NC Medicaid Managed Care

Requirements for Sharing Prior Authorization 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		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.
8.0	7/##/2022	• Updating and aligning of short names for PHPs/PIHPs • Update to referenced BCM046 file. • Updated sections for change to PIHPs
9.0	8/29/2023	• Update the language from ‘PHP’ to Health Plan and ‘PIHP’ to ‘LME/MCO’

External references identified in this document and stored/maintained in PCDU

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

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(1) Department to Health Plans: Medical Prior Authorizations

Scope:

- All prior authorizations (PA) approved by the Department and its Utilization Management (UM) Vendors for beneficiaries who transition from NC Medicaid Direct to a health plan with a PA end date greater than the health plan's managed care coverage effective date.
    - **Note for PA's with multiple details**: an approved PA may contain one or more details that do not have a status of "approved," but the overall status of the PA is still "approved."
- All PAs closed within 60 days of the beneficiary's health plan coverage effective date.
- Incremental files will include any new, updated or modified PAs for beneficiaries with PAs previously sent, along with any PA data for newly assigned beneficiaries.
- To comply with 42 CFR Part 2, PAs that meet the 42 CFR Part 2 criterion will not be transferred.

Data Source: NCTracks

Data Target(s): Health Plans

File Layout: The Department established a file layout to send medical PA data from NCTracks to health plans and a Data Element Dictionary (DED) supporting the Medical PA file layout. These files are maintained in 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 health plan. Below are the short names for each health plan:

Health Plan Short Name	Health Plan
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 MOVEit Site

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

1. Prior to the health plan's managed care launch, health plans will receive an initial full PA file for all beneficiaries assigned to them. This will be followed by daily files.
2. Health plans are to pick up these files daily, process and load this data for all beneficiaries assigned to them, in their respective systems that allows them to meet all the contractual obligations and requirements related to PAs as outlined in the health plan contract. Below are key functions health plans are to support using this data:
    a. Pay future claims they receive from providers for the remaining units on these PAs.
    b. Support care management functions.
    c. Support continuity of care for beneficiaries transitioning from NC Medicaid Direct or subsequently to another health plan or back to NC Medicaid Direct. The transferring health plan is to send all approved PA data to the receiving health plan or NC Medicaid Direct.
    d. Support any data reconciliation efforts related to this data. If the health plan has altered PA data due to their respective operational business rules (i.e., PA effective begin date to align with effective eligibility date), they should ensure the original source is stored with them to support any reconciliation efforts and transition of care.
3. Health plans will receive updates on existing approved PAs through the daily files. They are to update respective PAs within their operational systems with these updates up until the beneficiary's Standard Plan or Tailored Plan coverage effective date. After a beneficiary's health plan effective date (NC Medicaid Direct to health plan) the health plan is no longer required to load updates to previously approved PAs from NC Medicaid Direct into their operational system (i.e., beneficiary TP effective date is 1/1/2023, NCTracks sends PA #1 for dates of service 10/1/2022-12/31/2022 with two units and a PA #2 for dates of service 10/01/2022-2/1/2023 with two units. Both PAs are updated to three units, the health plan would only be required to update PA #2). They are required to load any newly approved PAs.
4. Health plans are to load PAs 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:** Health plans 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:** Health plans should store the MID in their data warehouse if they are unable to load into their operational system.
        i. **Merged ID:** Health plans should be able to ingest PA records for beneficiaries with merged IDs.
    c. **PA Type Code:** If health plans are unable to load the PA Type Code into their operation system, they should load into their data warehouse.
    d. **Requested Begin Date:** If health plans are unable to load requested begin date into their operational system, they should load into their data warehouse.

e. **Requested End Date:** If health plans are unable to load requested end date into their operational system, they should load into their data warehouse.

f. **PA Effective Begin Date:** If the effective begin date is before the Standard Plan or Tailored Plan eligibility the health plans can align the effective begin date in their operation system with the eligibility begin date. Health plans should store the original effective begin date (pre-eligibility) in their data warehouse.

g. **PA Effective End Date:** If the PA effective end date is before the Standard Plan or Tailored Plan effective date, it should be stored in their data warehouse for reference for reauthorization and transferable to a receiving health plan. If the effective end date is outside of your management system policy (>365 days) 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 health plans are unable to load the billing provider, the health plan should load into their data warehouse.

i. **Rendering Provider NPI:** Health plans should load servicing/rendering provider into their operation system.

j. **Blank Rendering NPI:** If there is a blank rendering NPI for a certain PA Type, the health plan is to assign a default code to such field and load into their management system. This is common for PA Type A11 (LTC PA).
Note: Default NPIs should not be included in PAs returned to NC Medicaid Direct as part of the Transition of Care.

k. **Requesting Provider NPI:** Health plans should load requesting provider, if available, into their operation system. If not available, health plans can use the rendering provider NPI as requesting NPI. Health plans can leverage any valid NPI associated with the PA to ingest in their system.

l. **Blank Procedure Code:** If there is a blank procedure code for a certain PA Type, the health plan is to assign a default code to such field and load into their management system.
Note: Default procedure codes should not be included in PAs returned to NC Medicaid Direct as part of the Transition of Care.

m. **Scrubbed Prior Authorizations:** Due to 42 CFR Part 2, PAs that meet the 42 CFR Part 2 criterion will not be transferred.

