CardinalCare

Virginia's Medicaid Program

Managed Care Technical Manual

Virginia Department of

Medical Assistance Services

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Version Change Summary

Ver.	Section	Description	Date
0.0	Multiple	Draft Cardinal Managed Care Technical Manual Created	03/15/2022
0.1	Multiple	Copied KL Sharepoint version as of 03/31/22. Accepted changes and removed Track Changes. Moved comments to document marked in red as 'CRWG'.	03/31/2022
0.2	Multiple	Updated based on MCO feedback	05/19/2022
0.3	2.2.6	Updated field descriptions and specifications. Updated headings in template.	5/26/2022
0.3	2.2.2	Revised HRA and ICP timely completion criteria on template	5/26/2022
0.4	2.1.3	Updated reporting period and template.	6/2/2022
0.4	2.2.27	Updated template.	6/2/2022
0.5	2.2.7	Changed deliverable name to NEMT Missed Trips; added "NEMT" to file name	6/16/2022
0.5	2.2.1	Changed population from Medallion only to both	6/16/2022
0.6	2.2.8	Updated Mental Health Services procedure codes	6/30/2022
0.6	2.2.9	Updated Mental Health Services procedure codes	6/30/2022
0.6	2.2.11	Updated Mental Health Services procedure codes	6/30/2022
0.6	2.3.17	Updated Mental Health Services procedure codes	6/30/2022
0.7	2.4.1	Updated Semi-Annual due dates	8/15/2022
0.7	2.4.1	Updated DMAS responsibility	8/15/2022
0.7	2.4.1.1	Updated file specification requirement fields.	8/15/2022
0.7	2.2.11	Updated deliverable title and file name. Revised narrative introduction to 2.2.11.1 Specifications to accurately convey scope of reporting requirements.	9/13/2022
0.7	2.2.6	Revised headings of report template	9/13/2022
0.7	2.3.16	Removed suspension status as report was reinstated.	9/14/2022
0.7	2.3.16.1	Updated requirement language.	9/14/2022
0.7	2.3.2	File name updated to *.yyyyQN* to identify year and quarter deliverable is submitted.	9/14/2022
0.7	2.3.2	Removed CCCPlus from file name.	9/14/2022
0.7	2.3.7	Removed CCCPlus from file name.	9/14/2022
0.7	2.3.17	Removed CCCPlus from file name.	9/14/2022
0.7	2.5.29	Removed CCCPlus from file name.	9/14/2022
0.7	2.7.11	Removed CCCPlus from file name.	9/14/2022
0.7	2.7.70	Removed CCCPlus from file name.	9/14/2022
0.7	2.7.85	Removed CCCPlus from file name.	9/14/2022
0.7	2.7.91	Removed CCCPlus from file name.	9/14/2022
0.7	3.3.1	Removed CCCPlus from file name.	9/14/2022
0.7	2.5.21	Updated requirements	9/14/2022
0.7	2.3.17	Updated "CMHRS" to "MHS"	9/14/2022
0.7	2.2.8	Updated "CMHRS" to "MHS"	9/14/2022

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<tr><td>0.7</td><td>2.2.8.2</td><td>Format for “file date” and “due date” on “MCO Appeals Open” updated.</td><td>9/14/2022</td></tr>
<tr><td>0.7</td><td>2.2.9.2</td><td>Format for “file date” and “due date” on “MCO Appeals Open” updated.</td><td>9/14/2022</td></tr>
<tr><td>0.7</td><td>2.2.9.1</td><td>Updated first tab file name to “APP_GRIEV_FAMIS”</td><td>9/14/2022</td></tr>
<tr><td>0.7</td><td>2.2.9.1</td><td>Removed “EPSDT”</td><td>9/14/2022</td></tr>
<tr><td>0.7</td><td>2.2.9.1</td><td>Updated “CMHRS” to “MHS”</td><td>9/14/2022</td></tr>
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<tr><td>0.8</td><td>2.2.23</td><td>Estate Recoveries - Deliverable eliminated</td><td>9/27/2022</td></tr>
<tr><td>0.8</td><td>2.2.24</td><td>Monies Recovered by Third Parties - Deliverable eliminated</td><td>9/27/2022</td></tr>
<tr><td>0.8</td><td>2.1.2</td><td>Revised specifications for ‘Validated Member Address Change’ report to match current MED4 requirements</td><td>9/27/2022</td></tr>
<tr><td>0.8</td><td>1.3</td><td>Updated support and contact info</td><td>10/13/2022</td></tr>
<tr><td>0.8</td><td>2.5.29</td><td>Value Based Payment Plan – Removed redundant deliverable (see 2.5.28)</td><td>10/20/2022</td></tr>
<tr><td>0.8</td><td>2.5.28</td><td>Changed file name. Updated methods and requirements.</td><td>10/20/2022</td></tr>
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<tr><td>0.8</td><td>5.5</td><td>Eliminated duplicative deliverable specification.</td><td>10/20/2022</td></tr>
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<tr><td>0.8</td><td>2.3.1</td><td>Added specification for provider network file</td><td>10/19/2022</td></tr>
<tr><td>0.8</td><td>2.5.1</td><td>Added ‘Critical Incident Policy & Procedures’ to Attestations</td><td>10/19/2022</td></tr>
<tr><td>1.0</td><td>2.1.1</td><td>Updated specifications to reflect current status</td><td>11/03/2022</td></tr>
<tr><td>1.0</td><td>Various in Monthly and Annual</td><td>Eliminated all previously ‘Removed’ deliverables and the CYSHCN Assessments report. Renumbered the following sections:
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<tr><td>2.2.25</td><td>2.2.19</td><td>Consumer-Directed EVV Report</td></tr>
<tr><td>2.2.26</td><td>2.2.20</td><td>Fiscal/Employer Agent (F/EA) Scorecard</td></tr>
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<tr><td>2.5.35</td><td>2.5.34</td><td>LOC Policies and Procedures</td></tr>
<tr><td>2.5.36</td><td>2.5.35</td><td>Program Integrity (PI) Plan</td></tr>
</table></td><td>11/03/2022</td></tr>
<tr><td>1.0</td><td>2.5.36</td><td>Added new deliverable “CMS Managed Care Program Annual Report.</td><td>11/03/2022</td></tr>
<tr><td>1.0</td><td>2.7.71</td><td>Updated file name.</td><td>11/03/2022</td></tr>
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<tr><td>2.7.71</td><td>2.7.70</td><td>Sentinel Event</td></tr>
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<tr><td>2.7.81</td><td>2.7.80</td><td>Provider Engagement Plan</td></tr>
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<tr><td>1.0</td><td>2.2.18</td><td>Revised specifications</td><td>11/03/2022</td></tr>
<tr><td>1.1</td><td>2.1.1</td><td>Revised Enrollment Broker Provider file specifications and Appendix 6.8 for consolidated Cardinal file.</td><td>11/15/2022</td></tr>
<tr><td>1.1</td><td>2.5.1</td><td>NEMT Quality Assurance Program Policies and Procedures eliminated</td><td>11/15/2022</td></tr>
<tr><td>1.1</td><td>2.7.89</td><td>Specifications updated</td><td>11/15/2022</td></tr>
<tr><td>1.1</td><td>2.7.99</td><td>Added deliverable NEMT TNC Project Plan per contract requirement</td><td>11/15/2022</td></tr>
</table>

Ver.	Section	Description	Date
1.1	2.3.1	Revised specifications for Provider Network File	11/15/2022
1.1	6.7	Replaced ARTS Taxonomy Codes with Network Adequacy PT PS Taxonomy and Sub-Class	11/15/2022
1.2	2.7.50	Deliverable removed because duplicative of 2.7.51 & 2.7.58	11/29/2022
1.2	2.7.52	Deliverable removed because duplicative of 2.7.51 & 2.7.58	11/29/2022
1.2	2.3.1	Revised specifications for Provider Network File – Deleted Servicing Provider FIPS field	11/29/2022
1.3	2.7.49	Revised due date	12/9/2022
1.3	2.7.51	Revised due date	12/9/2022
1.3	2.7.69	Revised requirements section	12/9/2022
1.3	2.2.2	Updated delivery method	12/9/2022
1.3	2.2.23	Corrected reference to trigger type values list	12/15/2022
1.3	3.2.9	Updated file specifications	12/20/2022
1.3	2.2.22	Corrected contract reference	12/20/2022
1.3	2.2.8	Updated file specifications	12/28/2022
1.3	2.4.1	Revised due date	02/06/2023
1.3	2.3.1	Added Optima identifier in MCO list.	02/26/2023
1.3	2.3.6	Removed deliverable 2.3.6. Duplicate of 2.3.7 per PI.	02/26/2023
1.3	2.5.29	Updated file specifications	03/01/2023
1.3	2.5.29	Updated file requirements section	03/01/2023
1.3	2.5.30	Deliverable Eliminated	03/01/2023
1.3	2.3.5	Changed deliverable due dates per PRD	03/28/2023
1.3	2.1.4.1	Eliminated term “Phase I” from specifications	04/20/2023
1.3	2.3.2.1	Updated file specifications	04/21/2023
1.3	2.2.24	Added deliverable Renewal and Closure Outreach Report	05/19/2023
1.4	6.7	Table values updated	07/24/2023
1.4	2.2.10	Updated file name	07/26/2023
1.4	2.7.97	Moved 2.7.97 from Other Reports to Monthly Reports as 2.2.25	07/26/2023
1.4	2.2.25	Added deliverable to Monthly Reports – formerly 2.7.97	07/26/2023
1.4	2.3.2.1	Updated file specifications	08/01/2023
1.4	2.3.18	Added deliverable Provider Credentialing Timeliness Report	08/01/2023
1.4	2.7.96	Removed deliverable ARTS Provider Network Change Affecting Member Access to Care	08/03/2023
1.4	2.7.100	Added deliverable ARTS Provider Network File	08/03/2023
1.5	2.1.3	Changed submission method from FTP to Email.	10/01/2023
1.5	2.2.20	Updated deliverable requirements.	10/11/2023
1.5	2.3.13	Updated deliverable requirements.	10/11/2023
1.5	2.1.3	Changed DMAS email address	10/11/2023
1.5	2.2.21	Changed DMAS email address	10/11/2023
1.5	2.2.26	Added Early Intervention Services report. This is an existing Medallion 4.0 report. Determination was made that this report is needed for Cardinal Care.	10/11/2023
1.5	2.7.93	Updated deliverable requirements.	10/18/2023
1.6	6.9	REMOVED	10/25/2023

Ver.	Section	Description	Date
1.6	6.10	REMOVED	10/25/2023
1.6	3.1.2	REMOVED – Claims Medical Transition – CCC PLUS	10/26/2023
1.6	3.2.13	REMOVED – Claims Medical Transition – Medallion 4.0	10/26/2023
1.6	3.2.14	REMOVED - Behavioral Health (BHSA) Claims History	10/26/2023
1.6	3.2.15	REMOVED – FFS Claims Report	10/26/2023
1.6	2.7.71	Updated the Format, Filename, DMAS, and Requirements section	11/01/2023
1.6	6.11	Section 6.11 moved to section 6.9	11/01/2023
1.6	2.3.14.1	Updated deliverable requirements	11/01/2023
1.6	2.3.15.1	Updated deliverable requirements	11/01/2023
1.6	2.1.4	Documented reporting period for report	11/01/2023
1.6	2.5.1	Added submission file names for attestation deliverables	11/01/2023
1.7	2.7.53	REMOVED – Notice of Provider Payment Suspension	11/08/2023
1.7	2.2.27	Added Deliverable for service going live 1/1/2024	11/14/2023
1.7	2.2.2	Changed due date to the 15th of the month	11/14/2023
1.7	2.1.3	Updated distribution list / method to match template instructions	11/28/2023
1.7	2.2.7	Added effective date of February 15, 2024 for first report due	11/28/2023
1.7	2.3.7	Added note to deliverable requirements	11/29/2023
1.7	2.5.12	Updated deliverable requirements	11/29/2023
1.7	2.7.49	Updated template	11/29/2023
1.7	2.7.51	Updated template	11/29/2023
1.7	2.7.58	Updated template	11/29/2023
1.7	2.2.7	Altered name of deliverable	11/29/2023
1.7	Various	Updated SharePoint links	11/29/2023
1.8	2.3.8	Updated deliverable requirements and template	12/1/2023
1.8	2.3.7	Updated template and instructions workbook; added reference to instructions workbook	12/1/2023
1.8	2.1.4	Updated submission method in template	12/1/2023
1.8	2.2.24	Updated File Name naming convention	12/5/2023
1.8	2.7.70	Updated File Naming convention	12/6/2023
1.8	2.3.2	Updated Requirements	12/6/2023
1.8	2.7.63	Updated submission method and requirements	12/7/2023
1.8	2.2.2	Updated template to allow entry of HRA/ICP dates back to 12/31/22	12/7/2023
1.9	2.7.70	Updated Requirements	12/20/2023
1.9	2.1.3	Updated email distribution list	1/3/2024
1.9	2.3.7	Updated template and instructions workbook	1/3/2024
1.9	2.2.25	Frequency changed from monthly to on request. Refer to deliverable 2.7.101 for specifications.	1/4/2024
1.10	2.5.29	Updated due date	1/17/2024
1.10	2.7.61	Updated file name, form name and requirements.	1/19/2024
1.10	2.7.51	Updated format to be used	1/19/2024
1.10	2.7.56	Updated requirements	1/19/2024
1.10	2.7.58	Updated format to be used	1/19/2024
1.10	2.5.8	Updated format (new template) and requirements section	1/22/2024
1.10	2.5.1	Updated contract references	1/23/2024

Ver.	Section	Description	Date
1.10	2.2.2	Added CMT Dashboard Version 1.3 for fully implemented model of care. Updated specifications with regard to the version of the dashboard to be used based on the model of care.	1/25/2024

Version Release Dates

Version	Release Date
0.1	05/06/2022
0.2	05/19/2022
0.3	05/26/2022
0.4	06/02/2022
0.5	06/16/2022
0.6	06/30/2022
0.7	09/22/2022
0.8	10/20/2022
1.0	11/03/2022
1.1	11/17/2022
1.2	12/01/2022
1.3	05/25/2023
1.4	08/03/2023
1.5	10/19/2023
1.6	11/02/2023
1.7	11/30/2023
1.8	12/07/2023
1.9	01/04/2024

1 General Information

1.1 Introduction

This manual provides detailed technical specifications for all contractual deliverables required for the Virginia Cardinal Care Managed Care program. The primary audience is the contracted Cardinal Care Managed Care plans (referred to as “Contractors” or “Health Plans” or “MCOs”). The purpose is to provide a clear and common understanding of the deliverable requirements. It is intended to ensure accuracy of the MCO data submissions and to reduce the need for corrections and resubmissions.

Cardinal Care Managed Care reports should include all Cardinal Care managed care populations and operations unless otherwise specified.

Where there are differences between the Cardinal Care Contract and the Cardinal Care Technical Manual, the Technical Manual is the source of truth for reporting specifications.

1.2 Deliverable Reporting Standards

DMAS **strongly recommends** that Contractors develop automated reporting processes for each deliverable in order to maintain the consistency and accuracy of ongoing deliverable submissions. It has been the Department's experience that manual reporting processes are prone to errors and inconsistencies. DMAS also recommends each Contractor develop and implement standardized processing for each deliverable submission, including comprehensive quality control procedures to ensure data integrity and accuracy.

All deliverable submissions must conform to the specifications documented in the current version of this Technical Manual, including all documented formatting requirements. It is the Contractor's responsibility to comply with these specifications. Any submission that does not comply with these specifications may be rejected by DMAS in total or in part. The Contractor may be required to correct and re-submit deliverables as necessary to comply with the reporting requirements set forth in this document. Any submission that does not comply with these specifications may be rejected by DMAS in total or in part, and may be subject to assessment of compliance penalties. All reporting manual reporting requirements are required at the contract level, unless otherwise indicated.

The source of truth for the functionality, scheduling, and data specifications of all system files included in this reporting manual (e.g., 834, 820, CRMS, PRSS), whether those files are generated by DMAS MMIS or received by DMAS from the Contractor, shall be the respective HIPAA-required transaction standards, MMIS system design documents, companion guides, and vendor manuals in which they were originally described. Where there is any conflict between this manual and those original sources, Cardinal health plans must comply with the original sources. A diligent effort will be made by DMAS to keep the *Cardinal Care Managed Care Technical Manual* aligned with those sources.

The version number of the Technical Manual will be incremented whenever any change is made within the document. Every change will be documented in the 'Version Change Summary' section at the front of the document.

DMAS reserves the right to request ad hoc reports. These reports may include those described in the *Cardinal Care Managed Care Technical Manual* outside the regular submission schedule, as well as others not covered in the manual. Upon such request, Cardinal Care Health Plans will be given a reasonable amount of time for ad hoc report submission.

It is the MCOs' responsibility to ensure that they are using the most current version of the Cardinal Managed Care Technical Manual for their next submission to DMAS.

Updated versions of the Cardinal Care Managed Care Technical Manual will be released once a month on the 15th (adjusted for weekends and state holidays). The Technical Manual will be updated no more frequently than once a month.

DMAS will post the Cardinal Care Managed Care Technical Manual on the state's secure SharePoint site that has been established for the MCOs.

1.3 Secure File Transfers and Data Exchanges

DMAS uses different methods to support the secure transfer of files with the MCOs. MCOs and/or individual users are issued a secure login account and each MCO has its own dedicated folders.

Cardinal Care Managed Care Contract Deliverables (Cardinal FTP)

Examples:	All deliverables listed in section 1 and 2 of this technical manual
Site:	mft.dmas.virginia.gov
Availability:	Batch transfers are executed 3 times daily at 6:00 AM, Noon, and 6:00 PM (EST).
Account(s):	Use the existing MEDALLION service center 'machine-to-machine' accounts (i.e., 1044, 1045, 1046, 1047, 1048, 1049). After 07/01/2022, do not use the CCC PLUS FTP accounts for Cardinal deliverables unless specifically directed to do so.
Support:	**managedcare.reporting@dmas.virginia.gov**

Cardinal Care Managed Care SharePoint (MCO SharePoint)

Examples:	Deliverable Templates, Cardinal Technical Manual
Site:	***TBD***
Availability:	Real-time transfers, 24hours / 7 days
Account(s):	***TBD***
Support:	***TBD***

MES System Files (ISS)

Examples:	File Transfers 834, 820, 270/271, MCF195/MCF196, PRSS PRNs & NPPR, CRMS.
Site:	MES ISS
Availability:	Real-time transfers, 24hours / 7 days
Account(s):	Each user is issued a unique MES account based on their email.
Support:	**Phone**: MES Technical Assistance – **(804)-371-7776** – Mon-Fri 8:00 AM – 5:00 PM EST (except for state holidays). *Please do not share this number with providers or members. This number is for MCO use only.* **Email**: *MES-Assist@dmas.virginia.gov*. **Documentation:** **ISS Files:** ISS File Naming Standards **FAS EDI:** DMAS 820 & 834 Companion Guides **MMHS Screening Files:** (MCF195/MCF196) See Section 4 of this document **PRSS:** Virginia Provider Network PRN File Guide & Virginia Provider NPPR File Guide, VA Crosswalk Legacy PT SPEC Taxonomy, PRSS Provider Code Value Descriptions, VA Enrollment Attachments. **CRMS:** CRMS MCO Technical Manual & MCO MTR Specifications

PRSS MCO Portal (Online)

Examples:	PRSS Provider Participation Requests, Provider Application Materials
Site:	MES SSO: https://login.vamedicaid.dmas.virginia.gov/SecureISS/landingpage
Availability:	Online, 24hours / 7 days
Account(s):	Each user is issued a unique MES account based on their email.
Support:	**Phone**: MES Technical Assistance – **(804)-371-7776** – Mon-Fri 8:00 AM – 5:00 PM EST (except for state holidays). *Please do not share this number with providers or members. This number is for MCO use only.* **Email**: *MES-Assist@dmas.virginia.gov*.

PRSS Provider Portal (Online)

Examples:	Member Eligibility Verification,
Site:	MES SSO: https://login.vamedicaid.dmas.virginia.gov/SecureISS/landingpage
Availability:	Online, 24hours / 7 days
Account(s):	Each user is issued a unique MES account based on their email.
Support:	**Phone**: MES Technical Assistance – **(804)-371-7776** – Mon-Fri 8:00 AM – 5:00 PM EST (except for state holidays). *Please do not share this number with providers or members. This number is for MCO use only.* **Email**: *MES-Assist@dmas.virginia.gov*.

Encounters and EPS Portal (Online)

Examples:	X12 (837I & 837P), NCPDP Technical Support Issues, EPS Business Rules, Encounter Data Certifications, Pymt Cycle Data, Encounter Reports.
Site:	EPS (MFTP) Submissions: mft.dmas.virginia.gov EPS Portal via MES SSO: https://login.vamedicaid.dmas.virginia.gov/SecureISS/landingpage
Availability:	Real-time, 24hours / 7 days
Account(s):	Each user is issued a unique MES account based on their email. Files should be submitted using the service center IDs issued by DMAS for each program and MCO (e.g., CP14 and M444). CCC PLUS and MEDALLION encounter data must be submitted separately using the appropriate service center identifier.
Support:	Refer to ***Cardinal Care Encounters Technical Manual - Section 2.4.3*** for detailed contact/ support information

1.4 Deliverable Monitoring and Compliance

DMAS will evaluate each deliverable submission according to the following requirements. Violation may result in compliance action from DMAS.

1.4.1.1 Transmittal Requirements

In particular, each of the following requirements must be met in order for a submission to be accepted by DMAS for processing:

- Submission must be transmitted via the method specified for the deliverable (e.g., DMAS secure FTP).
- File must be formatted as specified for the deliverable (e.g., comma separated values, Excel, Adobe PDF).
- The filename on the report must exactly match the filename specified for the deliverable (including extension).
- All columns/fields specified for the deliverable must be included in the submission in the order specified, with the inclusion of no additional columns/fields. Do not include a header row in .csv files. If there is no data to report for a specific report, submit the report, but leave it blank without headers or any other text.
- Except as otherwise specified, only one consolidated deliverable per report cycle is submitted. The Contractor cannot submit separate deliverables for their subcontractor(s).

In the event that a plan has no data to report for a regularly scheduled deliverable, the plan must submit a blank report to verify that no data was available and that the deliverable was not missed.

1.4.1.2 Timeliness and Resubmissions

Late submissions are submissions of a deliverable after the specified due date. Resubmissions are submissions either requested by the Contractor or by DMAS. Unless requested directly by DMAS, the Contractor shall request pre-approval for all resubmissions. The cut-off for timely delivery via the DMAS secure FTP is 6:00 PM EST/EDT on the specified due date.

In the event that a due date falls on a weekend day or a state holiday, the due date will be changed to the first business day following the weekend or holiday.

2 Contractor Deliverables

2.1 Weekly Reports

2.1.1 Enrollment Broker Provider Files

Contract 7.1.3

Method: Cardinal FTP

Format: Comma separated value (.csv) file. All columns/fields must be included in the order specified, with no additional/omitted columns. Do not include a header row.

File Name: EB_PROV.csv

Trigger: Weekly

Due Date: Every Monday

Population: Include CCC PLUS and MEDALLION

DMAS Provider, Enrollment Broker

2.1.1.1 File Specifications

Field	Specifications	Type
Provider Taxonomy	Required. Only taxonomy code values that are on the provider type crosswalk provided in the Appendix Table will be accepted.	CHAR(10)
NPI Number	Required. Must be a valid NPI assigned by NPPES.	NUM(10)
Filler	Fill with zeros or spaces.	CHAR(09)
Provider Name Type	Required. Identifies whether provider name provided is for business or individual. Valid values are: O= Organization; I= Individual. If value is 'O', then provider first name field must be blank.	CHAR(1)
Provider Last Name	Required. For provider name type = 'O', organization name is stored here.	CHAR(50)
Provider First Name	Situational. Field will be blank If value of Name Type is 'O'.	CHAR(30)
Address Line 1	Required. First line of provider's servicing location address.	CHAR(30)
Address Line 2	Optional. Second line of provider's servicing location address. Provide if available.	CHAR(30)
City	Required.	CHAR(30)
State	Required. Include only providers with servicing locations in Virginia and contiguous states. Providers in all other states will be dropped.	CHAR(2)
Zip Code	Required. Must provide the full 9-digit zip code. Use leading zeroes if necessary. If plus-four is unavailable, populate with '0000'.	NUM(9)
Phone Area Code	Required.	NUM(3)
Phone Number	Required.	NUM(7)
Phone Extension	Optional.	NUM(4)
Evening Hours	Required. Indicates that the provider offers evening hours for patient visits. Valid values are: Y, N, and U. Default to U if not available.	CHAR(1)
Weekend Hours	Required. Indicates that the provider offers weekend hours for patient visits. Valid values are: Y, N, and U. Default to U if not available.	CHAR(1)
Language 1	Optional. If provided, must use code values from the code set provided in this specification below.	CHAR(2)
Language 2	Optional. If provided, must use code values from the code set provided in this specification below.	CHAR(2)
Language 3	Optional. If provided, must use code values from the code set provided in this specification below.	CHAR(2)

Field	Specifications	Type
Wheelchair Accessible	Required. Indicates that the provider's service facility is wheelchair accessible. Valid values are: Y, N, and U. Default to U if not available.	CHAR(1)
Group Affiliation	Optional.	CHAR(50)
Provider's Gender	Required. Valid values: M, F, U. Default to U if not available.	NUM(1)
Low Age Limit	Required. Identifies any age restrictions imposed by provider. This is the lowest patient age served by the provider. Default to 0 if unavailable.	CHAR(3)
High Age Limit	Required. Identifies any age restrictions imposed by provider. This is the highest patient age served by the provider. Default to 120 if unavailable.	NUM(3)
Gender(s) Served	Required. Identifies any gender restrictions imposed by provider, i.e., if the provider serves only Males, Females, or Both genders. Valid values: M, F, B. Default to B if not available.	CHAR(1)
PCP Status	Required. Indicates that this provider meets the qualifications to serve as a Primary Care Physician for patients (as defined by the MCO). Valid values are Y and N. Default to N if not available.	CHAR(1)
Accepting New Patients	Required. Indicates that the provider is accepting new Medicaid patients. Valid values are: Y, N, and U. Default to U if not available.	CHAR(1)
Site Number	OPTIONAL VALUE – A unique value that identifies each of the different locations within an NPI.	NUM(3)

2.1.1.2 Requirements

Submit one consolidated file containing all CCC+ and MED4 network providers.

- File must be submitted every week. MCO can submit the same file from the prior week if there were no updates or if your extract process does not run every week. MCOs should update the file content on a monthly basis at minimum.
- Every file is a full file replacement. Do not submit partial / incremental / transactional update files.
- Do not submit more than one record with the same NPI, taxonomy, and zip code.
- The Provider Taxonomy value provided by the MCO will be used to determine the Maximus provider type reported in Enrollment Broker provider searches. See Appendix 6.8 for the crosswalk of taxonomy to Enrollment Broker provider type.
- MCO may provide records with different taxonomy codes for the same provider location when applicable, but only one record per service location and Maximus provider type is allowed.

2.1.2 Validated Member Address Change

Contract 4.3.6

Method: Cardinal FTP

Format: Comma separated value (.csv) file. All columns/fields must be included in the order specified, with no additional/omitted columns. Do not include a header row.

File Name: MEM_ADDR_CHNG.csv

Trigger: Weekly

Due Date: By 6 PM each Monday

Population: Include CCC PLUS and MEDALLION

DMAS: Eligibility & Enrollment Unit

2.1.2.1 File Specifications

Field Description	Optional/Required	Specifications
Program	Required	Valid Values are MED4 and CCCP
Medicaid ID	Required	Must be a valid Medicaid ID with active eligibility Format: 12 bytes with leading zeros
Member Last Name	Required	Must be 20 characters or less
Member First Name	Required	Must be 13 characters or less
Old Mailing Address 1	Required when new mailing address is provided	Must be 40 characters or less
Old Mailing Address 2		Must be 40 characters or less (Optional)
Old Mailing City		Must be 17 characters or less
Old Mailing State		Must be 2 characters or less Must be a valid 2-digit state code
Old Mailing Zip		Must be either 5 or 9-digit numeric
New Mailing Address 1	Required when old mailing address is provided	Must be 40 characters or less
New Mailing Address 2		Must be 40 characters or less (Optional)
New Mailing City		Must be 17 characters or less
New Mailing State		Must be 2 characters or less Must be a valid 2 digit state code
New Mailing Zip		Must be either 5 or 9-digit numeric
Old Physical Address 1	Required when new physical address is provided	Must be 40 characters or less
Old Physical Address 2		Must be 40 characters or less (Optional)
Old Physical City		Must be 17 characters or less
Old Physical State		Must be 2 characters or less Must be a valid 2-digit state code
Old Physical Zip		Must be either 5 or 9-digit numeric
New Physical Address 1	Required when old physical address is provided	Must be 40 characters or less
New Physical Address 2		Must be 40 characters or less (Optional)
New Physical City		Must be 17 characters or less
New Physical State		Must be 2 characters or less Must be a valid 2-digit state code
New Physical Zip		Must be either 5 or 9-digit numeric

Field Description	Optional/Required	Specifications
Telephone Number	Optional	10-digit number. Do include commas, hyphens, or other characters. Do not use default values.
Source Code	Required	Valid values are: M = Member F = Family N = NEMT O = Other X = Not applicable (default)
Method Code	Required	Valid values are: T = Text C = Call Center L = Letter O = Other X = Not applicable (default)

2.1.2.2 Requirements

Data Submission and Validation:

1. If the MCO doesn't have any updates for the week, they should submit an empty file to DMAS with zero records.
2. All columns/data elements must be included as specified above. Values must be provided for all required fields (including Source and Method). Use specified default values when other values are not available.
3. DMAS will generate and send a validation / error report to each MCO on Tuesdays. This report summarizes records received and lists all errors. Validation report name will be MCO_xxxx_AdrChgVal_yyyymmdd.xlsx.
4. Any record with one or more errors will not be used in the address updates. The MCO should correct these records and submit them with their next submission the following week.

Goal:

If there are multiple members in the household, DMAS would like to ensure that health plans ensure that all records are updated and changes are submitted to DMAS at the same time.

Things to consider:

- Does your plan's process include bringing up records if there are multiple household members on the same plan?
- Does your plan ask the caller if the address change affects more than one individual?

Scripts:

In order to meet the goal, scripts should include the following information:
Asking if there are other members on the same health plan if your system doesn't automatically pull them all up at the same time [e.g., Who else in your home is with (insert plan name here)?]. Stick to open ended questions instead of close ended. If the member indicates that only some of the household members have moved (meaning they are not in the same residence any longer) they need to call Cover VA or their local worker to let them know who has moved and who is no longer part of that household.

2.1.3 Transportation Network Company (TNC) Report

Contract:	5.14.24
Method	Upload to Cardinal FTP *AND* Send as email attachment to the following DMAS staff: Aaron.Moore@dmas.virginia.gov Nicki.Taylor@dmas.virginia.gov Charlotte.Bennett@dmas.virginia.gov Douglas.Gleason@dmas.virginia.gov Tina.Davis@dmas.virgnia.gov Joey.Miller@dmas.virginia.gov
Format	Use Cardinal TNC Report template
File Name	TNC_RPT.xlsx
Trigger	Weekly
Due Date:	By noon Wednesday following Saturday through Friday reporting period (or by noon on Thursday if Wednesday is not a business day)
Population:	Report CCC Plus and MEDALLION members on SEPARATE tabs
DMAS:	Transportation Unit

2.1.3.1 Requirements

Use the current version of the Weekly TNC Report template provided by DMAS. The report submission should include eight tabs with the CCC Plus members reported separately from MEDALLION members.

The daily statistics for each week's report should be appended to the report submitted the previous week (i.e., the report should contain the daily statistics for the current and all prior reporting periods on the same "TNC Weekly Stats" tab). The reporting of TNC complaints on the "TNC Complaint Details" tab as well as the weekly totals on the vaccination and booster shot tabs should also be cumulative for all reporting periods.

2.1.4 Care Management Report

Contract	Section 8.4 Care Management
Method:	Cardinal FTP
Format:	Use Cardinal Report template
File Name:	CCMOC_*Contractor Name*_mmddyyyy.xlsx
	(where mmddyyyy is the date of submission)
Trigger:	Weekly
Due Date:	Each Friday by noon for reporting period Sunday thru Saturday
Population:	Include CCC PLUS and MEDALLION
DMAS:	Care Management

2.1.4.1 Requirements

This report will function as a care management log, detailing which members have been classified as members of the Cardinal Care Targeted Population at any time up through the last day of the reporting period. The Targeted Population consists of the following members: CCC Plus Waiver members receiving PDN, Children receiving PDN through EPSDT and Ventilator-Dependent members (by setting).

Use the current version of the Model of Care template provided by DMAS. Reports submitted with headings that differ from those on the current template will be sent back for resubmission.

The Summary tab should include all Cardinal Care Targeted Population members who were actively enrolled within the targeted population at any time during the reporting period.

The Member Detail tab is updated each week to add new members identified since the last report and will list all members who have been classified as members of the targeted population *at any time* up through the last day of the reporting period.

2.2 Monthly Reports

2.2.1 MCO Claims Report

Contract	Section 12.1
Method:	Cardinal FTP
Format:	Comma separated value (.csv) file. All columns/fields must be included in the order specified, with no additional/omitted columns. Do not include a header row.
File Name:	MCO_RPT.csv
Trigger:	Monthly
Due Date:	By close of business on the 15th calendar day of the month following the end of the reporting month.
Population:	Include CCC PLUS and MEDALLION
DMAS:	Various

2.2.1.1 File Specifications

Field Description	Specifications
Month Begin Claims Inventory	Value must be ≥ 0
Claims Received This Month	Value must be ≥ 0
Claims Processed (Paid Or Denied) This Month	Value must be ≥ 0
Number Of Claims Paid This Month	Value must be ≥ 0
Number Of Claims Denied This Month	Value must be ≥ 0
Number Of Claims Pended This Month	Value must be ≥ 0
Claims Processed This Month: PMT DT - Receipt DT < 30	Value must be ≥ 0
Claims Processed This Month Within 31-90 Days Of Receipt	Value must be ≥ 0
Claims Processed In 91-365 Days	Value must be ≥ 0
Claims Processed Over 365 Days	Value must be ≥ 0
Number of Inpatient Authorizations Approved	Value must be ≥ 0
Number of Inpatient Authorizations Limited	Value must be ≥ 0
Number of Inpatient Authorizations Denied	Value must be ≥ 0
Number Of PCPs With Open Panels	Value must be ≥ 0
Number Of PCPs With Closed Panels	Value must be ≥ 0
Number Of PCPs With Restricted Panels	Value must be ≥ 0

This file shall only include original claims (i.e., not adjusted claims). Do not include "unclean" claims.

5. **Claims:** For those claims that have multiple denial or pend reasons, report that claim under each reason (i.e., some claims may be reported multiple times).
6. **Claims Volume:** The Month Begin Claims Inventory shall be equal to the prior month's Month End Claims Inventory.
7. **Claims Processed:** Number Of Claims Paid This Month + Number Of Claims Denied This Month = Claims Processed (Paid Or Denied) This Month.
8. **Claim Processing Turnaround:** Claims Processed This Month: PMT DT - Receipt DT < 30 + Claims Processed This Month Within 31-90 Days Of Receipt + Percent Processed In 91-365 Days + Percent Processed Over 365 Days = Claims Processed (Paid Or Denied) This Month.

2.2.2 CMT (Contract Monitoring Team) Dashboard

Contract	
Method:	Cardinal SharePoint
Format:	Use one of the CMT Dashboard report templates located on SharePoint: For the transitional model of care use CMT Dashboard Version 1.2 For the fully implemented Cardinal model of care use CMT Dashboard Version 1.3
File Name:	CMT_Dashboard_*MCO Name_MMM_yyyy*.xlsx where MMM = three-letter month (JAN, FEB, MAR, etc.)
Trigger:	Monthly
Due Date:	By close of business on the 15th calendar day of the month following the end of the reporting month.
Population:	Both
DMAS:	

2.2.2.1 Requirements

The CMT dashboard is used to monitor compliance with Cardinal Care contract requirements for vulnerable and high risk members (primarily CCC Plus). It contains the following tabs:

- Enrollment & Care Coordination
- HRA
- HRA %
- ICP
- ICP %
- Claims
- Pharmacy
- Authorizations
- Appeals & Complaints

For specific reporting requirements, see the CMT Dashboard instructions on SharePoint.

2.2.3 Live Births

Contract	Section 3.7 Enrollment Process for Newborns
Method:	Cardinal FTP
Format:	Comma separated value (.csv) file. All columns/fields must be included in the order specified, with no additional/omitted columns. Do not include a header row.
File Name:	BIRTHS.csv
Trigger:	Monthly
Due Date:	By close of business on the 15th calendar day of the month following the end of the reporting month.
Population:	Include CCC PLUS and MEDALLION
DMAS:	Newborns Team

2.2.3.1 File Specifications

Field Description	Specifications
Mother Last Name	Must be 20 characters or less
Mother First Name	Must be 13 characters or less
Mother ID Number	Must be a valid Medicaid ID Format: Numeric 12 bytes with leading zeros
Newborn Last Name	Must be 20 characters or less
Newborn First Name	Must be 13 characters or less
Date of Birth	Must be a valid date Format = mm/dd/yyyy Must be <= report date
MCO Newborn ID Number	Must be 13 characters or less
DMAS Newborn ID Number	Must be a valid Medicaid ID or blank Format: 12 bytes with leading zeros
Mother Enrolled in MCO Prenatal Program	Valid values are 'Y' and 'N'.
Newborn Birth Weight	Optional - Numeric value must be >= 244 and <=11,000.
Estimated Gestation Period	Optional - Numeric value must be >= 22 and <= 54.

2.2.3.2 Requirements

Eligibility: Report all newborn live births that occurred during the reporting period, plus any live births identified during the current reporting period that were not reported to DMAS by the MCO in a previous submission.

The MCO shall not report the same newborn to DMAS more than once.

MCO Newborn ID Number: ID number assigned to the newborn by the MCO. This shall be a unique number for that newborn.

DMAS Newborn ID Number: ID number assigned to the newborn by DMAS in the MMIS. Enter the Medicaid ID if known. Otherwise, leave blank. DMAS will research all newborns reported without valid Medicaid IDs and report back to the MCO on the weekly newborn report.

Mother Enrolled MCO Prenatal Program: Use the following values: Y = Yes or N = No.

Newborn Birth Weight: Report newborn weight at birth in grams. Reporting this information is optional.

Estimated Gestation Period: Report mother's gestation period in weeks. Reporting this information is optional.

2.2.3.3 Examples

In the examples below, the reporting cycle is August. This report is submitted to DMAS on September 15th.

#	Scenario	Outcome
1	Program: Medicaid Date of Birth: 08/12/xxxx First Time Member Reported? Y	Member shall be included in the report.
2	Program: FAMIS Date of Birth: 09/08/xxxx First Time Member Reported? Y	Member shall NOT be included in the report because they shall be reported in next month's cycle.
3	Program: FAMIS Age: Date of birth 07/12/xxxx First Time Member Reported? Y	Member shall be included in the report because even though they were born in prior month they were not previously reported.
4	Program: Medicaid Date of Birth: 07/12/xxxx First Time Member Reported? N	Member shall NOT be included in the report because they were previously reported in prior cycle.

2.2.4 Newborn Reconciliation File

Contract: Section 3.7.1 Infants of Contractor Enrolled Members

Method: Cardinal FTP

Format: Comma separated value (.csv) file. All columns/fields must be included in the order specified, with no additional/omitted columns. Do not include a header row.

File Name: NB_Recon.csv

Trigger: Monthly

Due Date: By close of business on the 15th calendar day of the month after the month the newborn turned age one.

Population: Include CCC PLUS and MEDALLION

DMAS: Newborn Unit

2.2.4.1 File Specifications

Field Description	Specifications
Mother Last Name	Must be 20 characters or less
Mother First Name	Must be 13 characters or less
Mother ID Number	Must be a valid Medicaid ID. Format: 12 bytes with leading zeros
Newborn Last Name	Must be 20 characters or less
Newborn First Name	Must be 13 characters or less
Date of Birth	Must be a valid date. Format = mm/dd/yyyy
MCO Newborn ID Number	Must be 13 characters or less. Required field. Must uniquely identify each child when there is a multiple birth.
DMAS Newborn ID Number	Must be a valid Medicaid ID or blank. Format: 12 bytes leading zeros

2.2.4.2 Requirements

The MCO NB_Recon file is submitted monthly by the MCO for each MCO newborn (live birth) when a payment was not received on the 820 payment report for the birth month (BM1), and/or birth month plus 1 (BM2) and/or birth month plus 2 (BM3). The report is submitted monthly. The submission month is the month following the month in which the newborn turned age one.

