313~
PER*IC**TE*7049397700~

- Member Cross Reference IDs/Merged Member IDs: Beneficiaries can have multiple Member IDs and those values are included in the 834 file – please refer to the 834 Companion Guide for appropriate loop and reference. PHPs are expected to use that data to link beneficiaries with multiple IDs with their active Member ID and properly ingest and map PA data with the appropriate active Member ID.

(3) PHPs to PHP (TPs and SPs): Behavioral Health Prior Authorizations

Please refer to the PHPs to PHPs: Medical Prior Authorizations section, same requirements will apply for Behavioral Health Prior Authorizations.