File Delivery, Acceptance & Processing Validation: The Department created 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 NC Medicaid Direct 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 will receive information on beneficiaries assigned to them through the daily 834 files. Health plans are to load their beneficiary assignments 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 files –refer to the 834 Companion Guide for appropriate loop and reference. Health plans are 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: Health plans will receive Medicaid provider data through the PEF Provider file and are to load that prior to processing the PA files.

(2) Health Plans to Department: Medical Prior Authorizations

Scope:

- Approved PAs (refer to the Companion Guide for applicable PA types) for beneficiaries transitioning from a health plan to NC Medicaid Direct after the health plan managed care go-live date, with a PA end date greater than NC Medicaid Direct coverage effective date.
- Services included in the document below (maintained in PCDU at the paths below) should be used to identify LME/MCO PAs.

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

- Health plans are required to accept PA requests up until 11:59:59 p.m. the night before the NC Medicaid Direct effective date. The transferring health plan has 14 calendar days after the new NC Medicaid Direct effective date to adjudicate any open and in process PAs.
- Health plans are not required to send incremental updates after the NC Medicaid Direct effective date to previously approved PAs. The health plans should only send newly approved PAs (within 14 days of the NC Medicaid Direct effective date) with a PA effective date that is after the beneficiary's NC Medicaid Direct effective date. These post-effective date, newly approved PAs constitute the daily file.
- To comply with 42 CFR Part 2, health plans 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. Health plans should not send substance abuse disorder (SUD) related PAs where consent has not been obtained.

Data Source: Health Plans

Data Target(s): NCTracks

File Layout: The Department established the BCM046 file layout for the Medical PA Extract must be used to send Medical PA data from health plans to NCTracks. This format will be used to support continuity of care when beneficiaries move from a Standard Plan or Tailored Plan to NC Medicaid Direct. Rules may differ due to NCTracks requirements for valid values. This file is maintained in PCDU at the paths below.

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

Standard Plan Path:

/ Library Documents / Standard Plan / Report Templates / C_Benefits_and_Care_Management

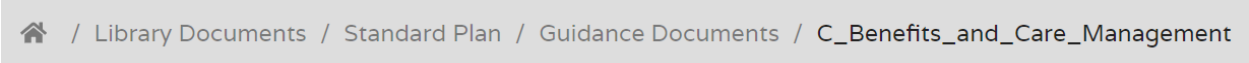
Tailored Plan Path:

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

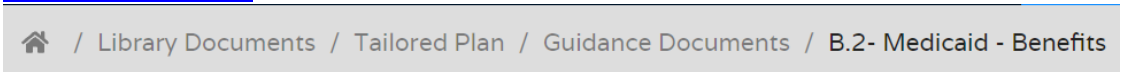
The Department developed a Companion Guide the health plans should use to produce valid values for NC Medicaid Direct to properly ingest. The Companion Guide is a living document and is maintained in PCDU at the paths below.

File Name: *NCMMIS_WPDT_CG_MM.DD.YY_Med PA.pdf*

Standard Plan Path:



Tailored Plan Path:



File Naming Convention:

The file naming standard is PA_MEDICAL_EXTRACT_DATA_XXXXXXXX_CCYYMMDD_HHMMSS.TXT, with XXXXXXXX being the health plan ID for each health plan.
The file name is populated per the following rules:

1. Health plan name varies according to the entity that creates the file and uses the health plan 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. Health plans are to send a full medical PA file to the Department the day before the beneficiary's new NC Medicaid Direct effective date. If the health plan receives a PA request after that initial PA

file transfer but before the beneficiary disenrolls, the health plan will process according to standard SLAs (within 14 days of receipt), even if the review extends beyond the beneficiary's disenrollment date. If this review results in a newly approved PA after the NC Medicaid Direct effective date, the health plan should send the newly approved PA in a daily file. This daily file will not include any updates to PAs previously sent. This information will be available in future eligibility segments in the 834 file and health plans are to use that data to trigger the flow of PA data to the Department.

2. Health plans are not expected to send any data to the Department for any beneficiaries who will transition into NC Medicaid Direct prior to the health plan managed care launch.
3. Health plans are to send approved PAs. If a state approved PA the health plan received when the beneficiary transitioned from NC Medicaid Direct to a Standard Plan or Tailored Plan is still active and the health plan has updated the PA data, they are to send the updated PA information to the Department. If the PA received from NC Medicaid Direct does not include a procedure code, it can be omitted in file transfers back to NCTracks.
4. Health plans are to ensure they do not accept or process any new PAs for beneficiaries that have transitioned to NC Medicaid Direct after their NC Medicaid Direct coverage effective date. For example: beneficiary moves back into NC Medicaid Direct with coverage effective date of 8/1/2021. Health plan should not accept PA requests received after 8/1/2021 for this beneficiary and advise the provider to submit them to NC Medicaid Direct.

File Delivery, Acceptance & Processing Validation: The Department created 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 NC Medicaid Direct 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.