MCO Newborn ID Number: ID number assigned to the newborn by the MCO. This shall be a unique number for that newborn. Twins shall be submitted individually each with a unique MCO ID Number.

DMAS Newborn ID Number: ID number assigned to the newborn by DMAS in the MMIS. Enter the Medicaid ID if known. Otherwise, leave blank.

2.2.4.3 Examples

MCO newborns with a date of birth (DOB) in the month of January 2013. If a payment was not received by the MCO for the BM1 - January 2013, and/or BM2-Feburary 2013, and/or BM3-March 2013, the MCO newborn shall be included on the February 2014 monthly NB_Recon submission report.

Upon receipt, the file submission is validated against MMIS data and a return file, DMAS Newborn Reconciliation Return File (**NB_Recon_Return**), is generated for the MCO.

2.2.5 MCO Call Center Statistics

Contract	Section 2.12.2 Member Call Center Requirements, Section 2.12.3 Provider Call Center Requirements
Method:	Cardinal FTP
Format:	Comma separated value (.csv) file. All columns/fields must be included in the order specified, with no additional/omitted columns. Do not include a header row.
File Name:	CALL_CENTER.csv
Trigger:	Monthly
Due Date:	By close of business on the fifteenth (15th) calendar day of the month following the end of the reporting month.
Population:	Include MEDALLION and CCC PLUS
DMAS:	TBD

2.2.5.1 File Specifications

The report will include statistics for the following call center lines:

- Member Customer Service
- Member Behavioral Health
- Care Management
- Nurse Triage
- Non-LTSS Provider Line
- LTSS Provider Line
- Pharmacy
- Transportation

Field Description	Specifications
Total Member Customer Service Calls Received	Value must be ≥ 0
Total Member Customer Service Calls Answered	Value must be ≥ 0
Total Member Customer Service Calls Abandoned	Value must be ≥ 0
Average Member Customer Service Speed of Answer	Format = mm:ss
Average Member Customer Service Hold Time	Format = mm:ss
Average Member Customer Service Handle Time	Format = mm:ss
Total Member Behavioral Health Calls Received	Value must be ≥ 0
Total Member Behavioral Health Calls Answered	Value must be ≥ 0
Total Member Behavioral Health Calls Abandoned	Value must be ≥ 0
Average Member Behavioral Health Speed of Answer	Format = mm:ss

Field Description	Specifications
Average Member Behavioral Health Hold Time	Format = mm:ss
Average Member Behavioral Health Handle Time	Format = mm:ss
Total Care Management Calls Received	Value must be ≥ 0
Total Care Management Calls Answered	Value must be ≥ 0
Total Care Management Calls Abandoned	Value must be ≥ 0
Average Care Management Speed of Answer	Format = mm:ss
Average Care Management Hold Time	Format = mm:ss
Average Care Management Handle Time	Format = mm:ss
Total Nurse Triage Calls Received	Value must be ≥ 0
Total Nurse Triage Calls Answered	Value must be ≥ 0
Total Nurse Triage Calls Abandoned	Value must be ≥ 0
Average Nurse Triage Speed of Answer	Format = mm:ss
Average Nurse Triage Hold Time	Format = mm:ss
Average Nurse Triage Handle Time	Format = mm:ss
Total Non-LTSS Provider Line Calls Received	Value must be ≥ 0
Total Non-LTSS Provider Line Calls Answered	Value must be ≥ 0
Total Non-LTSS Provider Line Calls Abandoned	Value must be ≥ 0
Average Non-LTSS Provider Line Speed of Answer	Format = mm:ss
Average Non-LTSS Provider Line Hold Time	Format = mm:ss
Average Non-LTSS Provider Line Handle Time	Format = mm:ss
Total LTSS Provider Line Calls Received	Value must be ≥ 0
Total LTSS Provider Line Calls Answered	Value must be ≥ 0
Total LTSS Provider Line Calls Abandoned	Value must be ≥ 0
Average LTSS Provider Line Speed of Answer	Format = mm:ss
Average LTSS Provider Line Hold Time	Format = mm:ss
Average LTSS Provider Line Handle Time	Format = mm:ss
Total Pharmacy Calls Received	Value must be ≥ 0
Total Pharmacy Line Calls Answered	Value must be ≥ 0
Total Pharmacy Line Calls Abandoned	Value must be ≥ 0
Average Pharmacy Line Speed of Answer	Format = mm:ss
Average Pharmacy Hold Time	Format = mm:ss

Field Description	Specifications
Average Pharmacy Handle Time	Format = mm:ss
Total Transportation Calls Received	Value must be ≥ 0
Total Transportation Line Calls Answered	Value must be ≥ 0
Total Transportation Line Calls Abandoned	Value must be ≥ 0
Average Transportation Line Speed of Answer	Format = mm:ss
Average Transportation Hold Time	Format = mm:ss
Average Transportation Handle Time	Format = mm:ss

Field Description	Definition
Calls Received	Total number of calls received by the call center during the reporting period EXCEPT those that met the following criteria: • The caller chose a self-service option that did not require the assistance of a call center representative. • The caller hung up in less than 60 seconds without speaking to a call center representative.
Calls Answered	Total number of calls reported under "Calls Received" where the caller spoke to a call center representative.
Calls Abandoned	Total number of calls abandoned during the reporting period. A call is considered abandoned when the caller disconnects while on hold after being on hold for 60 seconds or more.
Average Speed of Answer	The Average Speed of Answer is equal to the Total Waiting Time (in seconds) for Answered Calls divided by the Total Number of Answered Calls for the reporting period.
Average Hold Time	For all calls reported under either "Calls Answered" or "Calls Abandoned," the average time callers spent on hold whether before or after their calls were answered.

Field Description	Definition
Average Handle Time	For all calls reported under “Calls Answered,” the average time that callers spent on the phone after their calls were answered by a call center representative and before their calls were ended.

2.2.6 Behavioral Health Crisis Call Report

Contract	Section 2.12.2.2 Clinical Triage Line Requirements
Method:	Cardinal FTP
Format:	Use the template 'BH Crisis Calls.xlsx'
File Name:	BH_CRISIS_CALL.xlsx
Trigger:	Monthly
Due Date:	By close of business on the fifteenth (15th) calendar day of the month following the end of the reporting month.
Population:	Include CCC PLUS and MEDALLION
DMAS:	TBD

2.2.6.1 File Specifications (also see template)

Note: Where TBD appears under Specifications, the field specification is still to be determined.

Field Description	Specifications
Member Last Name	Member last name
Member First Name	Member first name
Medicaid ID	Must be a valid Medicaid ID Format: 12 digits with any leading zeros included
Member FIPS Code	FIPS code of member's residence as it appears on MCO 834 file
Member Street Address 1	First line of member address as it appears on MCO 834 file
Member Street Address 2	Second line of member address as it appears on MCO 834 file
Member City	Member city as it appears on the MCO 834 file
Member State	Member state as it appears on the MCO 834 file
Member Zip	Member Zip+4 code as it appears on MCO 834 file
Member Phone	Member Phone number as it appears on MCO 834 file
Active Treatment Status	Valid values: • "Y" = in active treatment • "N" = not in active treatment
Date of Call	Format: MM/DD/YYYY
Call Reason	Describe the reason for the call
Assessment	Describe the outcome of the clinical assessment of the member in crisis. • What is the need as identified by the individual? • What is the assessed need noted by the call center? • What is the level of risk assessed?

Field Description	Specifications
	• What level of care is needed? • What service is being sought, if any, by the individual? • What is the provider type (s) needed? • Provide clinical counseling/ de-escalation techniques used in an attempt to de-escalate the immediate situation.
Referral Provider #1 Last Name	Last name of provider to whom member was referred (if applicable – else, enter N/A)
Referral Provider #1 First Name	First name of provider to whom member was referred (if applicable – else, enter N/A)
Referral Provider #1 NPI	NPI of provider to whom member was referred (if applicable – else, enter N/A)
Referral Provider #1 Specialty	Specialty of provider to whom member was referred (if applicable – else, enter N/A)
Referral Provider #2 Last Name	Last name of provider to whom member was referred (if applicable – else, enter N/A)
Referral Provider #2 First Name	First name of provider to whom member was referred (if applicable – else, enter N/A)
Referral Provider #2 NPI	NPI of provider to whom member was referred (if applicable – else, enter N/A)
Referral Provider #2 Specialty	Specialty of provider to whom member was referred (if applicable – else, enter N/A)
Referral Provider #3 Last Name	Last name of provider to whom member was referred (if applicable – else, enter N/A)
Referral Provider #3 First Name	First name of provider to whom member was referred (if applicable – else, enter N/A)
Referral Provider #3 NPI	NPI of provider to whom member was referred (if applicable – else, enter N/A)
Referral Provider #3 Specialty	Specialty of provider to whom member was referred (if applicable – else, enter N/A)
Treating Provider #1 Last Name	Last name of provider (if applicable – else, enter N/A)
Treating Provider #1 First Name	First name of provider (if applicable – else, enter N/A)
Treating Provider #1 NPI	NPI of provider (if applicable – else, enter N/A)
Treating Provider #1 Specialty	Specialty of provider (if applicable – else, enter N/A)
Treating Provider #2 Last Name	Last name of provider (if applicable – else, enter N/A)
Treating Provider #2 First Name	First name of provider (if applicable – else, enter N/A)
Treating Provider #2 NPI	NPI of provider (if applicable – else, enter N/A)
Treating Provider #2 Specialty	Specialty of provider (if applicable – else, enter N/A)

Field Description	Specifications
Treating Provider #3 Last Name	Last name of provider (if applicable – else, enter N/A)
Treating Provider #3 First Name	First name of provider (if applicable – else, enter N/A)
Treating Provider #3 NPI	NPI of provider (if applicable – else, enter N/A)
Treating Provider #3 Specialty	Specialty of provider (if applicable – else, enter N/A)
Outcome	Describe actual or proposed resolution and member response.
Follow-up Treatment & Monitoring Activities	Describe the recommended treatment plan and how the contractor will provide monitoring activities. This shall include but not be limited to the following: • incorporation of the Federal Communications Commission (FCC) rule requiring all phone service providers to direct all 988 calls to the existing National Suicide Prevention Lifeline by July 16, 2022 • safety planning • general information about local or toll free programs (including Medicaid funded services, support groups, peer support, etc.) that may benefit the member in crisis • specific provider referral information • warm handoff process to treatment providers • coordination with the regional or statewide crisis line and mobile crisis response teams as appropriate • coordination with internal BH care coordination team for ongoing support and monitoring • next follow up scheduled

2.2.7 Provider Complaints

Contract	Section 2.12.3 Provider Call Center Requirements
Method:	Cardinal FTP
Format:	Use the template 'Provider Complaint Log.xlsx'
File Name:	PROV_COMPLAINT.xlsx
Trigger:	Monthly
Due Date:	Effective February 15, 2024 for the January 2024 reporting period, due by close of business on the fifteenth (15th) calendar day of the month following the end of the reporting month.
Population:	Include CCC PLUS and MEDALLION
DMAS:	TBD

2.2.7.1 Requirements

Note: Required oversight by the CFR

2.2.8 Appeals & Grievances Summary

Contract: Section 9.0 Grievances and Appeals

Method: Cardinal FTP

Format: Excel (.xlsx) file

File Name: APP_GRIEV_MCAID.xlsx

Trigger: Monthly

Due Date: By close of business on the 15th calendar day of the month following the end of the reporting month.

Population: Include CCC PLUS and MEDALLION

DMAS:

2.2.8.1 File Specifications

Tab Naming Conventions:
1st tab: APP_GRIEV_MCAID;
2nd tab: MCO Appeals Open;
3rd tab: MCO Appeals Resolved

Field Description	Provider Specifications	Member Specifications
EPSDT Services – Authorization Requests Received	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
EPSDT Services – Authorization Requests Denied/Limited (reduced)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
EPSDT Services – Benefit Denial or Limitation (Member Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
EPSDT Services – Benefit Denial or Limitation (Provider Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Pharmacy Services – Authorization Requests Received	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Pharmacy Services – Authorization Requests Denied/Limited (reduced)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Pharmacy Services – Benefit Denial or Limitation (Member Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Pharmacy Services – Benefit Denial or Limitation (Provider Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Benefit Denial or Limitation – Other (Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Contractor Administrative Issue (Member Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Contractor Administrative Issue (Provider Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces

Field Description	Provider Specifications	Member Specifications
Provider Enrollment (Member Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Provider Enrollment (Provider Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Transportation (Member Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Transportation (Provider Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
MHS (Member Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
MHS (Provider Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Other (Member Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Other (Provider Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Number of Adverse Actions (Member and Provider)	Value must be ≥0 Cannot be blank spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Standard Member Appeals Resolved Timely	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Standard Member Appeals Resolved Untimely	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Standard Extended Member Appeals Resolved Timely	Value must be ≥0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Standard Extended Member Appeals Resolved Untimely	Value must be ≥0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Expedited Member Appeals Resolved Timely	Value must be ≥0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Expedited Member Appeals Resolved Untimely	Value must be ≥0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Appeals Resolved At End Of Reporting Period	Value must be ≥0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total MHS Appeals – Fully Favorable	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total MHS Appeals – Partially Favorable	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total MHS Appeals - Unfavorable	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Appeals Resolved – Fully Favorable	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Appeals Resolved – Partially Favorable	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Appeals Resolved - Unfavorable	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Appeals Voided or Withdrawn	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces

Field Description	Provider Specifications	Member Specifications
Total Appeals Going to State Fair Hearing	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total New Appeals	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Active Appeals At End Of Reporting Period	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Average Time to Adjudicate Standard Member Appeals	Value must be ≥0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Average Time to Adjudicate Extended Member Appeals	Value must be ≥0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Average Time to Adjudicate Expedited Member Appeals	Value must be ≥0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Average Time to Adjudicate Provider Appeals	Value must be ≥0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Contractor Customer Service (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Access to Services/Providers (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Access to DME Services / Providers (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Medical Provider Care & Treatment – (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Pharmacy Provider Care & Treatment – (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Behavioral Health Care & Treatment – (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Transportation (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Administrative Issues (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Payment & Reimbursement Related (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Care Coordination (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Enrollment (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Other (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Grievances Resolved Timely	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Grievances Resolved Untimely	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total New Grievances	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Active Grievances	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces

2.2.8.2 Requirements

Provider & Member Appeals:

- Total from Members includes Appeals submitted by a provider on behalf of a member.
- Total from Providers includes Appeals submitted by a provider on behalf of the provider.

Type of Appeal**:**

Categorize appeals under the most appropriate type.

> Appeals related to addiction recovery and treatment services shall be included within the behavioral health category.

In separate tabs of the Excel sheet, please include one named for "MCO Appeals Open" and "MCO Appeals Resolved' in the format shown below:

Format for Breakdown of Total Number of MCO Appeals Open as of Reporting Date

Member ID	Type	File Date (mm/dd/yyyy)	Due Date (mm/dd/yyyy)	Extended? (Y/N)

Format for Breakdown of MCO Appeals Resolved

Field Description	Specifications
SERVICE_CENTER	NUM (4)
Program	MED4 or CCCP
Member_ID	NUM (12) include leading zeros
Service	Reference categories provided in ***Field Description*** of the specifications outlined for the first tab with the exception of CMHRS services (use procedure codes from table below).
Type	Member or Provider
File_Date	Must be a valid date Format = mm/dd/yyyy
Due_Date	Must be a valid date Format = mm/dd/yyyy
Extended	Y or N
Decision_Issued_Date	Must be a valid date Format = mm/dd/yyyy
Result	MCO, Member, Partial, Provider, or Invalid

> All fields are REQUIRED
>
> Include provider's 10-digit NPI under "Member ID" when appeal "TYPE" for a provider appealing payment for "SERVICE(S)". Specify applicable services under "SERVICE".
>
> With the exception of MHS services (use table below for reporting):

Mental Health Services (MHS)

Service Name	Proc. Code	Initial Request	Contd. Stay Request	Effective Date
1. Enhanced Behavioral Health Services (EBH)				•
23-Hour Crisis Stabilization	S9485	R	N/A	12/1/2021
Applied Behavior Analysis	97155 et al.	A	A	12/1/2021
Assertive Community Treatment	H0040	A	A	7/1/2021
Community Stabilization	S9482	R	A	12/1/2021
Functional Family Therapy	H0036	A	A	12/1/2021
Mental Health-Intensive Outpatient	S9480	A	A	7/1/2021
Mental Health-Partial Hospitalization Program	H0035	A	A	7/1/2021
Mobile Crisis Response	H2011	R	N/A	12/1/2021
Multisystemic Therapy	H2033	A	A	12/1/2021
Residential Crisis Stabilization Unit	H2018	R	A	12/1/2021
2. Community Mental Health Rehabilitation Services (CMHRS)				
Intensive In-Home	H2012	A	A	Prior to 7/1/2021
Intensive In-Home - Assessment	H0031	N/A	N/A	Prior to 7/1/2021
Mental Health Peer Support Services – Individual	H0024	R	R	Prior to 7/1/2021
Mental Health Peer Support Services – Group	H0025	R	R	Prior to 7/1/2021
Mental Health Skill-building Services (MHSS)	H0046	A	A	Prior to 7/1/2021
Mental Health Skill-building Services (MHSS) – Assessment		N/A	N/A	Prior to 7/1/2021
Psychosocial Rehabilitation	H2017	A	A	Prior to 7/1/2021
Psychosocial Rehabilitation – Assessment	H0032 U6	N/A	N/A	Prior to 7/1/2021
Therapeutic Day Treatment (TDT) for Children	H2016 – School based H2016 U7 – Summer program	A	A	7/1/2021

Service Name	Proc. Code	Initial Request	Contd. Stay Request	Effective Date
	H2016 UG – After-school program			
Therapeutic Day Treatment (TDT) for Children – Assessment	H0032 U7	N/A	N/A	Prior to 7/1/2021
3. Targeted Case Management				•
Mental Health Case Management	H0023	R	R	Prior to 7/1/2021

Provider & Member Grievances:

Only report on grievances received in the current month. Do not report any grievances carried forward from prior month(s). Report provider and member grievances separately.

Type of Grievance**:**

Categorize grievances under the most appropriate category.

- Contractor Customer Service - Treatment by member or provider services, call center availability, not able to reach a person, non-responsiveness, dissatisfaction with call center treatment, etc.
- Access to Services/Providers - Limited access to services or specialty providers, unable to obtain timely appointments, PCP abandonment, access to urgent or emergent care, etc.
- Provider Care & Treatment - Appropriateness of provider care, including services, timeliness, unsanitary physical environment, waited too long in office, etc.
- Transportation - Any transportation related grievance including transportation did not pick up member, waited too long for transportation provider, etc.
- Administrative Issues - Did not receive member ID card, member materials, etc.
- Reimbursement Related - Member billed for covered services, inappropriate co-pay charge, timeliness of clean claim payment by the Contractor, etc.
- Care Coordination - Any care management/care coordination related grievances; for example, expression of dissatisfaction with how a care manager conducted an HRA

2.2.9 FAMIS Appeals & Grievances Summary

Contract	Attachment D – FAMIS Program Exceptions, FAMIS Appeals and Member Requested External Review
Method:	Cardinal FTP
Format:	Excel (.xlsx) file
File Name:	APP_GRIEV_FAMIS.xlsx
Trigger:	Monthly
Due Date:	By close of business on the 15th calendar day of the month following the end of the reporting month.
Population:	FAMIS Only
DMAS:	Appeals

2.2.9.1 File Specifications

Tab Naming Conventions:
1st tab: APP_GRIEV_FAMIS;
2nd tab: MCO Appeals Open;
3rd tab: MCO Appeals Resolved

Field Description	Provider Specifications	Member Specifications
Pharmacy Services – Authorization Requests Received	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Pharmacy Services – Authorization Requests Denied/Limited (reduced)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Pharmacy Services – Benefit Denial or Limitation (Member Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Pharmacy Services – Benefit Denial or Limitation (Provider Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Benefit Denial or Limitation – Other (Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Contractor Administrative Issue (Member Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Contractor Administrative Issue (Provider Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Provider Enrollment (Member Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Provider Enrollment (Provider Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Transportation (Member Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Transportation (Provider Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces

Field Description	Provider Specifications	Member Specifications
MHS (Member Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
MHS (Provider Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Other (Member Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Other (Provider Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Number of Adverse Actions (Member and Provider)	Value must be ≥0 Cannot be blank spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Standard Member Appeals Resolved Timely	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Standard Member Appeals Resolved Untimely	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Standard Extended Member Appeals Resolved Timely	Value must be ≥0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Standard Extended Member Appeals Resolved Untimely	Value must be ≥0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Expedited Member Appeals Resolved Timely	Value must be ≥0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Expedited Member Appeals Resolved Untimely	Value must be ≥0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Appeals Resolved At End Of Reporting Period	Value must be ≥0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total MHS Appeals – Fully Favorable	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total MHS Appeals – Partially Favorable	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total MHS Appeals - Unfavorable	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Appeals Resolved – Fully Favorable	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Appeals Resolved – Partially Favorable	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Appeals Resolved - Unfavorable	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Appeals Going to State Fair Hearing	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total New Appeals	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Active Appeals At End Of Reporting Period	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Average Time to Adjudicate Standard Member Appeals	Value must be ≥0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Average Time to Adjudicate Extended Member Appeals	Value must be ≥0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces

Field Description	Provider Specifications	Member Specifications
Average Time to Adjudicate Expedited Member Appeals	Value must be ≥0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Average Time to Adjudicate Provider Appeals	Value must be ≥0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Contractor Customer Service (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Access to Services/Providers (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Access to DME Services / Providers (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Medical Provider Care & Treatment – (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Pharmacy Provider Care & Treatment – (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Transportation (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Administrative Issues (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Payment & Reimbursement Related (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Care Coordination (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Grievances Resolved Timely	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Grievances Resolved Untimely	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total New Grievances	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Active Grievances	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces

2.2.9.2 Requirements

Provider & Member Appeals:

- Total from Members includes Appeals submitted by a provider on behalf of a member.
- Total from Providers includes Appeals submitted by a provider on behalf of the provider.

Type of Appeal**:**

Categorize appeals under the most appropriate type.

Appeals related to addiction recovery and treatment services shall be included within the behavioral health category.

In separate tabs of the Excel sheet, please include one named for “MCO Appeals Open” and “MCO Appeals Resolved’ in the format shown below:

Format for Breakdown of Total Number of MCO Appeals Open as of Reporting Date

Member ID	Type	File Date (mm/dd/yyyy)	Due Date (mm/dd/yyyy)	Extended? (Y/N)

Format for Breakdown of MCO Appeals Resolved

Field Description	Specifications
SERVICE_CENTER	NUM (4)
Program	FAMIS
Member_ID	NUM (12) include leading zeros
Service	Reference categories provided in ***Field Description*** of the specifications outlined for the first tab with the exception of CMHRS services (use procedure codes from table below).
Type	Member or Provider
File_Date	Must be a valid date Format = mm/dd/yyyy
Due_Date	Must be a valid date Format = mm/dd/yyyy
Extended	Y or N
Decision_Issued_Date	Must be a valid date Format = mm/dd/yyyy
Result	MCO, Member, Partial, Provider, or Invalid

All fields are REQUIRED

Include provider's 10-digit NPI under "Member ID" when appeal "TYPE" for a provider appealing payment for "SERVICE(S)". Specify applicable services under "SERVICE".

With the exception of MHS services (use table below for reporting):

Mental Health Services (MHS)

Service Name	Proc. Code	Initial Request	Contd. Stay Request	Effective Date
1. Enhanced Behavioral Health Services (EBH)				•
23-Hour Crisis Stabilization	S9485	R	N/A	12/1/2021
Applied Behavior Analysis	97155 et al.	A	A	12/1/2021
Assertive Community Treatment	H0040	A	A	7/1/2021
Community Stabilization	S9482	R	A	12/1/2021
Functional Family Therapy	H0036	A	A	12/1/2021
Mental Health-Intensive Outpatient	S9480	A	A	7/1/2021

Service Name	Proc. Code	Initial Request	Contd. Stay Request	Effective Date
Mental Health-Partial Hospitalization Program	H0035	A	A	7/1/2021
Mobile Crisis Response	H2011	R	N/A	12/1/2021
Multisystemic Therapy	H2033	A	A	12/1/2021
Residential Crisis Stabilization Unit	H2018	R	A	12/1/2021
2. Community Mental Health Rehabilitation Services (CMHRS)				
Intensive In-Home	H2012	A	A	Prior to 7/1/2021
Intensive In-Home - Assessment	H0031	N/A	N/A	Prior to 7/1/2021
Mental Health Peer Support Services – Individual	H0024	R	R	Prior to 7/1/2021
Mental Health Peer Support Services – Group	H0025	R	R	Prior to 7/1/2021
Mental Health Skill-building Services (MHSS)	H0046	A	A	Prior to 7/1/2021
Mental Health Skill-building Services (MHSS) – Assessment		N/A	N/A	Prior to 7/1/2021
Psychosocial Rehabilitation	H2017	A	A	Prior to 7/1/2021
Psychosocial Rehabilitation – Assessment	H0032 U6	N/A	N/A	Prior to 7/1/2021
Therapeutic Day Treatment (TDT) for Children	H2016 – School based H2016 U7 – Summer program H2016 UG – After-school program	A	A	7/1/2021
Therapeutic Day Treatment (TDT) for Children – Assessment	H0032 U7	N/A	N/A	Prior to 7/1/2021
3. Targeted Case Management				•
Mental Health Case Management	H0023	R	R	Prior to 7/1/2021

Provider & Member Grievances:

Only report on grievances received in the current month. Do not report any grievances carried forward from prior month(s). Report provider and member grievances separately.

Type of Grievance:

Categorize grievances under the most appropriate category.

- Contractor Customer Service - Treatment by member or provider services, call center availability, not able to reach a person, non-responsiveness, dissatisfaction with call center treatment, etc.

- Access to Services/Providers - Limited access to services or specialty providers, unable to obtain timely appointments, PCP abandonment, access to urgent or emergent care, etc.
- Provider Care & Treatment - Appropriateness of provider care, including services, timeliness, unsanitary physical environment, waited too long in office, etc.
- Transportation - Any transportation related grievance including transportation did not pick up member, waited too long for transportation provider, etc.
- Administrative Issues - Did not receive member ID card, member materials, etc.
- Reimbursement Related - Member billed for covered services, inappropriate co-pay charge, timeliness of clean claim payment by the Contractor, etc.
- Care Coordination - Any care management/care coordination related grievances; for example, expression of dissatisfaction with how a care manager conducted an HRA

2.2.10 ARTS Appeals & Grievances Summary

Contract	Section 9.0 Grievances and Appeals
Method:	Cardinal FTP
Format:	Comma separated value (.csv) file. All columns/fields must be included in the order specified, with no additional/omitted columns. Do not include a header row.
File Name:	ARTS_APP_GRIEV.csv
Trigger:	Monthly
Due Date:	By close of business on the 15th calendar day of the month following the end of the reporting month.
Population:	Include CCC PLUS and MEDALLION
DMAS:	ARTS

2.2.10.1 File Specifications

Field Description	Provider Specifications	Member Specifications
ARTS (Appeal) Open/Received	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Appeals Resolved This Month (Resolution)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Appeals Sustained	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Appeals Reversed	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
ARTS (Grievance) Open/Received	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Grievances Resolved This Month (Resolution)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces

2.2.10.2 Requirements

Provider & Member Appeals:

- Include only ARTS appeals in this report.
- Total Member Appeals includes Appeals submitted by a provider on behalf of a member.
- Total from Providers includes Appeals submitted by a provider.
- Report Appeals separate from Grievances.
  - Report Provider and Member Appeals separately.

Provider & Member Grievances:

- Include only ARTS Grievances in this report.
- Total Member Grievances includes Grievances submitted by a provider on behalf of a member.
- Total from Providers includes Appeals submitted by a provider.
- Report Provider and Member Grievances separately.

Definitions:

- Member Appeal is a request to the MCO/FFS Contractor by a member or a member's representative to review the MCO/FFS Contractor's adverse action in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. Appeals to the MCO/FFS Contractor will be conducted in accordance with regulations at 42 C.F.R. § 431 Subpart E and the Client Appeals regulations at 12 VAC 30-110-10 through 12 VAC 30- 110-370.
- Provider Appeal is a request to the MCO/FFS Contractor by a provider to review the MCO/FFS Contractor's adverse action in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a provider exhausts the MCO/FFS Contractor's reconsideration process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.
- Grievance: In accordance with 42 CFR § 438.400, a grievance means an expression of dissatisfaction or complaint about any matter other than an "adverse benefit determination" that may be reported to the MCO/FFS Contractor. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights. A grievance does not constitute an appeal.
- Open/Received means any Appeal or Grievance currently open during this reporting period.
- Total Resolved This Month (Resolution) means any Appeal or Grievance that was resolved or closed out during this reporting period, including those carried over from the prior month(s).
- Total Appeals Sustained means the total adverse actions that were not overturned, original decision was upheld, and/or requested amounts have not changed based on final findings during the appeal process. This includes any appeals that were sustained in part.
- Total Appeals Reversed means the total adverse actions that were overturned, the MCO/FFS Contractor was in error. This includes any appeals that were reversed in part.

2.2.11 Mental Health Services (MHS) Service Authorizations & Registrations

Contract	Section 5.2 Mental Health Services (MHS)
Method:	Cardinal FTP
Format:	Comma separated value (.csv) file. All columns/fields must be included in the order specified, with no additional/omitted columns. Do not include a header row.
File Name:	MHS_SA_MCAID.csv
Trigger:	Monthly
Due Date:	By close of business on the 15th calendar day of the month following the end of the reporting month.
Population:	Include CCC PLUS and MEDALLION
DMAS:	TBD

2.2.11.1 Specifications

Include all Mental Health Services service authorizations and registrations that **were approved / denied / pended during the previous calendar month**.

Field Description	Specifications
Medicaid ID	Must be a valid Medicaid ID Format: 12 digits with leading zeros
Service Auth Category	Valid Values are: Adult Child under 21
Service Auth ID	Unique identifier for service authorization.
Type	Valid Values are: R = Registration S = Service Authorization P = Peer Support
Provider	If entered, must be a valid NPI.
Procedure Code	Must be a valid procedure code.
Procedure Code Using Modifier	Must be a valid modifier code.
Request From Date	Format = mm/dd/yyyy. Must be a valid date.
Request Through Date	Format = mm/dd/yyyy. Must be a valid date.
Auth From Date	Format = mm/dd/yyyy. Must be a valid date.
Auth Thru Date	Format = mm/dd/yyyy. Must be a valid date.
Number of Units Requested	Numeric. Must be greater than zero.
Unit Requested Qualifier	Valid Values are: 15 Minute Hour Day Week Month Unit Other

Field Description	Specifications
Frequency Requested	Valid Values are: Day Bi-weekly Week Month Year Other None
Number of Units Authorized	Numeric. Must be greater than or equal to zero.
Unit Approved Qualifier	Valid Values are: 15 Minute Hour Day Week Month Unit Other
Frequency Approved	Valid Values are: Day Bi-weekly Week Month Year Other None
Denial Type	Required. Valid Values are: Partial (partial denial = Number of Units Authorized/Dates of Service is less than Requested) Full (full denial = Number of Units Authorized is zero (0) N/A (not applicable if Service Auth Status is 'A' (approved) or 'P' (pending)
Denial Reason	Valid Values are: Administrative Medical Necessity
Service Auth Urgency Type	Required. Valid Values are: 'E' = Expedited (Urgent SA Request) 'N' = Non-Urgent (Standard SA Request)
Service Auth Status	Required. Valid Values are: 'A' = Approved for full/requested amount 'D' = Denied for full/requested amount, or partial denial for reduced amount 'P' = Pending due to supplemental information requested from provider.
Date Service Auth was Received by MCO or subcontractor	Required. Must be a valid date Format = mm/dd/yyyy Must be <= End Date of reporting period (calendar month)
Time Service Auth was Received by MCO or subcontractor	Required. Format = hh:mm:ss Must be a time value between 00:00:00 and 23:59:59
Date Response was sent to Provider	Required. Must be a valid date Format = mm/dd/yyyy Must be >= Begin Date and <= End Date of reporting period (calendar month)

Field Description	Specifications
Time Response was sent to Provider	Required. Format = hh:mm:ss Must be a time value between 00:00:00 and 23:59:59
MCO Response Time	Required. Must be total time from receipt of request to time provider response sent Must be in hhhh:mm:ss
Resubmission Indicator	Required. Valid Values are: 'Y' = This Service Authorization Request was previously pended due to supplemental information necessary for the SA review completion. 'N' = This Service Authorization Request was an original request (=did not require supplemental docs for review)

Mental Health Services (MHS)

Service Name	Proc. Code	Initial Request	Contd. Stay Request	Effective Date
1. Enhanced Behavioral Health Services (EBH)				•
23-Hour Crisis Stabilization	S9485	R	N/A	12/1/2021
Applied Behavior Analysis	97155 et al.	A	A	12/1/2021
Assertive Community Treatment	H0040	A	A	7/1/2021
Community Stabilization	S9482	R	A	12/1/2021
Functional Family Therapy	H0036	A	A	12/1/2021
Mental Health-Intensive Outpatient	S9480	A	A	7/1/2021
Mental Health-Partial Hospitalization Program	H0035	A	A	7/1/2021
Mobile Crisis Response	H2011	R	N/A	12/1/2021
Multisystemic Therapy	H2033	A	A	12/1/2021
Residential Crisis Stabilization Unit	H2018	R	A	12/1/2021
2. Community Mental Health Rehabilitation Services (CMHRS)				
Intensive In-Home	H2012	A	A	Prior to 7/1/2021
Intensive In-Home - Assessment	H0031	N/A	N/A	Prior to 7/1/2021
Mental Health Peer Support Services – Individual	H0024	R	R	Prior to 7/1/2021
Mental Health Peer Support Services – Group	H0025	R	R	Prior to 7/1/2021
Mental Health Skill-building Services (MHSS)	H0046	A	A	Prior to 7/1/2021
Mental Health Skill-building Services (MHSS) – Assessment		N/A	N/A	Prior to 7/1/2021
Psychosocial Rehabilitation	H2017	A	A	Prior to 7/1/2021

Service Name	Proc. Code	Initial Request	Contd. Stay Request	Effective Date
Psychosocial Rehabilitation – Assessment	H0032 U6	N/A	N/A	Prior to 7/1/2021
Therapeutic Day Treatment (TDT) for Children	H2016 – School based H2016 U7 – Summer program H2016 UG – After-school program	A	A	7/1/2021
Therapeutic Day Treatment (TDT) for Children – Assessment	H0032 U7	N/A	N/A	Prior to 7/1/2021
3. Targeted Case Management				•
Mental Health Case Management	H0023	R	R	Prior to 7/1/2021

2.2.12 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services

Contract	Section 5.8 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
Method:	Cardinal FTP
Format:	Comma separated value (.csv) file. All columns/fields must be included in the order specified, with no additional/omitted columns. Do not include a header row.
File Name:	EPSDT_SUMN.csv
Trigger:	Monthly
Due Date:	By close of business on the 15th calendar day of the month following the end of the reporting month.
Population:	Include CCC PLUS and MEDALLION
DMAS:	MCH

2.2.12.1 Requirements

Demonstrate the status of services for members under age 21 including administrative requirements outlined under the EPSDT benefit. Include information on the "medical necessity review," the secondary review process and denials issued under EPSDT. For all denials, indicate if the member was referred to care coordination to utilize other in network benefits to meet need. Information on the Contractor's care coordination efforts shall also be presented along with data on CYSHCN enrollment.

Population Captured

This report shall capture information related to applicable services rendered to members under the age of 21, regardless of aid category.

For the information related to Children and Youth with Special Healthcare Needs (CYSHCN), the Contractor shall include the **total** enrollment information for members who have been identified by the Contractor as being CYSHCN based on the below definition. This report shall include all CYSHCN members enrolled with the Contractor on a rolling basis. For example, Member C is in foster care for the months of June and July. That member would be counted on the July and August submissions of the report.

Care coordination data shall be presented for all members **under age 21** regardless of CYSHCN status, aid category or presence of the EI indicator.

General Data Requirements

The data in this report shall reflect internal programmatic data captured by the Contractor along with other enrollment data provided by DMAS on the 834.

This report shall be rolling and shall include all applicable administrative data, even if that data is duplicative by member. For example, if a secondary review was completed for a Member D for more than one service in a reporting period, all reviews shall be counted in this report. Member D has two services that were denied after secondary review for the month of June. In July's submission of the report, both denials will be counted.

Definitions

The below definitions reflect the information required for this report:

"*Children and Youth with Special Healthcare Needs*" – Children and youth with special health care needs up to age 21 who have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition(s) and may need health and related services of a type or amount over and above those usually expected for the child's age. These include, but are not limited to, the children in the eligibility categories of expansion, foster care and adoption assistance (aid categories 076 and 072), youth who have aged out of the foster care system (aid category 70), children identified as Early Intervention (EI) participants, members identified as experiencing childhood obesity and others as identified through the Contractor's assessment or by the Department. For the purposes of this report, the Contractor shall include **at minimum** all members in aid categories 070, 072 and 076 along with all members with the Early Intervention services indicator in the report submission. **The Contractor also shall include members who have been identified by the Contractor's internal screening processes as CYSHCN, regardless of aid category or EI indicator.**

"*Secondary Review*" – In addition to the traditional review for medical necessity, Medicaid children who request services that do not meet the plan's general coverage criteria must receive a secondary review to ensure that the EPSDT provision has been considered. The Contractor's secondary review process for medical necessity must consider the EPSDT's correct, or ameliorate criteria.

Report Format

Information shall be presented to members who are qualifying for services under EPSDT. The Contractor shall format this information based on the template provided below. Submit in the following format with Field Name information running horizontally

Field Name	Field Description	Specifications
SR	Number of Secondary Reviews under EPSDT completed	Valid value is greater than or equal to 0
DSR	Number of denials issued after Secondary Review	Valid value is greater than or equal to 0
RAD	Number of referrals provided after denial for other medically necessary services covered by the Contractor	Valid value is greater than or equal to 0
CYSHCN	Number of children identified as CYSHCN	Valid value is greater than or equal to 0
CC	Number of children under age 21 assigned care coordinator	Valid value is greater than or equal to 0

2.2.13 Family Planning and Well Woman Summary Report

Contract	Section 5.13.3 Family Planning
Method:	Cardinal FTP
Format:	Excel (.xlsx) file
File Name:	FAMILY_PLANNING_SVC.xlsx
Trigger:	Monthly
Due Date:	By close of business on the 15th calendar day of the month following the end of the reporting month
Population:	Include CCC PLUS and MEDALLION
DMAS:	Maternal & Child Health

2.2.13.1 Requirements

Demonstrate service utilization for reproductive health and family planning services as outlined below.

Population Captured

This report shall capture family planning and reproductive health services rendered to all female members enrolled with the Contractor, regardless of aid category.

General Data Requirements

The data in this report shall reflect claims payment data for this reporting month and not the date of service for the claim.

Multiple services rendered to a single member shall be captured in this report. For example, Member B has a Well Woman Exam (WWE) and a LARC insertion in the month of June. Claims for both the WWE and LARC insertion will be captured in this report.

The below list also includes suggested ICD-10 CM codes to be utilized for each service:

1. LARC Insertion/Administration (Provide separate information for the inpatient and outpatient settings, respectively.)
   - Suggested codes: Z30.013, Z30.014, Z30.017, Z30.430, Z30.433
2. LARC Removal
   - Suggested code: Z30.432
3. Family Planning Counseling
   - Suggested codes: Z30.40, Z30.41, Z30.42, Z30.431, Z30.44, Z30.45, Z30.46, Z30.49
4. Non-LARC Family Planning Access
   - Suggested codes: Z30.011, Z30.012, Z30.015, Z30.016, Z30.018, Z30.019, Z30.2
5. Hysterectomy
   - Suggested code: Z90.710
6. Well Woman Exam

- Suggested code: Z01.419

Definitions

The below definitions reflect the information required for this report:

"Long Acting Reversible Contraceptives" – A contraceptive device utilized to prevent unintended pregnancy and can, once administered, work without user action. LARC contraceptive methods include, but are not limited to, hormonal and non-hormonal IUDs, Implanon and the Depo-Provera contraceptive injection.