Processing Rules

- The Department worked with NCTracks to establish guidance on valid values and rules for sending PAs to NCTracks. These rules can be found in the Companion Guide.
- For NCTracks to ingest PAs, the health plan 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, delivered weekly through the GDIT MOVEit site.
- If there are multiple PA types for procedure codes at the line level, the health plan must split the PA to ensure there is one unique PA type at the header level with applicable procedure codes at the line for that PA type.
- If a PA type cannot be mapped to the procedure code based on the information given, the health plan should assign a default A00 code.
    - For PAs assigned an A00 default code there should be only one detail line. A unique PA should be created for each A00 default line.
- If a PA was ingested from NC Medicaid Direct with a default NPI or procedure code, it should be removed before it is sent back to NC Medicaid Direct.
- If a requesting provider NPI is not available, the rendering provider NPI should be submitted in that field.

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

File Delivery, Acceptance & Processing Validation: The Department created 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 NC Medicaid Direct 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 enrollment changes: Health plans will receive information on a beneficiary's enrollment changes through the daily 834 files. Health plans 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 files – refer to the 834 Companion Guide for appropriate loop and reference. Health plans are 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.

Additional File Layouts:
Pharmacy PA Drug Name/NDC Crosswalk

The naming convention for drug names is as follows: Pharmacy_PA_Drug_Name_NDC_XWALK-CCYYMMDD-HHMMSS.txt

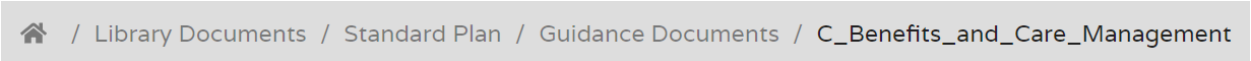
The PA Drug Name/NDC Crosswalk is a text file, '~' delimited, that will be posted to the Tailored Plans daily.

Field	Length	Formatting
PA DRUG NAME	10 characters	
NDC	11 characters	
EFF DATE	10 characters	CCYY-MM-DD
END DATE	10 characters	CCYY-MM-DD

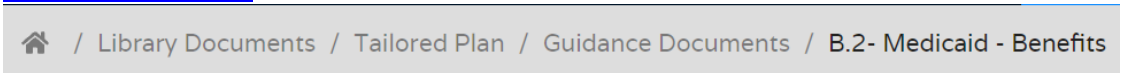
Procedure Code to PA Type Crosswalk:
The weekly Procedure Code to PA Type Crosswalk file can be found at the path below:

File Name:
Medical_TOC_PA_Companion_Guide_v10.docx

Standard Plan Path:



Tailored Plan Path:



(3) Health Plans to Health Plans (Tailored Plans and Standard Plans): Medical and Behavioral Prior Authorizations

Scope:

Medical PAs:

- All approved PAs for beneficiaries transitioning from one health plan to another after the health plan managed care launch, with a PA end date greater than the receiving health plan coverage effective date.
- Health plans are required to include PA history with an end date 60 days prior to the receiving health plan effective date.
- Sending health plans are required to accept PA requests up until 11:59:59 p.m. the night before the receiving health plan's effective date. The sending health plan has 14 calendar days after the receiving health plan's effective date to approve/deny any open and in process PAs.
- Health plans are not required to send daily updates to PAs after the receiving health plan's effective date, only newly approved PAs (within the 14 days) should be sent in the daily updates.

To comply with 42 CFR Part 2, health plans are required to remove PAs that meet the 42 CFR Part 2 criterion unless they receive consent from the beneficiary to share the data and transfer consent to the receiving entity. Health plans should not send SUD-related PAs where consent has not been obtained.

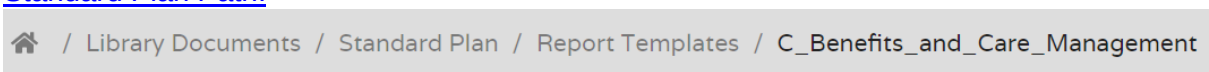
Data Source: Health Plans

Data Target(s): Health Plans

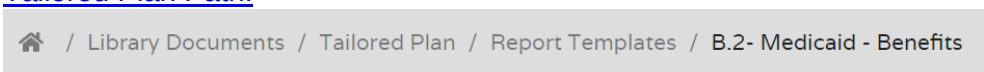
File Layout: The Department established the BCM046 file layout for the Medical or Behavioral PA Extract must be used to send medical or behavioral PA data from health plan to health plan. This format will be used to support continuity of care when beneficiaries move between health plans / LME/MCOs. Rules may differ due to differing Transition of Care requirements for valid values. This file is maintained in PCDU at the paths below.

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

Standard Plan Path:



Tailored Plan Path:



File Naming Convention:

PA_MEDICAL_EXTRACT_DATA_XXXXX_YYYYY-CCYYMMDD-HHMMSS.TXT, with XXXXX being a short name for each transferring health plan and YYYYY being a short name for target health plan. Below are the short names for each health plan:

Health Plan Short Name	Health Plan
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	LME/MCO – Alliance
EASB	LME/MCO – Eastpointe
PARB	LME/MCO – Partners Health Management
SANB	LME/MCO – Sandhills Center
TRIB	LME/MCO – Trillium Health Resources
VAYB	LME/MCO – 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 health plan (Health Plan 1) is to send a full Medical PA file to a receiving health plan (Health Plan 2) the day before the beneficiary's new Health Plan 2 effective date. If Health Plan 1 receives a PA request after the initial PA file transfer, but before the beneficiary disenrolls, Health Plan 1 will process according to standard SLAs (within 14 days of receipt), even if review extends beyond the beneficiary's disenrollment date. If this review results in a newly approved PA after Health Plan 2's effective date, Health Plan 1 should send the newly approved PAs in a daily file. This daily file will not include any updates to PAs Health Plan 1 sent in original PA file. Information on receiving health plan will be available in the future eligibility segments in the 834 file and health plans are expected to use that data to trigger this process.
2. Transferring health plans are not expected to send any data to the receiving health plan for beneficiaries who will transition to another health pan prior to the health plan managed care launch.
3. Transferring health plans are to send approved PAs in their system for a beneficiary transitioning to a new health plan.
4. Sending health plans are not required to send historical PAs from GDIT or LME/MCOs to a receiving health plan.
5. Health plans are to ensure they do not accept or process any new PAs for beneficiaries that have transitioned to a new health plan after their coverage effective date with the new health plan. For example: beneficiary is currently assigned to Health Plan 1 and moves to Health Plan 2 with coverage effective date of 8/1/2021. Health Plan 1 should not accept PA requests for the beneficiary on or after 8/1/2021 and should advise the provider to submit them to Health Plan 2.
6. Receiving health plans are to process and load this data for all beneficiaries assigned to them, in their respective systems that allows them to meet all the contractual obligations and requirements related to PAs outlined in the health plan contract. Below are key functions health plans are to support using this data:
    a. Pay future claims they receive from providers for the remaining units on the PAs.
    b. Support care management functions.
    c. Support continuity of care for beneficiaries transitioning to another health plan or NC Medicaid Direct. The transferring health plan is to send all approved PA data to the receiving health plan or to NC Medicaid Direct.

d. Support any data reconciliation efforts related to this data. If the health plan has altered PA data due to their respective operational business rules (i.e., PA effective begin date to align with effective eligibility date), they should ensure the original source is also stored with them to support any reconciliation efforts and transition of care.

7. Receiving health plans will load PAs even if there are data fields not aligned with their operation systems.
8. Both transferring and receiving systems/entities are 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 created 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.

Dependencies:

- Beneficiary enrollment changes: Both transferring and receiving health plans will receive information on a beneficiary's enrollment changes through the daily 834 files. They are 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 files – refer to the 834 Companion Guide for appropriate loop and reference. Health plans are 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 health plans will receive Medicaid provider data through the PDC Provider file and are to load that prior to processing the PA files.

Pharmacy Prior Authorizations:

(1) Department to Health Plans: Pharmacy Prior Authorizations

Scope:

- All approved pharmacy PAs approved by the Department and its UM vendors for beneficiaries transitioning from NC Medicaid Direct to a health plan with a PA end date greater than the health plan managed care coverage effective date.
- All PAs closed within 45 days of the beneficiary's health plan coverage effective date.
- Daily files will include any new, updated, or modified PAs for beneficiaries with PAs previously sent, along with any PA data for newly assigned beneficiaries. After a beneficiary's effective date (NC Medicaid Direct to health plan), the health plan is not required to load updates to previously approved PAs from NC Medicaid Direct into their operational system. They are required to load any newly approved PAs.
- To comply with 42 CFR Part 2, PAs that meet the 42 CFR Part 2 SUD criterion will not be transferred.

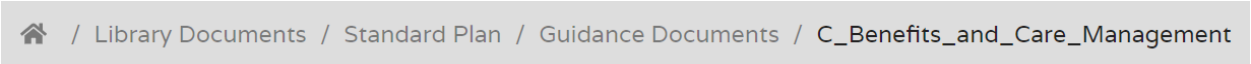
Data Source: NCTracks

Data Target(s): Health Plans

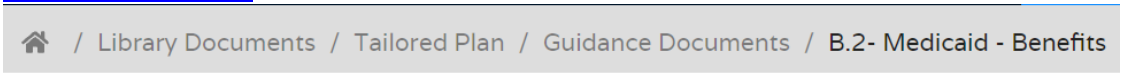
File Layout: The Department established a file layout to send pharmacy PA files between NCTracks and health plans and a DED supporting the pharmacy PA file layout. These files are maintained in PCDU at the paths below.

File Names:
PA_TOCDPPH_PharmPAFileLayout_MMDDYYYY.docx
PA_TOCDPPH_PharmPAFileLayoutDED_MMDDYYYY.xlsx

Standard Plan Path:



Tailored Plan Path:



File Naming Convention:

PA_PHARMACY_EXTRACT_DATA_XXXXX-CCYYMMDD-HHMMSS.TXT, with XXXXX being the health plan ID for each health plan. Below are the health plan IDs for each health plan:

Health Plan ID	Health Plan Full Name
AMESTC00	AmeriHealth Caritas North Carolina
BLUSTC01	Blue Cross and Blue Shield of North Carolina
CARSTP02	Carolina Complete Health
UNISTC03	UnitedHealthcare of North Carolina
WELSTC04	WellCare 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. Health plans will receive an initial full file for all beneficiaries assigned to them. This will be followed by daily files.