"Non-LARC Family Planning Access" – This shall include all family planning methods accessed by members that do not include LARCs.

Report Format

The Contractor shall format this information based on the template provided below.

Tab #1

Field Name	Field Description	Specifications
Family Planning Inquiries	List the number of referrals made for family planning services for any member during the reporting month	Valid number greater than or equal to 0
LARC Insertion or Administration Outpatient	List the number of claims related to LARC insertion or administration in the outpatient setting	Valid number greater than or equal to 0
LARC Insertion of Administration Inpatient	List the number of claims related to LARC insertion or administration in the inpatient setting	Valid number greater than or equal to 0
LARC Removal	List the number of claims related to LARC removal	Valid number greater than or equal to 0
FP Counseling	List the number of claims related to birth control counseling	Valid number greater than or equal to 0
Non-LARC FP Access	List the number of claims related to family planning services that are not for LARCs	Valid number greater than or equal to 0
Hysterectomies	List the number of claims related to hysterectomies	Valid number greater than or equal to 0
Well Woman Exams	List the number of claims related to Well-Woman Exams	Valid number greater than or equal to 0

Tab #2

Report frequency by procedure code for any *additional* reproductive health and family planning services procedure codes that the MCO may utilize to reflect and reimburse for these services beyond the codes listed in the description above.

2.2.14 Foster Care & Adoption Assistance Member Care Coordination

Contract	Section 8.12.1 Foster Care Management
Method:	Cardinal FTP
Format:	Excel (.xlsx) file
File Name:	FC_AA_SERVICE.xlsx
Trigger:	Monthly
Due Date:	By close of business on the 15th of the month following the end of the reporting month
Population:	Include CCC PLUS and MEDALLION
DMAS:	MCH

2.2.14.1 Requirements

The purpose of this report is to demonstrate the Contractor's care coordination efforts, assessments and service utilization for all foster care and adoption assistance members. Efforts related to Foster Care Transition Planning shall be captured in a subsequent report. The Contractor shall include all foster care members, former foster care and adoption assistance members, respectively, who are enrolled in the Contractor's health plan. This report shall provide information on the status of all foster care, former foster care and adoption assistance members enrolled with the Contractor.

Population Captured

This report shall reflect data on all foster care (aid category 076), former foster care youth (aid category 070) and adoption assistance (aid category 072) members who are identified **in the end of month 834 enrollment file**. This includes members in active care coordination and those who are not.

For example, for a July submission of this report, members captured should include all those listed as aid categories 070, 072 and 076 on the 834 file sent to the Contractor at the beginning of June (6/1) to reflect full June enrollment.

All members including those who are newly enrolled and those who have had continuous coverage shall also be included.

Foster care members (aid category 076) aged 17 years and older shall be included in this report and the Foster Care Transition Planning Report.

General Data Requirements

If a member does not have any services, assessments, care coordination, etc. rendered for the reporting period, they shall still be included in this report. For the reporting fields reflecting data for a service not rendered for a member, the field shall read as "0" or "N" (as directed in the below table) to indicate no care coordination plan, care coordinator or completed assessment.

All foster care and adoption assistance members regardless of services, care coordination and/or assessments rendered shall be included in this report and there shall be no blank fields.

There shall be no duplication of member information on this report. Each member shall have information contained in only one row.

This report is rolling and DMAS expects members who maintain their foster care or adoption assistance status to remain on this report month by month.

Reporting Claims Data

There are no specific procedure codes that are requested for this report. The MCO shall report all services rendered to foster care and adoption assistance members. These data shall reflect services rendered to members and not service authorizations. For all encounter data reflected in this report, the MCO shall include all claims paid in the reporting month regardless of date of service.

Behavioral health information shall include services that occurred in both the inpatient and outpatient settings along with substance use treatment services utilized through the ARTS benefit. This report shall also include members at all applicable ASAM levels and shall solely be specific to the foster care and adoption assistance populations utilizing these services.

Reporting Care Coordination Data

Care coordination data reflected in this report shall include all care coordination efforts that occurred for members in aid categories 070, 072 and 076, respectively, during the reporting period. Per the Cardinal Care contract, the Contractor shall provide care coordination for adoption assistance members as requested by the member's parents and care coordination for former foster care youth as requested by the member.

The Contractor shall report if a member is in active care coordination and/or if the member has an established care coordination plan.

Reporting Assessment Data

The Contractor shall ensure that all assessments completed within the reporting period be reflected in this report. For members who have previously received an assessment prior to the implementation of this report, the Contractor shall list "P" indicating that the assessment has been previously completed. For members who received an assessment in a previous month that was included in an earlier submission of this report, the Contractor shall utilize "PR." Assessment dates shall be listed for all members with a completed assessment, regardless of the date of completion.

Definitions

The below definitions reflect the information required for this report:

"*Adoption Assistance Member*" – A member enrolled with an aid category of 072.

"*Assessment*" – The Contractor's appraisal and evaluation of its members to determine level of health and necessary interventions as may be appropriate. A successful assessment is considered a contact made by the health plan that assesses all health care needs, interventions received, and any additional services or referral needs. The health plan must submit the assessment procedures plan and a copy of the assessment tool annually to the Department.

"*Behavioral Health Referral*" – A referral made by the Contractor's clinical team for any inpatient or outpatient behavioral health service, respectively, including, but not limited to, those related to substance use treatment and Community Mental Health Rehabilitative Services (CMHRS).

"*Care Coordination*" – The process of identifying patient needs and the subsequent development, implementation, monitoring, and revision (as necessary) of a plan of care (see also Care Coordination Plan) to efficiently achieve the optimum quality patient outcomes in the most cost-effective manner.

"*Care Coordination Plan*" – A plan established by the Contractor's clinical team to support the care coordination needs of the member.

"*Former Foster Care Youth*" – A member enrolled with aid category of 070 who was in the custody of a local department of social services in Virginia, another state, or a U.S. Territory and receiving Medicaid until discharge from foster care upon turning age 18 years or older, is not eligible for Medicaid in another mandatory Medicaid covered group (LIFC parent, Pregnant Woman, Child Under Age 18 or SSI), and is under age 26 years. A child age 18 and over who is in an Independent Living arrangement or in the Fostering Futures Program with a local department of social services may be eligible in this covered group.

"*Foster Care Barrier Report*" – A monthly foster care report also outlined in the Cardinal Care Managed Care Technical Manual addressing MCO barriers to communication about foster care member assessments, care coordination needs, etc.

"*Foster Care Member*" – A member enrolled with an aid category of 076.

"*Medical Referral*" – A referral made by the Contractor's clinical team for any medical service. These services shall not include behavioral health services.

Report Format

The Contractor shall format this information based on the template provided below.

Tab #1

Foster Care Members:

Field Name	Field Description	Specifications
Member ID	Member Medicaid ID	Valid member Medicaid number
DOB	Member date of birth	Valid date presented in the following format: • MMDDYYYY
Member Assessment	State whether member health risk assessment was conducted	• 'Y' = Yes • 'N' = No • 'PR' = Previously reported on another submission of this report • 'P' = Previously Assessed Prior to Report Implementation
Barrier Report	State if this member was presented on this month's Foster Care Barrier Report	• 'Y' = Yes • 'N' = No • 'P' = Previously Represented on Barrier Report
Assessment Date	For completed assessments, list the date the assessment was completed	• Valid date presented in the following format: ▪ MMDDYYYY • There shall be no blanks in this field. If member has not been assessed, the contracted shall state "NULL".
CC Assign	Care coordinator assignment	• 'Y' = Yes • 'N' = No • 'P' = Previously Assigned

Field Name	Field Description	Specifications
Reason No CC	Reason no active care coordination	• For members or custodial agencies who declined active care coordination (indicated in previous column), specify one of the following two character valid values: ▪ '01' = Custodial agency nonresponsive to care coordination efforts ▪ '02' = Phone number not working ▪ '03' = Custodial agency declined care coordination ▪ '04' = Other • List the following two-digit number if member received care coordination outreach: ▪ '05' = Care coordination ongoing
CC Plan	State whether the member has an established care coordination plan	• 'Y' = Yes • 'N' = No • 'P' = Previously Assigned
PCP Visit	Number of PCP visits	Valid value is greater than or equal to 0
ER Utilization	Number of visits to ER	Valid value is greater than or equal to 0
Other Medical Services Utilization	Number of other medical and non-behavioral health services utilized other than PCP visits and ER visits, which shall be captured in the previous two rows	Valid value is greater than or equal to 0
Medical Referral	State whether a referral for medical services was made	• 'Y' = Yes • 'N' = No • Optional field
Outpatient BH Utilization	Number of times outpatient behavioral health services were accessed	Valid value is greater than or equal to 0
Inpatient BH Utilization	Number of times inpatient behavioral health services were accessed	Valid value is greater than or equal to 0
BH Services Referral	State whether a referral for behavioral health services was made	• 'Y' = Yes • 'N' = No • Optional field
Dental Referral	State whether a referral for dental services was made	• 'Y' = Yes • 'N' = No • Optional field

On a separate tab (#2), please include a summary (frequency) of all services utilized for foster care members for this reporting month. This shall be done by procedure code.

Tab # 3

Adoption Assistance Members:

Field Name	Field Description	Specifications
Member ID	Member Medicaid ID	Valid member Medicaid number
DOB	Member date of birth	Valid date presented in the following format: • MMDDYYYY
Member Outreach	State whether member outreach was conducted	• 'Y' = Yes • 'N' = No
Reason No Outreach	Reason for no member outreach	• For members with no outreach for this month (indicated in previous column), specify one of the following two character valid values: ▪ '01' = Member's guardian nonresponsive to outreach ▪ '02' = Phone number not working ▪ '03' = Member's guardian declined outreach ▪ '04' = Not needed this month ▪ '05' = Other • List the following two-digit number if member received care coordination outreach: ▪ '06' = Outreach completed
CC Assign	Care coordinator assignment	• 'Y' = Yes • 'N' = No • 'P' = Previously Assigned
Reason No CC	Reason for no active care coordination	• For members or their guardian who declined active care coordination (indicated in previous column), specify one of the following two character valid values: ▪ '01' = Member's guardian nonresponsive to care coordination efforts ▪ '02' = Phone number not working ▪ '03' = Member's guardian declined care coordination ▪ '04' = Other • List the following two-digit number if member received care coordination outreach: ▪ '05' = Care coordination ongoing

Field Name	Field Description	Specifications
CC Plan	State whether the member has an established care coordination plan	▪ 'Y' = Yes ▪ 'N' = No ▪ 'P' = Previously Assigned
PCP Visit	Number of PCP visits	Valid value is greater than or equal to 0
ER Utilization	Number of visits to ER	Valid value is greater than or equal to 0
Other Medical Utilization	Number of other medical and non-behavioral health services utilized other than PCP visits and ER visits, which shall be captured in the previous two rows	Valid value is greater than or equal to 0
Med Referral	State whether a referral for medical services was made	• 'Y' = Yes • 'N' = No • Option Field
Outpatient BH Utilization	Number of times outpatient behavioral health services were accessed	Valid value is greater than or equal to 0
Inpatient BH Utilization	Number of times inpatient behavioral health services were accessed	Valid value is greater than or equal to 0
BH Services Referral	State whether a referral for behavioral health services was made	• 'Y' = Yes • 'N' = No • Optional Field
Dental Referral	State whether a referral for dental services was made	• 'Y' = Yes • 'N' = No • Optional field

On a separate tab (#4), please include a summary (frequency) of all services utilized for adoption assistance members for this reporting month. This shall be done by procedure code.

Tab #5

Former Foster Care Youth

Field Name	Field Description	Specifications
Member ID	Member Medicaid ID	Valid member Medicaid number
DOB	Member date of birth	Valid date presented in the following format: • MMDDYYYY
Member Outreach	State whether member outreach was conducted	• 'Y' = Yes • 'N' = No

Field Name	Field Description	Specifications
Reason No Outreach	Reason for no member outreach	• For members with no outreach for this month (indicated in previous column), specify one of the following two character valid values: ▪ '01' = Member's guardian nonresponsive to outreach ▪ '02' = Phone number not working ▪ '03' = Member's guardian declined outreach ▪ '04' = Not needed this month ▪ '05' = Other • List the following two-digit number if member received care coordination outreach: ▪ '06' = Outreach completed
CC Assign	Care coordinator assignment	• 'Y' = Yes • 'N' = No • 'P' = Previously Assigned
Reason No CC	Reason for no active care coordination	• For members who declined active care coordination (indicated in previous column), specify one of the following two character valid values: ▪ '01' = Member nonresponsive to care coordination efforts ▪ '02' = Phone number not working ▪ '03' = Member declined care coordination ▪ '04' = Other • List the following two-digit number if member received care coordination outreach: ▪ '05' = Care coordination ongoing
CC Plan	State whether the member has an established care coordination plan	• 'Y' = Yes • 'N' = No • 'P' = Previously Assigned
PCP Visit	Number of PCP visits	Valid value is greater than or equal to 0
ER Utilization	Number of visits to ER	Valid value is greater than or equal to 0
Other Medical Utilization	Number of other medical and non-behavioral health services utilized other than PCP visits and ER visits, which shall be captured in the previous two rows.	Valid value is greater than or equal to 0

Field Name	Field Description	Specifications
Med Referral	State whether a referral for medical services was made	• 'Y' = Yes • 'N' = No • Option Field
Outpatient BH Utilization	Number of times outpatient behavioral health services were accessed	Valid value is greater than or equal to 0
Inpatient BH Utilization	Number of times inpatient behavioral health services were accessed	Valid value is greater than or equal to 0
BH Services Referral	State whether a referral for behavioral health services was made	• 'Y' = Yes • 'N' = No • Optional Field
Dental Referral	State whether a referral for dental services was made	• 'Y' = Yes • 'N' = No • Optional field

Tab #6

Summary (Frequency)

On a separate tab (#6), please include a summary (frequency) of all services utilized for former foster care members for this reporting month. This shall be done by procedure code.

2.2.15 Foster Care Barrier Report

Contract	Section 8.12.1.4 Foster care/Adoption Assistance Reporting Requirements
Method:	Cardinal FTP
Format:	Comma separated value (.csv) file. All columns/fields must be included in the order specified, with no additional/omitted columns. Do not include a header row.
File Name:	BARRIER.csv
Trigger:	Monthly
Due Date:	By close of business on the 15th calendar day of the month following the end of the reporting month.
Population:	Include CCC PLUS and MEDALLION
DMAS:	MCH

2.2.15.1 Report Summary

The purpose of this report is to provide DMAS with the opportunity to assist the Contractor with completing a health risk assessment (HRA) for a foster care member within 60 days of enrollment. For the purposes of this report, "foster care member" shall be defined as a member with an aid category of 076. Members who do not have an aid category of 076 shall not be presented on this report.

For the purposes of this report, members who have had coverage with the Contractor with a previous aid category shall be considered "newly enrolled" in foster care when the Contractor receives notice via the MCO EOM 834 file of the updated member aid category (076).

Prior to including barriers on this report related to "LDSS not responsive" (as listed in category '08', in the below table), the Contractor shall make **three outreach attempts** to the member's guardian to complete the HRA. The Contractor shall make a reasonable attempt to address all barriers (regardless of barrier type) prior to including on this report.

A particular barrier for a member included in a previous month's report shall not be reported again for that member once DMAS has provided information regarding that barrier. The same barrier shall not be reported more than once for the same member in a single reporting month. The Contractor shall also only include barriers to HRAs that were attempted during that reporting period. Barriers shall not be retroactively included in this report.

2.2.15.2 Requirements

Field Description	Specifications
Medicaid ID	Must be a valid Medicaid ID. Must be twelve digits. Fill with leading zeroes if necessary.
Member First Name	Member's first name as it appears on MCO 834 file
Member Last Name	Member's last name as it appears on MCO 834 file

Field Description	Specifications
Member Aid Category	Member aid category as it appears on MCO 834 file Note: This report should *only* include members in aid category 076.
Member Street Address 1	First line of member address as it appears on MCO 834 file
Member Street Address 2	Second line of member address as it appears on MCO 834 file
Member Zip	Member Zip+4 code as it appears on MCO 834 file
Member Phone	Member Phone number as it appears on MCO 834 file
Barrier Category	Specify one of the following two character valid values: • '01' = Adopted / reunified • '02' = Aged out • '03' = Aid category change • '04' = Can't locate with current address • '05' = Deceased • '06' = In a facility/ incarcerated • '07' = Invalid telephone number • '08' = LDSS non-responsive • '09' = Lost eligibility • '10' = Moved out of coverage area • '11' = New address reported • '12' = New phone number • '13' = Non-cooperative/ refusal to release info • '14' = Not in custody of LDSS • '15' = Other • '16' = Out of state • '17' = Returned mail Note that missing or invalid Case FIPS is no longer a valid reason for Barrier after the development of the Member Supplemental File titled: "EOM834_Suppl" and accessible to all MCOs beginning June 2019.
Data Source	Specify one of the following one character valid values: • 'P' = Foster Care Parent • 'D' = Local DSS • 'M' = DMAS MMIS / 834 • 'R' = Returned Mail • 'O' = Other
Date MCO Aware	• Must be a valid date • Format = mm/dd/yyyy • Must be <= End Date of reporting period (calendar month)

Field Description	Specifications
Additional MCO Comments	Maximum 75 characters, no "LF" within the data. This field is optional for any barrier type, but is REQUIRED IF: • Reported Barrier Category is ‘15’ or ‘16’ If other Barrier Category with no needed comments, leave entry blank.
First Name of Contact	REQUIRED IF: • Reported Barrier Category is ‘05’, ‘06’, ‘10’, ‘11’, ‘12’, ’14’, or ‘15’; Provide name of contact (or attempted contact if ‘08’). If other Barrier Category, leave entry blank.
Last Name of Contact	REQUIRED IF: • Reported Barrier Category is ‘05’, ‘06’, ‘10’, ‘11’, ‘12’, ’14’, or ‘15’; Provide name of contact (or attempted contact if ‘08’). • If other Barrier Category, leave entry blank.
Area Code of Contact	REQUIRED IF: • Reported Barrier Category is ‘08’, ‘12’, ‘13’, or ‘17’ • If category ‘07’, report number attempted • • If other Barrier Category, leave entry blank.
Phone Number of Contact	REQUIRED IF: • Reported Barrier Category is ‘08’, ‘12’, ‘13’, or ‘17 • If category ‘07’, report number attempted • • If other Barrier Category, leave entry blank.
Date of Contact First Attempt	• Format date as mm/dd/yyyy • REQUIRED IF: ▪ Reported Barrier Category is ‘08’; ▪ ▪ If other Barrier Category, leave entry blank.
Date of Contact Second Attempt	• Format date as mm/dd/yyyy • REQUIRED IF: • Reported Barrier Category is ‘08’; • • If other Barrier Category, leave entry blank.
Date of Contact Third Attempt	• Format date as mm/dd/yyyy • REQUIRED IF: • Reported Barrier Category is ‘08’; • • If other Barrier Category, leave entry blank.
Name of LDSS Agency	• Max 75 characters; • REQUIRED IF: • Reported Barrier Category is ’08’ or ‘14’’ • • If other Barrier Category, leave entry blank.

Field Description	Specifications
MCO Aware of New Location?	• Valid values: Y (=Yes) or N (=No) • REQUIRED IF: • Reported Barrier Category is '10'; • • If other Barrier Category, leave entry blank.
Address Line 1	REQUIRED IF: • Reported Barrier Category is '11'; OR • Reported Barrier Category is '10' AND MCO Aware of New Location = Y • • If other Barrier Category, leave entry blank.
Address Line 2	• OPTIONAL IF: • Reported Barrier Category is '11'; OR • Reported Barrier Category is '10' AND MCO Aware of New Location = Y • • If other Barrier Category, leave entry blank.
City	• REQUIRED IF: • Reported Barrier Category is '11'; OR • Reported Barrier Category is '10' AND MCO Aware of New Location = Y ▪ ▪ If other Barrier Category, leave entry blank.
State	• Format: 2-character state abbreviation • REQUIRED IF: • Reported Barrier Category is '11'; OR • Reported Barrier Category is '10' AND MCO Aware of New Location = Y; OR • Reported Barrier Category is '16' to designate non-VA location ▪ ▪ If other Barrier Category, leave entry blank.
Zip Code	REQUIRED IF: • Reported Barrier Category is '11'; OR • Reported Barrier Category is '10' AND MCO Aware of New Location = Y • • If other Barrier Category, leave entry blank.
Other Barrier	REQUIRED IF: • Reported Barrier Category is '15'; • Note: Describe the barrier; Maximum 75 characters, no "LF" within the data. Only letter values to be utilized, no numbers. • • If other Barrier Category, leave entry blank.

All fields are required unless otherwise indicated. MCO must provide a valid value for all fields. For fields where data is not required, MCO to leave entry blank.

2.2.16 Foster Care Transition Planning Report

Contract	Section 8.12.1.2 Foster Care Transition Planning
Method:	Cardinal FTP
Format:	Comma separated value (.csv) file. All columns/fields must be included in the order specified, with no additional/omitted columns. Do not include a header row.
File Name:	FC_TRANSITION.csv
Trigger:	Monthly
Due Date:	By close of business on the 15th calendar day of the month following the end of the reporting month.
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.2.16.1 Requirements

The Contractor shall demonstrate Foster Care Transition Planning for all foster care members (aid category 076) beginning at age 17. Information shall be included about outreach to local DSS offices regarding the case.

For the purposes of this report, "Foster Care Transition Planning" shall include instances when the Contractor's clinical team:

- Provides information to a member on that member's current medications and doctors;
- Helps with scheduling any member medical or behavioral health appointments;
- Educates the member on what should they know about their medical and behavioral health care and what questions should they ask doctors as they navigate their care on their own;
- Works with the member's guardian to assist in LDSS or LCPA transition planning for member;
- Assists the member with all aspects of the eligibility determination process to ensure transition to aid category 070;
- Educates the member on Virginia's Fostering Futures program;
- Provides other care coordination services deemed clinically appropriate by the Contractor to address member needs as they transition from the Child Welfare System.

<u>Population Captured</u>

This report shall reflect data on all foster care (aid category 076) members who are identified in the end of month **834 enrollment file** and are *at minimum* **aged 17 years or older** at any point in the reporting period. All foster care members age 17 years and older shall be captured in this report. This includes members in active case coordination and those who are not. *The Contractor can decide to provide transition planning for a member prior to age 17*. Those members shall also be captured on this report at the Contractor's discretion.

For example, for a July report submission members captured should include all those age 17 or older listed as aid category 076 on the 834 file sent to the MCOs at the beginning of June (6/1) to reflect full June enrollment.

All members with aid category 076 who are 17 years or older should be included in this report, including those who are newly enrolled and those who have had continuous coverage.

If a member turns 17 during the reporting month, they shall also be included in this report for the reporting period in which they turn 17.

This report is rolling and if a member is continuously aged 17 years and above and in aid category 076, they should be continuously included on this report.

General Data Requirements

If a member does not have any services or care coordination rendered for the reporting period, they shall still be included in this report. For the reporting fields reflecting data for a service not rendered for a member, the field shall read as "0" for the fields indicating the number of services rendered and "N" to indicate no care coordination plan, care coordinator or completed assessment.

There shall be no blank fields on this report.

There shall be no duplication of member information on this report. Each member shall have information contained in only one row.

Definitions

The below definitions reflect the information required for this report:

"*Assessment*" – The Contractor's appraisal and evaluation of its members to determine level of health and necessary interventions as may be appropriate. A successful assessment is considered a contact made by the health plan that assesses all health care needs, interventions received, and any additional services or referral needs. The health plan must submit the assessment procedures plan and a copy of the assessment tool annually to the Department.

"*Behavioral Health Referral*" – A referral made by the Contractor's clinical team for any inpatient or outpatient behavioral health service, respectively, including, but not limited to, those related to substance use treatment and Community Mental Health Rehabilitative Services (CMHRS).

"*Care Coordination*" – The process of identifying patient needs and the subsequent development, implementation, monitoring, and revision (as necessary) of a plan of care to efficiently achieve the optimum quality patient outcomes in the most cost-effective manner.

"*Former Foster Care Youth*" – A member enrolled with aid category of 070 who was in the custody of a local department of social services in Virginia, another state, or a U.S. Territory and receiving Medicaid until discharge from foster care upon turning age 18 years or older, is not eligible for Medicaid in another mandatory Medicaid covered group (LIFC parent, Pregnant Woman, Child Under Age 18 or SSI), and is under age 26 years. A child age 18 and over who is in an Independent Living arrangement or in the Fostering Futures Program with a local department of social services may be eligible in this covered group.

"*Foster Care Member*" – A member enrolled with an aid category of 076.

"*Foster Care Transition Planning*" – Instances when the Contractor's clinical team supports members who are transitioning out of the child welfare system from aid category 076 to aid category 070 with services including, but not limited to, the following:

- Provides information to a member on that member's current medications and doctors;
- Helps with scheduling any member medical or behavioral health appointments;
- Educates the member on what should they know about their medical and behavioral health care and what questions should they ask doctors as they navigate this on their own;

- Works with the member's guardian to assist in LDSS or LCPA transition planning for member;
- Educates the member on Virginia's Fostering Futures program;
- Assists the member with all aspects of the eligibility determination process to ensure transition to aid category 070;
- Provides other care coordination services deemed clinically appropriate by the Contractor to address member needs as they transition from the Child Welfare System.

"*Fostering Futures*" – Virginia's program implementing provisions of the federal Fostering Connections to Success and Increasing Adoptions Act of 2008 that permit states to utilize federal title IV-E funding to provide foster care maintenance payments and services and adoption assistance for youth ages 18 to 21. The program offers services and support to youth transitioning to adulthood and self-sufficiency regardless of funding source.

"*Guardian*" – An adult who is legally responsible for the care and management of a minor child or another adult.

"*Medical Referral*" – A referral made by the Contractor's clinical team for any medical service. These services shall not include behavioral health services.

Report Format

The Contractor shall format this information based on the template provided below.

Field Name	Field Description	Specifications
Member ID	Member Medicaid ID	Valid member Medicaid number
Member Age	Member age	Valid value is greater than or equal to 0
DOB	Member date of birth	Valid date presented in the following format: • MMDDYYYY
Date Member Ages Out	The date the member turns 18 years old and ages out of Virginia's Child Welfare System	Valid date presented in the following format: • MMDDYYYY
Transition Planning Initiated for Member	Indicate if the member's transition planning has been initiated by the Contractor's clinical team	• 'Y' = Yes • 'N' = No • 'P' = Previously Initiated
CC Assign	The member has been assigned a care coordinator for transition planning	• 'Y' = Yes • 'N' = No • 'P' = Previously Assigned

Field Name	Field Description	Specifications
Reason No CC	Reason for no active care coordination for transition planning	• For members or custodial agencies who declined active care coordination (indicated in previous column), specify one of the following two character valid values: ▪ '01' = Custodial agency nonresponsive to care coordination efforts ▪ '02' = Phone number not working ▪ '03' = Custodial agency declined care coordination ▪ '04' = Other ▪ • List the following two-digit number if member received care coordination outreach: ▪ '05' = Care coordination ongoing
MCO Communication with Guardian	Indicate if the MCO clinical team is in communication with the member's legal guardian about their transition planning	• 'Y' = Yes • 'N' = No • 'P' = Previously Communicated • 'D' = Transition Planning Outreach Completed and Guardian Declined
Education on Member Medication and Doctors	• Indicate if information was provided to member during this reporting period on member's current medications and doctors. • This information shall include all medications the member is currently taking during this reporting month and all doctors the member is actively seeing during this reporting month.	• 'Y' = Yes • 'N' = No • 'P' = Previously Educated
Help Scheduling Appointments	Number of times the Contractor's clinical team helped with scheduling any member medical or behavioral health appointments	Valid value is greater than or equal to 0
Medical Care Education	Number of times the Contractor's clinical team educated the member about their medical care	Valid value is greater than or equal to 0
Behavioral Health Care Education	Number of times the Contractor's clinical team educated the member about their behavioral health care	Valid value is greater than or equal to 0

Field Name	Field Description	Specifications
Eligibility Determination	Clinical team assisted member with education about the eligibly process to transition from aid category 076 to aid category 070	• 'Y' = Yes • 'N' = No • 'P' = Previously Educated
Fostering Futures Education	Member educated about Virginia's Fostering Futures Program	• 'Y' = Yes • 'N' = No • 'P' = Previously Educated
Notes	Option for MCO to provide any additional notes about member's case	• Valid alphabetical characters. • Optional Field

2.2.17 Maternal Care Monthly Frequency

Contract	Section 5.13.1.6 Maternity Reporting for Pregnant and Postpartum Individuals
Method:	Cardinal FTP
Format:	Comma separated value (.csv) file. All columns/fields must be included in the order specified, with no additional/omitted columns. Do not include a header row.
File Name:	MATERNAL_SRV_FRQ.CSV
Trigger:	Monthly
Due Date:	By close of business on the 15th calendar day of the month following the end of the reporting month
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.2.17.1 File Specifications

Field Name	Field Description	Specifications
Procedure Code	Procedure Codes	Valid procedure codes
High Risk Count	High Risk Member Procedure Counts	>=0
NON High Risk Count	NON High Risk Member Procedure Counts	>=0

The data in this report shall reflect claims payment data for this reporting month and not the date of service for the claim.

2.2.18 Maternal Care Monthly Report

2.2.18.1 Specifications

Contract	Section 5.13.1.6 Maternity Reporting for Pregnant and Postpartum Individuals
Method:	Cardinal FTP
Format:	Comma separated value (.csv) file. All columns/fields must be included in the order specified, with no additional/omitted columns. Do not include a header row.
File Name:	MATERNAL_SERVICE.CSV
Trigger:	Monthly
Due Date:	By close of business on the 15th calendar day of the month following the end of the reporting month
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.2.18.2 Requirements

The Contractor shall include information for pregnant and postpartum members enrolled in the Contractor's high-risk (HR) maternity program and pregnant and postpartum members not in the Contractor's HR maternity program, respectively. Include specific information on care coordination services and other service utilization as indicated in below specifications.

Population Captured

This report shall capture information for members who are in the prenatal and/or 12 month postpartum period during the reporting month. This report is applicable to all members regardless of aid category. **All** pregnant and/or members 12 months postpartum shall be captured in this report regardless of service utilization, identified risk status during the reporting month, or aid category. "Postpartum members" shall only include members with a live birth. This report is separated by the risk status identified by the Contractor.

The Contractor shall, at a minimum, include members identified in the End of Month (EOM) 834 Enrollment File, as outlined below. The Contractor shall also include pregnant members on this report who are deemed pregnant but not enrolled in one of the below aid categories or have an estimated delivery date (EDD) on their enrollment file. This information may be obtained through claims or care coordination data, etc. **The below specifications shall only represent the minimum number of members included in this report**.

End of Month (EOM) 834 Report Aid Category Specifications

PREG_091	PREG_005	PREG_EDD
• Pregnant Medicaid Moms • *For this report, this aid category applies to members age seven and above. Members below age seven shall not be captured on this report.	Pregnant FAMIS Moms	• Estimated Delivery Date (EDD) • *This indicator is included for members not in the listed aid categories that have an EDD on their enrollment file.

Each Aid Category (091 and 005) and unique files with an EDD indicator will total the minimum number of members reported monthly.

If a member is identified as pregnant or postpartum at any point during the reporting month, she shall still be captured in this report. If a member leaves the 12 month postpartum period at any time during the reporting month, she shall still be captured in this report. Members who give birth during the reporting month shall have their prenatal and postpartum services reported.

General Data Requirements

The service utilization data in this report shall reflect claims payment data for this reporting month and not the date of service for the claim. The data reported shall also include internal care coordination data provided by the Contractor to also reflect care coordination rendered during the reporting month.

There shall be no blank fields on this report unless below specifications indicate that a field is optional. There shall also be no duplicate member IDs presented on this report.

All data on this report shall be the most up to date information the Contractor can present in each data field. For members who are on this report for consecutive months, the Contractor shall ensure that the member information is updated as needed and appropriate.

For example, Member B has an original EDD of 6/19/19. After a prenatal care visit, she reports to her care coordinator that her provider has changed her EDD to 5/31/19. The month this information is obtained, the Member's EDD should read "05312019". This shall also apply to member care coordination status and any other care coordination, medical or behavioral health services rendered. This shall also apply to a member's substance use diagnosis status and maternal mental health screen completion indicator. *For members who are postpartum, the EDD shall match the date the member delivered.*

Definitions

The below definitions reflect the information required for this report:

"Care Coordination" – The process of identifying patient needs and the subsequent development, implementation, monitoring, and revision (as necessary) of a plan of care to efficiently achieve the optimum quality patient outcomes in the most cost-effective manner.

"High-Risk" – The Contractor is required to report identified risk status in this report for all pregnant and postpartum women. The Contractor may include various risk factors in screening for this population as stated in the maternity policies and procedures outlined in their annual submissions to DMAS. At a minimum, the screening process for risk status must consider:

- The presence of co-morbid or chronic conditions, sexually transmitted infections, etc.;
- Previous pregnancy complications and adverse birth outcomes;
- History of\or current substance use (e.g., alcohol, tobacco, prescription or recreational drug use);
- History of\or a current positive screen for depression and/or other behavioral health issues;
- The member's personal safety (e.g., housing situation, violence).

"Maternal Mental Health Screen" – For the purposes of this report, this information shall include mental health screenings conducted for women in the prenatal period until 12 months postpartum. These screenings will indicate information such as, but not limited to, member experiences with perinatal mood and anxiety disorders such as postpartum depression along with screening related to the identification of

substance use disorders. The screenings utilized by the Contractor's clinical teams and/or providers may include, but are not limited to: 1) PHQ2/9; 2) SBIRT; 3) Edinburgh Postnatal Depression Assessment; 4) IHR Integrated 5P's Screening Tool; 5) AUDIT-C; and 6) NIDA. These screening shall be unique to the general risk screening completed by the Contractor to identify the risk status of pregnant members. However, this screening does not have to be unique if evidence-based maternal mental health screening questions are embedded in the Contractor's general pregnancy risk screening process utilized by the Contractor.

"Postpartum" – For the purposes of this report, this term shall refer to members who are between 0 to 12 months postpartum. This report shall only capture postpartum members with a live birth.

"Pregnancy Risk Screen" – For the purposes of this report, this term shall refer to the risk screens conducted by the Contractor to identify member pregnancy/postpartum risk status. These screenings shall reflect those developed by the Contractor to identify appropriate enrollment into Contractor's high-risk maternity programs, as outlined above and specified in the Cardinal Care contract. These screenings shall be autonomous to the Contractor's maternal mental health screen, which is defined above. However, the two screenings may be conducted simultaneously.

Report Format

Field Name	Field Description	Specifications
Member ID	Member Medicaid ID	Valid member Medicaid number
Category	Indicate if member is considered "High-Risk" or "Non High-Risk" by the Contractor. **Note**: "High-Risk" status shall reflect requirements in Cardinal Care contract (indicated, above) and the MCO's maternity program policies.	• 'H' = High-Risk • 'N' = Non High-Risk
EDD	Indicate member estimated delivery date. **Note**: The Contractor is expected to conduct sufficient outreach to obtain members EDD if not provided on the 834 enrollment file.	Valid date presented in the following format: • MM/DD/YYYY • If no EDD has been obtained by the Contractor or provided by DMAS, the Contract shall include the word 'NULL' for that member. Note this applies to members regardless of identified risk status. • If a member is postpartum, the EDD shall reflect the day she delivered.
PP Care	State if member is currently postpartum. **Note**: If a member gives birth during a reporting month, she shall be considered postpartum.	• 'Y' = Yes • 'N' = No
Pre Care Visit	Member participating in prenatal care visits	• 'Y' = Yes • 'N' = No

Field Name	Field Description	Specifications
		• 'PP' = Member is Postpartum • 'Z' = High Risk Member only • If a member gives birth during a reporting month, her prenatal and postpartum claims paid shall both be represented.
Attempted Pregnancy Risk Screen	• Demonstrate attempt made to conduct the Contractor's pregnancy risk screen. These attempts shall include outreach that is both successful and unsuccessful at reaching the member and completing the screen. • All completed screens – as indicated in the subsequent field – shall be marked as "Yes." The data in this field is rolling. Previous completed attempts shall be marked also as "Yes" in subsequent reports.	• 'Y' = Yes • 'N' = No • 'Z' =High-Risk Member only
Completed Pregnancy Risk Screen	• Indicate that member has been screened for pregnancy risk status based on the requirements set forth in the Contractor's high-risk pregnancy program. • This field shall only reflect screens that have been completed and not attempts made to screen which will be indicated in the previous field.	• 'Y' = Yes • 'N' = No • 'P' = Previously Completed
Post Care Visit	Member is participating in postpartum care visits	• 'Y' = Yes • 'N' = No • 'P' = Member is Prenatal • If a member gives birth during a reporting month, her prenatal and postpartum claims paid shall both be represented.
Date Enroll	Date member was identified via claims, screening, and/or other methods as being "high-risk." Includes the date the member was enrolled in the Contractor's High-Risk Maternity Program. For Non High-Risk members, the Contractor shall list "NULL".	For High-Risk members: Valid date presented in the following format: • MM/DD/YYYY For Non High-Risk members: • NULL
CC Assign	Care coordinator assignment	• 'Y' = Yes • 'N' = No • 'P' = Previously Assigned

Field Name	Field Description	Specifications
Monthly OR/CC	Indicate if MCO staff conducted outreach during the reporting month to member.	• 'Y' = Yes • 'N' = No
Reason No OR/CC	Reason for no member outreach	For members with no care coordination for this month (indicated in previous column), specify one of the following two character valid values: • '01' = Member nonresponsive to outreach • '02' = Phone number not working • '03' = Member declined outreach • '04' = Other • List the following two-digit number if member received care coordination outreach: • '05' = Outreach Completed
Num Pre Care	Number of prenatal care visits	• Valid value is greater than or equal to 0 • If member is postpartum, list the following three characters: o '999' = Postpartum o If a member gives birth during a reporting month, her prenatal and postpartum claims paid shall both be represented.
Num Post Care	Number of postpartum care visits	• Valid value is greater than or equal to 0 • If member is prenatal, list the following three characters: o '888' = Prenatal o If a member gives birth during a reporting month, her prenatal and postpartum claims paid shall both be represented.
Substance Use DX Status	Indicate if a member has been identified as having a diagnosis at any point prior to the 12 month postpartum period of any one or combination of the following: 1) Substance Use Disorder (SUD); 2) Opioid Use Disorder (OUD); 3) Alcohol Use Disorder (AUD).	• 'Y' = Yes • 'N' = No
Maternal Mental Health Screen	Indicate the completion of maternal mental health screen completed by either the Contractor's care coordination team	• 'Y' = Yes • 'N' = No • 'P' = Previously Completed

Field Name	Field Description	Specifications
	or a provider indicated through claims data. Screening to have occurred in either the prenatal or postpartum periods.	
MedEx	Indicate whether this member is currently enrolled in an expansion aid category.	• 'Y' = Expansion aid category • 'N' = Non-expansion aid category
Exclusion Indicator	Indicate if member is included on report based on the "*Population Captured*" section of these specifications, but MCO has identified that member is no longer pregnant or in 12 month postpartum period.	• 'Y' = Yes • 'N' = No
Comments	Optional field.	CHAR(90); Do not use commas in this comma separated values (CSV) format.

2.2.19 Consumer-Directed Electronic Visit Verification (EVV) Report

Contract	Section 11.14 Electronic Visit Verification (EVV) System
Method:	Cardinal FTP
Format:	Excel (.xlsx) file
File Name:	CD_EVV_*agentname_ContractorName.xlsx*
Trigger:	Monthly
Due Date:	By close of business on the 20th calendar day of the month following the reporting month
Population:	CCC PLUS Only
DMAS:	Office of Community Living

2.2.19.1 File Specifications

The EVV report consists of a summary report and a detailed report.