2. Health plans are to pick up these files daily and process and load this data for all beneficiaries assigned to them in their respective systems that allows them to meet all the contractual obligations and requirements related to PAs outlined in the health plan contract. Below are key functions health plans are to support using this data:
    a. Pay future claims they receive from providers for the remaining units on the PAs.
    b. Support care management functions.
    c. Support continuity of care for beneficiaries transitioning from NC Medicaid Direct or subsequently to another health plan or back to NC Medicaid Direct. The transferring health plan is to send all approved PA data to the receiving health plan or NC Medicaid Direct.
    d. Support any data reconciliation efforts related to this data. If the health plan has altered PA data due to their respective operational business rules (i.e., PA effective begin date to align with effective eligibility date) they should ensure the original source is stored with them to support any reconciliation efforts and transition of care.
3. Health plans will receive updates on existing approved PAs through the daily files. They are to update respective PAs within their operational systems with these updates up until the beneficiary's health plan managed care coverage effective date. After a beneficiary's health plan managed care effective date (NC Medicaid Direct to health plan) the health plan is not required to load updates to previously approved PAs from NC Medicaid Direct into their operational system. They are required to load any newly approved PAs.
4. Health plans are to load PAs even if there are data fields not easily translated into their operational systems. The following rules have been established for certain data fields:
    a. **Medicaid PA ID:** Health plans should store the reference Medicaid PA ID in their data warehouse if they are unable to load downstream system. Claims that come through will likely have the reference ID.
    b. **Medicaid Recipient ID:** Health plans should store the MID in their data warehouse if they are unable to load into their operation system.
    c. **Merged ID:** Health plans should be able to ingest PA records for beneficiaries with merged IDs.
    d. **PA Type Code:** If health plans are unable to load the PA Type code into their operation system, they should load into their data warehouse.
    e. **Requested Begin Date:** If health plans are unable to load the requested begin date into their operational system, they should load into their data warehouse.
    f. **Requested End Date:** If health plans are unable to load the requested end date into their operational system, they should load into their data warehouse.
    g. **PA Effective Begin Date:** If the effective begin date is before the managed care eligibility, the health plans can align the effective begin date in their operation system with the eligibility begin date. Health plans should store the original effective begin date (pre-eligibility) in their data warehouse.
    h. **PA Effective End Date:** If the PA effective end date is before the health plan's managed care effective date, it should be stored in their data warehouse for reference for reauthorization and transferable to a receiving health plan. If the effective end date is outside of your management system policy (>365 days) health plans should either include the original end date somewhere within their operation system (notes section) or store it in their data warehouse. 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 health plan is unable to load the billing provider, the health plan should load into their data warehouse.

j. **LI-REQ-30-DAY-UNITS:**

k. **FDB-DRUG-CD/DRUG-CD:** If the health plan is unable to load a PA due to a proprietary GDIT drug name, the health plan is to use the Drug Name to NDC crosswalk file sent by GDIT to load the PA record.

l. **Scrubbed PAs:** Due to 42 CFR Part 2, PAs that meet the 42 CFR Part 2 SUD criterion will not be transferred.

5. Both Source & Target systems/entities are 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 created 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.

Dependencies:

- Beneficiary assignments: Health plans will receive information on beneficiaries assigned to them through the daily 834 files. Health plans should 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 files – refer to the 834 Companion Guide for appropriate loop and reference. Health plans should 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: Health plans will receive Medicaid provider data through the PEF Provider file and should load that prior to processing the PA files.

(2) Health Plans to Department: Pharmacy Prior Authorizations

Scope:

- All approved PAs for beneficiaries transitioning from a health plan to NC Medicaid Direct after the health plan's managed care go-live date, with PA end date greater than NC Medicaid Direct coverage effective date.
- Health plans are required to accept PA requests up until 11:59:59 p.m. the night before the NC Medicaid Direct effective date. The sending health plan has 14 calendar days after the new NC Medicaid Direct effective date to adjudicate any open and in process PAs.
- Health plans are not required to send daily updates after the NC Medicaid Direct effective date to previously approved PAs. The health plan should only send newly approved PAs (within 14 days of NC Medicaid Direct effective date) after NC Medicaid Direct effective date. These post-effective date, newly approved PAs constitute the daily file.

- To comply with 42 CFR Part 2, health plans are required to remove PAs that meet the 42 CFR Part 2 criterion unless they receive consent from the beneficiary to share the data. Health plans should not send SUD-related PAs where consent has not been obtained.

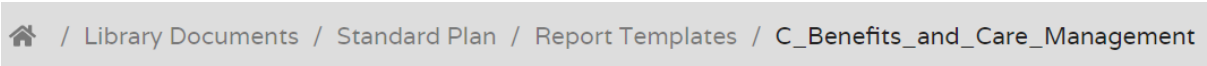
Data Source: Health Plans

Data Target(s): NCTracks

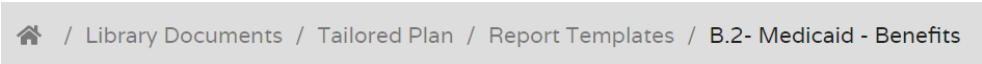
File Layout: The Department established the BCM047 file layout for the Pharmacy PA Extract must be used to send pharmacy PA data from health plans to NCTracks. This format is used to support continuity of care when beneficiaries move from a health plan to NC Medicaid Direct. Rules may differ due to NCTracks requirements for valid values. This file is maintained in PCDU at the paths below.