Sample of a Summary Report Template that includes all Required EVV Fields

Timesheet Submission Method	Attendants		Shift	
PAY DATE 11/27/2020	**Count**	**Percent**	**Count**	**Percent**
EVV Compliant Totals				
EVV – Mobile App w/GPS				
EVV - IVR				
EVV – Mobile App w/GPS Edited				
EVV - IVR Edited				
EVV Non-Compliant Totals				
EVV – Mobile App w/GPS adjusted more than 15 minutes after shift entry				
EVV – IVR adjusted more than 15 minutes after shift entry				
EVV – Mobile App w/o GPS				
Manual - Web Portal				
Manual - IVR				
Unduplicated Active Attendant Totals (Distinct Count)				
Attendants using IVR				
Attendants using mobile app				

Required EVV Fields:

- Unduplicated Active Attendant Total for the pay period
- EVV Mobile App w/GPS attendants
- EVV Mobile App w/GPS shifts
- EVV-IVR Attendants
- EVV-IVR Shifts
- EVV – Mobile App w/GPS Edited Attendants (edited within 15 minutes of shift entry)
- EVV – Mobile App w/GPS Edited Shifts (edited within 15 minutes of shift entry)
- EVV – IVR Edited Attendants (edited within 15 minutes of shift entry)
- EVV – IVR Edited Shifts (edited within 15 minutes of shift entry)
- EVV – Mobile App w/GPS adjusted more than 15 minutes after shift entry - Attendants
- EVV – Mobile App w/GPS adjusted more than 15 minutes after shift entry - Shifts
- EVV – IVR adjusted more than 15 minutes after shift entry - Attendants
- EVV – IVR adjusted more than 15 minutes after shift entry – Shifts
- EVV - Mobile App w/o GPS Attendants
- EVV - Mobile App w/o GPS Shifts
- Manual - Web Portal Attendants
- Manual - Web Portal Shifts
- Manual – IVR attendants
- Manual – IVR shifts
- Distinct Total of Attendants using IVR
- All IVR shifts
- Distinct Total of Attendants using mobile app
- All Mobile App Shifts
- All EVV Compliant Shifts
- EVV Compliance Percentage = (All EVV compliant shifts/ Total Shifts)*100
- All EVV Non-Compliant Shifts
- EVV Non-Compliant Shift Percentage = (All EVV non-compliant shifts/ Total Shifts)*100
- Total Shifts

Percentage fields corresponding to the fields listed above are also required.

Notes:

- *MCOs are required to report Live-in attendant totals on MCO monthly scorecards.*
- *MCOs are required to submit a summary detail report only. EVV detail submission is optional.*

EVV Compliant Attendants and Shifts: The required fields are EVV compliant.

- EVV attendants (mobile app w/GPS)
- EVV shifts (mobile app w/GPS)
- EVV – IVR attendants
- EVV – IVR shifts
- EVV – Mobile App w/GPS Edited Attendants (edited within 15 minutes of shift entry)
- EVV – Mobile App w/GPS Edited Shifts (edited within 15 minutes of shift entry)
- EVV – IVR Edited Attendants (edited within 15 minutes of shift entry)
- EVV – IVR Edited Shifts (edited within 15 minutes of shift entry)

EVV Non-Compliant Attendants and Shifts: The required fields that are EVV non-compliant.

- EVV – Mobile App w/GPS adjusted more than 15 minutes after shift entry - Attendants
- EVV – Mobile App w/GPS adjusted more than 15 minutes after shift entry - Shifts
- EVV – IVR adjusted more than 15 minutes after shift entry - Attendants
- EVV – IVR adjusted more than 15 minutes after shift entry – Shifts
- EVV - Mobile App w/o GPS Attendants
- EVV - Mobile App w/o GPS Shifts
- Manual - Web Portal Attendants
- Manual - Web Portal Shifts
- Manual – IVR attendants
- Manual – IVR shifts

2.2.20 Fiscal/Employer Agent (F/EA) Scorecard

Contract	
Method:	Per existing arrangement with DMAS
Format:	Per existing arrangement with DMAS
File Name:	Per existing arrangement with DMAS
Trigger:	Monthly
Due Date:	By close of business on the 20th calendar day of the month
Population:	CCC Plus Only
DMAS:	Office of Community Living

2.2.20.1 Requirements

The Contractor shall add live-in attendants and overtime standardized reporting to the monthly scorecard. Follow requirements directly communicated to the MCOs by the DMAS Office of Community Living.

The Contractor will add Legally Responsible Individuals (LRI) to standardize reporting on the monthly report card requirement. The elements to be added should include:

1. The total number of LRIs (spouse)
2. The total amount paid to LRIs (spouse)
3. The total number of LRIs (parent of a minor under the age of 18)
4. The total amount paid to LRIs (parent of a minor under the age of 18)

2.2.21 NEMT Missed Trips

Contract	Section 5.14.12 Late or Missed Trips
Method:	Cardinal FTP AND attachment to Aaron.Moore@dmas.virginia.gov and Nicki.Taylor@dmas.virginia.gov
Format:	Use the new Cardinal reporting template located on SharePoint.
File Name:	NEMT_MISSED_TRIPS_C*ontractorName_mmddyy-mmddyy*.xlsx (where *mmddyy-mmddyy* is the reporting period) Example: NEMT_MISSED_TRIPS_ABCHealthPlan_060119-063019.xlsx
Trigger:	Monthly
Due Date:	By close of business on the 10th calendar day of the month (or the first business day thereafter) following the end of the reporting month.
Population:	Report CCC Plus and MEDALLION on separate tabs
DMAS:	Transportation Unit

2.2.21.1 Requirements

Enter all missed trips for the reporting period. If the member did not arrive at the initial destination of a scheduled round trip, do not report the scheduled return trip as a separate missed trip. Do not report trips cancelled by the member. The report submission should include two tabs: CCCPlus on one tab, MEDALLION on the following tab.

In the Member Mobility column, indicate how the member was able to move to and from the vehicle, whether the member was ambulatory, used a wheelchair or was moved by stretcher.

In the Type of Service column, indicate the range of service given by the transportation provider in moving the member to and from the vehicle:

- Curb-to-curb: Member was not assisted by the transportation provider in moving between the vehicle and the exit or entry point of the pickup and drop-off locations.
- Door-to-door: Member was assisted by the transportation provider in moving between the vehicle and the exit or entry point of the pickup and drop-off locations.
- Hand-to-hand: Member was assisted at all times by the transportation provider in moving between the hands-on care of the member's caregiver and the hands-on care of another provider.

In the Reason for Missed Trip column, select one of the options available in the drop down list. If "Other" is selected, explain the reason along with the resolution in the Resolution column.

In the resolution column, please explain what steps were taken to address the specific missed trip in question - e.g., the arrangement of alternative transportation, the intervention of the care coordinator in rescheduling a missed appointment, etc.

2.2.22 Pharmacy Prior Authorizations

Contract: Section 5.15.4 Utilization Management for Pharmacy Services

Method: Cardinal FTP

Format: Comma separated value (.csv) file. All columns/fields must be included in the order specified, with no additional/omitted columns. Do not include a header row.

File Name: PA_REPORT.csv

Trigger: Monthly

Due Date: By close of business on the 15th calendar day of the month following the end of the reporting month.

Population: Include CCC PLUS and MEDALLION

DMAS:

2.2.22.1 File Specifications

Field Description	Specifications
Service Authorization Identifier	Required This identifier shall match the service authorization number in the MCO's system. Maximum length allowed for this field is 25 characters. See requirement below for unique key edit.
Medicaid ID	Required Must be a valid Medicaid ID. Must be 12 digits. Fill with leading zeroes if necessary.
Service Auth Response Type	Required Must use one of the following one character valid values: • 'A' = Approved • 'D'= Denied for Cause • 'S' = Requires supplemental information from provider. If not supplied within 72 hours, this request is considered a denial.
Date Service Auth was Received by MCO or subcontractor (PBM)	• Required • Must be a valid date • Format = mm/dd/yyyy • Must be <= End Date of reporting period (calendar month)
Time Service Auth was Received by MCO or subcontractor (PBM)	• Required • Format = hh:mm:ss • Must be a time value between 00:00:00 and 23:59:59
Date Response was sent to Provider	• Required • Must be a valid date • Format = mm/dd/yyyy • Must be >= Begin Date and <= End Date of reporting period (calendar month)

Field Description	Specifications
Time Response was sent to Provider	• Required • Format = hh:mm:ss • Must be a time value between 00:00:00 and 23:59:59
MCO Response Time	• Required • Must be total time from receipt of request to time provider response sent • Must be in hh:mm:ss
Drug Product Name Submitted on Prior Authorization Request	• Max Length 60 characters
Generic Name of Requested Product	• Max Length 60 characters
Drug Strength	• Max length 60 characters.
Resubmission Indicator	Required • Y = This record is a re-review of a previously submitted request. A service auth record with the same service auth ID and a 'Service Auth Response Type' of 'S' must have been previously submitted. • N = This is an original request, i.e., first time that this service was submitted to the MCO.

2.2.22.2 Requirements

Identification of Pharmacy Service:

- Drug Product submitted on PA request, generic name of drug product requested and drug strength are required fields for each prior authorization request.

Records to be Included:

- Include all pharmacy prior authorizations that were approved, denied, or pended for supplemental info during the previous calendar month.
- When the MCO receives an authorization request and additional documentation is needed from the provider, the provider has 72 hours to respond to the MCO. If no response is received within 72 hours, the request is considered denied.
- When the requestor sends the supplemental information for a previously submitted service auth, that record shall be included in this report as a separate line with the same Identifier value as the initial request, and a Resubmission Indicator of 'Y'.
- Every initial submission must have a Resubmission Indicator of 'N'. 'Identifier' values must be unique for all records with Resubmission Indicator of 'N'.

Requests for Supplemental Information:

- If a service auth is resubmitted multiple times, there can be multiple records with the same 'Identifier' value, but each of those records, except the original, must have a Resubmission Indicator of 'Y'.
- The date/time of receipt on 'resubmitted' records must reflect the date/time that the supplemental info was submitted, and not the date/time of the original request.
- The response date/time on 'resubmitted' records shall reflect the date/time that the approval/denial response from the MCO to the requester's resubmission was sent, and not the date/time of the MCO's response to the original request.

2.2.23 Patient Utilization Management and Safety Program (PUMS) Members

Contract: Section 6.3 Patient Utilization Management and Safety (PUMS) Program for Members

Method: Cardinal FTP

Format: Comma separated value (.csv) file. All columns/fields must be included in the order specified, with no additional/omitted columns. Do not include a header row.

File Name: PUMS.csv

Trigger: Monthly

Due Date: By close of business on the 15th calendar day of the month following the end of the reporting month.

Population: Include CCC PLUS and MEDALLION

DMAS: Pharmacy & ARTS

2.2.23.1 File Specifications

Field Name	Format	Specifications
Health Plan	Char	Service center ID number
Member Medicaid or FAMIS ID	Char	Must be a valid Medicaid or FAMIS ID with any leading zeros included
Date Member Became Eligible in the MCO/ Plan	Date	Must be a valid date mm/dd/yyyy
Initial Date Identified (Date Identified of possible PUMS trigger)	Date	Must be a valid date mm/dd/yyyy
PUMS Trigger Type (What caused the trigger for further review)	Char	Must contain a valid value. See 2.2.23.2 below for valid values list.
Final Decision Date	Date	Must be a valid date mm/dd/yyyy
Decision Outcome (whether or not Action was taken by organization)	Num	Valid Values are: '1' for Enrolled in PUMS '2' for Not Enrolled in PUMS
PUMS Action Type	Char	Valid values are: "1" for Case Management Only "2" for MAT Referral Only "3" for Case Management and MAT Referral Only "4" for Lock In "5" for Reviewed and No Action Taken
PUMS End Date	Date	Valid date where Decision Outcome value is '1'; Null where Decision Outcome is '2'
PUMS Pharmacy/Provider Name	Char	Must be 40 characters or less Valid Name where Action Type is '4' for Lock In; Null where Action Type is not equal to '4'
PUMS Pharmacy/ Provider ID Number	Char	Must be 10 characters or less Valid Provider ID where Action Type is '4' for Lock In; Null where Action Type is not equal to '4'

Field Name	Format	Specifications
PUMS Pharmacy/ Provider Address	Char	Must be 40 characters or less Valid Address where Action Type is '4' for Lock In; Null where Action Type is not equal to '4'
PUMS Pharmacy/Provider City	Char	Must be 17 characters or less Valid City where Action Type is '4' for Lock In; Null where Action Type is not equal to '4'
PUMS Pharmacy/Provider State	Char	Must be 2 characters or less Must be valid state code (USPS standards) where Action Type is '4' for Lock In; Null where Action Type is not equal to '4'
PUMS Pharmacy/Provider Zip	Numeric	5-digit zip code for each unique service location Valid zip code where Action Type is '4' for Lock In; Null where Action Type is not equal to '4'
PUMS Provider Lock In Type	Numeric	Must be 1 character or less Valid Values are: '1' for Physician '2' for Pharmacy Null where Action type is not equal to '4'
PUMS Pharmacy Contract Status	Numeric	Must be 1 character or less Valid Values are: '1' for In-Network Provider '2' for Out-of-Network Provider Null where Action type is not equal to '4'

2.2.23.2 Requirements

Include members enrolled in Medicaid and FAMIS. Use the following codes for PUMS reason:

1=<u>Opioid Use Disorder (OUD) Case Management</u>: PLAN may review any members receiving OUD and provide case management:

- Members with any history of opioid overdose(s) in the past three (3) years; ER visits, inpatient hospitalization, or inpatient rehabilitation stay related to OUD in the past three

  (3) years; pregnant women with OUD; individuals with OUD with current or recent involvement (in the past three (3) years) with the criminal justice system: must be evaluated for case management and referred as appropriate;

- Clinical expertise and judgment shall be used to identify and manage any members the plan determines should be placed in, or remain in, a lock-in to a prescriber or practice group ("cluster").

2 = <u>High Average Daily Dose</u>: <u>></u> ninety (90) cumulative morphine milligram equivalents (MME) per day over the past ninety (90) days,

3 = <u>Opioids and Benzodiazepines concurrent use</u> – at least one (1) Opioid claim and fifteen

(15) day supply of Benzo (in any order),

4 = <u>Doctor and/or Pharmacy Shopping</u>: <u>></u> three (3) prescribers OR <u>></u> three (3) pharmacies writing/filling claims for any controlled substance in the past sixty (60) days,

5 = <u>Use of a Controlled Substance with a History of Dependence, Abuse, or</u> <u>Poisoning/Overdose</u>: Any use of a controlled substance in the past sixty (60) days with at least two (2) occurrences of a medical claim for controlled Substance Abuse or Dependence in the past three hundred and sixty-five (365) days,

6 = <u>History of Substance Use, Abuse or Dependence or Poisoning/Overdose</u>: Any member with a diagnosis of substance use, substance abuse, or substance dependence on any new* claim in any setting (e.g., ED, pharmacy, inpatient, outpatient, etc.) within the past sixty (60) day **Only include members who are currently in the PUMS program.**

2.2.24 Renewal and Closure Outreach Report

Contract	Section 1.3.1 COVID-19
Method:	Email to the following recipients: Mariam.Siddiqui@dmas.virginia.gov peter.sokol@dmas.virginia.gov
Format:	Use the reporting template located on SharePoint.
File Name:	Renewal_Outreach_ContractorName_yyyymm.xlsx (where yyyymm is the reporting period month)
Trigger:	Monthly
Due Date:	By close of business on the 15th calendar day of the month following the end of the reporting month.
Population:	Include CCC PLUS and MEDALLION
DMAS:	Director's Office

2.2.24.1 Requirements

See reporting template.

2.2.25 ARTS Service Authorizations (SA) and Registrations

Refer to section 2.7.101.

Deliverable frequency changed from monthly to on request.

2.2.26 Early Intervention Services

Contract	12.2.4
Method:	Cardinal FTP
Format:	Comma separated value (.csv) file. All columns/fields for this deliverable must be included in the order specified, and no additional columns shall be included. Do not include a header row in .csv files.
File Name:	EI_SRC_RPT.csv
Trigger:	Monthly
Due Date:	By close of business on the 15th calendar day of the month following the end of the reporting month.
Population:	Include CCC PLUS and MEDALLION
DMAS:	MCH

2.2.26.1 Requirements

The Contractor shall demonstrate the following information related to the provision of Early Intervention services including:

1. Number of total EI Claims (adjudicated and pending adjudication) received
2. Number of total EI claims pending adjudication (unprocessed or that have not gone through the adjudication process) at month's end
3. Number of EI Claims paid within 14 calendar days of clean claim submission that have gone through the adjudication process
4. Number of EI claims paid between 15 and 30 calendar days
5. Number of EI claims not paid within 30 calendar days of clean claim submission that have gone through the adjudication process and why
6. Number of total EI claims denied (and why) that have gone through the adjudication process

<u>Population Captured</u>

This report shall primarily capture information related to claims rendered for members with the Early Intervention indicator presented on the 834 enrollment file. The report shall be rolling and information shall be captured for members on various months, as appropriate, as long as they maintain enrollment in Virginia's Early Intervention program.

The Contractor shall also provide information outlined in the below specifications for all Early Intervention providers.

<u>General Data Requirements</u>

The data in this report shall reflect claims payment data for this reporting month and not the date of service for the claim. For example, data reported in the July submission of this report shall include data for the entire month of June.

This report is rolling and, should information be applicable for a subsequent reporting month, it shall be reported on as many reports as applicable. For example, if Provider A is in the contracting process with the MCO for the months of June and July, that provider shall be reported on the submissions for July and August. The rolling nature of this report shall be applicable for all fields of the report.

Duplicate claims data shall be reported in the data captured here. For example, if Provider B had a claim rejected because the service was not in the scope of the IFSP and the member had aged out of Early Intervention services, that claim will be submitted in both applicable denied claims categories on this report.

Definitions

The below definitions reflect the information required for this report:

"*Clean Claim*" – A claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made on the claim under this title. See sections 1816(c)(2)(B) and 1842(c)(2)(B) of the Social Security Act., or as applicable under 42 CFR § 447.45.

For the purpose of this report, clean claims shall also meet the requirements for Early Intervention services set forth in the Medallion 4.0 contract including, but not limited to: 1) The provider is appropriately credentialed through the Virginia Department of Behavioral Health and Developmental Services as an Early Intervention Services Provider; 2) The claim submitted is for a child enrolled in Virginia's Early Intervention program; 3) The claim submitted is for services outlined in that child's Individualized Family Service Plan (IFSP); and 4) The claim utilizes the designated CPT codes for Early Intervention Services as outlined in the DMAS Early Intervention Provider Manual.

"*Early Intervention Services (EI)*" – Early Intervention (EI) services are provided through Part C of the Individuals with Disabilities Education Act (20 USC § 1431 et seq.), as amended, and in accordance with 42 CFR § 440.130(d). EI services are designed to meet the developmental needs of children and families and to enhance the development of children from birth to the day before the third birthday who have (i) a 25% developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay. Per 12 VAC 35-225-70 children are not eligible to receive EI services on or after their third birthday. EI services provided in the child's natural environment to the maximum extent appropriate.

"*Early Intervention Individualized Family Service Plan (IFSP)*" – A written plan developed by the Member's interdisciplinary team for providing early intervention supports and services to eligible children and families that: 1) Is based on evaluation for eligibility determination and assessment for service planning; 2) Includes information based on the child's evaluation and assessments, family information, results or outcomes, and supports and services based on peer-reviewed research (to the extent practicable) that are necessary to meet the unique needs of the child and the family and to achieve the results or outcomes; and 3) Is implemented as soon as possible once parental consent is obtained. The IFSP requires a physician signature for the initial IFSP, annual IFSP and anytime a service is added or services change (as determined through the IFSP Review process). Medical necessity is established by the IFSP combined with physician certification and shall serve as the authorization for the identified early intervention services. **Per the Medallion 4.0 Contract, no additional service authorizations shall be required for EI services**.

"*Early Intervention Provider*" – A provider credentialed with the Virginia Department of Behavioral Health and Developmental Services to render Early Intervention services as defined in Part C of the Individuals

with Disabilities Education Act (20 USC § 1431 et seq.), as amended, and in accordance with 42 CFR § 440.130(d).

"Early Intervention Provider Master Roster" – The credentialing of Early Intervention (EI) providers requires the Contractor develop and maintain a network of EI providers, certified by DBHDS, with sufficient capacity to serve its Members in need of EI services. The Early Intervention Provider Master Roster is a document developed and maintained by DMAS in collaboration with DBHDS containing all EI certified providers associated with all 40 Local Lead Agencies (LLAs) in the state of Virginia. This document shall be updated and shared with the Contractor monthly.

Formula for Calculating Total Number of Claims

The Contractor shall utilize the below formula when reporting data for this report.

Total Claims Adjudicated (Paid/Denied) + Total Claims Pending Adjudication = Total Number of Claims Received

Total Claims Adjudicated – All Claims that have gone through the Contractor's adjudicationprocess (Clean Claims Paid in 14 days, Clean Claims Paid between 15 – 30 days, Clean Claims Not Paid in 30 days, and Total Denied)**Total Claims Pending Adjudication** – All Claims that have not yet gone through the adjudication process (Unprocessed at Month's End)

2.2.26.2 File Specifications

Report the following information as one row with multiple columns. Submit in the following format with Field Name information running horizontally.

Field Name	Field Description	Specifications
Total Claims Received (Adjudicated and Pending Adjudication)	Total number of EI Claims received, that have both been adjudicated and those that are pending adjudication, in the reporting month	Valid value is greater than or equal to 0
Total Claims Pending Adjudication	Total number of EI Claims unprocessed or that have not gone through the adjudication process at months end.	Valid value is greater than or equal to 0
Clean Claims Paid in 14 Days	• Number of Claims paid Within 14 Days of Clean Claim submission • If a provider has multiple clean claims that have been processed within 14 days, they shall all be captured in this field.	Valid value is greater than or equal to 0
Clean Claims Paid Between 15 - 30 Days	• Number of Claims paid Between 15 - 30 Days of Clean Claim submission • If a provider has multiple clean claims that have been processed between 15 - 30 days, they shall all be captured in this field.	Valid value is greater than or equal to 0

Field Name	Field Description	Specifications
Clean Claims Not Paid in 30 Days	• Number of Clean Claims submitted by EIProviders not paid Within 30 Days of thatClean Claim that have gone through the adjudication process. • If a provider has multiple clean claims that have not been processed within 30 days, theyshall all be captured in this field. For example,if Provider C has three clean claims that werenot paid within 30 days, they shall all be represented in the total reporting number.	Valid value is greater than or equal to 0
Provider Pay Info Incorrect	Number of Clean Claims Not Paid Within 30 Days Reason: Provider Payment Information Not Valid	Valid value is greater than or equal to 0
Processing Error	Number of Clean Claims Not Paid Within 30 Days Reason: Internal MCO Systems Payment Processing Error	Valid value is greater than or equal to 0
Other Reason	• Number of Clean Claims Not paid Within 30 days reason: Other • This category shall only be utilized when a claim denial does not meet the above denial reason criteria.	• Valid value is greater than or equal to 0 • For values greater than 1, comments section shall be completed describing additional reason claims were not paid.
Comments	Additional comments	If 'Other' field value is greater than 1, describe additional reason(s) claims were not paid.
Denied Claims	Number of Denied Claims	Valid value is greater than or equal to 0
Prwk Incomplete	Number of denied claims for reason: Paperwork incomplete	Valid value is greater than or equal to 0
Prwk Invalid	Number of denied claims for reason: Paperwork incorrect	Valid value is greater than or equal to 0
Not in MCO Network	Number of denied claims for reason: Provider not in MCO network	Valid value is greater than or equal to 0
Invalid Proc Code	Number of denied claims for reason: Invalid procedure code	Valid value is greater than or equal to 0
Not EI Provider	Number of denied claims for reason: Provider not EI credentialed	Valid value is greater than or equal to 0
Not EI Member	Number of denied claims for reason: Member not EI eligible	Valid value is greater than or equal to 0

Field Name	Field Description	Specifications
Not in IFSP Scope	Number of denied claims for reason: Service not in scope of IFSP	Valid value is greater than or equal to 0
Member Aged Out	Number of denied claims for reason: Member aged out of EI services	Valid value is greater than or equal to 0
Duplicate Service/Claim	Number of denied claims for reason: Duplicate service/claim	Valid value is greater than or equal to 0
Other Denial	Number of denied claims for reason: Other	Valid value is greater than or equal to 0

2.2.27 Traumatic Brain Injury (TBI) Targeted Case Management (TCM) Service Authorization

Contract	5.19 Traumatic Brain Injury Services and Waiver
Method:	Cardinal FTP
Format:	Excel (.xlsx) file
File Name:	TBI_TCM_SA_MM/YYYY_ContractorName.xlsx
Trigger:	Monthly
Due Date:	By close of business on the 15th calendar day of the month following the end of the reporting month.
Population:	Include CCC PLUS and MEDALLION
DMAS:	Division of High Needs Support/Brain Injury Unit

2.2.27.1 File Specifications

Field Description	Provider Specifications
Service Center	Service center ID – CCC Plus vs Medallion
SA Number	Service Authorization number
Medicaid ID	Member Medicaid ID – 12 digits
Procedure code	S0281 - TBI TCM S0280 - Only of SA is being completed due to member meeting maximum service limit TBI assessment
Diagnosis	TBI diagnosis
MPAI-T Score	Members MPAI- T score
SA Begin Date	MM/DD/YYYY format – date following SA review
SA End Date	MM/DD/YYYY format – date following SA review
Request Begin Date	MM/DD/YYYY format - date provider requested
Request End Date	MM/DD/YYYY format – date provider requested
SA Decision	Drop box – choose from Approval; Denial or Partial Denial

2.2.27.2 Requirements

- Service will go live 1/1/2023. The first monthly report will be due on 2/15/2024 for January's data.
- Only the reporting template provided by DMAS is to be utilized. The template is **NOT** to be altered in any way and all fields must be completed with no blank spaces.
- Dates must follow the format of mm/dd/yyyy.
- "Member Medicaid ID" must be 12 digits.
- Drop-down boxe within this report must be utilized for SA Decision
    - Folder: Care Coordination Collaboration
    - Sub Folder: IES for ADHC
- Any template **NOT** meeting these requirements will be automatically returned for resubmission.

2.3 Quarterly Reports

2.3.1 MCO Network Provider File

Contract: Section 7.1.8 Assurances That Access Standards Are Being Met

Method: Cardinal FTP

Format: Comma separated value (.csv) file. All columns/fields must be included in the order specified, with no additional/omitted columns. Do not include a header row.

File Name: PROV_NTWK.csv

Trigger: Quarterly

Due Date: Submissions are due by close of business on the last calendar day of the month following the end of the reporting period / quarter.

Population: Include CCC PLUS and MEDALLION

DMAS: Provider Team

2.3.1.1 File Specifications

Field Name	Req	Data Specification
Health Plan Name	Yes	3 byte MCO identifier. Must use the following valid values: AET = Aetna ANT = Anthem MCC = Molina OPT = Optima UHC = United Healthcare VAP = Virginia Premier
Health Plan NPI/API	No	10 digit health plan API/NPI assigned by DMAS
Provider NPI	Yes	All providers listed must include an NPI
Provider Last Name	Yes	Provider Last Name
Provider First Name	No	Provider First Name
Group Affiliation	No	Medical or Provider Group Affiliation
Hospital Affiliation	No	If provider is affiliated with a hospital. Valid values are: 'Y' = Yes 'N' = No
Provider Taxonomy Code	Yes	Unique ten character alphanumeric code that enables providers to identify their specialty at the claim level.
Primary Taxonomy Code Indicator	Yes	If provider taxonomy is primary or not. Valid values are: 'Y' = Yes 'N' = No
Provider Designation Sub-Classification	Yes	If the provider is a Long Term Services & Supports (LTSS), ARTS or Behavioral Health provider, please refer to the Taxonomy list for a valid value list.
Provider Address Line 1	Yes	Physical location Address required. P.O. Box cannot be used as a service location. If there are multiple service locations for this provider, please list each new service location address on a separate row. Therefore, if a specific provider has 5 different service location addresses, then there needs to be 5 separate rows. One for each address on a separate row.
Provider Address Line 2	No	Provider Suite or Room Number

Field Name	Req	Data Specification
Provider City	Yes	Physical location City. Same practice as the 'Address Line1' field; if there are 5 different service locations, please repeat the information for each on a separate row for the City.
Provider FIPS Code	Yes	Physical location FIPS Code. Submit five-digit FIPS Code appropriate for each unique service location(s).
Provider State	Yes	Physical location State Code. 2 character State abbreviation for each unique service location(s).
Provider Zip Code	Yes	5-digit zip code for each unique service location(s).
24 Hour Access	Yes	Valid Values: 'Y' = Yes 'N' = No 'U' = Unknown
Other Language Spoken 1	No	Refer to the Cardinal Technical Guide for valid language values list
Other Language Spoken 2	No	Refer to the Cardinal Technical Guide for valid language values list
CSB Satellite Office	Yes	Valid Values: 'Y' = Yes 'N' = No 'U' = Unknown
ADA Compliant	Yes	Valid Values: 'Y' = Yes 'N' = No 'U' = Unknown
Accepting New Patients	Yes	Valid Values: 'Y' = Yes 'N' = No 'U' = Unknown

2.3.1.2 Requirements

As specified above.

2.3.2 Critical Incidents

Contract: Section 16.3 Reporting and Notification to the Department of Critical Incidents

Method: Cardinal FTP

Format: Use the reporting template located on SharePoint.

File Name: CRITICAL_INCIDENTS_*yyyyQn_ContractorName.xlsx*

where *yyyyQn* is the reporting period state fiscal year and quarter.

For example: 2023Q1 for reporting period July-September 2022.

State Fiscal Quarter	**Due Date***
Q1 = July - September	October 31
Q2 = October - December	January 31
Q3 = January - March	April 30
Q4 = April - June	July 31

Trigger: Quarterly

Due Date: By close of business on the last calendar day of the month following the reporting quarter.

Population: Include CCC PLUS and MEDALLION

DMAS:

2.3.2.1 File Specifications

Field Description	Specifications
MCO	Valid Values: • Aetna • Anthem • Molina • Optima • United HealthCare
Year	Format = yyyy
Qrt	Valid Values: • 1 • 2 • 3 • 4
Plan Benefit	Valid Value: • Med4 • CCCPlus

Field Description	Specifications
Medicaid ID	Must be a valid Medicaid ID Format = 12 digits with any leading zeros included
Member DOB	Format = mm/dd/yyyy
Member Gender	Valid Value: • M • F • Other
Member Dually Eligible?	Valid Value: • Yes • No
Member Identified Medicaid-Funded Service at Time of Incident	Select one of the following values from the drop-down list in template: • Addiction and Recovery Treatment Services "ARTS" • CCCPlus Waiver w/o PDN • CCCPlus Wavier with PDN • Inpatient Behavioral Health • Inpatient Substance Use Disorder Treatment • Mental Health Service • Nursing Facility • Other
Identified Case Management Level at Time of Incident	Select one of the following values from the drop-down list in template: • Mandatory High Population • Mandatory Priority • MCO-Determined Priority Population • Other Member Needing Care Management
Date of Event	Format = mm/dd/yyyy
Date of Discovery	Format =mm/dd/yyyy
Date Closed	Format = mm/dd/yyyy Leave blank if case is not yet closed and describe reason why under "Action Taken by MCO" column.
Provider Name	Name of provider if applicable; "N/A" if the incident is not provider-related (for example, a home-based injury,)
Provider NPI	Provider NPI if provider name was entered; Leave Blank if no provider name entered. Format: Ten digits with leading zeros included

Field Description	Specifications
Provider Type	Select one of the following values from the drop-down list in template: • HCBS • Hospital • Inpatient behavioral health facility • Nursing facility • PCP/Specialist • Transportation • Other
Incident Category	Valid Values • Sentinel Event • Quality of Care • Other
Incident High-Level Description Description #1 Description #2(if needed) Description #3(if needed)	Designate at least one high-level description. Up to three high-level descriptions may be designated if a single descriptor does not adequately describe the nature of the incident. Valid values: • Abuse • Attempted Suicide • Deviation from standards of care • Exploitation, financial or other • Medical error • Medication discrepancy • Missing person • Neglect • Sentinel death • Serious injury • Serious injury -Fall Related • Theft • Other *In the case of medication discrepancy specify the name of medicine, dosage and frequency in the Incident Detailed Description Column.
Incident Detailed Description	Detailed description of incident must include but is not limited to identifying: • All parties involved including emergency personal and law enforcement. • The location of incident. • Any significant events leading up to incident. To ensure a detailed description is provided use the 5 W's as a guide (Who-What-When-Where-Why).

Field Description	Specifications
APS/CPS Notified	Valid Values • Yes • No • N/A **If YES is chosen provide date in Incident Detailed Description Column if known.*
Did a Hospitalization occur due to incident	Valid Values • Yes • No • N/A
Cause of Death	Cause of death if applicable (i.e., cardiac arrest, respiratory failure etc.). "N/A" if not applicable
Date of Death	Format = mm/dd/yyyy Leave blank if death did not occur.
Autopsy Performed or Ordered	*Valid Values* • Yes • No • Unknow • N/A **If YES is chosen provide date in "Actions Taken by MCO column" if known.*
Source of Critical Incident Data	Personal or Professional Relationship to Member. e.g., member's sister, caregiver, care coordinator, etc.
Contact Name	Name of person who can be contacted for further information about the incident
Contact Phone Number	Phone number of person who can be contacted for further information about the incident (include area code) Format = (999) 999-9999
Contact E-mail	E-mail address of person who can be contacted for further information about the incident
Date of Initiation of MCO Actions	Format: mm/dd/yyyy Do not leave blank.

Field Description	Specifications
Actions Taken by MCO	Detailed description of actions taken by Case Manager/MCO to address or resolve the incident may include the following examples but are not limited to the actions descriptions: • Outcome of Critical Incident. • Support and/or resources offered. • Ensure the member is safe withing their home. • Confirm the member has viable, reliable back-up plan. • Identify if an APS/CPS report was made to the local DSS or the State VDSS Hotline for "suspected" abuse, neglect, or exploitation. • Implementation of protocols (i.e. fall, suicide prevention wound care, PERS, safety measures, etc.). • For Sentinel Death indicate if the MCO Medical Director reviewed the case. ** Inability to procure medical records is NOT a valid reason for not investigating.*

2.3.2.2 Requirements

Include all critical incidents discovered by the contractor and/or reported to the contractor during the reporting period.

The Contractor must provide appropriate follow-up on reported Critical Incidents within thirty (30) days or as expeditiously as the Member's condition or situation warrants.

Critical incidents are reported for incidents that occur during:

1. The provision of Medicaid-funded services to Members in nursing facilities, inpatient behavioral health settings, and inpatient substance use disorder treatment facilities; and
2. Participation in or receipt of Mental Health Services, ARTS or CCC Plus Waiver services in any setting

A critical incident is defined as any actual or alleged event or situation that threatens or impacts the physical, psychological, or emotional health, safety, or wellbeing of the Member.

Critical incidents are categorized as either Quality of Care Incidents, Sentinel Events or Other Critical Incidents as defined below

> *Quality of Care Incident:* Any incident that calls into question the competence or professional conduct of a healthcare provider in the course of providing medical services and has adversely affected, or could adversely affect, the health or welfare of a member. These are incidents of a less critical nature than those defined as Sentinel Events.

Sentinel Event: A patient safety event involving a sentinel death (not primarily related to the natural course of the illness or underlying condition for which the member was being treated or monitored by a medical professional at the time of the incident) or serious physical or psychological injury, or the risk thereof. All sentinel events are critical incidents.

See section 2.7.70 under Sentinel Event in this manual for a more detailed description of sentinel events.

Other Critical Incident: An event or situation that creates a significant risk to the physical or mental health, safety, or wellbeing of a member not resulting from a quality of care issue and less severe than a Sentinel Event.

Reportable Critical Incidents:

1. Abuse
2. Attempted Suicide
3. Deviation from standards of care
4. Exploitation, financial or otherwise
5. Medical error
6. Medication discrepancy
7. Missing person
8. Neglect
9. Sentinel death
10. Serious Injury (including falls that require medical evaluation).
11. Theft
12. Other

Critical Incident Report Form

DMAS encourages MCOs to incorporate the model Critical Incident Report Form developed by DMAS into their Critical Incident reporting process for provider use. Promoting this standardized form for the reporting of critical incidents by providers and other interested parties will help ensure that all information pertinent to the quarterly Critical Incident Report is captured with each incident reported.

The model Critical Incident Report Form is available on SharePoint

2.3.3 Calls for ED Patients Needing Assistance Accessing Alternative Care

Contract

Method: Cardinal FTP

Format: Excel (.xlsx) file

File Name: ALT_ED_CARE.xlsx

Trigger: Quarterly

Due Date: By close of business on the last calendar day of the month following the reporting quarter.

Population: Include CCC PLUS and MEDALLION

DMAS:

2.3.3.1 Requirements

The contractor shall have in place a specific process for hospitals that have elected to refer patients with non-urgent/emergent conditions to alternative settings for treatment, whereby the Emergency Department (ED) can contact the Contractor twenty-four (24) hours a day, seven (7) days a week (24/7) via a toll free phone line to obtain assistance for members with non-urgent/emergent conditions who do not require inpatient admission and who are requesting assistance in scheduling an appointment in an alternate treatment setting. The Contract may elect to utilize the 24/7 nurse triage line for this purpose**. The total number of calls received pertaining to patients in EDs needing assistance in accessing care in an alternative setting shall be tracked and reported.**

Field Name	Field Description	Specifications
PART_HOSP	Total number of participating in-network hospitals (statewide) who elected to refer patients with non-urgent/emergent conditions to alternative settings. Report the number as of the last day of the reporting quarter.	Number greater than or equal to 0
TOT_CALL	Total number of calls received pertaining to patients in EDs needing assistance in accessing care in an alternative setting for reporting quarter.	Number greater than or equal to 0
M1_TOT_CALL	Total number of calls received pertaining to patients in EDs needing assistance in accessing care in an alternative setting for the 1st month of the reporting quarter.	Number greater than or equal to 0
M2_TOT_CALL	Total number of calls received pertaining to patients in EDs needing assistance in accessing care in an alternative setting for the 2nd month of the reporting quarter.	Number greater than or equal to 0
M3_TOT_CALL	Total number of calls received pertaining to patients in EDs needing assistance in accessing care in an alternative setting for the 3rd month of the reporting quarter.	Number greater than or equal to 0

2.3.4 BOI Filing – Quarterly

Contract	Section 15.3.3 Financial Report to the Department
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	BOI_QTRLY.pdf
Trigger:	Quarterly
Due Date:	On the same day on which it is submitted to the Bureau of Insurance
Population:	Include CCC PLUS and MEDALLION
DMAS:	Provider Reimbursement

2.3.4.1 Requirements

All data for this deliverable must be submitted to DMAS in a single PDF file via the FTP as specified above. Do not submit any hardcopy files to DMAS.

2.3.5 Financial Report

Contract	Section 15.3.3 Financial Report to the Department
Method:	Cardinal FTP
Format:	Excel (.xlsx) file- use the MCO Financial Report template (MCONAME_FIN_QRTLY_MMDDYYYY) found on the DMAS SharePoint site
File Name:	FIN_QTRLY.xlsx
Trigger:	Quarterly
Due Date:	July thru September report is due November 30th
	October thru December report is due March 15th
	January thru March report is due May 31st
	April thru June report is due August 31st
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.3.5.1 Requirements

As specified by contract and additional guidance provided by DMAS Provider Reimbursement Division. The MCO Financial Report template (MCONAME_FIN_QRTLY_MMDDYYYY) for submission of this report is provided by DMAS.

All data for this deliverable must be submitted to DMAS in a single Excel (.xlsx) file via the FTP as specified above. Do not submit any hardcopy files to DMAS.

2.3.6 REMOVED

2.3.7 Program Integrity Overpayment and Recovery Report

Contract:	Section 18.8.1 Quarterly Fraud/Waste/Abuse Report
Method:	Cardinal FTP
Format:	Use the reporting template located on SharePoint
File Name:	PI_ACTIV_*yyyy*Q*n*_*ContractorName*.xlsx where *yyyy*Q*n* is the reporting period state fiscal year and quarter. For example: 2021Q1 for reporting period July – September 2020 State fiscal year quarters: Q1 = July - September Q2 = October - December Q3 = January - March Q4 = April - June
Trigger:	Quarterly
Due Date:	By close of business on the last calendar day of the month following the reporting quarter.
DMAS:	Program Integrity Division
Population:	Include CCC PLUS and MEDALLION
DMAS:	Program Integrity Division

2.3.7.1 Requirements

As specified in the contract section referenced above. Include all components as specified by the contract. See the *Quarterly PI Overpayment and Recovery Report Instructions Workbook* located on SharePoint for additional instructions.