File Name: *BCM047-J PharmPALayout_T_YYYY_v##.xlsx*

Standard Plan Path:



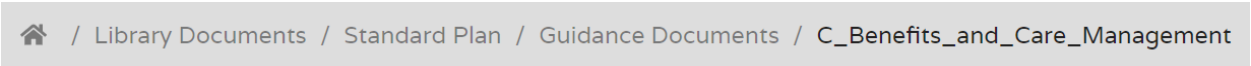
Tailored Plan Path:



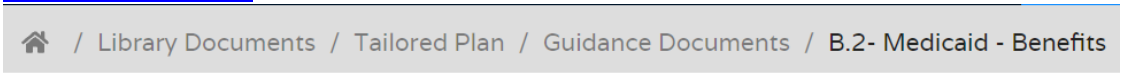
NCTracks developed a Companion Guide health plans should use to ensure the proper values are sent to NCTracks. This file is maintained in PCDU at the paths below.

File Name: *NCMMIS_WPDT_CG_MM.DD.YY_Med PA.pdf*

Standard Plan Path:



Tailored Plan Path:



File Naming Convention:

The format of the file name is as follows:

<File Identifier>_ <Health Plan 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
- Health plan 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. For example, PA_PHARMACY_INPUT_BLUSTC01_20210704_000000.TXT

File Type: Fixed width flat file

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

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

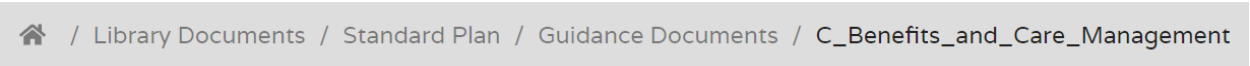
1. Health Plans are to send a full pharmacy PA file to the Department the day before the beneficiary's new NC Medicaid Direct effective date. If the health plan receives a PA request after the initial PA file transfer but before the beneficiary disenrolls the health plan should process according to standard SLAs (within 14 days of receipt), even if the review extends beyond the beneficiary's disenrollment date. If the review results in a newly approved PA after the NC Medicaid Direct effective date, the health plan is to send the newly approved PA in a daily file. This daily file will not include any updates to PAs previously sent.
2. Health plans do not need to send any data to NC Medicaid Direct for beneficiaries transitioning into NC Medicaid Direct prior to the health plan's managed care launch.
3. Health plans should send all approved PAs. If a state approved PA was received by the health plan when the beneficiary transitioned from NC Medicaid Direct to managed care is still active and the health plan has updated the PA data, they should send the updated PA information to NC Medicaid Direct.
4. Health plans are to ensure they do not accept or process any new PAs for beneficiaries that have transitioned to NC Medicaid Direct after their NC Medicaid Direct coverage effective date. For example, beneficiary moves back into NC Medicaid Direct with coverage effective date of 8/1/2021. The health plan should not accept PA requests received after 8/1/2021 for the beneficiary and should advise the provider to submit the PA requests to NC Medicaid Direct.
5. Both sending and receiving systems/entities are 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. Health plans should send pharmacy PAs at the NDC level, as NCTracks does not process GPI. Health plans should 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 health plan.
2. Health plans must populate the PA quantity with a default value of all 9's for all reason codes.
3. Health plans must populate the PA quantity accumulated with a default value of all 9's.
4. After the health plan file is processed, NCTracks will create a reject file with the details of all rejected files from the health plan. The file will be posted in the health plan's outbound server folder. Rejected PAs should be reviewed, corrected, and resubmitted on a subsequent daily file within five business days of the rejection. The format of this file can be found in the Companion Guide in PCDU at the paths below.

File Name: NCMMIS_*WPDT_CG_MM.DD.YY_NCPDP PA.pdf*

Standard Plan Path:



Tailored Plan Path:

File Delivery, Acceptance & Processing Validation: The Department created 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 NC Medicaid Direct 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 enrollment changes: Health plans will receive information regarding a beneficiary's enrollment change through the daily 834 files. Health plans should load and use the data to trigger generation of PA files to the appropriate target.
- Member Cross Reference IDs/Merged Member IDs: Beneficiaries can have multiple Member IDs and those values are included in the 834 files – refer to the 834 Companion Guide for the appropriate loop and reference. Health plans should use the 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) Health Plans to Health Plans (Tailored Plans and Standard Plans): Pharmacy Prior Authorizations

Scope:

- All approved PAs for beneficiaries transitioning from one health plan to another health plan after the health plan's managed care launch, with a PA end date greater than new health plan coverage effective date.
- Health plans are required to include PA history with an end date 45 days prior to the receiving health plan effective date.
- Sending health plans are required to accept PA requests up until 11:59:59 p.m. the night before the receiving health plan's effective date. The sending health plan has 14 calendar days after the receiving health plan's effective date to approve/deny any open and in process PAs.
- Health plans are not required to send daily updates to PAs after the receiving health plan's effective date, only newly approved PAs (within the 14 days) should be sent in the daily updates.
    - To comply with 42 CFR Part 2, health plans are required remove PAs that meet the 42 CFR Part 2 SUD criterion unless they receive consent from the beneficiary to share the data. Health plans should not send SUD-related PAs where consent has not been obtained.