The Contractor must submit electronically to the Department each quarter all activities conducted on behalf of PI by the Contractor and include findings related to these activities. The report must follow the format specified in the Cardinal Care Technical Manual. This report will serve as the annual report of overpayment recoveries required under 42 CFR §§438.604(a)(7), 438.606, and 438.608(d)(3). The report must include, but is not limited to, the following:

1. Allegations received and results of preliminary review;
2. Investigations conducted and outcome;
3. Payment Suspension notices received and suspended payments summary;
4. Claims Edits/Automated Review summary;
5. Coordination of Benefits/Third-Party Liability savings and recoveries;
6. Service Authorization/Medical Necessity savings;
7. Provider Education Savings;
8. Provider Screening reviews and denials;
9. Unsolicited Refunds (Provider-identified Overpayments);
10. Archived Referrals (Historical Cases); and
11. Other Activities.

NOTE All cases, whether opened or closed remain on the quarterly report until the end of the contract year. Closed cases do not carry over to the next contract year. Only open cases would carry over to the next contract year.

2.3.8 Providers Failing Accreditation/Credentialing & Terminations

Contract	Section 7.3.4 Provider Credentialing Standards
Method:	Cardinal FTP
Format:	Use the reporting template located on SharePoint
File Name:	PRV_CRED.xlsx
Trigger:	Quarterly
Due Date:	By close of business on the last calendar day of the month following the reporting quarter.
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.3.8.1 Requirements

The Contractor shall report quarterly all providers who have failed to meet accreditation/credentialing standards or been denied application (including MCO-terminated providers). This includes providers terminated from the MCO network.

- All terminations the MCO received from DMAS for the specific quarter should be reflected on the deliverable.
- MCOs should include all terminated Providers regardless of PAR or NON PAR status.
- Each submission should only contain terminated providers for that quarter; e.g., Quarter 2 of SFY 2024: October 1, 2023 – December 31, 2023.
- Ensure the 5-digit zip code is included in “Address” field.
- MCO must differentiate between those providers terminated with cause and those without cause.

2.3.9 Drug Rebates

Contract: Section 5.15.10 Drug Rebates

Method: Cardinal FTP

Format: Excel (.xlsx) file – use template Drug Rebate Report Quarterly Template provided by DMAS

File Name: RXREBATE_QTRLY.xlsx

Trigger: Quarterly

Due Date: By close of business 45 days following the end of the reporting quarter.

State Fiscal Quarter	Due Date*
Q1 = July – September	November 15
Q2 = October – December	February 15
Q3 = January – March	May 15
Q4 = April – June	August 15

Population: Include CCC PLUS and MEDALLION

DMAS:

2.3.9.1 Requirements

Please use the template Drug Rebate Quarterly Template provided by DMAS, available on the Cardinal Care SharePoint site.

2.3.10 Medication Therapy Management (MTM)

Contract Section 5.15.3 Medication Therapy Management (MTM)

Method: Cardinal FTP

Format: Excel (.xlsx) file

File Name: MTM_QTRLY.xlsx

Trigger: Quarterly

Due Date: By close of business on the last calendar day of the month following the reporting quarter.

Population: Include CCC PLUS and MEDALLION

DMAS:

2.3.10.1 File Specifications

Field Description	Specifications
Number of members identified for MTM	Numeric value must be > 0
Number of MTM interventions performed	Numeric value must be > 0
For each unique member and disease:	
Disease state or type	Description of disease state or type
Number of interventions	Numeric value must be > 1
Delivery	Must use one of the following values: • 'P/P' = Person to person • 'T' = Telephonic • 'TC' = Telehealth Consultation • 'M' = Mail
Consultation	Must use one of the following values: • 'M' = Member • 'P' = Provider

2.3.11 Fiscal Employer Agent Quarterly Payroll Review

Contract: Attachment M – F/EA Requirements

Method: Cardinal FTP

Format: Refer to the reporting template located on SharePoint.

File Name: CCCP_FEA_*agentname*_PAYROLL_REVIEW_*yyyyQN*_*ContractorName*.pdf.
Where yyyyQn is the reporting period based on a calendar year and quarter.
For Example: 2021Q1 for reporting period January – March 2021
Calendar Quarters:
Q1 – January – March
Q2 – April – June
Q3 – July - September
Q4 – October – December

Trigger: Quarterly

Due Date: Within 30 days of scheduled due dates for F/EA reports submitted to Contractor.

Quarter End Date	**Due date for F/EA Reports To Contractor**	**Due date for Payroll Review to DMAS**
March 31	May 20	June 19
June 30	August 20	September 19
September 30	November 20	December 20
December 31	February 20	March 22

DMAS: Waiver Policy and Consumer Directed Services Unit

Population: CCC Plus Only

DMAS:

2.3.11.1 Requirements

The Contractor shall provide to the Department quarterly reviews and analysis of F/EA withholdings and tax processes. Follow the format of the reporting template located on SharePoint.

2.3.12 ID/D Waiver Reports for the Department of Justice

Contract	Section 5.14.25 Reporting on Transportation provided to Individuals Enrolled in DD Waivers
Method:	Cardinal FTP
Format:	Use the reporting templates located on SharePoint
File Name:	See details below for each report name
Trigger:	Quarterly
Due Date:	1st Quarter - for July, August, September - by October 15th 2nd Quarter – for October, November, December - by January 15th 3rd Quarter – for January, February, March - by April 15th 4th Quarter – for April, May, June - by July 15th
Population:	CCC Plus Only
DMAS:	Transportation Unit

2.3.12.1 Requirements

Note: The DMAS transportation unit will follow up with MCOs with further details on reporting requirements.

The Contractor provides transportation services for DD Waiver individuals to and from non-DD waiver services.

Pursuant to a Department of Justice (DOJ) investigation in which Virginia was found out of compliance with the Americans with Disabilities Act (ADA) and the U.S. Supreme Court Olmstead ruling, Virginia and the DOJ reached a settlement agreement under which Virginia is to ensure that transportation services for DD Waiver individuals are of "good quality, appropriate, available and accessible to the DD population."

In accordance with this agreement, the Contractor shall submit the following reports each quarter concerning the quality of transportation provided to DD waiver individuals:

1) Six Advisory Board meeting minute summaries – one for each region or group with which the Contractor met if applicable.
   File Name: Advisory Board Minutes *region number mmm yyyy*.pdf
   Example: Advisory Board Minutes R1 Jun 2018.pdf

2) DMAS IDD Accident Incident Report
   File Name: DMAS IDD Accident Incident Report *mmm-mmm yyyy*.xlsx
   Example: DMAS IDD Accident Incident Report Apr-Jun 2018.xlsx

3) Training Outreach by Region
   File Name: Training Outreach by Region *mmm-mmm yyyy*.xlsx
   Example: Training Outreach by Region Apr-Jun 2018.xlsx

4) Three DMAS IDD Quality Assurance Reports

File Name: DMAS IDD Quality Assurance Report – *mmm yyyy*.xlsx
Example: DMAS IDD Quality Assurance Report – Aug 2018.xlsx
Submit one report for each month of the quarter.

5) DMAS IDD Complaint Report Summary – Summary of all three months in one report
File Name: DMAS IDD Complaint Summary – *mmm-mmm yyyy*.xlsx
Example: DMAS IDD Complaint Summary – Apr-Jun 2018.xlsx

2.3.13 Individual Experience Surveys (IES) – Adult Day Health Care

Contract	5.12.2.3
Method:	Cardinal FTP
Format:	Use the reporting template 'IES Quarterly Reporting Temp.xlsx' provided on DMAS SharePoint
File Name:	CCCP_IES_Quarterly_Report_*yyyyQn_ContractorName.xlsx* where *yyyyQn* is the reporting period state fiscal year and quarter. For example: 2023Q1 for the first quarter of fiscal year 2023 Q1 = July - September Q2 = October - December Q3 = January - March Q4 = April - June
Trigger:	Quarterly
Due Date:	By close of business on the last calendar day of the month following the end of the reporting quarter
Population:	CCC PLUS Only
DMAS:	Integrated Care

2.3.13.1 Requirements

- Completed Individual Experience Surveys (IES) with members attending Adult Day Health Care through the CCC Plus Waiver are reported on a quarterly basis to ensure compliance with CMS' HCBS Settings Rule for 1915(c) waivers. Note: Member's refusing to complete an IES are also documented in this reported.
- Only the reporting template provided by DMAS is to be utilized. The template is **NOT** to be altered in any way and all fields must be completed with no blank spaces.
- Each quarterly worksheet within the template will be updated on a continual basis and by fiscal year end all four worksheets will be complete.
- "Date Completed" must follow the format of mm/dd/yyyy.
- "Member Medicaid ID" must be 12 digits.
- Drop-down boxes within this report must be utilized for "Issues Found" and "Critical Incident".
- "Remediation" must be completed if a "Yes" is entered under "Issues Found" and must encompass the action taken. If "No" issues found document N/A under remediation.

- Refer to DMAS SharePoint site for details:
  - https://covgov.sharepoint.com/sites/dmas/health-plans/SitePages/shared-documents.aspx
  - Folder: Care Coordination Collaboration
  - Sub Folder: IES for ADHC
- Any template **NOT** meeting these requirements will be automatically returned for resubmission.

2.3.14 QMR Finished Review Report

Contract	Section 5.12.10 Waiver Assurances
Method:	Cardinal FTP
Format:	Use reporting template provided on SharePoint
File Name:	CCCP_QMR_FRR_C*ontractorName_yyyymmdd*.xlsx where *yyyymmdd* is the date of submission
Trigger:	Quarterly
Due Date:	By close of business on the last calendar day of the month following the end of the reporting quarter
Population:	CCC Plus Only
DMAS:	Quality Improvement Specialist - Division of Integrated Care

2.3.14.1 Requirements

See *QMR Process Guide* for specific reporting requirements.

2.3.15 Quality Improvement Team (QIT) Report

Contract	
Method:	Cardinal FTP
Format:	Use reporting template provided on SharePoint
File Name:	CCCP_QIT_C*ontractorName_yyyymmdd*.xlsx where *yyyymmdd* is the date of submission
Trigger:	Quarterly
Due Date	By close of business on the last calendar day of the month following the end of the reporting quarter
Population:	CCC Plus Only
DMAS:	Quality Improvement Specialist - Division of Integrated Care

2.3.15.1 Requirements

See *QMR Process Guide* for specific reporting requirements.

2.3.16 Waiver Enrollees w/o PDN with HRAs Overdue 3 months or Greater

Contract	
Method:	Cardinal FTP
Format:	Use the reporting template located on SharePoint.
File Name:	Overdue_HRAReport_*ContractorName_yyyyQn.xlsx* where *yyyyQn* is the reporting period state fiscal year and quarter. For example: 2021Q1 for reporting period July – September 2020 State fiscal year quarters Q1 = July – September Q2 = October - December Q3 = January – March Q4 = April - June
Trigger:	Quarterly
Due Date:	By close of business on the 10th of the month following the end of the reporting quarter.
Population:	CCC Plus Only
DMAS:	Contract Monitoring Team

2.3.16.1 Requirements

All information pertaining to an individual member should be reported on a single row of the report. Multiple instances of any data element within that row (dates of member or provider contact attempts, waiver providers, successful provider contact outcomes, and other sources) should be reported within the same cell and separated by commas.

Report should include:

- ONLY CCC PLUS Waiver Enrollees with and without PDN whose Initial HRA is overdue for completion 3 months or more at the end of the reporting period.
- The reason why it is overdue should also be listed (select reasons from drop-down selection in reason column within template):
  - UTC
  - Deceased
  - Moved Out of State/Country
  - Incarcerated
  - Other

Report should NOT include:

1) Individuals who have refused the HR, (these individuals should be captured under the “refusal” column on the monthly Dashboard).
2) Individuals who have a completed assessment by report submission date.

Data/Information included on template:

A. Enrollee Last Name
B. Enrollee First Name
C. Medicaid ID number (12 digits)
D. Initial Date of Enrollment with Plan
E. Date of Waiver Enrollment
F. Reason Initial HRA not Completed within Required Time Frame (90 days) (drop-down choices: UTC, Moved Out of State, Deceased, Incarcerated, Other)
G. Dates of Attempted **Telephone** Contact with Enrollee (list all dates, to include all call attempts during member's enrollment with the plan).
H. Dates of **Mail** Sent to Enrollee (list all dates). Only include mailings that relate to HRA completions such as attempt to contact or UTC.
I. Dates of Enrollee Home Visit Attempts (list all dates)
J. Successful Enrollee Contact Attempt(s) (Y/N)
K. If Enrollee Contact was Successful, Document Outcome (drop-down choices: HRA Scheduled, HRA Deferred-hospitalized, No Longer Receiving Waiver Services, Other). If there has been more than one successful contact, select the outcome that indicates the current status of the MCO's efforts to complete the member's initial HRA.
L. Does Enrollee have Active Waiver Service Authorizations (Y/N)
M. Was MTR Reviewed for Transition Authorizations (Y/N)
N. Name of Waiver Provider(s) (from authorizations, MTR file, or other).
    - List all waiver providers with current authorizations. (SF, Agency, ADHC)
    - If no current authorizations are found, list any prior waiver providers identified.
O. Dates of Attempted Telephone Contacts to Provider(s) (list all dates). Include provider name along with date of contact attempt.
P. Successful Waiver Provider Contact(s) (Y/N)
Q. If Provider Contact was Successful, Document Provider Name and Outcome
R. Other Sources Researched/contacted. For example, PCP offices, pharmacies, etc.
S. Comments

2.3.17 Mental Health Services (MHS) Appeals

Contract

Method: Cardinal FTP

Format: Excel (.xlsx)

File Name: MHS_APPEALS _C*ontractorName_yyyyQN*.xlsx
where *yyyyQN* is the reporting period state fiscal year and quarter.
For example: 2023Q1 for reporting period July-September 2022.

State Fiscal Quarter	**Due Date***
Q1 = July - September	October 31
Q2 = October - December	January 31
Q3 = January - March	April 30
Q4 = April - June	July 31

*If the due date falls on a weekend or state holiday, the due will be extended to the next business day.

Trigger: Quarterly

Due Date: By close of business on the last day of the month following the reporting period

Population: Include CCC PLUS and MEDALLION

DMAS:

2.3.17.1 File Specifications

Field Description	**Specifications**
Procedure Code for Service Denied/Reduced (include applicable modifier(s))	Valid values: 97155 et al. H0023 H0024 H0025 H0031 H0032 U6 H0032 U7 H0032 U8 H0035 H0036 H0040 H0046 H2011 H2012 H2016 H2016 U7 H2016 UG H2017 H2018 H2033 S9480 S9482 S9485

Appeals Received	Value must be > 0 Cannot be blank/spaces
Fully Favorable Appeal Decisions (i.e., original decision overturned)	Value must be ≥ 0 Cannot be blank/spaces
Partially Favorable Appeal Decisions (i.e., original decision partially upheld; appeal partially denied)	Value must be ≥ 0 Cannot be blank/spaces
Unfavorable Appeal Decisions (i.e., original decision upheld; appeal denied)	Value must be ≥ 0 Cannot be blank/spaces
Appeals in Progress (i.e., decision not yet rendered)	Value must be ≥ 0 Cannot be blank/spaces
Appeals Withdrawn	Value must be ≥ 0 Cannot be blank/spaces
Invalid Appeals	Value must be ≥ 0 Cannot be blank/spaces

2.3.17.2 Requirements

Report the following totals separately for each MHS procedure code associated with a service for which authorization was requested and subsequently either denied or approved at a reduced rate AND where the denial or reduction resulted in one or more appeals. If an appeal relates to an authorization request which included more than one procedure code, that appeal must be counted in the totals for each procedure code that was included in the authorization request.

Appeals Received: the total number of MHS appeals filed during the reporting period.

Fully Favorable Appeal Decisions: the total number of MHS appeals that were approved during the reporting period, thereby overturning the MCO's original authorization denial.

Partially Favorable Appeal Decisions: the total number of MHS appeals that were partially denied during the reporting period, thereby approving the requested services at a reduced rate.

Unfavorable Appeal Decisions: the total number of MHS appeals that were fully denied during the reporting period, thereby upholding the MCO's original authorization denial.

Appeals in Progress: the total number of MHS appeals filed at any time for which the MCO has not yet rendered a decision.

Appeals Withdrawn: the total number of appeals filed at any time that were withdrawn during the reporting period.

Invalid Appeals: the total number of appeals filed at any time determined by the MCO during the reporting period to be invalid.

The department will publish these totals on the DMAS website quarterly.

Mental Health Services (MHS):

Service Name	Proc. Code	Initial Request	Contd. Stay Request	Effective Date
1. Enhanced Behavioral Health Services (EBH)				•
23-Hour Crisis Stabilization	S9485	R	N/A	12/1/2021
Applied Behavior Analysis	97155 et al.	A	A	12/1/2021
Assertive Community Treatment	H0040	A	A	7/1/2021
Community Stabilization	S9482	R	A	12/1/2021
Functional Family Therapy	H0036	A	A	12/1/2021
Mental Health-Intensive Outpatient	S9480	A	A	7/1/2021
Mental Health-Partial Hospitalization Program	H0035	A	A	7/1/2021
Mobile Crisis Response	H2011	R	N/A	12/1/2021
Multisystemic Therapy	H2033	A	A	12/1/2021
Residential Crisis Stabilization Unit	H2018	R	A	12/1/2021
2. Community Mental Health Rehabilitation Services (CMHRS)				
Intensive In-Home	H2012	A	A	Prior to 7/1/2021
Intensive In-Home - Assessment	H0031	N/A	N/A	Prior to 7/1/2021
Mental Health Peer Support Services – Individual	H0024	R	R	Prior to 7/1/2021
Mental Health Peer Support Services – Group	H0025	R	R	Prior to 7/1/2021
Mental Health Skill-building Services (MHSS)	H0046	A	A	Prior to 7/1/2021
Mental Health Skill-building Services (MHSS) – Assessment		N/A	N/A	Prior to 7/1/2021
Psychosocial Rehabilitation	H2017	A	A	Prior to 7/1/2021
Psychosocial Rehabilitation – Assessment	H0032 U6	N/A	N/A	Prior to 7/1/2021
Therapeutic Day Treatment (TDT) for Children	H2016 – School based H2016 U7 – Summer program H2016 UG – After-school program	A	A	7/1/2021
Therapeutic Day Treatment (TDT) for Children – Assessment	H0032 U7	N/A	N/A	Prior to 7/1/2021

Service Name	Proc. Code	Initial Request	Contd. Stay Request	Effective Date
3. Targeted Case Management				•
Mental Health Case Management	H0023	R	R	Prior to 7/1/2021

Codes expired or converted.

- *Note: Expired or converted codes may be used in reporting when deemed necessary (e.g. during the appeals process).*

Service Name	Proc. Code	Expired/Converted Date
Therapeutic Day Treatment	H0035 HA, H0035 HA U7, H0035 HA UG	Expired 6/30/2021 Converted 7/1/2021 to H2016, H2016 UG, H2016 U7
Day Treatment/Partial Hospitalizations	H0035 HB	Expired 6/30/2021
Intensive Community Treatment (ICT)	H0039	Expired 6/30/2021
Behavioral Therapy	H2033	Expired 11/30/2021 Converted 12/1/2021 to Multisystemic Therapy
Crisis Intervention	H0036	Expired 11/30/2021 Converted 12/1/2021 to Functional Family Therapy (FFT)
Crisis Stabilization		Expired 11/30/2021
Behavioral Therapy Assessment	H0032 UA	Expired 11/30/2021

2.3.18 Provider Credentialing Timeliness Report

Contract	Section 7.3.4 Provider Credentialing Standards
Method:	Cardinal FTP
Format:	Use reporting template located on SharePoint
File Name:	PROV_CRED_TIMELINESS.xlsx
Trigger:	Quarterly
Due Date:	By close of business on the last calendar day of the month following the end of the reporting quarter
Population:	Include CCC PLUS and MEDALLION
DMAS:	TBD

2.3.18.1 Requirements:

The MCO must report on the timeliness of processing all credentialing applications received from new acute, primary, behavioral, ARTS, and LTSS network providers.

The following applications are to be included on each quarterly report:

- All applications received but not yet completed (whether received in the current or a previous reporting period)
- Applications completed during the reporting period (whether received in the current or a previous reporting period)

Further clarification of conditionally required data elements:

Application Receipt Notification Date: Enter the date on which the provider was notified of the receipt of his/her application. **This date only applies when the application was received outside of the MCO's online application system.**

Further Info Request Date: Enter the date on which a request was sent to the provider for further information required to complete the application. **This date applies only when an incomplete application is received.**

Further Info Receipt Date: Enter the date on which the required information is received in response to a request from the MCO for further information required to complete an application.

2.4 Bi-Annual / Semi-Annual Reports (Twice Yearly)

2.4.1 Drug Formulary & Authorization Requirements

Contract	Section 5.15.1 Legend and Non-Legend Drug Coverage: Common Core Formulary
Method:	Cardinal FTP
Format:	Excel (.xlsx) file
File Name:	FORMULARY.xlsx
Trigger:	Prior to Implementation Biannually (twice yearly) Upon Revision Upon Request
Due Date:	60 calendar days prior to implementation 60 days after a full pharmacy coding file is provided by DMAS 45 calendar days prior to the effective date of the change
Population:	Include CCC PLUS and MEDALLION
DMAS:	Pharmacy Unit

2.4.1.1 Requirements

The Contractor is required to maintain a formulary to meet the unique needs of the Members they serve; at a minimum, the Contractor's formulary must include all preferred drugs on the DMAS Preferred Drug List (PDL) available at https://www.virginiamedicaidpharmacyservices.com.

The Contractor shall include the DMAS Preferred Drug List (PDL) as a "common core" formulary for all Members enrolled in the Cardinal Care program who have a pharmacy benefit covered by the Contractor's Medicaid plan. The DMAS PDL is not an all-inclusive list of drugs for Medicaid Members.

The Contractor's formulary must be developed and reviewed at least semi-annually by an appropriate Pharmacy and Therapeutics (P&T) Committee. The Contractor must submit their formulary to DMAS annually after review by its P&T Committee and inform DMAS of changes to their formulary by their P&T Committee.

The Contractor must receive the Department's approval for all formulary and pharmacy related policy changes including prior authorizations and quantity limits.

Field Header Name	Field Description	Specifications	Required
Drug Code Type	Drug classification code type used in formulary coding	Numeric Field Valid Values: • 1 = GPI • 2 = GSN • 3 = NDC	Y
Drug Code	Drug classification code used in formulary coding	Numeric Field If 1 above use 14-digit code If 2 above use 5- or 6-digit code If 3 above use 11-digit code	Y

NDC	National Drug Code	14-digit code Required only for brand over generic drugs – include ALL NDCs	N
Drug Class	Therapeutic Class	Character Field	Y
Med Name	Drug Name that is associate product	Character Field	Y
HCFA_DC	HCFA_DC Multisource Indicator	Valid Values: • 1 = generic • 2 = multisource brand • 3 = single source brand	Y
PDL Status	Preferred Drug List Status	Valid Values: • 1 = preferred • 2 = non-preferred	Y
PA	Prior Authorization Required	Valid values: • 1 = PA required • 0 = no PA required	Y
PA Type	Prior Authorization Type	One-digit response; Valid values: • 1 = PDL • 2 = Clinical • 3 = Both	Y
ST	Step Therapy Required	Valid Values: • 1 = if ST • 0 = no ST	Y
QL	Quantity Limit	Valid values: • 1 = QL • 0 = no QL	Y
Age Restriction	Age Restriction for PA	Valid Values: • 1 = age restriction • 0 = no age restriction	Y
Gender Restriction	Gender Restriction	• 1 = gender restriction • 0 = no gender restriction	Y

2.5 Annual

2.5.1 Policies & Procedures

MCOs are required to submit an annual attestation for each of the following contractually required policy and procedure documents. MCOs are also required to submit a copy of each Policy & Procedure document during initial readiness review and upon any material change (refer to definition of 'material change' within this document).

All attestations and Policy and Procedure documents are to be submitted as a PDF through the DMAS sFTP site. Use the DMAS template whenever provided.

Deliverable	File Name (pdf)	Contract
Business Continuity / Disaster Recovery Plan	BC_DR_PLAN	2.6.1
Changes in a Member's Circumstances that May Affect Eligibility Notification Procedures	ELIG_CHANGE_POLICY	1.4
Compliance for Sterilizations & Hysterectomies	STERL_HYST	5.13.3.1, 5.13.3.2
Continuity of Operations (COOP) Plan	COOP_PLN	2.6
Critical Incident Policy & Procedures	CRIT_INCID_PP	16
CYSHN Identification and Policy Summary Report	CYSHCN_PGM_POLICY	1.4
Data Confidentiality Policies & Procedures	DATA_CONFID	11.7
Data Quality Strategic Plan	DQ_STRATEGY	11.12.2
Data Security Plan for Department Data	DATA_SECUR	11.7
Early Intervention Services Policies and Procedures	EI_PGM_POLICY	5.9
Encounter Data Plan for Completeness	ENC_PLAN	11.3
Enrollment Verification for Providers Policies & Procedures	ENROL_VER	7.3.8
EPSDT Policies and Procedures	EPSDT_PLAN	5.8
Excess Capitation Payment Policies and Procedures	EXC_CAP_PAY_POLICY	1.15.00
Expansion Enhanced Fraud Prevention Policies and Procedures	MEDEX_EFP	1.4
Family Planning and Well Woman Policies and Procedures	FAMPLAN_WW_POLICY	5.13.3
Formal Referral and Assistance Process for Homeless Members	REF_HMLSS	8.13.3
Foster Care and Adoption Assistance Member Service Plan	FCAA_MBR_SVC_PLAN	3.6
Health Risk Assessment Policies & Procedures	HRA_POLICY	1.8.00
Marketing and Member Materials	MKTG_MBR_MTLS	4.4
Marketing Plan	MKTG_PLAN	4.4
Maternal Substance Use Intervention Plan	MAT_SUB_USE_POLICY	5.13.1.5
MCO Contacts for FAMIS Appeals to External Review Organization	CONTACTS_FAMIS_APPEALS	Attach. D
MCO Member Health Screening (MMHS) Policies and Procedures	MMHS_POLICY	8.3.0
Medical Necessity Guidelines	MED_NEC_GUIDE	6.1.6
Medical Record Safeguards	MED_REC_SAFE	4.1.4
Member Grievance & Appeals Policies & Procedures	MEMBER_GA	9
Member Health Education & Prevention Plan	EDUC_PGM	4.4.3
Member Health Education Materials	MBR_HLTH_EDU_MTR	4.4.3
Member Rights - Policies & Procedures	MBR_RIGHTS	4.1
Newborn Identification Policy & Procedures	NEWBORN_ID	3.7
Organizational Charts	ORG_CHART	2.10
Overpayments Identified or Recovered Policies and Procedures	OVERPAY_POLICY	17.3, 19
Patient Utilization Management and Safety (PUMS) Prior Auth Requirements	PUMS_PRIOR_AUTH	6.3
Physician Incentive Plan	PRV_INCENT	12.1.8
PIP / Incentive Arrangements Policy	PIP_ARRANG	7.3.1
Policies and Procedures for Selection & Retention of Network Providers	NET_RET_POLICY	7.3.1
Practice Guidelines	PRACT_GUIDE	7.3.10
Provider Appeals Process Policy and Procedures	PROV_APPEALS	9.8
Provider Credentialing & Recredentialing Policies and Procedures	PROV_CRED	7.3.4
Provider Manual Managed Care References	PROV_MANUAL	7.4.5
PUMS Program Policies and Procedures	PUMS_OUTCM	6.3
Referral of Fraud, Waste, or Abuse to Virginia MFCU Notification Procedures	FWA_NOTIF_POLICY	18.8
Risk Management and Security Plan	RSK_MNG_PLAN	11.7.0
Services for Justice-Involved Members Policies and Procedures	JUST_SVC	8.19
Social Determinants of Health Policies and Procedures	SDOH_POLICY	8.17
Substance Exposed Infants Care Coordination Policies and Procedures	SEI_POLICY	8.21.2
Third Party Administrator (TPA) Contracts	TPA_CONTRACTS	14
Third Party Administrator (TPA) Firewall	TPA_FIREWALL	14
Transportation Services Policies and Procedures	TRANSPORT	5.14.24
Trauma-Informed Care Development Plan	TIC_POLICY	7.2.6

Deliverable	File Name (pdf)	Contract
Utilization Management Plan	UM_PLAN	6
Virginia ED Care Coordination Program Report	EDCC	5.7.6
Vision Services Plan	VISION_PLAN	5.8.10
Wellness and Member Incentive Programs	MBR_WELL	4.2.2.1
Change in Network Provider's Circumstances that May Affect Eligibility Notification Procedure	PROV_NTWK_CHG	1.4
FQHC/RHC Reimbursement Methodology	FQHC_REIMBS	7.1.5
PCP Assignment Policies & Procedures	PCP_ASSIGN	7.1.3
Provider Disenrollment Policies & Procedures	PROV_DISENROLL	7.3.7

2.5.2 BOI Annual Filing

Contract	7.3.1
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	BOI_ANNUAL.pdf
Trigger:	Annual
Due Date:	On the same day on which it is submitted to the BOI
Population:	Include CCC PLUS and MEDALLION
DMAS:	PRD

2.5.2.1 Requirements

All data for this deliverable must be submitted to DMAS in a single PDF file via the FTP as specified above. Do not submit any hardcopy files to DMAS.

2.5.3 Audit by Independent Auditor (Required by BOI)

Contract	Section 15.3.5 Financial Solvency
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	IND_AUDIT.pdf
Trigger:	Annual
Due Date:	At the time it is submitted to the Bureau of Insurance or within 60 days of completion of audit (whichever is sooner)
Population:	Include CCC PLUS and MEDALLION
DMAS:	PRD

2.5.3.1 Requirements

As specified in contract. All data for this deliverable must be submitted to DMAS in a single PDF file via the FTP as specified above. Do not submit any hardcopy files to DMAS.

2.5.4 Health Maintenance Organization State Corporation Commission License

Contract	Section 2.1 Licensure and Solvency
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	HMO_SCC_LICENSE.pdf
Trigger:	Annually with contract renewal
Due Date:	TBD
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.5.4.1 Requirements

The Contractor shall obtain and retain at all times during the period of the Contract a valid license issued with "Health Maintenance Organization" Lines of Authority by the State Corporation Commission and comply with all terms and conditions set forth in the Code of Virginia §§ 38.2-4300 through 38.2-4323, 14 VAC 5-211-10 et seq., §38.2-5800 through 38.2-5811 and any and all other applicable laws of the Commonwealth of Virginia, as amended.

A copy of this license shall be submitted with the signature page at each annual contract renewal.

2.5.5 Service Area Approval Certification by State Health Commissioner

Contract	Section 2.2 Certification of Quality
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	SERV_APP_CERT.pdf
Trigger:	Annually with contract renewal
Due Date:	TBD
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.5.5.1 Requirements

Pursuant to § 32.1-137.1 through § 32-137.6 *Code of Virginia*, and 12 VAC 5-408-10 et seq., all managed care health insurance plan licensees must obtain service area approval certification and remain certified by the State Health Commissioner Center for Quality Health Care Services and Consumer Protection to confirm the quality of health care services delivered. A copy of this certification shall be submitted with the signature page at each annual contract renewal.

2.5.6 Insurance Coverage Verification

Contract	Section 21.18 Insurance
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	INS_COVG.pdf
Trigger:	Prior to Implementation Annual Upon Revision Upon Request
Due Date:	60 calendar days prior to implementation September 30th Within ten (10) business days prior to any revision Within ten (10) business days of receiving a request from DMAS
Population:	Include CCC PLUS and MEDALLION
DMAS:	PRD

2.5.6.1 Requirements

As specified in the contract, including all required components.

2.5.7 Disclosure of Ownership & Control Interest Statement (CMS 1513)

Contract	Section 2.9 Ownership and Control Interest
Method:	Email MCOHelp@dmas.virginia.gov
Format:	Adobe PDF
File Name:	CMS1513.pdf
Trigger:	Prior to Implementation Annually with contract renewal Department request
Due Date:	Annually with contract renewal Within thirty five (35) days of request by the Department
Population:	Include CCC PLUS and MEDALLION
DMAS:	PRD

2.5.7.1 Requirements

As specified in the contract. Please use the CMS 1513 form for this deliverable.

2.5.8 Medical Loss Ratio (MLR) Report

Contract	Section 15.4 Minimum Medical Loss Ratio (MLR) and Limit on Underwriting Gain
Method:	Cardinal FTP
Format:	Use the Cardinal Care MLR Reporting Template provided on DMAS SharePoint
File Name:	MLR_RPT.xlsx
Trigger:	Annual
Due Date:	June 1st following the report year
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.5.8.1 Requirements

The Contractor shall report a medical loss ratio (MLR) annually for Cardinal Care for each contract/reporting year based on 42 CFR § 438.8 and any additional CMS guidance.

See the Cardinal Care MLR Reporting Instructions provided on DMAS SharePoint.

2.5.9 List of Subcontractors

Contract

Method: Cardinal FTP

Format: Comma separated value (.csv) file. All columns/fields for this deliverable must be included in the order specified, and no additional columns shall be included. Do not include a header row in .csv files. Numeric fields shall not include commas, dollar signs, or other extraneous characters.

File Name: SUBCONTRACT.csv All columns/fields for this deliverable must be included in the order specified, and no additional columns shall be included.

Trigger: Annually and prior to any changes

Due Date: On September 30th of each year and 30 calendar days prior to implementation of any changes

Population: Include CCC PLUS and MEDALLION

DMAS:

2.5.9.1 Requirements

Field Description	Specifications
Name of Subcontractor	Must not be blank – 100 character limit
Effective Date	• Must be a valid date • Format = mm/dd/yyyy
Term of Contract	Must not be blank – 25 character limit
Status	Valid values: • New • Existing • Revised
Scope of Service	Valid Values: • Planning • Finance • Reporting Systems • Administration • Quality Assessment • Credentialing/Recredentialing • Utilization Management • Member Services • Claims Processing • Provider Services • Transportation • Vision • Behavioral Health • Prescription Drugs • Other Providers

Report shall utilize the List of Subcontractors Template provided by DMAS and submit file in comma-separated value (.CSV) format.

Include all subcontractors who provide any delegated administrative and medical services in the areas of planning, finance, reporting systems, administration, quality assessment, credentialing/ re-credentialing,

utilization management, member services, claims processing, provider services, transportation, vision, behavioral health, prescription drugs, or other providers.

Report submission must include a listing of these subcontractors and the services each provides.

2.5.10 Network Management Policies and Procedures

Contract 7.3

Method: Cardinal FTP

Format: Adobe PDF

File Name: NCQA_Net_Mgmt ContractorName

Trigger: Annual

Due Date: July 31st

Population: Include CCC PLUS and MEDALLION

DMAS: Office of Quality and Population Health

2.5.10.1 Requirements

Pursuant to 42 CFR § 438.68, in establishing and maintaining its network, the contractor shall submit policies, materials, and reports compliant with applicable federal regulations and adhere to NCQA standard Network Management from the most recent version of NCQA's Standards and Guidelines for the Accreditation of Health Plans; including the following:

- The organization evaluates the availability of practitioners who provide primary and specialty care services; including geographic distribution.
- The organization collects and performs an annual analysis on members' access to primary and specialty care services to include performance pertaining to routine care, urgent care and after hours care.
- The organization has a web-based physician directory to include; name, gender, specialty, hospital affiliations, Medical group affiliations, board certification, new patient's acceptance, and languages spoken by the physician and staff and office locations and phone numbers.
- The organization must perform an annual evaluation of its physician directories for accuracy of office locations and phone numbers, accuracy of hospital affiliation, accuracy of accepting new patients and awareness of physician office staff of physicians' participation in the organizations' network.

Additionally, when the Contractor is assessed by NCQA for either accreditation or renewal, it must provide the Department with a copy of the final/comprehensive report from NCQA and with the accompanying letter from NCQA that summarizes the findings, deficiencies, and resultant score and accreditation status of the Contractor, within thirty (30) days. The Department must also be notified in writing within ten (10) days of any change to an MCO's accreditation level. As required per 42 CFR § 438.332 the accreditation status of each MCO will be posted to the Department's Cardinal Care website.

Submit the documented processes and materials described in the below table. Submit all information as one file.

Policies and procedures must address all elements of the applicable contract section and any referenced regulations.

DMAS reserves the right to request changes to a revised policy and/or procedure if the submitted policy and/or procedure does not meet contractual specifications, including current or future contract amendments. In the event DMAS requests a policy and/or procedure change, updated versions are due to DMAS within ten (10) business days of that request.

Document	Standard	Element	Purpose
Practitioners Providing Specialty Care (documented process)	Network 1	Element C/ Practitioners Providing Specialty Care	The organization evaluates the availability of practitioners who provide specialty care services; including geographic distribution.
Practitioners Providing Specialty Care (documented process)	Network 1	Element C/ Practitioners Providing Specialty Care	The organization evaluates the availability of practitioners who provide specialty care services; including geographic distribution.
Physician Directory Data (Material)	Network 5	Element A/ Physician Directory Data	The organization has a web-based physician directory to include; name, gender, specialty, hospital affiliations, Medical group affiliations, board certification, new patients acceptance, languages spoken by the physician and staff and office locations and phone numbers.
Physician Directory Updates (Documented Process)	Network 5	Element B/ Physician Directory Updates	The organization updates its web-based physician directory within 30 calendar days of receiving new information from the physician.
Physician Directory Updates (material)	Network 5	Element B/ Physician Directory Updates	The organization updates its web-based physician directory within 30 calendar days of receiving new information from the physician.

2.5.11 Member Handbook

Contract	Section 4.3.7
Method:	Cardinal FTP
Format:	Adobe PDF file
File Name:	MBR_HNDBK.pdf
Trigger:	Prior to Printing Annually Upon Revision Upon Request
Due Date:	Sixty (60) calendar days prior to printing (new or revised). September 30th Within ten (10) business days of receipt of DMAS request
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.5.11.1 Requirements

The Contractor shall submit a copy of the Member Handbook to the Department for approval sixty (60) calendar days prior to distribution. The Department will respond within thirty (30) calendar days of the date of the Department's receipt of the request. The Contractor must update the Member Handbook annually, addressing changes in policies through submission of a cover letter identifying sections that have changed and/or a red-lined handbook showing before and after language. The red-lined document may be submitted on paper or electronically.

MCOs must follow the requirements as specified by the contract and use the Model Handbook template provided by DMAS.

2.5.12 Program Integrity Internal Monitoring and Audit Annual Plan

Contract:	Section 18.2.1 Monitoring and Auditing Plan
Method:	Cardinal FTP
Format:	As Specified by the MCO
File Name:	PI_MONITOR_AUDIT_PLAN.pdf
Trigger:	Annual Upon Revision Upon Request
Due Date:	May 31th of each year Within five (5) business days of revision Within ten (10) business days of request
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.5.12.1 Requirements

Include members enrolled in Medicaid and FAMIS.

Include the MCO's Living Document showing updates/changes made to the Program Integrity Internal Monitoring and Audit Annual Plan.

Policies and procedures must be submitted to the Department on an annual basis and upon revision (or request).

Revised policies must be submitted to the Department within five (5) business days of finalized revision. Include the following when submitting revisions:

- Version with "Track Changes" identifying updates and edits.
- Signed version of revised policy

Policies and procedures must address all elements of the applicable contract section and any referenced regulations.

DMAS reserves the right to request changes to a revised policy and/or procedure if the submitted policy and/or procedure does not meet contractual specifications, including current or future contract amendments. In the event DMAS requests a policy and/or procedure change, updated versions are due to DMAS within ten (10) business days of that request.

NOTE: The Program Integrity Internal Monitoring and Audit Annual Plan is a contributing factor to aid the MCOs in reaching the contractual required 3% medical expenditure. The Program Integrity Internal Monitoring and Audit Annual Plan details the audits to be conducted by the MCO during the contract year. Those audits are reflected on the Program Integrity Overpayment and Recovery Report which is used by Program Integrity to calculate the MCOs' 3% medical expenditure for the contract year.

2.5.13 Compliance Monitoring Process (CMP) Report

Contract	Section 17.2
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	CMP.pdf
Trigger:	Annual Upon Revision Upon Request
Due Date:	September 30th of each year Within five (5) business days of revision Within ten (10) business days of receiving a request from DMAS
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.5.13.1 Requirements

The Department shall be responsible for conducting an ongoing contract monitoring process. To support this work, the Contractor shall have its own Compliance Unit and reporting processes and submit annually to the Department a report detailing its compliance unit's policies, procedures, and activities.

Policies and procedures must be submitted to the Department on an annual basis and upon revision (or request).

Revised policies must be submitted to the Department within five (5) business days of finalized revision. Include the following when submitting revisions:

- Version with "Track Changes" identifying updates and edits.
- Signed version of revised policy

Policies and procedures must address all elements of the applicable contract section and any referenced regulations.

DMAS reserves the right to request changes to a revised policy and/or procedure if the submitted policy and/or procedure does not meet contractual specifications, including current or future contract amendments. In the event DMAS requests a policy and/or procedure change, updated versions are due to DMAS within ten (10) business days of that request.

2.5.14 Internal Controls Report

Contract	Section 21.2.17 Certification of Internal Controls
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	See specification within the CCC Plus MCTM
Trigger:	Annual, in accordance with CMS and AICPA requirements
Due Date:	June 1st, no later than thirty (30) days after the report is issued
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.5.14.1 Requirements:

MCOs must follow all CMS and AICPA specifications for this report. Type 2 reports include a description of the service auditor's tests of controls and the results of the tests. SSAE 18 "Concepts common to all Attestation Engagements" superseded the SSAE 16 standard in 2017 and provides the standards for SOC2 reports. SOC 2 focuses on controls at a Managed Care Organization relevant to the security, availability, processing integrity, confidentiality, and privacy of a system. It ensures that their data is kept private and secure while in storage and in transit and is available to access at any time.

Include attestation statement upon submission that states that the MCO agrees that this SOC 2 Report Submission accounts for both Cardinal Care and CCC Plus Contract requirements.

Please note that this report only needs to be submitted once via the CCC Plus SFTP server.

2.5.15 Payment Cycle Schedule Disclosure

Contract	Section 11 Information System Management
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	PAY_CYCLE.pdf
Trigger:	Annual Upon Revision Upon Request
Due Date:	September 30th Within five (5) business days of revision Within ten (10) business days of request
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.5.15.1 Requirements

The Contractor shall disclose its payment cycle schedules to the Department and notify the Department immediately of any changes to the payment cycle. The Contractor shall provide prior notification to the Department of any anticipated changes that may have an impact on the substance or process of data exchanges between the parties, and shall engage with testing in order to ensure continuity of existing data exchanges.

2.5.16 HEDIS Results

Contract	
Method:	Cardinal FTP
Format:	Excel file
File Name:	HEDIS.xlsx
Trigger:	Annual
Due Date:	July 31st
Population:	Include CCC PLUS and MEDALLION
DMAS:	OPH

2.5.16.1 Requirements

As specified in the contract, include the full locked Interactive Data Submission System (IDSS) file.

2.5.17 FAMIS HEDIS Immunizations for 2 year olds

Contract	
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	FAMIS_VAX.pdf
Trigger:	Annual
Due Date:	On September 30th of each year and thirty (30) calendar days prior to implementation of any changes
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.5.17.1 Requirements

The Contractor shall report annually to the Department, in accordance with HEDIS, the percent of two (2) year-old FAMIS members who have received each immunization specified in the most recent ACIP standards.

2.5.18 CAHPS Survey Results

Contract	Section 10.6.2 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey
Method:	Cardinal FTP
Format:	Excel or PDF file
File Name:	CAHPS.pdf or CAHPS.xlsx
Trigger:	Annual
Due Date:	July 31st
Population:	Include CCC PLUS and MEDALLION
DMAS:	QPH

2.5.18.1 Requirements

As specified in the contract, including all detailed survey results.

2.5.19 Health Equity Report

Contract	Section 2.17 Health Equity
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	HLTH_DISP_RPT.pdf
Trigger:	Annual
Due Date:	September 30th of each year
Population:	Include CCC PLUS and MEDALLION
DMAS:	OPH

2.5.19.1 Requirements

In the development of its various programs to provide services to Cardinal Care members the Contractor shall consider the importance of health equity and health disparities amongst the Cardinal Care population. The Contractor must submit an annual report to the Department outlining its efforts to address health disparities for the Cardinal Care population. The Contractor may refer to the Virginia Department of Health's Office of Health Equity for more information regarding health disparities in the Commonwealth of Virginia.

2.5.20 Population Health Assessment

Contract

Method: Cardinal FTP

Format: Adobe PDF

File Name: TBD

Trigger: Annual

Due Date: July 31st

Population: Include CCC PLUS and MEDALLION

DMAS: Office of Quality and Population Health

2.5.20.1 Requirements

Pursuant with 42 CFR 440.230(d), services must be provided to Medicaid beneficiaries based on individual assessments of need, rather than a one size-fits-all approach. The contractor shall submit policies, materials and reports compliant with applicable federal regulations and adhere to NCQA's standard Population Health Management (Population Identification) from the most recent version of NCQA's Guidelines for the Accreditation of Health Plans to include the following:

-The contractor annually assesses member sub-population including; members of racial or ethnic groups, members with limited English proficiency.
- The contractor annually assesses the characteristics and needs of the member; including social determinants of health.
- The contractor annually uses the population assessment to update PHM activities; to address member needs, update needed resources, review and update health care disparities and review community resources to address member needs.

Additionally, when the Contractor is assessed by NCQA for either accreditation or renewal, it must provide the Department with a copy of the final/comprehensive report from NCQA and with the accompanying letter from NCQA that summarizes the findings, deficiencies, and resultant score and accreditation status of the Contractor, within thirty (30) days. The Department must also be notified in writing within ten (10) days of any change to an MCO's accreditation level. As required per 42 CFR § 438.332 the accreditation status of each MCO will be posted to the Department's Cardinal Care website.

2.5.21 Quality Improvement Plan (QIP) for New and Existing Health Plans

Contract	Section 10.3.1 Annual Evaluation of the QAPI Program
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	QIP_NEW.pdf (New health plans)
	QIP_Annual.pdf (Annual)
Trigger:	New health plans to Cardinal Care
	Annually on July 31st
Due Date:	At least sixty (60) days before the first membership file is provided to MCO
	Annually on July 31st
Population:	Include CCC PLUS and MEDALLION
DMAS:	Office of Quality and Population Health

2.5.21.1 Requirements

The contractor shall submit a plan compliant with applicable federal regulations and adheres to the Quality Management and Improvement Program Structure, located under Standards for Quality Management and Improvement from the most recent version of NCQA's Standards and Guidelines for the Accreditation of Health Plans.

Health Plans new to Virginia Medicaid shall provide their Quality Improvement Plan (QIP) at least sixty (60) days before the first membership file is provided to the MCO. The new MCO shall submit a plan that adheres to NCQA's, Standards for Quality Improvement Plan Structure. The new health plan must provide the Department with an update to its QIP at least once every twelve months for possible review by both the Department and the EQRO.

Additionally, when the Contractor is assessed by NCQA for either accreditation or renewal, it must provide the Department with a copy of the final/comprehensive report from NCQA and with the accompanying letter from NCQA that summarizes the findings, deficiencies, and resultant score and accreditation status of the Contractor, within thirty (30) days. The Department must also be notified in writing within ten (10) days of any change to an MCO's accreditation level. As required per 42 CFR § 438.332 the accreditation status of each MCO will be posted to the Department's Cardinal Care website.

2.5.22 Quality Assessment & Performance Improvement (QAPI) Program

Contract	Section 10.3.1 Annual Evaluation of the QAPI program
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	QAPI_PLAN.pdf
Trigger:	Annual
Due Date:	July 31st
Population:	Include CCC PLUS and MEDALLION
DMAS:	Office of Quality and Population Health

2.5.22.1 Requirements

Pursuant to 42 CFR § 438.330 the comprehensive QAPI must include a mechanism to detect underutilization and overutilization of services; and, to assess the quality and appropriateness of care furnished to enrollees with special health care needs, as defined by the State Quality Strategy. The Standards for Quality Management and Improvement are from the most recent version of the NCQA's Standards and Guidelines for the Accreditation of Health Plans for Quality Improvement (QI) Annual Evaluation and must comply with applicable federal regulations. The Contractor shall conduct an annual written evaluation of the QI program that includes the following information:

- The evaluation of the QAPI shall address quality studies and other activities completed; and ongoing QI activities that address quality and safety of clinical care and quality of services;
- Trending of clinical and service indicators and other performance data; demonstrated improvements in quality; areas of deficiency and recommendations for corrective action; and
- An analysis and evaluation of the overall effectiveness of the QAPI program to include its progress toward influencing network wide safe clinical practices.

Additionally, when the Contractor is assessed by NCQA for either accreditation or renewal, it must provide the Department with a copy of the final/comprehensive report from NCQA and with the accompanying letter from NCQA that summarizes the findings, deficiencies, and resultant score and accreditation status of the Contractor, within thirty (30) days. The Department must also be notified in writing within ten (10) days of any change to an MCO's accreditation level. As required per 42 CFR § 438.332 the accreditation status of each MCO will be posted to the Department's Cardinal Care website.

2.5.23 QHP Localities for Outreach to QHP Members Who Qualify for Expansion

Contract:

Method: Cardinal FTP

Format: Adobe .pdf file

File Name: MEDEX_QHP_LOC_C*ontractorName_yyyymmdd*.pdf
where *yyyymmdd* is the date of submission

Trigger: Annual

Due Date: August 1 of each year

DMAS: TBD

Population: Include CCC PLUS and MEDALLION

DMAS:

2.5.23.1 Requirements

The Contractor shall notify the Department of all localities in which the Contractor offers a QHP certified by the Federal Health Insurance Marketplace under the Affordable Care Act, members of which may qualify for Medicaid expansion. The Contractor shall also notify the Department of all localities in which the Contractor has ceased offering such a QHP since the last notification.

2.5.24 Outreach to Pregnant Members Who Qualify for Expansion Transition Planning Report

Contract	
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	MEDEX_PREG.pdf
Trigger:	Annual and ninety (90) days of contract implementation Upon Revision Upon Request
Due Date:	Within ninety (90) days of contract implementation September 30th each year Within five (5) business days of revision Within ten (10) business days of request
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.5.24.1 Requirements

The Contractor shall assist pregnant members who are two months postpartum and who may qualify for another aid category with assistance in transitioning to that aid category. The contractor shall develop a transition plan to assist members to assure that their newborn child gets enrolled in Medicaid and submit it to DMAS.

Policies and procedures must be submitted to the Department on an annual basis and upon revision (or request).

Revised policies must be submitted to the Department within five (5) business days of finalized revision. Include the following when submitting revisions:

- Version with “Track Changes” identifying updates and edits.
- Signed version of revised policy

Policies and procedures must address all elements of the applicable contract section and any referenced regulations.

DMAS reserves the right to request changes to a revised policy and/or procedure if the submitted policy and/or procedure does not meet contractual specifications, including current or future contract amendments. In the event DMAS requests a policy and/or procedure change, updated versions are due to DMAS within ten (10) business days of that request.

2.5.25 Maternity Program Policies and Procedures

Contract	Section 10.7.3
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	MAT_PGM_POLICY.pdf
Trigger:	Annual
	Upon Revision
	Upon Request
Due Date:	On September 30th of each year
	Thirty (30) calendar days prior to implementation of any changes
	Within ten (10) business days of request
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.5.25.1 Requirements

Include information on high-risk maternity programs and all other initiatives to support members during the prenatal and postpartum periods. Information shall be included for both members who are high-risk and members who are not. Include information on policies related to increasing member prenatal and postpartum visits, respectively.

A subsection shall be created for members in the high-risk maternity programs. Include screening criteria utilized to identify members to enter high-risk programs. Provide a 3 to 5-page description of the MCO's accomplishments, challenges, and partnerships during the last contract year. Include the number of participating pregnant women and how many were identified as high-risk. Include any changes in the MCO's maternity program from the previous contract year and the results of one initiative to support positive birth outcomes.

Another subsection shall that outline how the Contractor will provide access to prenatal services, including identifying and tracking high risk members. At a minimum, the policies and procedures must outline how the following requirements will be met:

- Within ten (10) days of identification, the Contractor shall send information to pregnant women to inform them of prenatal programs, prenatal benefits, and to assist with accessing needed prenatal services;
- The Contractor shall cover all obstetric and gynecological services as stated in Section 8.2.X;
- The Contractor shall ensure that the travel time and distance standards stated in Section 4.7.B are met;
- The Contractor shall ensure network adequacy to provide the spectrum of covered maternity care services and to provide initial prenatal care appointments for pregnant members as follows:
    - First trimester - within seven (7) calendar days of request;
    - Second trimester - within seven (7) calendar days of request;
    - Third trimester - within three (3) business days of request.

- Appointments shall be scheduled for high-risk pregnancies within three (3) business days of identification of high risk to the Contractor or maternity provider, or immediately if an emergency exists;

Submit all information as one file.

Policies and procedures must address all elements of the applicable contract section and any referenced regulations.

DMAS reserves the right to request changes to a revised policy and/or procedure if the submitted policy and/or procedure does not meet contractual specifications, including current or future contract amendments. In the event DMAS requests a policy and/or procedure change, updated versions are due to DMAS within ten (10) business days of that request.

2.5.26 CMS Annual DUR Report

Contract	Section 5.15.8 Drug Utilization Review (DUR) Program
Method:	Cardinal FTP
Format:	Adobe PDF file
File Name:	DUR_CMS.pdf
Trigger:	Annual, in accordance with CMS requirements
Due Date:	August 15th of each year
Population:	Include CCC PLUS and MEDALLION
DMAS:	Pharmacy

2.5.26.1 Requirements

MCOs must follow all CMS specifications for this report. Additional report details to be provided by CMS. See CMS' Medicaid Drug Utilization Review Program at www.medicaid.gov/medicaid/prescription-drugs/drug-utilization-review/index.html for additional information about the data to be collected.

A copy of the MCO's CMS report must be sent to DMAS 45 days prior to submission to CMS.

FFY 2017 Report - The CMS Annual DUR report for FFY 2017 (10/01/16 through 09/30/17) is due to CMS 06/30/18. **The MCOs do not need to submit any data to CMS for FFY 2017.**

FFY 2018 Report - The MCOs must start collecting the required DUR data effective 10/01/17. The MCOs will be required to submit their DUR data for FFY 2018 in the CMS Annual DUR report (report period 10/01/17 through 09/30/18). The FFY 2018 DUR report is due to CMS on 06/30/19.

In order to meet the reporting requirements, the MCO must implement procedures to collect the necessary data for DUR reporting to CMS starting 10/01/2017. DMAS may conduct a desk review/ audit of the MCO's DUR data and/or data collection processes prior to the submission of this data to CMS.

2.5.27 Medication Therapy Management (MTM) Annual Report

Contract	Section 5.15.3 Medication Therapy Management (MTM)
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	MTM_ANNUAL.pdf
Trigger:	Annual
Due Date:	Within forty-five (45) days of the end of each contract year
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.5.27.1 Requirements

The Contractor's MTM program shall be developed to identify and target Members who would most benefit from these interactions and report interventions quarterly. An annual MTM outcomes report will be submitted within forty-five (45) days of the end of each contract identifying positive outcome in drug therapies and potential cost savings.

2.5.28 Value-Based Purchasing (VBP) Plan

Contract:	Section 12.1.7 Value-Based Payments (VBP)
Method:	Cardinal FTP
	OVBP/DMAS will distribute, by secure mail, to each contractor a pre-populated template at least 60 days prior to the due date.
Format:	Adobe PDF file
File Name:	VBP_PLAN.pdf
Trigger:	Annual
Due Date:	January 1st
Population:	Include CCC PLUS and MEDALLION
DMAS:	Value-Based Purchasing

2.5.28.1 Requirements

As specified in the contract section referenced above (i.e., Contractor VBP Plan). Submission must include all components referenced in the contract section "Contractor VBP Plan," including the Current State Review, Provider Readiness, Performance Review, and Communication, and Strategy and Alignment sections and related subsection requirements. Contractor will submit the completed Annual Plan using the pre-populated Annual Plan template.

2.5.29 Value-Based Purchasing (VBP) Data Collection Tool and Status Report

Contract	Section 12.1.7.3 VBP Status Report
Method:	Cardinal FTP
Format:	Template available from DMAS web site
File Name:	VBP_STATUS.xlsx
Trigger:	Annual
Due Date:	First Cardinal Report due June 15, 2024. April 1st following end of reporting year thereafter.
Population:	Include CCC PLUS and MEDALLION
DMAS:	Value Based Purchasing

2.5.29.1 Requirements

As specified in the contract section referenced above (i.e., VBP Status Report). Submission must include all components referenced in the contract section "VBP Status Report," including General Information, Medicaid Metrics, and VBP Initiatives. The VBP Initiative section of the template will be completed for each VBP Initiative that the Contractor has in place.

2.5.30 Value Based Purchasing (VBP) Status Report (Eliminated)

2.5.31 Care Management Policies and Procedures

Contract:

Method: Cardinal FTP

Format: Adobe PDF

File Name: CARE_MGMT_PP.pdf

Trigger: Annual

Due Date:

Population: Include CCC PLUS and MEDALLION

DMAS:

2.5.31.1 Requirements

As specified in the contract section referenced above.

2.5.32 Communication and Interpreter Assistance Policies and Procedures

Contract:	TBD – see comment.
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	COM_INT_POLICY.pdf
Trigger:	Annual
	Upon Revision
	Upon Request
Due Date:	On September 30th of each year
	Thirty (30) calendar days prior to implementation of any changes
	Within ten (10) business days of request
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.5.32.1 Requirements

Include detailed information regarding all policies and procedures related to member communication and interpreter services. Information should include all available interpreter services and related member communications.

A subsection shall be created to identify the different interpreter services available and the populations who receive these services.

Another subsection shall detail how the Contractor will provide members and providers with access to available interpreter services. This should include the Contractor's processes and procedures related to requesting and providing services, vendor management, quality assurance, and the grievance process.

A final subsection shall outline the communications and other outreach efforts the Contractor will utilize to ensure members and providers are fully informed of and able to access available interpreter services.

Submit all information as one file.

Policies and procedures must address all elements of the applicable contract section and regulations.

DMAS reserves the right to request changes to a revised policy and/or procedure if the submitted policy and/or procedure does not meet contractual specifications, including current or future contract amendments. In the event DMAS requests a policy and/or procedure change, updated versions are due to DMAS within ten (10) business days of that request.

2.5.33 DD Waivers Policies and Procedures

Contract: 5.2.2

Method: Cardinal FTP

Format: Adobe PDF

File Name: DD_WVR_PP.pdf

Trigger: Annual

Due Date:

Population: CCC Plus Only

DMAS:

2.5.33.1 Requirements

As specified in the contract section referenced above.

2.5.34 Level of Care (LOC) Waivers Policies and Procedures

Contract:	5.12.2.1
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	LOC_WVR_PP.pdf
Trigger:	Annual
Due Date:	
Population:	CCC Plus Only
DMAS:	

2.5.34.1 Requirements

As specified in the contract section referenced above.

2.5.35 Program Integrity (PI) Plan

Contract:	18.2
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	PI_PLAN.pdf
Trigger:	Annual
Due Date:	
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.5.35.1 Requirements

As specified in the contract section referenced above.

2.5.36 CMS Managed Care Program Annual Report

Contract:	Section 11.6 Collected Data Available to the Department and CMS
Method:	Cardinal FTP
Format:	Use the reporting template located on SharePoint
File Name:	MCPAR.xlsx
Trigger:	Annual
Due Date:	On September 30th of each year.
Population:	Include CCC PLUS and MEDALLION
DMAS:	TBD

2.5.36.1 Requirements

See reporting template provided by DMAS for instruction.

2.6 Biennial Reports (Every Two Years)

2.6.1 Provider Satisfaction Survey Instrument

Contract	Section 7.4.3 Provider Satisfaction Survey
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	PROV_SRVY.pdf
Trigger:	Biennial (Once every two years)
Due Date:	Submit copy of the survey instrument 30 days prior to distribution
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.6.1.1 Requirements

As specified in the contract.

2.6.2 Provider Satisfaction Survey Methodology

Contract	Section 7.4.3 Provider Satisfaction Survey
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	PROV_SRVY_METH.pdf
Trigger:	Biennial (Once every two years)
Due Date:	Submit copy of methodology 30 days prior to distribution
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.6.2.1 Requirements

As specified in the contract.

2.6.3 Provider Satisfaction Survey Results

Contract	Attachment L – F/EA Requirements, Satisfaction Survey
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	PROV_SRVY._RSLTS.pdf
Trigger:	Biennial (Once every two years)
Due Date:	Submit results within 120 days after conducting the survey
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.6.3.1 Requirements

As specified in the contract.

2.7 Other Reports

2.7.1 BOI Filing – Revisions

Contract

Method: Cardinal FTP

Format: Adobe PDF

File Name: BOI_REVISION.pdf

Trigger: Upon Revision

Due Date: On the same day on which it is submitted to the Bureau of Insurance

Population: Include CCC PLUS and MEDALLION

DMAS:

2.7.1.1 Requirements

As specified in the contract.

2.7.2 BOI Risk Capitol Sanctions/Changes

Contract	
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	RESERVE.pdf
Trigger:	Written notification received by the MCO from BOI or any other entity requiring sanctions or/or changes to the MCO's reserve requirements
Due Date:	Must be submitted to DMAS within 2 business days
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.2.1 Requirements

The Contractor shall report to the Department within two (2) business days of any sanctions or changes in risk based capital requirements imposed by the Bureau of Insurance or any other entity.

2.7.3 Basis of Accounting Changes

Contract	Section 15.3.4 Financial Records
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	BOA_CHANGE.pdf
Trigger:	Implementation of any change(s) to the MCO's basis of accounting
Due Date:	Must be submitted to DMAS 30 calendar days prior to implementation of change(s)
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.3.1 Requirements

As specified in contract.

2.7.4 Financial Report – Revisions

Contract

Method: Cardinal FTP

Format: Adobe PDF

File Name: FIN_REVISION.pdf

Trigger: Upon Revision

Due Date: On the same day on which it is submitted to the Bureau of Insurance

Population: Include CCC PLUS and MEDALLION

DMAS:

2.7.4.1 Requirements

As specified by contract and additional guidance provided by DMAS Provider Reimbursement Division.

Includes detail medical expenditure categories, total member months related to the expenditures, Incurred but Not Reported (IBNR) amounts, and all administrative expenses associated with the Cardinal Care Program.

Department reserves the right to approve the final format of the report.

2.7.5 Underwriting Gain Limit Impact

Contract	Section 15.4 Minimum Medical Loss Ratio (MLR) and Limit on Underwriting Gain
Method:	Cardinal FTP
Format:	Excel (.xlsx) file
File Name:	UNDERWRITING_GAIN_LIMIT.xlsx
Trigger:	In the event that this limit impacted the financial results reported for a quarter
Due Date:	Due within five (5) business days to DMAS after discovery of the event that the limit has impacted the financial results reported for a quarter
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.5.1 Requirements

Contractors are required to notify the Department and provide supplemental information in the event that this limit impacted the financial results reported for a quarter. This supplemental financial information shall include revised values for Medicaid underwriting gain and Medicaid premium income determined without application of the limit.

2.7.6 Certification of Non-Encounter Data for Rate Setting

Contract	Section 15.3.1 Certification (Non-Encounters)
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	NON_ENC_DATA_CERT.pdf
Trigger:	Submission of Non-encounter Data for Rate Setting
Due Date:	Within one (1) week of the date of submission
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.6.1 Requirements

Any payment information from the Contractor that is used for rate setting purposes or any payment related data required by the state must be certified with the signature of the Contractor's Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer of the Contractor.

The Contractor must use Cardinal Care Attachment F, Certification of Data, for certification of non-encounter payment related data submissions within one (1) week of the date of submission.

The use of this form will ensure that the amount paid to providers by the Contractor shall not be subject to Freedom of Information Act (FOIA) requests. The Department can deny FOIA requests for such protected information pursuant to § 2.2 - 4342 (F) of the Procurement Act.

2.7.7 Enhanced Services

Contract

Method: Email MCOHelp@dmas.virginia.gov

Format: N/A

File Name: N/A

Trigger: Upon Implementation
Upon Revision

Due Date: Thirty (30) calendar days prior to implementing any new and/or revised enhanced services

Population: Include CCC PLUS and MEDALLION

DMAS:

2.7.7.1 Requirements

As specified in the contract. Please specify if there any enhanced services specific to the Medicaid Expansion population.

2.7.8 Utilization of Enhanced Services

Contract

Method: Varies

Format: Varies

File Name: Varies

Trigger: Upon Request

Due Date: Varies

Population: Include CCC PLUS and MEDALLION

DMAS:

2.7.8.1 Requirements

The Contractor must be able to provide to the Department, upon request, data summarizing the utilization of enhanced services provided to members during the contract year for rate setting purposes.

2.7.9 Recovery Funds from Class Action and Qui Tam Litigation

Contract	Section 19.2 Class Action and Qui Tam Litigation
Method:	Email MCOhelp@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	Upon obtaining recovery funds from class action and qui tam litigation
Due Date:	Upon obtaining recovery funds from class action and qui tam litigation
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.9.1 Requirements

The Contractor shall notify the Department upon obtaining recovery funds from class action and qui tam litigation involving any of the programs administered and funded by the Department.

2.7.10 Excess Capitation Payments

Contract	Section 15.2.1 General Capitation Payments and Processes
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	EXC_CAP_PAY.pdf
Trigger:	Identification of capitation payments or other payments in excess of amounts specified in the Contract.
Due Date:	Within sixty (60) calendar days of identification of excess payment
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.10.1 Requirements

Under 42 C.F.R. 438.608(c), the Contractor and any subcontractor shall report to the Department within sixty (60) calendar days when it has identified capitation payments or other payments in excess of amounts specified in the Contract.

2.7.11 Rebalancing Activities

Contract

Method: Cardinal FTP

Format: Adobe .pdf file

File Name: REBALANCING_*yyyy*Q*n*_*ContractorName*.pdf
where *yyyy*Q*n* is the reporting period state fiscal year and quarter.

For example: 2021Q1 for reporting period July – September 2020

State fiscal year quarters:

Q1 = July – September
Q2 = October - December
Q3 = January – March
Q4 = April - June

Trigger: Upon request

Due Date: Within ten (10) calendar days of request

DMAS: CMT

Population: Include CCC PLUS and MEDALLION

DMAS:

2.7.11.1 Requirements

As specified in the contract section referenced above.

Narrative report is required.

The report shall include the following narrative:

- Description of current rebalancing efforts/activities including innovative activities.
- Assessment of community capacity issues (for all regions served).
- Description of barriers encountered.
- Description of additions/changes to rebalancing activities planned for future months.
- Other important information.

2.7.12 MCO Staffing Changes

Contract	Section 2.10.1 Cardinal Care Managed care Key Personnel
Method:	Email: ManagedCare.Compliance@dmas.virginia.gov
Format:	'Key Personnel Change' template provided by DMAS
File Name:	N/A
Trigger:	Change in key staff position at MCO as specified in the Cardinal Care contract
Due Date:	For Staff Departure: The Contractor must provide notification to the Department within five (5) calendar days from receipt of formal written *notice* of departure For New Hire/Internal Promotion: The Contractor must provide notification, a resume, and an updated organizational chart to the Department within five (5) calendar days of the start date.
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.12.1 Requirements

MCO must provide all of the relevant documentation for each staffing change as specified in the contract to include (as applicable per Contract):

- Staff Change Template
- Resume (New staff person)- Each resume is limited to two (2) pages
- Updated Organizational Chart (New staff person)

Must use template provided by DMAS.

2.7.13 Acquisition/Merger/Sale

Contract	Section 2.9.1 Proposed Acquisition and Purchase/Sale of Health Plan
Method:	Email MCOHelp@dmas.virginia.gov
Format:	Adobe PDF
File Name:	MERGER.pdf
Trigger:	Public announcement of agreement as identified in the Cardinal Care contract.
Due Date:	Within 5 calendar days of any such agreement
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.13.1 Requirements

As specified in the contract.

2.7.14 Ownership Change

Contract	Section 2.9 Ownership and Control Interest
Method:	Email MCOHelp@dmas.virginia.gov
Format:	Adobe PDF
File Name:	OWNERSHIP.pdf
Trigger:	Change to MCO's ownership as identified in the Cardinal Care contract
Due Date:	At least ninety (90) days or upon reasonable certainty, but no less than thirty-five (35) days prior to any change in ownership
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.14.1 Requirements

As specified in the contract.

2.7.15 Ownership/Control of Other Entity

Contract	Section 2.9 Ownership and Control Interest
Method:	Email MCOHelp@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	Prior to implementation Change in MCO's ownership and/or control of another entity
Due Date:	Five (5) calendar days prior to change in ownership
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.15.1 Requirements

As specified in the contract.

2.7.16 Transaction with Other Party of Interest

Contract	
Method:	Email MCOHelp@dmas.virginia.gov
Format:	Adobe PDF
File Name:	OTH_INTEREST.pdf
Trigger:	Occurrence of material transaction between the Contractor (MCO) and other party of Interest
Due Date:	Must be submitted to DMAS within five (5) business days after transaction occurs
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.16.1 Requirements

As specified in the contract, so include all required components.

2.7.17 Other Categorically Prohibited Affiliations

Contract	
Method:	Email: MCOhelp@dmas.virginia.gov
Format:	PDF
File Name:	OTH_EXCL.pdf
Trigger:	Action taken by contractor to exclude entity(s) based on the provisions of contract
Due Date:	Within forty-eight (48) hours of action
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.17.1 Requirements

As specified in the contract.

2.7.18 Notification of Potential Conflict of Interest

Contract	Section 21.8 Conflict of Interest
Method:	Email MCOHelp@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	Prior to implementation
Due Date:	Sixty (60) days or more prior to implementation
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.18.1 Requirements

As specified in the Contract.

2.7.19 Contractor or Subcontractor on LEIE

Contract	
Method:	Email: MCOhelp@dmas.virginia.gov
Format:	PDF
File Name:	SUB_LEIE.pdf
Trigger:	Identification of any Contractor or subcontractor owners or managing employees on the Federal List of Excluded Individuals/Entities (LEIE) database.
Due Date:	Within five (5) business days of identification
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.19.1 Requirements

As specified in the contract.

2.7.20 MCO Principal Conviction or Criminal Offense

Contract	
Method:	Email: MCOhelp@dmas.virginia.gov
Format:	PDF
File Name:	OFFENSE.pdf
Trigger:	Identification any person, principal, agent, managing employee, or key provider of health care services who (1) has been convicted of a criminal offense related to that individual's or entity's involvement in any program under Medicaid or Medicare since the inception of those programs (1965) or (2) has been excluded from the Medicare and Medicaid programs for any reason.
Due Date:	Within forty-eight (48) hours of identification
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.20.1 Requirements

As specified in the contract.

2.7.21 MCO Medicaid Managed Care Business Changes

Contract	
Method:	Email MCOHelp@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	Change to MCO's Medicaid managed care business as required under the Cardinal Care contract
Due Date:	Within five (5) business days of change
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.21.1 Requirements

As specified in the contract.

2.7.22 Medicaid Business Change (Virginia and Out of State)

Contract

Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	BUSINESS_CHANGE.pdf
Trigger:	Any organizational change or major decision affecting its Medicaid managed care business in Virginia or other states
Due Date:	At least ninety (90) days or upon reasonable certainty, but no less that thirty-five (35) days prior to the effective date of any organizational change or major decision affecting its Medicaid managed care business in Virginia or other states
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.22.1 Requirements

As specified in the contract.

2.7.23 MCO Expansion Plan

2.7.23.1

Contract

Method: Email MCOHelp@dmas.virginia.gov

Format: N/A

File Name: N/A

Trigger: Initiated by MCO

Due Date: Within thirty (30) days of the Department's approval of request to expand

Population: Include CCC PLUS and MEDALLION

DMAS:

2.7.23.2 Requirements

Upon approval by the Department of the expansion / entry request, the MCO must provide the following within thirty (30) days of the Department's approval of request to introduce one or more manage care plans into a new area:

- A plan of action to secure advocate and community support in the planned entry/expansion area.
- A project plan for the entry/expansion including completion of network development, information technology requirements, and communication deadlines.
- A list of the entry/expansion team at the MCO with their title and role on the team.
- A designee who will manage the entry/expansion project and will work with the Department as the primary contact.
- An assessment of political ramifications, if any, for the entry/expansion area. The Department will review and respond to this.
- Profit and enrollment projections for the two-year period following the planned entry/expansion.
- An outreach and education plan (both long and short term) including the names of the team when available.
- A plan detailing how the entry/expansion will be incorporated in to the MCOs current processes.
- A list of subcontractors impacted and a communication plan for notifying the subcontractor of changes.
- A detailed care transition plan.
- Assurances that all ancillary programs (i.e., prenatal, disease state management) will be operational and in place prior to implementation.
- A detailed request from the Department for information which will assist the MCO in its entry/expansion process.
- A draft of the member, marketing and provider materials at least one hundred twenty (120) days before the planned entry/expansion date. The Department will review and respond within thirty (30) days of receipt of the materials.
- A primary care network that includes contracting with all area health departments, major hospitals, community services boards (CSBs), Federally Qualified Health Centers (FQHC) & Rural Health Clinics

(RHC), the top 50% utilized primary care providers, OB/GYNs and pediatricians in both rural and urban areas.

- A specialty care network plan detailing development for therapy, laboratory, vision, pharmacy, psychiatric, and transportation service providers.

A network development plan must include the specialties listed in the Contract.

The Department will determine network adequacy based on specific utilization for the entry/expansion area not later than ninety (90) days prior to the planned implementation date. The MCO must meet any network requirements established by the Department. The MCO must demonstrate adaptability to the special requirements of certain populations like pregnant women in rural areas. The final MCO network must be submitted before assignment deadlines established by the Department.

A written plan indicating the date when BOI and VDH approval will be secured, if at the time of the initial letter of intent BOI and VDH approval are not secured. The MCO must provide the Department with copies of BOI and VDH letters in addition to a written plan outlining a plan for achieving an acceptable accreditation ranking (NCQA), outlining plans for achievement of major milestones as appropriate.

In order to pursue the entry/expansion, if approved by the Department, the MCO will submit a letter accepting the terms of the contract and of these guidelines. The MCO must provide written assurances that it will accept all members, will submit to an operational readiness review, and will adhere to the all requirements of the contract (including reporting).

2.7.24 Expansion Request (Letter of Intent)

Contract	
Method:	Email MCOHelp@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	Initiated by MCO
Due Date:	At least six months prior to the desired expansion date
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.24.1 Requirements

As specified in contract, including all required components.

A letter of intent which describes the purpose and manner of the sale, including the acquisition plan, method and terms (e.g. stock or asset transfer);

2.7.25 Notification of Opt Out of Automatic Contract Renewal Clause

Contract Method:	Email MCOHelp@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	Decision to Opt Out of Automatic Contract Renewal Clause
Due Date:	Six (6) months or more prior to renewal date
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.25.1 Requirements

As specified in the contract.

2.7.26 Notification that Contractor Does Not Intend to Seek Renewal

Contract	
Method:	Email MCOHelp@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	Contractor does not intend to seek renewal
Due Date:	At least twelve (12) full calendar months prior to renewal
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.26.1 Requirements

If the Contractor does not intend to seek a renewal the Contractor must notify the Department in writing at least twelve (12) full calendar months prior to the renewal.

2.7.27 Notification of Potential MCO Liability

Contract Method:	Email MCOHelp@dmas.virginia.gov
Format:	Adobe PDF - use the MCO Subcontractor Liability Notification template provided by DMAS
File Name:	LIABILITY_NOTIFICATION.pdf
Trigger:	Involvement in a situation in which the contractor or one of its subcontractors may be held liable for damages or claims against the contractor or subcontractor
Due Date:	Within twenty-four (24) hours of involvement
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.27.1 Requirements

The Notification of Potential MCO Liability must use the template provided by DMAS and include all required information on the form.

2.7.28 Request for Exemption from Contract Requirement(s)

Contract	Section 21.9 Contract Requirement Exemptions Process
Method:	Email: ManagedCare.Compliance@dmas.virginia.gov
Format:	Adobe PDF - use the Request for Exemption from Contract Requirements Form provided by DMAS
File Name:	CONTRACT_EXEMPT.pdf
Trigger:	Signing of contract
Due Date:	Thirty (30) days prior to effective date
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.28.1 Requirements

The Contractor may request to be exempted from any contract requirement; however, such request for exemption must be requested in writing as required in Section 17. Any release by the Department of any contractual requirement must be approved by the Department's management and the Health Care Services Compliance Unit. No approval will be granted if the request affects the delivery of covered services, access to providers, or quality of care for members.

Use the Request for Exemption from Contract Requirements Form provided by DMAS.

2.7.29 Independent Audit (DMAS Request)

Contract	Section 15.3.5 Financial Solvency
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	AUDIT.pdf
Trigger:	DMAS request in writing or via email
Due Date:	Within 60 days of audit completion
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.29.1 Requirements

The Department reserves the right to require the Contractor to engage the services of an outside independent auditor to conduct a general audit of the Contractor's major managed care functions performed on behalf of the Commonwealth. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards. [42 C.F.R § 438.3(m)] The Contractor shall provide the Department a copy of such an audit within sixty (60) calendar days of completion of the audit.

2.7.30 Clarification and/or Disagreement with Audit Findings

Contract	Section 21.5 Audit Findings
Method:	Email: ManagedCare.Compliance@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	MCO Request
Due Date:	MCO Request
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.30.1 Requirements

The Department shall provide the results of any audit findings to the Contractor for review. The Department may seek clarification of the results of any audit findings from the Contractor or its duly authorized representative for the purpose of facilitating the Contractor's understanding of how the audit was conducted and/or how the audit findings were derived. **Any such request for clarification shall be in writing from the Contractor to the Department. If the Contractor disagrees with the audit findings, the Contractor may signify its disagreement by submitting a claim in writing to the Department.**

2.7.31 Corrective Action Plan (CAP) for Failure to Perform Administrative Function(s)

Contract Method:	Email: ManagedCare.Compliance@dmas.virginia.gov
Format:	Adobe PDF
File Name:	ADMIN_CAP.pdf
Trigger:	Notification to contractor in writing by DMAS
Due Date:	Within 30 calendar days of notification
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.31.1 Requirements

The Corrective Action Plan form is available from the DMAS web site. A separate plan must be submitted for each identified compliance violation, failure or deficiency. The plan must contain:

- Compliance Violation/Failure/Deficiency to be addressed (one per report);
- A description of the "root cause" process that the MCO used to determine the reason for the compliance violation/failure/deficiency;
- Intervention(s) that are intended to correct the identified issue;
- Timeline for intervention implementation;
- Individuals responsible for intervention implementation; and
- Improvement goal(s)/benchmark(s) for the noted deficiency.

The Contractor must submit a completed CAP to the department within thirty (30) calendar days from the date of the received compliance violation notification. The CAP must identify how the Contractor plans to remedy the issue within a Sixty (60) day timeframe, which will begin from the date the Department approves the proposed CAP. During such time as the Contractor is under a CAP with the Department the Contractor will not receive any additional compliance violation points for the specific issue under a corrective action plan. The Contractor must include in its correct action plan milestone dates for progress and an anticipated date of resolution for the issue. The contractor must provide the department with updates on the dates listed to ensure operational compliance with the CAP as proposed. The implementation of a corrective action plan does not preclude the Contractor from the accumulation of non-CAP related violations.

2.7.32 MCO Improvement Plan (MIP) for Failure to Perform Administrative Function(s)

Contract	
Method:	Email: ManagedCare.Compliance@dmas.virginia.gov
Format:	Adobe PDF - use template provided by DMAS
File Name:	ADMIN_MIP.pdf
Trigger:	Notification to Contractor in writing by DMAS
Due Date:	Within fifteen (15) calendar days of notification
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.32.1 Requirements

This report must be submitted using the MCO Improvement Plan (MIP) provided by DMAS. A separate plan must be submitted for each identified compliance violation, failure or deficiency.

The report must contain:

- Compliance Violation/Failure/Deficiency to be addressed (one per report);
- Description of area of non-compliance;
- Action steps(s) that are intended to correct the performance issue; and
- Timeline for intervention implementation.