Data Source: Health Plans

Data Target(s): Health Plans

File Layout: The Department established the BCM047 file layout for the pharmacy PA extract must be used to send Pharmacy PA data from health plan to health plan. This format will support continuity of care when beneficiaries move between health plans. Rules may differ due to differing Transition of Care requirements for valid values. This file is maintained in 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 health plan and YYYYY being a short name for the target health plan. Below are the short names for each health plan:

Health Plan Short Name	Health Plan
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 incremental files.

1. A transferring health plan (Health Plan 1) should send the full Pharmacy PA file to a receiving health plan (Health Plan 2) the day before the beneficiary's new Health Plan 2 effective date. If Health Plan 1 receives a PA request after the initial PA file transfer, but before the beneficiary disenrolls, Health Plan 1 will process according to standard SLAs (within 14 days of receipt), even if review extends beyond a beneficiary's disenrollment date. If this review results in a newly approved PA after Health Plan 2's effective date, Health Plan 1 should send the newly approved PAs in a daily file. This daily file should not include updates to PAs Health Plan 1 sent in original PA file. Information on receiving health plan will be available in the future eligibility segments in the 834 file and health plans are to use that data to trigger this process.
2. Transferring health plans are not to send any data to the receiving health plan for any beneficiaries who transition to another health plan prior to health plan's managed care launch.
3. Transferring health plans are to send all approved PAs in their system for a beneficiary transitioning to a new health plan.

4. Sending health plans are not required to send historical PAs (from GDIT) to a receiving health plan.
5. Health plans should ensure they do not accept or process any new PAs for beneficiaries that transitioned to a new health plan after their coverage effective date with the new health plan. For example: beneficiary is currently assigned to Health Plan 1 and moves to Health Plan 2 with a coverage effective date of 4/1/2020. Health Plan 1 should not accept PA requests for the beneficiary on or after 4/1/2020 and should advise the provider to submit them to the Health Plan 2.
6. Receiving health plans are to process and load this data for all beneficiaries assigned to them in their respective systems to allow them to meet all contractual obligations and requirements related to PAs outlined in the health plan contract. Below are key functions health plans are expected to support using this data:
    a. Pay future claims they receive from providers for the remaining units on the PAs.
    b. Support care management functions.
    c. Support continuity of care for beneficiaries transitioning to another health plan or NC Medicaid Direct. The transferring health plan should send all approved PA data to the receiving health plan or NC Medicaid Direct.
    d. Support any data reconciliation efforts related to the data. If the health plan has altered PA data due to their respective operational business rules (i.e., PA effective begin date to align with effective eligibility date) they are to ensure the original source is also stored with them to support any reconciliation efforts and transition of care.
7. Receiving health plans are to load PAs even if there are data fields that are not easily translated into their operational systems.
8. Both source and target systems/entities are 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 health plans will receive information on a beneficiary's enrollment changes through the daily 834 files. They are to load and use the data to trigger generation of PA files to the 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 the values are included in the 834 files – refer to the 834 Companion Guide for appropriate loop and reference. Health plans are to use the 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 health plans will receive Medicaid provider data through the PDC Provider file and are to load prior to processing the PA files.

Behavioral Health Prior Authorizations:

(1) LME/MCOs to Health Plans / LME/MCOs: Behavioral Health PAs

Scope:

This scope is effective 12/01/2022 forward for behavioral health authorizations previously provided by the LME/MCOs. The LME/MCO Data Interface Requirements document should be referenced for behavioral health requirements prior to the launch of the LME/MCOs. When a beneficiary moves from an inpatient

health plan (LME/MCO) to a health plan, the LME/MCO will send the behavioral health PAs for the beneficiary to the plan.

- All approved open behavior health PAs, for beneficiaries transitioning from the LME/MCOs (NC Medicaid Direct) to a health plan's managed care with a PA end date greater than the managed care coverage effective date.
    - At the health plan's managed care go-live, outpatient behavioral health service PAs provided by directly enrolled providers are excluded from the transfer.
- All behavioral health PAs closed within 60 days of the beneficiary's health plan managed care coverage effective date.
- Daily incremental files will include any new, updated or modified PAs for beneficiaries with PAs previously sent, along with any PA data for newly assigned beneficiaries.
- To comply with 42 CFR Part 2, LME/MCOs are required to remove PAs that meet the 42 CFR Part 2 criterion unless they received consent from the beneficiary to share that data and transfer consent form to the receiving entity. LME/MCOs should not send SUD-related PAs where consent has not been obtained.