The Contractor must submit a completed MIP to the department within fifteen (15) calendar days from the date of the received compliance violation notification. The MIP must identify how the Contractor plans to remedy the issue within a thirty (30) day timeframe, which will begin from the date the Department approves the proposed MIP. If a MIP does not contain the necessary information, an additional sanction or violation point value may be assessed, and the Contractor may be required to submit a corrective action plan.

2.7.33 Investigation Audit Report

Contract	
Method:	Send as email attachment to mcopideliverables@dmas.virginia.gov
Format:	Adobe PDF
File Name:	PI_INVESTIGATION_AUDIT.pdf
Trigger:	Conclusion of a completed FWA investigation
Due Date:	Conclusion of a completed FWA investigation and as determined via communication with Program Integrity division
Population:	Include CCC PLUS and MEDALLION
DMAS:	Program Integrity

2.7.33.1 Requirements

The Contractor shall produce, and provide to the Department upon conclusion of each investigation, a standard report for each completed investigation. This report shall include, at a minimum, the following:

- Purpose
- Methodology
- Findings (including identified overpayments)
- Proposed Action and Final Resolution
- Claims Detail List/Spreadsheet

As noted in the Cardinal Care Managed Care Contract, final resolution shall include, at a minimum, repayment of any identified overpayments.

2.7.34 Medical Management Committee Report

Contract

Method: Cardinal FTP

Format: Adobe PDF

File Name: MEDMGT_MTG.pdf

Trigger: MCO Medical Management Committee Meeting

Due Date: Due ten (10) days after approval by the Committee

Population: Include CCC PLUS and MEDALLION

DMAS:

2.7.34.1 Requirements

As specified in Contract.

At a minimum, must provide list of attendees, date/time, location, agenda, and meeting minutes.

2.7.35 HIPAA Violation Notification

Contract	
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	HIPAA_VIOL.pdf
Trigger:	Upon MCO violation
Due Date:	Promptly report to DMAS upon discovery of violation in accordance with the BAA
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.35.1 Requirements

The Contractor shall promptly remedy any violation of any term of HIPAA and shall certify the same to the Department in writing.

2.7.36 PHI Disclosure and/or Security Incident Notification to DMAS

Contract	
Method:	Email MCOHelp@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	PHI Disclosure and/or Security Incident
Due Date:	As set forth in the BAA.
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.36.1 Requirements

As specified in additional detail in the BAA and contract.

2.7.37 PHI Disclosure Log

Contract	
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	PHI_LOG.pdf
Trigger:	Upon Request
Due Date:	Within thirty (30) days of the initial request
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.37.1 Requirements

As specified below.

The Contractor shall maintain an ongoing log of the details relating to any disclosures of PHI it makes (including, but not limited to, the date made, the name of the person or organization receiving the PHI, the member's address, if known, a description of the PHI disclosed, and the reason for the disclosure), as required by 45 CFR § 164.528. The Contractor shall, within thirty (30) days of the Department's request, make such log available to the Department as needed, for the Department to provide a proper accounting of disclosures to its patients.

2.7.38 Subcontractor Contracts

Contract	Section 2.11 Changes to Contractor Organizational Structure and Operation
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	SUBCONT.pdf
Trigger:	New subcontractor contract or change in existing subcontractor contract
Due Date:	At least thirty (30) days prior to effective date of new contract or change
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.38.1 Requirements

Separate submissions will be required for Cardinal Care review and approval, and will require the MCO Vendor Subcontract Review Cover sheet, available on the DMAS SharePoint site.

MCO Vendor Subcontract Review Cover sheet must be completed and attached to the subcontract PDF.

2.7.39 Subcontractor Termination Notification

Contract	Section 14 Subcontractor Delegation
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	SUB_TERM_NOT.pdf
Trigger:	Upon the termination of any subcontractor agreement
Due Date:	At least ninety (90) calendar days advanced written notice prior to the termination of any subcontractor agreement
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.39.1 Requirements

The Contractor shall give the Department at least ninety (90) calendar days advanced written notice prior to the termination of any subcontractor agreement.

2.7.40 Subcontractor Termination Transition Plan

Contract	Section 14 Subcontractor Delegation
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	SUB_TERM_TRAN_PLAN.pdf
Trigger:	Upon DMAS request with the termination of any subcontractor agreement
Due Date:	At least ninety (90) calendar days prior to termination
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.40.1 Requirements

The Contractor shall give the Department at least ninety (90) calendar days advanced written notice prior to the termination of any subcontractor agreement. In addition to prior written notice, the Contractor shall also provide the Department with a transition plan upon request, which shall include, at a minimum, information regarding how continuity of the project shall be maintained.

2.7.41 Data Validation Assessments

Contract	Section 11.12.1 Data Reconciliation and Potential Audit Requirements
Method:	Cardinal FTP
Format:	Determined upon DMAS request
File Name:	Determined upon DMAS request
Trigger:	Upon Request
Due Date:	Within thirty (30) calendar days of the request
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.41.1 Requirements

Department, or its designee, for the purpose of evaluating the completeness of the Contractor's data inventory as disclosed to the Department, and to evaluate the collection and maintenance of data required by the Department. **Upon request by the Department, or its designee and with thirty (30) calendar days' notice, the Contractor shall provide DMAS-specified Member records in order to permit the Department to conduct data validation assessments.**

2.7.42 Encounter Data Deficiencies

Contract	
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	ENC_DEFIC.pdf
Trigger:	Identification of deficiency(s) in encounter data processes
Due Date:	Within forty-eight (48) hours of discovery that the data is not complete or accurate
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.42.1 Requirements

As specified in the contract.

2.7.43 Encounter Data Corrective Action Plan

Contract	Refer Section 11.13 Encounter Data
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	ENC_CAP.pdf
Trigger:	Notification to DMAS of deficiency(s) in encounter data processes
Due Date:	Within thirty (30) calendar days of notification
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.43.1 Requirements

As specified in the contract, the Contractor must submit for Department approval a Corrective Action Plan to implement improvements or enhancements to bring the accuracy and/or completeness to an acceptable level. The timeframe for submission must be established by the Department, not to exceed thirty (30) calendar days from the day the Contractor identifies or is notified that it is not in compliance with the encounter data requirements.

2.7.44 Member Appeal Summary

Contract	Section 9.7 State Fair Hearing Process
Method:	Submitted through AIMs
Due Date:	Within twenty-one (21) days of the date on which the Appeals Division initially notifies the Contractor of the appeal OR For expedited Appeals, the appeal summary must be faxed to the Department and faxed or overnight mailed to the member, as expeditiously as the member's health condition requires, but no later than four (4) business hours after the Department informs the Contractor of the expedited appeal
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.44.1 Requirements

The Department's Appeals Division requests that the Contractor submit the appeal summary to the Department within twenty-one (21) days of the date on which the Appeals Division initially notifies the Contractor of the appeal. For all cases, the summary must be received by the Department at least ten (10) calendar days prior to the scheduled hearing date and mailed to the member on the date submitted to the Department's Appeals Division.

For expedited appeals that meet the criteria set forth in 42 C.F.R. § 438.410, the appeal summary must be faxed to the Department and faxed or overnight mailed to the member, as expeditiously as the member's health condition requires, but no later than four (4) business hours after the Department informs the Contractor of the expedited appeal.

2.7.45 Appeals where Reconsideration Process is Not Exhausted and/or the Appeal Does Not Meet Timeliness Requirements

Contract	Section 9.8.2 Provider Appeals to the Department
Method:	AIMS
Format:	N/A
File Name:	N/A
Trigger:	Any appeals where the provider has not exhausted the Contractor's reconsideration process and/or where the appeal does not appear to meet the Department's timeliness requirements (based upon the Contractor's records).
Due Date:	Within two (2) business days of the receipt of the appeal notice to the Department, of any appeals where the provider has not exhausted the Contractor's reconsideration process and/or where the appeal does not appear to meet the Department's timeliness requirements (based upon the Contractor's records).
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.45.1 Requirements

The Contractor must notify the Department's Appeals Division within two (2) business days of the receipt of the appeal notice to the Department, of any appeals where the provider has not exhausted the Contractor's reconsideration process and/or where the appeal does not appear to meet the Department's timeliness requirements (based upon the Contractor's records).

2.7.46 Notification of Adverse Internal Member Appeal Decision

Contract	Section 9.8.2 Provider Appeals to the Department
Method:	AIMS
Format:	See below
File Name:	N/A
Trigger:	See below
Due Date:	See below
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.46.1 Requirements

Upon receipt of notification that the Department has received an appeal request from a member for services to the Contractor's member, the Contractor must provide sufficient information regarding the adverse internal appeal decision to allow the Department to determine whether the appeal request meets the timeliness requirements (i.e., the appeal was filed within one hundred and twenty (120) days of the of the member's receipt of the Contractor's internal appeal decision). The Contractor must respond to requests for information within one (1) business day of receipt of notification by the Department that a member has filed an appeal.

The Contractor is required to comply with all applicable state and federal laws when issuing a Notice of Adverse Benefit Determination or an Internal Appeal Notice. Those notices are required to contain the contents specified in 42 C.F.R. § 431.206 and 438.404, and may be required to contain any other contents required elsewhere in state and federal law.

The Contractor may use any template(s) provided by DMAS on SharePoint or may develop its own Notice of Adverse Benefit Determination and Internal Appeal Notice templates. However, any notices issued must comply with all applicable state and federal laws, and must contain all mandated contents.

2.7.47 Provider Informal Written Appeals Case Summary

Contract	Section 9.8.3 Informal Appeals
Method:	AIMS
Format:	Adobe PDF
File Name:	INFORMAL_APPEAL_SUMMARY.pdf
Trigger:	Filing of a provider's notice of informal appeal
Due Date:	Within thirty (30) days of the filing of the provider's notice of informal appeal
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.47.1 Requirements

The Contractor shall file a written case summary with the Department's Appeals Division within thirty (30) days of the filing of the provider's notice of informal appeal. The Contractor shall mail a complete copy of the case summary to the Department's MCO Contract Monitor and the provider on the same day that the case summary is filed with the Department's Appeals Division.

2.7.48 Practitioner Infractions

Contract	Section 7.3.2.2 Notice to the Department of Provider Termination
Method:	Email MCOhelp@dmas.virginia.gov
Format:	Excel .xlsx file – Use the current Provider Infraction template provided by DMAS
File Name:	INFRACTION.xlsx
Trigger:	Suspension or termination of a practitioner's license
Due Date:	Within five (5) business days
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.48.1 File Specifications

Field Description	Specifications
Provider ID	• Provider's NPI or API identifier. • Format: Numeric 10 digits, leading zeroes. • Required.
Name	• Provider's name • Format: Character 40 • Required
License	• Provider's License Number • Optional
Specialty	• Provider's type / specialty. • Must select value from drop down provided in template. • Required.
Notification Date	• Date that the MCO was notified of the provider infraction. • Format: mm/dd/yyyy • Required
Source	• Identifies who reported the infraction to the MCO. • Must select value from drop down provided in template. • Required.
Action	• Action taken by the Board against this provider • Must select value from drop down provided in template. • Required.

2.7.48.2 Requirements

Submission must adhere to all content and format requirements specified in the MCTM above and the template provided by DMAS.

2.7.49 Notification of Provider Investigation

Contract:	Section 18.3 Program Integrity Reporting and Investigation Process
Method:	Send as email attachment to mcopideliverables@dmas.virginia.gov
Format:	Use the reporting template located on SharePoint.
File Name:	PROV_INV_C*ontractorName_yyyymmdd*.pdf where *yyyymmdd* is the date of submission
Trigger:	Discovery of possible fraud, waste, or abuse
Due Date:	Within forty-eight (48) hours of determining that concerns of possible fraud, waste, or abuse warrant further investigation
DMAS:	Program Integrity Division
Population:	Include CCC PLUS and MEDALLION
DMAS:	Program Integrity

2.7.49.1 Requirements

As specified in the contract section referenced above. If the start date of any pre-payment review process is known prior to submission of the initial Notification of Provider Investigation, it is not necessary to submit an additional notification upon initiation of pre-payment review.

2.7.50 REMOVED

Contract	Removed
Method:	Removed
Format:	Removed
File Name:	Removed
Trigger:	Removed
Due Date:	Removed
Population:	Removed
DMAS:	Removed

2.7.50.1 Requirements

Removed

2.7.51 Referral of Suspected Provider Fraud

Contract	Section 18.8 Reporting Suspected Fraud and Abuse to the Department
Method:	Send as email attachment to mcopideliverables@dmas.virginia.gov
Format:	Use the reporting template located on SharePoint
File Name:	PI_PROV_FRAUD_*ContractorName*_yyyymmdd.pdf where yyyymmdd is the date of submission
Trigger:	MCO identifies suspected fraud by one of its providers or subcontractors
Due Date:	Within forty-eight (48) hours of determining that suspicion of fraud, waste or abuse warrants referral to the Medicaid Fraud Control Unit
Population:	Include CCC PLUS and MEDALLION
DMAS:	Program Integrity

2.7.51.1 Requirements

The Contractor shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR §§ 455.13 and 455.14). When the Contractor identifies suspected fraud (as defined in 42 CFR 455.2) by one of its providers or subcontractors, it shall be reported to the Department within forty-eight (48) hours of discovery on the *Referral of Suspected Provider Fraud* form provided by DMAS. This notification shall be sent to DMAS via the email address provided on the form. Any case sent to DMAS as a Referral of Suspected Medicaid Fraud will be forwarded to the Medicaid Fraud Control Unit (MFCU).

Submission of the Referral of Suspected Provider Fraud form does not mean the MCO is to cease their investigation of the provider. Unless formally notified by DMAS or MFCU to cease the MCO's investigation, the MCO is expected to continue their investigation.

2.7.52 REMOVED

Contract

Method:	Removed
Format:	Removed
File Name:	Removed
Trigger:	Removed
Due Date:	Removed
Population:	Removed
DMAS:	Removed

2.7.52.1 Requirements

Removed

2.7.53 REMOVED

Contract	Removed
Method:	Removed
Format:	Removed
File Name:	Removed
Other Trigger:	Removed
Due Date:	Removed
Population:	Removed
DMAS:	

2.7.53.1 Requirements

- Removed

2.7.54 Good Cause Exemption for Provider Payment Suspension

Contract	Section 19.5 Payment Suspension
Method:	In response to DMAS' secure email request
Format:	Adobe PDF
File Name:	GOOD_CAUSE_EXEMP.pdf
Trigger:	Only submit completed GOOD_CAUSE_EXEMP.pdf if the Contractor believes there is good cause, as defined in 42 C.F.R.§ 455.23, to not suspend payments or to suspend payment only in part to such a provider
Due Date:	Notify the Department immediately
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.54.1 Requirements

Upon notification from the Department that such a determination has been made, the Contractor must suspend payment as soon as possible. Unless the Contractor believes there is good cause, as defined in 42 C.F.R.§ 455.23, to not suspend payments or to suspend payment only in part to such a provider. In this case, the Contractor must notify the Department immediately and a good cause exemption form must be submitted to the Department outlining the reasons for exempting the provider from payment suspension.

2.7.55 Provider Pre-Payment Review Notification

Contract	Section 18.2.2 Pre-Payment Review
Method:	Email MCOhelp@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	MCO initiating provider pre-payment review
Due Date:	Within forty-eight (48) hours of initiation of pre-payment review
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.55.1 Requirements

The Contractor shall notify the Department of each provider subject to pre-payment review within forty-eight (48) hours of initiating a pre-payment review process, using the *Notification of Provider Investigation.*

2.7.56 Provider Recovery from MCO Audit

Contract	
Method:	Email MCOhelp@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	Prior to formal initiation of a recovery from an investigation
Due Date:	Prior to formal initiation of a recovery from an investigation
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.56.1 Requirements

The Contractor shall notify the Department prior to formal initiation of a recovery from an investigation by the Contractor on its own network. Submission of an Investigation Audit Report (also known as the *Completed Investigation Report)* will serve as this notification.

2.7.57 Provider Termination Notification

Contract	Section 7.3.7.2 Notice to the Department of Provider Termination
Method:	Email MCOHelp@dmas.virginia.gov
Format:	Adobe PDF (attachment to email)
File Name:	PRV_TERM_NOTICE.pdf
Trigger:	Provider Termination (see below)
Due Date:	See below for notification standards
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.57.1 Requirements

The Contractor shall notify the Department regarding provider terminations as follows:

- At least thirty (30) business days in advance (when possible) of a contract termination that could reduce Member access to care, and no later than within thirty (30) business days prior to implementing any changes to a network provider agreement made by the Contractor, a subcontractor, or network provider where the termination, pending termination, or pending modification could reduce Member access to care;
- in advance of, and within five (5) business days where the provider termination would create any network deficiencies whereby the Contractor is unable to meet the Department's network time and distance standards;
- as soon as possible and no later than within forty-eight (48) hours for suspected or actual fraud or abuse;
- immediately upon receipt of notice, regarding the termination of any contracts with hospitals or health systems; and
- immediately upon receipt of notice, including notice to the appropriate authorities for any actions that seriously impact quality of care and that may result in suspension or termination of a practitioner's license.

Please include in this notification ALL of the following information:

- Provider Full Name (or Facility, Hospital, Health System Full Name)
- NPI(s)
- Taxonomy codes associated with the provider
- Reason for Termination (if the reason includes providing inappropriate services to Medallion members, please be sure to indicate as such in this notification)
- Estimated number of members impacted by the termination
- Effective Date for Termination
- Notification Classification (which of the five above listed provider termination circumstances the MCO is utilizing to notify DMAS, may use numeric designation from above in response)

2.7.58 Notice of Suspected Recipient Fraud or Misconduct

Contract	Section 18.8 Reporting Suspected Fraud and Abuse to the Department
Method:	Email as attachment to mcopideliverables@dmas.virginia.gov
Format:	Use the reporting template located on SharePoint
File Name:	PI_RECIP_FRAUD
Trigger:	MCO identifies suspected fraud by a member
Due Date:	Within forty-eight (48) hours of discovery
Population:	Include CCC PLUS and MEDALLION
DMAS:	Program Integrity

2.7.58.1 Requirements

All confirmed or suspected member fraud and program abuse shall be reported to the Department within forty-eight (48) hours of discovery on the *Notice of Suspected Recipient Fraud or Misconduct* form. This notification shall be sent to DMAS via the email address provided on the form.

Submission of the Notice of Suspected Recipient Fraud or Misconduct form does not mean the MCO is to cease their investigation. Unless formally notified by DMAS or MFCU to cease the MCO's investigation, the MCO is expected to continue their investigation.

2.7.59 Changes to Claims Operations

Contract	Section 12.1 General Provider Payment Processes
Method:	Email MCOHelp@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	Any significant changes to the MCO's claims processing operations
Due Date:	45 calendar days in advance of any change
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.59.1 Requirements

As mentioned in Section 12.1 of the Contract, the Contractor must notify the Department forty-five (45) days in advance of any proposal to modify claims operations and processing that includes relocation of any claims processing operations. Any expenses incurred by the Department or its contractors to adapt to the Contractor's claims processing operational changes (including, but not limited to costs for site visits) must be borne by the Contractor.

2.7.60 Services Not Covered Due to Moral or Religious Objections

Contract	
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	OBJ_SRVCS.pdf
Trigger:	Prior to implementation Upon adoption and/or revision of such a policy Upon Request
Due Date:	Sixty (60) calendar days prior to implementation Thirty (30) calendar days prior to implementation of any change(s) Within ten (10) business days of receiving a request from DMAS
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.60.1 Requirements

As specified in the contract.

2.7.61 Marketing and Informational Materials

Contract	Section 4.3.1 Approval Process for Written Materials and Section 4.4.1 Approval and Distribution of Marketing Materials
Method:	Cardinal FTP
Format:	Adobe PDF file- use Marketing and Informational Materials Submission Form provided by DMAS
File Name:	MKTG_INFO_MATL.pdf
Trigger:	Planned distribution of marketing and informational materials to members as defined in the Cardinal Care contract
Due Date:	30 days prior to their planned distribution
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.61.1 Requirements

As specified in the Cardinal Care contract.

Refer to the Marketing and Informational Materials Submission Form Instructions provided by DMAS. All submissions must include the *Marketing and Informational Materials Submission Form* as the cover page within the document.

2.7.62 Member Enrollment, Disenrollment, and Educational Materials

Contract	
Method:	Cardinal FTP
Format:	Adobe PDF file
File Name:	MBR_EDE.pdf
Trigger:	Prior to Implementation Upon Revision Upon Request
Due Date:	Sixty (60) calendar days prior to implementation Ten (10) business days prior to any published revision Within ten (10) business days of receiving a request from DMAS
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.62.1 Requirements

Refer to the 'DMAS MCO Marketing Submission Form Instructions.pdf' that is provided by DMAS.

All submissions must include the 'DMAS Member Communication and Marketing Submission Form' as the cover page within the document.

Including, but not limited to the following:

- New Member Packet
- All enrollment, disenrollment, and educational materials made available to members by the MCO
- All member health education materials, including any newsletters sent to members

2.7.63 Community Education, Networking, and Outreach Event Materials

Contract	Section 4.4.2 Approval of Marketing Venues
Method:	Cardinal FTP
Format:	Microsoft Excel file (Marketing and Outreach template provided by DMAS)
File Name:	OUTREACH.xlsx
Trigger:	Community education, networking or outreach program event
Due Date:	Two weeks prior to event date
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.63.1 Requirements

Use the current version of the Marketing and Outreach template provided by DMAS.

2.7.64 Marketing Fraud/Waste/Abuse

Contract	
Method:	Email: MCOhelp@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	Discovery of an incident of potential or actual marketing services fraud, waste and abuse
Due Date:	Within 48 hours of discovery of incident
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.64.1 Requirements

Report must use the Notification of Provider Investigation template available from DMAS Managed Care web site.

2.7.65 Request for Publication or Presentation of DMAS-Related Subjects

Contract	Section 21.27.1 Presentations and Publication Involving Virginia Data and Information
Method:	Email MCOHelp@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	Presentation or publication of any DMAS data to any third party entity
Due Date:	Thirty (30) calendar days prior to the publication / presentation / release of data
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.65.1 Requirements

As specified in the contract.

2.7.66 Use of FAMIS Logo

Contract	
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	FAMIS_LOGO.pdf
Trigger:	Prior to FAMIS logo use by Contractor
Due Date:	Prior to FAMIS logo use by Contractor (DMAS must pre-approve usage)
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.66.1 Requirements

The MCOs may utilize the Department designed FAMIS logo on member identification cards and member handbooks. All items or materials containing the FAMIS logo must be pre-approved by the Department prior to final printing and distribution.

2.7.67 Member Healthy Incentives Award

Contract	Section 4.2.2 Member healthy Incentives
Method:	Cardinal FTP
Format:	Adobe PDF file
File Name:	INCENT_AWD.pdf
Trigger:	Implementation of incentive award program
Due Date:	Thirty (30) days prior to implementation
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.67.1 Requirements

Refer to the Marketing Submission Form Instructions provided by DMAS.

All submissions must include the 'DMAS Member Communication and Marketing Submission Form' as the cover page within the document.

2.7.68 Member Identification Cards

Contract	Section 4.3.6 Member Identification Card
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	MBR_ID.pdf
Trigger:	Prior to production of identification cards Upon Revision
Due Date:	See trigger- approval must be received from DMAS prior to production of Member Identification Cards
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.68.1 Requirements

The Contractor shall submit and receive approval of the identification card from the Department prior to production of the cards.

2.7.69 Enrollment – Excluding Members

Contract	Section 3.9 Contractor Responsibilities Related to Enrollment
Method:	Cardinal FTP
Format:	Use the reporting template located on SharePoint
File Name:	ENROL_EXCLUSION.xlsx
Trigger:	Upon learning that a member meets one or more of the exclusion criteria
Due Date:	Within two (2) business days upon learning that a Member meets one (1) or more of the Cardinal Care managed care exclusion criteria.
Population:	Include CCC PLUS and MEDALLION
DMAS:	IC and HCS

2.7.69.1 Requirements

Multiple members may be included in each individual report submitted.

2.7.70 Sentinel Event

Contract	Section 16.4 Reporting to the Department of Sentinel Events
Method	Cardinal FTP
Format	Use the reporting template located on SharePoint.
File Name	*ContractorName*.SENTINEL*mmddyyyy*.xlsx
Trigger	Identification by the MCO of any member sentinel event
Due Date	Within forty-eight (48) hours of identification
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.70.1 Requirements

Contractor must utilize the reporting template provided by DMAS.

Sentinel events shall be reported for all CCCPlus and Medallion Program members. Review specified contract reference for definition of Sentinel Events.

Sentinel events are a subcategory of Critical Incidents. Therefore, they shall also be reported on the Quarterly Critical Incident report according to date of discovery.

Only the reporting template provided by DMAS is to be utilized. The template is **NOT** to be altered in any way.

2.7.71 Incarcerated Members

Contract	Section 3.9 Contractor Responsibilities Related to Enrollment
Method:	Cardinal FTP
Format:	Use the reporting template located on SharePoint
File Name:	ENROL_EXCLUSION.xlsx
Trigger:	Identification of incarcerated member
Due Date:	Within two (2) business days of knowledge
Population:	Include CCC PLUS and MEDALLION
DMAS:	IC and HCS

2.7.71.1 Requirements

Contractor must utilize the reporting template provided by DMAS.

Multiple members may be included in each individual report submitted.

2.7.72 Medical Record Access

Contract	
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	MED_RECORD_ACCESS.pdf
Trigger:	Upon Request
Due Date:	Twenty (20) business days or as specified in request, whichever is longer for all members' records Ten (10) business days for a single record or small number of requested records
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.72.1 Requirements

The Department shall be afforded access within twenty (20) calendar days to all members' medical records, whether electronic or paper. Access shall be afforded within ten (10) calendar days upon request for a single record or a small volume of records.

2.7.73 Transition of Care Data

Contract	
Method:	Cardinal FTP
Format:	Determined upon DMAS request
File Name:	Determined upon DMAS request
Trigger:	Upon receipt of the notice of disenrollment
Due Date:	Within three (3) business days from receipt of the notice of disenrollment to the Contractor in the method and format specified by DMAS
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.73.1 Requirements

The Contractor shall transfer SA and other pertinent information, as defined by Contract, necessary to assure transition of care to another Contractor, to DMAS, or its designated entity for enrollees who transfer to another health plan or back to fee-for-service. The information shall be provided within three (3) business days from receipt of the notice of disenrollment to the Contractor in the method and format specified by DMAS. The Contractor shall work with the Department to develop and implement an automated process for sharing and honoring SAs for members who transition between the fee-for-service and Cardinal Care or other DMAS programs and from one health plan to another. The Contractor shall share the necessary data in a HIPAA compliant format as directed by DMAS.

2.7.74 Formulary and Utilization Management Updates

Contract	Section 5.15.1 Legend and Non-Legend Drug Coverage: Common Core Formulary
Method:	Cardinal FTP
Format:	Adobe (.pdf) file
File Name:	FORMULARY_CHG.pdf
Trigger:	Upon Revision
Due Date:	Forty-five (45) calendar days prior to the effective date of the change
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.74.1 Requirements

The Contractor must receive the Department's approval for all formulary and pharmacy related policy changes including prior authorizations, step therapies, and quantity limits. The Contractor shall submit changes for review and approval via the FTP at least forty-five (45) calendar days prior to the effective date of the change. DMAS will respond to these submissions within fifteen (15) days of receipt of changes.

2.7.75 Pharmacy Program Changes

Contract	Section 5.15.4 Utilization Management for Pharmacy Services
Method:	Email MCOHelp@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	Prior to implementation Upon revision
Due Date:	Prior to implementation Within five (5) business days of revision
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.75.1 Requirements

As specified in the contract.

2.7.76 DUR Board Members Financial Disclosure Forms

Contract	Section 5.15.8 Drug Utilization Review (DUR) Program
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	DUR_MEM_FIN_DISC.pdf
Trigger:	Upon Request
Due Date:	Within ten (10) business days of request
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.76.1 Requirements

The Contractor shall require all individuals participating on the DUR Board to complete a financial disclosure form annually which is reviewable by the Department upon request.

2.7.77 MCO DUR Board Minutes

Contract	Section 5.15.8 Drug Utilization Review (DUR) Program
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	DUR_MTG.pdf
Trigger:	MCO DUR Board Meeting
Due Date:	Within thirty (30) days of meeting
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.77.1 Requirements

As specified in contract.

Per contract, MCO DUR board meetings are required twice a year.

Minutes shall not contain any PHI (redact PHI).

2.7.78 Prescription Monitoring Program (PMP) Access Request Form for DMAS Agents

Contract	Section 5.15.5 Prescription Monitoring Program (PMP)
Method:	Email: MCOHelp@dmas.virginia.gov
Format:	Adobe PDF - use PMP Registration Form template provided by DMAS.
File Name:	PMP_ACCESS.pdf
Trigger:	Staff change requiring new PMP access
Due Date:	N/A
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.78.1 Requirements

Must be submitted using the PMP Registration form provided by DMAS.

Completed form must be signed by the applicant (user) and witnessed by a notary public prior to submission to DMAS.

2.7.79 Children on Anti-Psychotics (Atypical Drug Utilization Reporting)

Contract	
Method:	Email MCOHelp@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	DMAS request
Due Date:	Within 30 calendar days of request
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.79.1 Requirements

As specified in the contract.

2.7.80 Provider Engagement Plan

Contract	Section 7.1 Provider Network
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	PROV_ENG_PLAN.pdf
Trigger:	Ad hoc Upon Request
Due Date:	Within ten (10) business days of request
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.80.1 Requirements

As specified in the contract, the Contractor will be required to develop and maintain a Provider Engagement Plan that outlines the Contractor's plan for engagement with and recruitment of providers in each specialty where the Contractor is deficient, providers in each specialty where there may be the potential for inadequacy or insufficient access based on the Contractor's current network, and for provider types identified by DMAS in order to ensure that the Contractor has an adequate network of providers. Such Provider Engagement Plan must be submitted to the Department in accordance with these requirements.

Policies and procedures must be submitted to the Department on an annual basis and upon revision (or request).

Revised policies must be submitted to the Department within five (5) business days of finalized revision. Include the following when submitting revisions:

- Version with "Track Changes" identifying updates and edits.
- Signed version of revised policy

Policies and procedures must address all elements of the applicable contract section and any referenced regulations.

DMAS reserves the right to request changes to a revised policy and/or procedure if the submitted policy and/or procedure does not meet contractual specifications, including current or future contract amendments. In the event DMAS requests a policy and/or procedure change, updated versions are due to DMAS within ten (10) business days of that request.

2.7.81 Network Provider Agreement Changes

Contract	
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	PROV_NTWK_CHG.pdf
Trigger:	Any change(s) to network provider agreements
Due Date:	Within thirty (30) business days of any change(s) to network provider agreements
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.81.1 Requirements

Any changes to a network provider agreement made by the Contractor, a subcontractor, or network provider regarding termination, pending termination, or pending modification in the subcontractor's or network provider's terms and not otherwise addressed in Attachment III of the Cardinal Care contract, that could reduce member access to care. The Contractor shall notify the Department where it experiences difficulty in contracting or re-contracting with hospitals or hospital systems.

Refer to contract for complete details.

2.7.82 Provider Agreements

Contract	Section 5.1.A and Attachment III
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	PRV_AGRMT_CHG.pdf
Trigger:	Creation of new provider network agreement or modification of existing agreement
Due Date:	At least 30 days prior to effective date, and upon request thereafter
Population	Include CCC PLUS and MEDALLION
DMAS	

2.7.82.1 Requirements

As specified in the contract.

2.7.83 Rate Adjustment Notification to Providers

Contract	Section 12.1.9 Legislatively Mandated Rates
Method:	Email MCOHelp@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	A new rate adjustment notification to providers
Due Date:	Upon request
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.83.1 Requirements

The Contractor shall provide written notice to providers in a format determined by the Contractor advising of the rate adjustment and when it shall be effective. A facsimile notice is an acceptable format. A copy of such notification shall be provided to the Department upon the request

2.7.84 Network Deficiency and Exemption Request

Contract	Section 7.1 Provider Network
Method:	Cardinal FTP
Format:	Use the reporting template located in SharePoint.
File Name:	NETWORK_DEF_*ContractorName_yyyymmdd*.pdf where *yyyymmdd* is the date of submission
Trigger:	Identification of network deficiency Network deficiency could be identified through many means, for example (but not limited to): Complaint Authorization Request Need for emergency, urgent or specialty care Provider/Group termination Provider/Group decision to leave network
Due Date:	Within five (5) business days of identification of deficiency
Population:	Include CCC PLUS and MEDALLION
DMAS:	CMT

2.7.84.1 Requirements

As specified in the contract section referenced above.

Provide a narrative report that includes the following information:

- Type of provider
- Services impacted
- Region(s) impacted
- Localities impacted
- Number of members impacted
- Description of network access issues
- Plan of action to remedy
- Date of exemption request
- Length of exemption request
- Contractor point of contact

2.7.84.2 Examples

Examples of network access issues include the following:

- The MCO has a sufficient network, but does not have the type of provider participating in the network to provide the covered service to the member; or
- The MCO does not have a participating provider available to provide the covered service to the member without unreasonable travel or delay; or
- Provider(s) available, but have declined to contract with the MCO.

2.7.85 Hospital Access Contract Changes

Contract	Section 7.2.4 Inpatient Hospital Access
Method:	Email MCOhelp@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	Change to hospital contracts if changes impact the scope of covered services, the number of members covered and/or the units of service covered
Due Date:	Within fifteen (15) calendar days of change
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.85.1 Requirements

Notification must include information on the impacts on the scope of covered services, the number of members covered and/or the units of service covered.

2.7.86 NCQA Accreditation Renewal

Contract	Section 2.3 National Committee for Quality Assurance (NCQA) Accreditation
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	NCQA_RENEW.pdf
Trigger:	NCQA Accreditation Assessment or Renewal
Due Date:	Within thirty (30) calendar days after NCQA notification to the MCO
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.86.1 Requirements

Must include all components as specified in the contract.

2.7.87 NCQA Accreditation Status Changes

Contract	Section 2.3 National Committee for Quality Assurance (NCQA) Accreditation
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	NCQA_ACRED.pdf
Trigger:	Notification by NCQA of Change in MCO's Accreditation Status
Due Date:	Ten (10) calendar days after NCQA notification
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.87.1 Requirements

The contractor must report to the Department any change to the MCO's accreditation status, separate from their standard NCQA Accreditation Assessment or Renewal (ex. During annual reevaluation of HEDIS/CAHPS results). The standard NCQA Accreditation Renewals are performed every three (3) years.

2.7.88 NCQA Deficiencies

Contract	Section 2.3 National Committee for Quality Assurance (NCQA) Accreditation
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	NCQA_DEF.pdf
Trigger:	MCO receipt of notification from NCQA of deficiency(s)
Due Date:	Thirty (30) calendar days after NCQA notification
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.88.1 Requirements

The contractor must report to the Department any deficiencies noted by NCQA, separate from their standard NCQA Accreditation Assessment or Renewal. The standard NCQA Accreditation Renewals are performed every three (3) years.

2.7.89 Non-Emergency Medical Transportation Services Transport Provider and Driver Trip Logs

Contract	Section 5.14.22 Transportation Provider and Driver Trip Logs
Method:	Cardinal FTP
Format:	Excel (.xlsx) file
File Name:	NEMT_TRIP_LOG.xlsx
Trigger:	Upon request
Due Date:	Within five (5) business days of DMAS's request.
Population:	Include CCC PLUS and MEDALLION
DMAS:	Transportation Unit

2.7.89.1 File Specifications

At a minimum, the following information must be contained in the trip log:

- Date of service;
- Driver's name;
- Driver's signature (written or digital);
- Attendant's full name (if applicable);
- Member's name;
- Member's or attendant's signature (if applicable);
- Vehicle Identification Number (VIN) or other identifying number on file with the Contractor;
- Mode of transportation authorized;
- A unique transportation provider number, assigned by Contractor. For providers of ambulance service, the Department's ambulance provider number must be utilized;
- Actual start time (from base station) (in military time);
- Each authorized Member transported with the actual pick-up time (in military time);
- Trip indicator (i.e. Trip completed, Member no-show, etc.);
- Each actual drop off time (military time) for authorized Member;
- Actual number of wheel chairs, attendants, and children, per trip;
- Actual return time (to base station) in military time;
- Authorized stamp or signature of the transportation provider; and,
- Other pertinent information regarding completion of the trips.

2.7.89.2 Requirements

Must include all components as specified in the Contract.

2.7.90 Other Coverage Claims History

Contract

Method: To be determined by the Contractor

Format: Excel (.xlsx) file

File Name: CLAIM_HIST_C*ontractorName*.yyyymmddxlsx
where *yyyymmdd* is the date of submission

Trigger: Upon request

Due Date: Within five (5) business days of request. ASAP and second requests are due within two (2) business days.

DMAS: Third Party Liability Unit

Population: Include CCC PLUS and MEDALLION

DMAS:

2.7.90.1 File Specifications

Field Name	Data Specification
Member Name	First and last name of member
DMAS Medicaid Member ID #	DMAS Medicaid member ID #
Date of Service	mm/dd/yyyy
Full Provider Name	First and last name of provider who rendered service
Diagnosis Code	List all diagnosis codes found on claim
Diagnosis Code word description	List all diagnosis descriptions found on claim
Procedure Code	List all procedure codes found on claim
Total Charge	Total Charge
Status (Paid or Denied)	Status (Paid or Denied)
Amount Paid	Amount Paid
Reason denied	Reason denied
Date Paid or date denied	Date Paid or date denied mm/dd/yyyy

2.7.90.2 Requirements

Upon initial notification of the Contractor, DMAS will require the names of at least two contacts to whom the claims history request can be sent. Contact information must include phone numbers, email addresses, and fax numbers.

The Contractor must let DMAS know how the claims history will be transmitted and ensure DMAS will have access to any secured email.

The Contractor will be required to pull claims data from archived claim history if the begin date of request predates the Contractor's current claim history.

2.7.91 Screening and Care Coordination Report for SEI

2.7.91.1 Specifications

Contract	Section 8.12.2.2 Substance Exposed Infants (SEIs) and Neonatal Abstinence Syndrome (NAS) Infants
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	SEI_SERVICE_REPORT.pdf
Trigger:	Upon Request
Due Date:	Within five (5) business days of DMAS's request.
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.91.2 File Specifications

Field Description	Specification	
SRVC_CTR_ID	NUM(4)	Service Center ID
MEMBER_ID	NUM(12)	Include leading zeros
MCO_CLAIM_NUM	CHAR(30)	MCO claim number
SRVC_NPI	NUM(10)	Servicing provider NPI
SRVC_NAME	CHAR(50)	Servicing provider name
SRVC_TXNMY	CHAR(10)	Servicing provider taxonomy code
FRM_DTE	DATE(10)	MM/DD/YYYY - Date of Service
THRU_DTE	DATE(10)	MM/DD/YYYY - Date of Service
BILLTYPE	CHAR(3)	Bill type
ICD_CDE	CHAR(7)	ICD code (Health Acquired-Condition)
POA_IND	CHAR(1)	Present on Admission Indicator (N, U)
PAY_AMT	NUM(10)	Paid amount

All fields are required.

2.7.91.3 Requirements

Demonstrate care coordination efforts for all substance exposed infants including those identified as having Neonatal Abstinence Syndrome. Include information on the development of a Plan of Safe Care for each member. Include information on how care coordination efforts are matched with those of the member's mother and/or primary guardian(s).

2.7.92 Performance Withhold Program Measures

Contract

Method:

Format:

File Name:

Trigger:

Due Date:

Population: Include CCC PLUS and MEDALLION

DMAS:

2.7.92.1 Requirements

As specified in the contract.

2.7.93 Level of Care Review

Contract	Section 5.12.2.2 Level of Care (LOC) Reviews
Method:	Virginia Medicaid Web Portal
Format:	see Requirements below
File Name:	N/A
Trigger:	see Requirements below
Due Date:	see Requirements below
DMAS:	TBD
Population:	Include CCC PLUS Only
DMAS:	

2.7.93.1 Requirements

Level of Care (LOC) reviews shall be completed with members enrolled in the CCC Plus Waiver at least annually. The annual LOC review may be completed up to sixty (60) calendar days prior to the annual due date for the Member. These reviews ensure that Members enrolled in the CCC Plus Waiver continue to meet the functional and medical criteria for enrollment in the waiver (CFR 42 §441.302 (c) (2)).