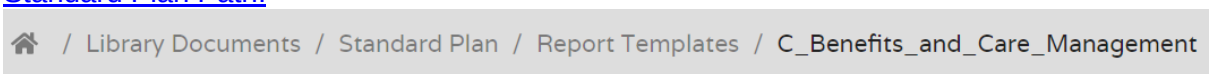
Data Source: LME/MCOs

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

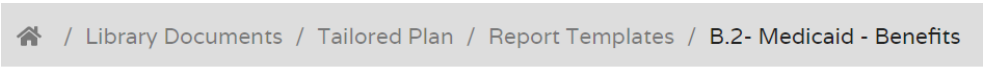
File Layout: The Department established the BCM046 file layout for the behavioral PA extract must be used to send behavioral PA data from health plan to health plan. This format will be used to support continuity of care when beneficiaries move between health plans / LME/MCOs. Rules may differ due to differing Transition of Care requirements for valid values. This file is maintained in PCDU at the paths below.

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

Standard Plan Path:



Tailored Plan Path:



File Naming Convention:
PA_MEDICAL_EXTRACT_DATA_XXXXX_YYYYY-CCYYMMDD-HHMMSS.TXT, with XXXXX being a short name for each transferring health plan and YYYYY being a short name for target health plan. Below are the short names for each health plan:

Health Plan Short Name	Health Plan
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	LME/MCO– Alliance
EASB	LME/MCO – Eastpointe
PARB	LME/MCO – Partners Health Management
SANB	LME/MCO – Sandhills Center
TRIB	LME/MCO – Trillium Health Resources
VAYB	LME/MCO – Vaya Health

File Type: Fixed width flat file

Transmission Type: Secure File Transfer Protocol (sFTP)

File Delivery Frequency & Processing Rules: Daily files

1. Health plans will receive an initial full file for all beneficiaries assigned to them. This will be followed with daily files until the beneficiary's managed care effective date.
2. Health plans are to pick up these files daily, process and load the data for all beneficiaries assigned to them in their respective systems that allows them to meet all the contractual obligations and requirements related to PAs as outlined in the health plan contract. Below are key functions health plans are expected to support using this data:
    a. Pay future claims they receive from the providers for the remaining units on the PAs for services covered under the health plan.
    b. Support care management functions.
    c. Support continuity of care for beneficiaries transitioning to another health plan or NC Medicaid Direct. The transferring health plan is to send all approved PA data to the receiving health plan or the Department.
    d. Support any data reconciliation efforts related to this data. If the health plan has altered PA data due to their respective operational business rules (i.e., PA effective begin date to align with effective eligibility date), they should ensure the original source is also stored with them to support any reconciliation efforts and transition of care.
    e. Rejected PAs are to be reviewed, corrected and resubmitted on a subsequent daily file within five business days of the rejection.
3. The LME/MCO will send PA to the health plans up until 11:59:59 p.m. the night before the health plan managed care effective date. Health plans are to update respective PAs within their operational systems with these updates up until the beneficiary's health plan coverage effective date.
4. Health plans are to load behavioral health PAs 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:** Health plans should store the reference LME/MCO PA ID in their data warehouse if they are unable to load in their downstream system. Claims that come through will likely have the reference ID.
    b. **Medicaid Recipient ID:** Health plans should store the MID in their data warehouse if they are unable to load into their operation system.

c. **Merged ID:** Health plans should be able to ingest claims records for beneficiaries with merged IDs.

d. **PA Type Code:** If health plans are unable to load the PA Type Code into their operation system, they should load into their data warehouse.

e. **Requested Begin Date:** If health plans are unable to load the requested begin date into their operational system, they should load into their data warehouse.

f. **Requested End Date:** If health plans are unable to load the requested end date into their operational system, they should load into their data warehouse.

g. **PA Effective Begin Date:** If the effective begin date is before the health plan eligibility, the health plan can align the effective begin date in their operation system with the eligibility begin date. Health plans 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 health plan effective date, it should be stored in your warehouse for reference and for reauthorization and transfer to a receiving health plan. If the effective end date is outside of your management system policy (>365 days) you should either include the original end date somewhere within your operation system (notes section) or store it in their data warehouse. 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 send rendering NPIs on their PAs. The direction is for the health plans to assign a default code to ingest these PAs.

j. **Blank Procedure Code:** if there is a blank procedure code for a certain PA Type, the health plan is to assign a default code to such field and load into their management system.

5. For the LME/MCO PAs health plans should expect incomplete data. If health plans are not able to load PA data into their operational systems, they are to store the PAs in their data warehouse for reference. Health plans are to use this reference data to adjudicate future claims which will have the reference IDs. If the health plan requires additional information to pay a claim, the health plan should reach out to the LME/MCO or provider to obtain additional information.

File Delivery, Acceptance & Processing Validation: The Department created 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 NC Medicaid Direct 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: LME/MCOs will receive information on beneficiaries assigned to them through the daily 834 files. Health plans are to load their beneficiary assignments 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 files – refer to the 834 Companion Guide for appropriate loop and reference. LME/MCOs are 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: Health plans will receive Medicaid provider data through the PEF Provider file and are to load prior to processing PA files.

(2) Health Plans to LME/MCOs / Health Plans: Behavioral Health Prior Authorizations

Please refer to the LME/MCOs to health plans / LME/MCOs: Behavioral health PAs section, same requirements apply for behavioral health PAs.