In addition to the annual LOC review, the Contractor must initiate a LOC review at any time that there is evidence that the Member may not meet the CCC Plus Waiver LOC criteria. This could be based on the Care Coordinator assessment or information received from other sources.

LOC Reviews shall be conducted using an assessment that includes all elements of the Level of Care Review Instrument (LOCERI) also known as the DMAS-99 Series Form.

For Members who transition from CCC Plus Waiver with PDN to CCC Plus Waiver without PDN (Waiver LOC A to 9) or CCC Plus Waiver without PDN to CCC Plus Waiver with PDN (Waiver LOC 9 to A) the Contractor must complete a LOCERI and submit it into the CRMS Portal to validate the LOC change. This must occur prior to making any waiver LOC change in the Virginia Medicaid Web Portal Based upon CRMS Portal LOC entry outcome, the Contractor will enter any necessary waiver LOC changes directly into the Virginia Medicaid Web Portal within five (5) business days.

The Contractor must provide the Department with all LOC review data and results for its CCC Plus Waiver participants via the CRMS Portal within five (5) business days of completion of the LOC face-to-face review. All submitted information must be accurate and complete.

2.7.94 Care Management Reporting

Contract

Method: Cardinal FTP

Format:

File Name:

Trigger:

Due Date:

Population: Include CCC PLUS and MEDALLION

DMAS:

2.7.94.1 Requirements

Upon request:

- Care Management staffing report that demonstrates the Contractor's level of compliance with the Department's caseload ratio requirements (defined within this Technical Manual).
- All members assigned to Care Management and identified per intensity level.
- Report providing the number and percentage of Members assigned to a) CM (including Low, Moderate and High Intensity CM); b) Low Intensity CM; c) Moderate Intensity CM; and d) High Intensity CM
- Detailed documentation of efforts taken (dates, times, type of attempts made, etc.) to reach specific Members and with an explanation of the reason why they were unable to successfully reach Members and complete contract deliverables (including HRAs, ICPs, etc.);

2.7.95 Behavioral Health Home Approval

Contract	Section 5.5.1.4 Behavioral Health Homes
Method:	Cardinal FTP
Format:	Adobe PDF
File Name:	BH_HOME_APPRV.pdf
Trigger:	Prior to implementation of Behavioral Health Home
Due Date:	
Population:	Include CCC PLUS and MEDALLION
DMAS:	

2.7.95.1 Requirements

2.7.96 REMOVED

Contract

Method: REMOVED

Format: REMOVED

File Name: REMOVED

Trigger: REMOVED

Due Date: REMOVED

Population: REMOVED

DMAS: REMOVED

2.7.96.1 Requirements

REMOVED

2.7.97 REMOVED

Contract	Removed
Method:	Removed
Format:	Removed
File Name:	Removed
Trigger:	Removed
Due Date:	Removed
Population:	Removed
DMAS:	Removed

2.7.97.1 Requirements

Removed

2.7.98 Individual Experience Policies and Procedures

Contract	5.12.2.3
Method:	Cardinal FTP
Format:	Adobe.pdf
File Name:	CCCP_IES_POLICY_*ContractorName_yyyymmdd.*xlsx where *yyymmdd* is the date of submission
Trigger:	Prior to Implementation 7/1/2022 Upon revision Upon request
Due Date:	Prior to Implementation 7/1/2022 Within five business days of revision Within ten business days of request
Population:	CCC PLUS Only
DMAS:	Integrated Care

2.7.98.1 Requirements

- Prior to 7/1/2022
  - The Contractor must create Policies and Procedures which include:
    - Identification of ADHC members that are eligible for an IES
    - Strategies to complete in conjunction with the LOCERI assessment.
    - Tracking and monitoring of completion of the IES training by Care Managers
    - Tracking completion of IES for ADHC members.
    - Conducting quality reviews of completed IESs, for example:
      - frequency and sampling methodologies of quality reviews
      - monitoring completeness of IES (all questions of the IES are answered
      - monitoring accuracy of IES (e.g. only one (1) answer is selected)
    - Utilize the IES for analysis and as part of the re-credentialing process of ADHC providers
    - Provide remediation at a CM level to work with the member and ADHC for any objective findings

- Succeeding 7/1/2022 Contractor must submit policies and procedures upon revision and request.

  DMAS reserves the right to request changes to a revised policy and/or procedure if the submitted policy and/or procedure does not meet contractual specifications, including current or future contract amendments.

  When submitting revisions the Contractor must include a version with tracked changes.

2.7.99 NEMT Transportation Network Company (TNC) Project Plan

Contract	5.14.21
Method:	Email to transportation@dmas.virginia.gov
Format:	Adobe.pdf
File Name:	N/A
Trigger:	Startup of new Transportation Network Company
Due Date:	Sixty (60) days prior to the startup of the TNC
Population:	CCC PLUS and MEDALLION
DMAS:	Transportation Team

2.7.99.1 Requirements

The Non-Emergency Medical Transportation (NEMT) Transportation Network Company (TNC) Project Plan must include but is not limited to the following:

1. Identification of the type(s) of TNC to be utilized (Type 1 or Type 2).
2. Statements ensuring TNC(s) meet all applicable Virginia Department of Motor Vehicles (DMV), Department, and contractor requirements, including complete explanations;
3. Plan for compliance with the 21st Century CURES Act requirements related to identifying National Provider Identifier (NPI) and taxonomy codes for each TNC;
4. Assurance of maintenance of a TNC contact to provide same day information upon request.
5. Description of how members will receive notifications and/or instructions on TNC utilization, as well as a description for the auto-assignment process for members that meet exception criteria.
6. Explanation of which NEMT TNC driver and vehicle requirements waived;
7. Plan to ensure that TNC(s) undergo staff training to include call center, reservations, ride assist/customer service, and operational staff as well as training on the exceptions list for each type of TNC utilized in the NEMT program;
8. Assurance that the contractor's information technology (IT) understands and complies with TNC encounter submission requirements (Refer to the Medallion Encounter Manual).
9. Overview of how TNC is to be used in the contractor's NEMT program (i.e., trip types, service levels, trips under ten (10) miles, late night/holiday ambulatory hospital discharges).
10. Description of how the contractor will maintain a viable NEMT provider network along with utilizing a TNC;
11. Estimates on the percentage of trips that the contractor plans on using the TNC;

2.7.100 ARTS Provider Network File

Contract

Method: Cardinal FTP

Format: Comma separated value (.csv) file. All columns/fields for this deliverable must be included in the order specified, and no additional columns should be included. Do not include a header row in .csv files

File Name: ARTS_PROV_NTWK.csv

Trigger: Upon request

Due Date: Upon request

Population: CCC PLUS and MEDALLION

DMAS: Behavioral Health

2.7.100.1 File Specifications

Field Name	Required	Format	Data Specification – Variations and Examples
HEALTHPLAN	Y	Character	Legal name of the Contractor
HEALTHPLANNPI	Y	Numeric	NPI of Contractor
PROVIDERNPI	Y	Numeric	All providers listed must include an NPI
PROVIDERLN	Y	Character	Provider Last Name
PROVIDERFN	Y	Character	Provider First Name
GROUPAFFIL	Y	Character	Medical or Provider Group Affiliation. Enter only if Applicable.
HOSPITALAFFIL	Y	Numeric	Yes or No if provider is affiliated with a hospital. Valid value is '1' for Yes or '0' for No.
TAXONOMYCODE	Y	Numeric	Unique ten character alphanumeric code that enables providers to identify their specialty at the claim level.
PRIMARYTAX	Y	Numeric	Yes or No for whether that taxonomy code is the primary code for that provider. Valid value is '1' for Yes or '0' for No

Field Name	Required	Format	Data Specification – Variations and Examples
ASAMLEVEL* ***Contracted Providers Only**	Y	Numeric	Must contain a valid value. Valid values include: '1' for ASAM 2.1 (Intensive Outpatient); '2' for ASAM 2.5 (Partial Hospitalized/Outpatient Managed Withdrawal); '3' for ASAM 3.1 (Clinically Managed Low- Intensity Residential Services); '4' for ASAM 3.3 (Clinically Managed Population-specific High-Intensity Residential Services – 24 hours); '5' for ASAM 3.5 (Community-based Residential); '6' for ASAM 3.5 (Specialty unit); '7' for ASAM 3.7 (Community-based Residential); '8' for ASAM 3.7 (Intensive Inpatient); '9' for ASAM 4 (Medically Managed Intensive In-patient); '10' for OTP; '11' for Preferred OBOT "12" for Substance Use Case Management; and "13" for In-network (Non-Preferred OBOT) Buprenorphine Waivered Prescribers (BWP)
ROOMSUITE	N	Numeric	Provider Suite or Room Number
ADDRESSLINE	Y	Character	Physical location Address required. P.O. Box cannot be used as a service location. If there are multiple service locations for this provider, please list each new service location address on a separate row. Therefore, if a specific provider has 5 different service location addresses, then there needs to be 5 separate rows. One for each address on a separate row. If the address includes a Suite Number, specify this in the ROOMSUITE Column.
CITY	Y	Character	Physical location City. Same practice as the 'Address Line1' field; if there are 5 different service locations, please repeat the information for each on a separate row for the city.

Field Name	Required	Format	Data Specification – Variations and Examples
STATE	Y	Character	Physical location State Code. 2 character state abbreviation for each unique service location(s). Only providers for the following states may be submitted: Virginia, West Virginia, Tennessee, Kentucky, North Carolina, Maryland, Delaware, Pennsylvania, and the District of Columbia (Washington, D.C.)
ZIPCODE	Y	Numeric	5-digit zip code for each unique service location(s).
CSBSAT	Y	Numeric	Yes or No if provider is CSB. Valid value is '1' for Yes or '0' for No.

2.7.100.2 Requirements

Include ARTS providers participating in Medicaid and FAMIS.

The complete provider file; i.e., all ARTS providers by ASAM level must be submitted. The entire network should be in a single file submission, formatted as above; not separate files.

Include only network participating providers. Do not include any out of network providers in this file.

For providers with multiple service office locations, each office location must be listed on a different line.

The address provided should represent the provider's actual servicing address (not billing, mailing, or corporate). Do not submit P.O. boxes for the provider's servicing address.

Provider last name field must contain the valid individual or business name for the NPI/API provided. Do not use default values for the provider last name.

Use the latest taxonomy code list from Washington Publishing Company.

2.7.101 ARTS Service Authorizations (SA) and Registrations

Contract Section 5.5.6 Addiction and Recovery Treatment Services (ARTS)

Method: Cardinal FTP

Format: Comma separated value (.csv) file. All columns/fields for this deliverable must be included in the order specified, and no additional columns shall be included. Do not include a header row in .csv files

File Name: ARTS_SA.csv

Trigger: Upon Request

Due Date: Varies

Population: Include CCC PLUS and MEDALLION

DMAS: ARTS

2.7.101.1 File Specifications

Field Name	Format	Specifications
Health Plan NPI	Char	10-digit NPI of Contractor
Medicaid ID	Char	Must be a valid Medicaid ID Format: 12 bytes with leading zeros
Service Auth ID	Num	Unique identifier for service authorization.
Type	Char	R = Registration S = Service Authorization P = Peer Support
Auth From Date	Date	Format = mm/dd/yyyy. Must be a valid date. Must be greater than 04/01/2017.
Auth Thru Date	Date	Format = mm/dd/yyyy. Must be a valid date. Must be greater than 04/01/2017.
Provider	Char	Must be a valid NPI.
Procedure Code	Char	Must be a valid procedure code.
Procedure Code using Modifiers	Char	***Conditional***. Include only when a Modifier Code was used. Must be a valid Modifier code.
Number Requested	Num	Must be greater than zero.
Number Authorized	Num	Must be greater than or equal to zero.
Denial Reason	Character	***Conditional***. Provide only when auth was denied or number of services requested was cut back. If using a denial code, please describe.

2.7.101.2 Requirements

Include all ASAM Level Service Authorizations, Registrations (for Substance Use Case Management and Substance Abuse Peer Support only) that were approved / denied / pended during the previous calendar month.

3 DMAS Generated Reports

The following reports are prepared by DMAS and sent to the MCOs.

DMAS has established a secure FTP server for transfer of files with the MCOs and each MCO has its own secure login. All DMAS reports will be transmitted via DMAS' secure FTP server and shall be picked up by the MCO.

The Department will notify the MCO in a timely manner of any changes to the reporting format and/or content. Changes may be communicated via memo or electronic.

3.1 Weekly

3.1.1 Newborns and Error Report

Method	Cardinal FTP
Format	Excel (.xlsx)
File Name	NB_ddMMyyyy.xlsx
Schedule	Weekly
Popuation	MEDALLION and CCC Plus

3.1.1.1 File Specifications

DATA FIELD	DESCRIPTION
MCO	MCO that submitted report
DATE_SUBMIT	Month and Year of report submission (MM/YY)
MOM_ID	Mother ID of the newborn submitted by MCO
LASTNAME_MCO	Last Name of the newborn's mother submitted by MCO
FIRSTNAME_MCO	First Name of the newborn's mother submitted by MCO
LASTNAME_DMAS	Last Name of the newborn's mother entered in the MMIS (based on the Mother ID submitted by MCO)
FIRSTNAME_DMAS	First name of the newborn's mother entered in the MMIS (based on the Mother ID submitted by MCO)
MOM_WARNING	Identifies Name mismatches for the Newborn's Mother between MCO submission and MMIS data
NB_DOB_MCO	Newborn Date of Birth submitted by MCO
NB_DOB_DMAS	Newborn Date of Birth entered in the MMIS
NB_ID_MCO	Newborn ID submitted by MCO
NB_ID_DMAS	Newborn ID entered in the MMIS
NB_LASTNAME_MCO	Newborn Last Name submitted by MCO
NB_FIRSTNAME_MCO	Newborn First Name submitted by MCO
NB_LASTNAME_DMAS	Newborn Last Name entered in the MMIS
NB_FIRSTNAME_DMAS	Newborn First Name entered in the MMIS
WARNING_NB	Identifies Name mismatches for the Newborn between MCO submission and MMIS data

3.1.1.2 Description

This report has **TWO** tabs: Tab "ID" provides the member IDs for newborns submitted on the MCO's monthly newborn submission report. The specifications above are for the format of this tab.

Tab "Errors" identifies each instance where a MCO deliverable submission does not comply with the specifications and/or requirements documented in the Technical Manual. Feedback is provided on the overall report and on the detail row / field level where appropriate. Below are the specifications for the "Errors" tab:

DATA FIELD	DESCRIPTION
MCO	MCO that submitted report

DATA FIELD	DESCRIPTION
Date_Submit (MM/YY)	Month and Year of report submission
Rsn_Desc	Mother ID Invalid – does not exist in the MMIS – MCO must research and resubmit on subsequent monthly report
LastName_MCO	Last Name of the newborn's mother submitted by MCO
FirstName_MCO	First Name of the newborn's mother submitted by MCO
nb_DOB_MCO	Newborn Date of Birth submitted by MCO
nb_ID_MCO	Newborn ID submitted by MCO
nb_LastName_MCO	Newborn Last Name submitted by MCO
nb_FirstName_MCO	Newborn First Name submitted by MCO

3.2 Monthly

3.2.1 Managed Care Enrollment (Flash)

Method	Cardinal FTP
Format	Adobe PDF
File Name	Flash_yyyymm.pdf
	Flash_Region_yyyymm.pdf
Schedule	Monthly - Approximately the 10th of the month
Population:	CCC PLUS and MEDALLION Combined

3.2.1.1 Description

This report summarizes Medicaid enrollment numbers various ways. In addition to the Flash report, an Excel spreadsheet with the regional information is also provided. It contains a summary of the enrollment numbers by program, region, locality, and delivery system.

3.2.2 Plan Change Report

Method: MEDALLION: Cardinal FTP
CCC Plus: Email

Format: Excel

File Name: MEDALLION: Plan_Chg_yyyymm.xlxs
CCC+: N/A

Schedule: Monthly After 18th of the month

Population: CCC+ and MED4 - Separate Reports

3.2.2.1 File Specifications

Change Report - MM CCYY

Transferred From MCO	Transfer To MCO	Reason for MCO Change	Reason Description	Total Number of Members

Transfer To MCO	Transferred From MCO	Reason for MCO Change	Reason Description	Total Number of Members

3.2.2.2 Description

This report is generated monthly by DMAS' enrollment broker, Maximus, and forwarded to the MCOs around the 18th of the month. The report identifies the total number of recipients in each plan who have contacted the Managed Care Helpline to change MCOs and the reasons for the changes. This report does not contain recipient-specific information but rather is to provide the MCOs with information about why recipients are moving from their health plan. This report may be helpful in identifying potential access issues, barriers, etc.

3.2.3 EOM 834 Supplemental File

Method: Cardinal FTP

Format: Excel (.xlsx) file

File Name: MEDALLION: EOM834_Suppl_yyyymm.xlsx
CCC Plus:

Schedule: Within 3 business days after end of month 834 creation

Population: CCC Plus and MEDALLION - Separate Reports

3.2.3.1 File Specifications

This report reflects additional information for all MCO recipients on the EOM 834.

Variable	Description
SRV_CTR	MCO Service Center
RECIP	Member ID
CASEFIPS	Case FIPS
CASEWORK	Case Worker
CASE_L_NAME	Case Last Name
CASE_F_NAME	Case First Name
CASE_MI	Case Name Middle Initial
CASE_S_NAME	Case Name Suffix
CASE_D_REVIEW	Case Review Date
DATEADD	Date Add
MOM_ID	Mother ID
EXP_DLVY_DTE	Expected Delivery Date
AID_CAT	Aid Category
CITIZEN_CD	Citizenship Code

3.2.4 TPL

Method	Cardinal FTP
Format	Excel 2007
File Name	TPL_yyyymm
Schedule	Monthly After the 18th of the month
Population	MEDALLION Only

3.2.4.1 File Specifications

Variable	Description
RECIP	Member Id
R_L_NAME	Member Last Name
R_F_NAME	Member First Name
R_M_NAME	Member Middle Initial
PROV	Provider NPI (MCO)
ENR_BEG	Benefit Enrollment Begin
ENR_END	Benefit Enrollment End
TPL_INS	TPL Carrier Code
CARRIER_NAME	TPL Carrier Name
TPL_POL	TPL Policy Number
COV	TPL Coverage Code
COV_DESC	TPL Coverage Description
COVBEG	TPL Coverage Begin
COVEND	TPL Coverage End

3.2.4.2 Description

This file provides TPL information (except for limited type coverage such as dental) for recipients who have been enrolled in the health plan during the last 12-month period, and who may have also had TPL during that 12 month period. Information contained in the TPL file includes the carrier name, policy, coverage begin and end dates, and coverage type. This information provides health plans with another source of information to coordinate past payments to providers, if needed.

3.2.5 Early Intervention Provider Roster

Method	Cardinal FTP
Format	Excel
File Name	MCO_XXXX_EI_Masterroster_yyyymmdd.xlsx
Trigger	Monthly
Population	Both (Combined Report)

3.2.5.1 File Specifications

Field Name	Field Description
Provider's First Name	EI Service Provider's legal first name
Provider's Last Name	EI Service Provider's legal last name
Provider's NPI (If applicable)	EI provider specified identifier to be used when submitting data to the health plans
Tax ID of Billing Agency	Billing agency Federal Employer Identification Number (FEIN)
Bill as Individual or Group	Indicate whether the provider is billing individually or under the agency NPI
Name of Billing Entity	LLA affiliation
NPI of Billing Entity	Unique number identifier of the billing agency
Physical Address of Provider's Administrative Office	Legal address of the EI provider's administrative office
Mailing Address for Provider	Legal mailing address for the EI provider
Billing Address for Following Up with Claims	Legal billing address for the EI provider's claims department
Provider's Email Address	Current email address of the EI provider
Provider's Phone Number	Current phone number to contact EI provider
Provider's Fax Number	Current fax number of EI provider
Provider's Discipline	Indicate the specified therapeutic discipline of the EI provider (OT, PT, SLP, etc.)
License Number (If applicable)	Indicate the full license number, if applicable
License Expiration Date	Indicate current expiration date of EI provider license
EI Certification Type 1	Indicate any certifications of the provider
EI Certification 1 Begin Date	Indicate most recent certification dates of EI provider. You do not need to indicate the very first certification date the provider obtained at the beginning of practice.
EI Certification 1 Expiration Date	Indicate most recent certification expiration date of the EI provider.
EI Certification Type 2	Indicate any other certifications aside from certification Type 1
EI Certification 2 Begin Date	Indicate most recent period of certification dates of EI provider
EI Certification 2 Expiration Date	Indicate most recent certification expiration date of EI provider

Field Name	Field Description
CAQH ID (If applicable) Streamlines Credentialing	Provide CAQH if applicable

3.2.5.2 Description

The Contractor will maintain a network of early intervention providers certified by DBHDS and associated with one of the 40 Local Lead Agencies (LLA) in the state of Virginia. The Contractors EI network will encompass all disciplines to provide assessments and ongoing services in accordance with DMAS program requirements. This report is a monthly file containing a list of EI providers who are contracted with the local lead agencies for the catchment area in which the member resides, as well as certified by DBHDS to provide EI services.

3.2.6 DMAS Foster Care Barrier Report

Method: DMAS email to identified MCO Foster Care Case Coordinators

Format: Excel (.xlsx) file

File Name: *MCOName* Barrier Report *Month year*.xlsx

Schedule: Monthly by close of business on the last calendar day of the month following the receipt of the Foster Care Barrier Report from the MCOs.

Population: Both (Combined Report)

3.2.6.1 File Specifications

Field Description	Specifications
Medicaid ID	Must be a valid Medicaid ID. Must be twelve digits. Fill with leading zeroes if necessary.
Member First Name	Member's last name as it appears on MCO 834 file
Member Last Name	Member's first name as it appears on MCO 834 file
Member Aid Category	Member aid category as it appears on MCO 834 file
Member Street Address 1	First line of member address as it appears on MCO 834 file
Member Street Address 2	Second line of member address as it appears on MCO 834 file
Member Phone	Member Phone number as it appears on MCO 834 file
Barrier Category	Specify one of the following two character valid values: • '01' = Adopted / reunified • '02' = Aged out • '03' = Aid category change • '04' = Can't locate with current address • '05' = Deceased • '06' = In a facility/ incarcerated • '07' = Invalid telephone number • '08' = LDSS non-responsive • '09' = Lost eligibility • '10' = Moved out of coverage area • '11' = New address reported • '12' = New phone number • '13' = Non-cooperative/ refusal to release info • '14' = Not in custody of LDSS • '15' = Other • '16' = Out of state • '17' = Returned mail
Date MCO Aware	Must be a valid date Format = mm/dd/yyyy Must be <= End Date of reporting period (calendar month)
Additional MCO Comments	Optional - Maximum 75 characters, no "LF" within the data.
DMAS Comments	DMAS Comments address listed barriers to assist MCOs

3.2.7 DMAS Newborn Reconciliation Return File

Method: Cardinal FTP

Format: Excel file.

File Name: NB_Recon_Return_yyyymm.xlsx

Schedule: Monthly. If possible, DMAS will send this file the week following the MCO submission of the NB_Recon_yyyymm file. However, delivery of this report may be a delayed if payments need to be generated through the MMIS capitation claim process.

Any response files must be submitted by the MCO within ten business days of DMAS' posting the NB_Recon_Return file to the FTP. Submit the response file in Excel Format to the DMAS email box at MCOhelp@dmas.virginia.gov. Include the file name, NB_Recon_Return_yyyymm, in the email Subject line.

Population: Both – Combined Report

3.2.7.1 File Specifications

Field Description	Specifications
Mom_LastName	Mother Last Name submitted by MCO
Mom_FirstName	Mother First Name submitted by MCO
Mom_ID	Mother ID Number submitted by MCO
NB_LastName	Newborn Last Name submitted by MCO
NB_FirstName	Newborn First Name submitted by MCO
NB_DOB	Newborn DOB submitted by MCO
NB_ID_MCO	Newborn MCO ID Number submitted by MCO
NB_ID_DMAS MCO	Newborn DMAS ID Number submitted by MCO
NB_LastName_DMAS	Newborn Last Name from DMAS/MMIS
NB_FirstName_DMAS	Newborn First Name from DMAS/MMIS
NB_DOB_DMAS	Newborn DOB from DMAS/MMIS
NB_ID_DMAS	Newborn ID Number from DMAS/MMIS
BM	Reconciliation Status for BM1, BM2, BM3
NB_AC	Newborn Eligibility Aid Category
NB_MCO	Newborn MCO Plan AB4 – Aetna (Medallion) ABC - Aetna (CCC Plus) AH4 - Anthem (Medallion) AHC - Anthem (CCC Plus) MC4 - Molina (Medallion) MCC - Molina (CCC Plus) OH4 - Optima (Medallion) OHC - Optima (CCC Plus) UH4 - United (Medallion) UHC - United (CCC Plus) VP4 - VA Premier (Medallion) VPC - VA Premier (CCC Plus) Blank – newborn not enrolled in MCO/newborn ID not found
Cap_Pymt	Capitation Payment Amount
Ref_Num	ICN - Payment made by MMIS OFFLINE PYMT – Payment made by Recon
DMAS Comment	DMAS explanation when no payment is made 30 bytes
Mom MCO	MCO Plan Mother ID enrolled in at NB DOB

Field Description	Specifications
Mom AC	Aid Category Mother ID enrolled in at NB DOB
Mom FIPS	FIPS Code Mother ID enrolled in at NB DOB
Program	Valid Values: 01= Medicaid; 07-= FAMIS
MCO Comment	MCO response regarding newborn nonpayment 30 bytes

3.2.7.2 Description

This file is generated from the validation of the MCO Newborn Reconciliation file (**NB_Recon_yyyymm**) submission against MMIS data. The return file contains the data fields submitted by the MCO, additional fields validating the MCO data submission and payment information for the MCO newborn.

The payment information identifies: 1.) the payment amount for the newborn for all three months (BM1, BM2, and BM3); 2.) whether the payment was made by the MMIS (ICN Ref Number provided), or the payment will be made through the offline reconciliation process or that no payment will be made. If no payment will be made, the nonpayment reason is provided in the field DMAS Comment.

A payment will not be processed for the following reasons:

- MOM not in MCO on NB DOB - The mother of the newborn must be enrolled in the MCO benefit plan on the newborn's DOB.
- NB Deceased (date of death provided) - Payment is not processed if the newborn's date of death is a month prior to the BM2 or BM3.
- NB in different MCO - Newborn changed MCO's for BM2 and/or BM3 and payment was made to that MCO. The MCO in which the newborn was enrolled is provided for claims coordination.
- NB not found - No Paid Encounter for Live Birth Delivery - Newborn was not found in the MMIS and DMAS was unable to locate a paid encounter from the MCO for the live birth delivery.

MCO Comment

- The MCO may submit a response file for that newborn and provide the reference number in the MCO Comment field for the paid encounter submitted for the mother for the live birth so that DMAS can research and verify the delivery.

The Return file will include 4 Worksheets tabs:

- **ALL** – Includes all newborns submitted by the MCO on the NB_Recon_yyyymm file. Each newborn will have 3 rows with enrollment/payment information for all three months, BM1-Birth Month, BM2-Birth Month Plus 1, BM3-Birth Month Plus 2.
- **OFFLINE** - A subset of the **ALL** worksheet. Only includes the Newborns for which DMAS **is making** an Offline payment.
- **No Pymt** – A subset of the **ALL** worksheet. Only includes the Newborns for which DMAS **is not making** an Offline payment.
- **Certify** - A Newborn Reconciliation Certification is included with the return file. The certification is acknowledgement that payment will be made for the payment amount for the newborns identified on the return file. The payment amount will be broken down into 2 payments, one for Medicaid and

one for FAMIS and the Total. Once the Certification is signed and received from the MCO, the Newborn Reconciliation File is processed for payment. The signed document shall be scanned and submitted using the file name **NB_Recon_CertLetter_YYYYMMDD** in .pdf format through the FTP site. When the signed Certification is received, the Add pay will be processed for payment.

YYYYMMDD in naming convention should appear as the birth month of the newborns listed with DD always as 01; i.e., January 2020 DOBs would be 20200101.

3.2.8 DMAS Newborn Enrollment Enhancement – E213 Live Births Report

Method: Cardinal FTP

Format: Excel file.

File Name: MCO_XXXX_E213_Live_Births_yyyymm.xlsx

Schedule: Monthly. If possible, DMAS will send this file on the 5th day of each month. Date may vary (see below).

Population

3.2.8.1 File Specifications

Field Description	Specifications
MCO	Mother's MCO Plan AB4- Aetna AH4- Anthem MC4- Molina OH4- Optima UH4- United VP4- VA Premier
mom_LastName_DMAS	Mother Last Name from DMAS/MMIS
mom_FirstName_DMAS	Mother First Name from DMAS/MMIS
mom_ID	Mom Medicaid ID submitted by MCO
mom_ssn	Mom Social Security Number from DMAS/MMIS
nb_LastName	Newborn Last Name submitted by MCO; Replaced by VDH last name, if available
nb_FirstName	Newborn First Name submitted by MCO; Replaced by VDH first name, if available
nb_DOB	Newborn Date of Birth (DOB) submitted by MCO; Replaced by VDH DOB if different
nb_ID_MCO	Newborn ID created by and submitted by MCO
mom_comment	DMAS field use ONLY – Health Care Services Newborn Not Found (HCS NB NF)
Gender	(M) Male or (F) Female
diag_cde	ICD-10 code
mom_dob	Mother's date of birth
mom_Citizen_Cd	• A= mother under FAMIS Prenatal benefit. • C= US Citizen • P= Full-benefit Qualified Alien • N= Naturalized US Citizen • I= Immigrant Children

This data is not required on the E213 form, we are simply using the field as another method for tracking those babies born to these managed care mothers.

E213 Live Births Reporting Schedule	
DMAS Date File Posted	**Newborn DOB Month File(s) Sent**
July 12, 2022	March-22
August 9, 2022	April-22
September 6, 2022	May-22
October 11, 2022	June-22
November 8. 2022	July-22
December 6, 2022	August-22

3.2.8.2 Description

It is essential that newborns of mothers enrolled in Medicaid/FAMIS/FAMIS MOMs Programs are correctly enrolled with their own 12-digit Medicaid ID number. Ideally, this enrollment will occur prior to discharge from the hospital. Newborns directly enrolled will receive a Medicaid identification number assigned to the case of the mother, which will facilitate newborns receiving their full program benefit, MCO assignment, and ensure appropriate reimbursement is received for the Medicaid covered services provided to newborns of enrolled mothers. The Cardinal Care Managed Care Contract describes the responsibilities of the Contractor and the Department. The Contractor shall have the following responsibilities to ensure newborns receive a Medicaid ID number before the end of the birth month plus two period. Healthy newborns receiving coverage is a prime focus for the Department, thus the Department is taking on the additional responsibility of producing.

MCO Responsibilities:

9. Continue to conduct outreach to pregnant women to track births including contacting mom at hospital once notified of the birth.
10. Continue to submit newborn information monthly on the Live Births Report (MCTM 1.6.5).
11. Review the monthly ***E213 Live Births Report***.
12. Conduct outreach to the parents/guardians of newborns without Medicaid IDs to get official newborn first and last name, as well as, spelling.
13. Complete a DMAS E213 form via the Virginia Medicaid Provider Portal for all newborns listed on the ***E213 Live Births Report.***
14. The MCO will have 60 days to complete a DMAS E213 form for each live birth identified on the ***E213 Live Births Report.***
15. Monitor the 834 to ensure those newborns entered on the DMAS E213 are listed on the 834.

DMAS Responsibilities:

16. Upon receipt of the Live Births Report (MCTM 1.6.5), DMAS staff will research the information, then, generate a monthly report including all newborns missing Medicaid ID numbers by MCO, Mother, and newborn's DOB.
17. Each MCO will receive a monthly ***E213 Live Births Report,*** which will identify each newborn without a Medicaid number.
18. Monitor the outgoing ***E213 Live Births Report*** to identify newborns that have entered the system with a Medicaid ID number.

3.2.9 PUMS Member Plan Transfer Report

Method	Cardinal FTP
Format	Comma separated value (.csv) file. All columns/fields for this deliverable must be included in the order specified, and no additional columns should be included. Do not include a header row in .csv files.
File Name	MCO_*Service Center ID number*_PUMS.yyyymmdd.csv
Schedule	To all plans within 3 business days of the first of the month.
Population	

3.2.9.1 File Specifications

Field Name	Format	Specifications
Previous Health Plan	Character	MCO Service Center ID
Member Medicaid or FAMIS ID	Numeric	Must be a valid Medicaid or FAMIS ID with any leading zeros included
Date Member Became Eligible in the MCO/ Plan	Date	Must be a valid date mm/dd/yyyy
Initial Date Identified (Date Identified of possible PUMS trigger)	Date	Must be a valid date mm/dd/yyyy
PUMS Trigger Type (What caused the trigger for further review)	Character	Must contain a valid value. See below for valid values list.
Final Decision Date	Date	Must be a valid date mm/dd/yyyy
Decision Outcome	Character	Must be 1 character. Valid Values are: '1' for Enrolled in PUMS
PUMS Action Type	Character	Valid Values are: "1" for Case Management Only "2" for MAT Referral Only "3" for Case Management and MAT Referral Only "4" for Lock-in "5" for Reviewed and No Action Taken
PUMS End Date	Date	Valid date where Decision Outcome value is '1'
PUMS Pharmacy/ Provider Name	Character	Must be 40 characters or less Valid Name where Action Type is '4'
PUMS Pharmacy/ Provider ID Number	Character/ Numeric	Must be 10 characters or less Must be a valid Provider ID Valid ID where Action Type is '4'

Field Name	Format	Specifications
PUMS Pharmacy/ Provider Address	Character	Must be 40 characters or less Valid Address where Action Type is '4'
PUMS Pharmacy/ Provider City	Character	Must be 17 characters or less Valid City where Action Type is '4'
PUMS Pharmacy/Provider State	Character	Must be 2 characters or less Must be valid state code (USPS standards) Valid State where Action Type is '4'
PUMS Pharmacy/Provider Zip	Numeric	5-digit zip code for each unique service location where Action Type is '4'
PUMS Provider Lock- in Type	Numeric	Must be 1 character or less Valid Values are: '1' for Physician, '2' for Pharmacy, Null where Action Type is not equal to '4'
PUMS Pharmacy Contract Status	Numeric	Must be 1 character or less Valid Values are: '1' for In-Network Provider, '2' for Out-of-Network Provider, Null where Action Type is not equal to '4'
Plan ID For Plan Submitting PUMS data	Numeric	Must be 4 digits Values are MCO Service Center ID number

3.2.9.2 Description

The purpose of this report is to notify the plans when a new member to their plan had been identified as a PUMS member by the previous plan. This report will be produced and delivered to all the MCO plans via the FTP site within 3 business days of the first of the month. In the event that there are no new members identified, DMAS will send a blank file with the receiving plan's name and service center ID.

The following codes are used for PUMS reason:

1=<u>Opioid Use Disorder (OUD) Case Management</u>: PLAN may review any members receiving OUD and provide case management:

- Members with any history of opioid overdose(s) in the past three (3) years; ER visits, inpatient hospitalization, or inpatient rehabilitation stay related to OUD in the past three

(3) years; pregnant women with OUD; individuals with OUD with current or recent involvement (in the past three (3) years) with the criminal justice system: must be evaluated for case management and referred as appropriate;

- Clinical expertise and judgment shall be used to identify and manage any members the plan determines should be placed in, or remain in, a lock-in to a prescriber or practice group ("cluster").

2 = <u>High Average Daily Dose</u>: <u>></u> ninety (90) cumulative morphine milligram equivalents (MME) per day over the past ninety (90) days,

3 = <u>Opioids and Benzodiazepines concurrent use</u> – at least one (1) Opioid claim and fourteen (14) day supply of Benzo (in any order),

4 = <u>Doctor and/or Pharmacy Shopping</u>: <u>></u> three (3) prescribers OR <u>></u> three (3) pharmacies writing/filling claims for any controlled substance in the past sixty (60) days,

5 = <u>Use of a Controlled Substance with a History of Dependence, Abuse, or</u> <u>Poisoning/Overdose</u>: Any use of a controlled substance in the past sixty (60) days with at least two (2) occurrences of a medical claim for controlled Substance Abuse or Dependence in the past three hundred and sixty-five (365) days,

6 = <u>History of Substance Use, Abuse or Dependence or Poisoning/Overdose</u>: Any member with a diagnosis of substance use, substance abuse, or substance dependence on any new* claim in any setting (e.g., ED, pharmacy, inpatient, outpatient, etc.) within the past sixty (60) days.

3.2.10 Validation and Scoring Report

Method	Cardinal FTP
Format	Excel (XLSX)
File Name	MCO_xxx_Monthly_Report_yyyymmdd.xlsx
Trigger	Monthly (see schedule details below)
Population	Both – Combined Report

3.2.10.1 Requirements

Any deliverable submission that does not meet the basic transmittal requirements set forth for the deliverable will be scored as a zero. In particular, each of the following requirements must be met in order for a submission to be accepted by DMAS for processing:

- Submission must be transmitted via the method specified for the deliverable (e.g., DMAS secure FTP).
- File must be formatted as specified for the deliverable (e.g., comma separated values (CSV), Excel (XLSX), or PDF).
- The filename on the report must exactly match the filename specified for the deliverable (including extension, spaces, underscores, etc.).
- All columns / fields specified for the deliverable must be included in the submission in the order specified, and no additional columns / fields are included. Do not include a header row in *.csv files. If there is no data to report for a specific report, submit the report, but leave it blank without headers or any other text.
- Except as otherwise specified, only one consolidated deliverable per report cycle is submitted. The MCO cannot submit separate deliverables for their subcontractor(s).
- All deliverables that meet the Transmittal Requirements will be edited for compliance with the specific field-level format and content criteria specified for the particular report. Results of this validation are documented in the error report (see below).
- MCOs may be subject to compliance action if the deliverable is submitted after the specified due date. Note that the cut-off for delivery via the DMAS secure FTP is 6:00 PM EST each day.

3.2.10.2 Schedule

The standard schedule for generation of the Validation and Scoring report is as follows:

- First preliminary report is generated in the morning of the 14th and returned to the MCOs via FTP in the mid-day batch transfer.
- Second preliminary report is generated on the morning of the 15th and returned to the MCOs via FTP in the mid-day batch transfer.
- All MCO corrections should be completed and re-submitted prior to the cut-off at close of business on the 15th.
- Validation and Scoring report is generated again on the morning of the 16th using the most recent MCO submissions received via the batch transfer process. These report cards are returned to the MCOs via FTP in the mid-day batch transfer. If the MCO did not resubmit any deliverables, their scores will be the same as the report generated previously on the 15th. This is the first 'official' report card.

- On the 16th, the MCO can submit correction (replacement) file(s) if desired. However, note that when a deliverable is submitted or re-submitted after the cut-off on the 15th, the deliverable may be subject to compliance action. It is DMAS' intent for all reports to be submitted according to the specified standards prior to the deadline on the 15th as specified in the Cardinal Care Managed Care Contract.
- DMAS will run the report card generation process up to a total of 3 business days in order to collect all corrections submitted by the MCOs.
- Validation and Scoring report is not generated on weekends or State holidays. The delivery schedule is adjusted accordingly for these events. For example, if the 15th falls on a Sunday, deliverables are not due until close of business on the 16th.

3.2.10.3 Description

Monthly_Reports Worksheet

The workbook file is divided into worksheets. Each tab provides different information.

The first tab (MONTHLY_REPORTS) provides a summary of the monthly submission.

Rpt_month	MCO	RPT_NAME	fname	Penalty	Record_Cnt	Error_Cnt	Percent_Correct	Final_score
2016_01	XXX	APP_GRIEV.CSV	MCO_XXX_20160211160102_APP_GRIEV.csv	0	12	0	100	100
2016_01	XXX	ASSESS_EXCEPTION.CSV	MCO_XXX_20160211160110_ASSESS_EXCEPTION.csv	0	69	0	100	100
2016_01	XXX	BHH_ENROLL.CSV	MCO_XXX_20160211160128_BHH_ENROLL.csv	0	59	0	100	100
2016_01	XXX	BHH_QUALITY.CSV	MCO_XXX_20160211160134_BHH_QUALITY.csv	0	7	0	100	100
2016_01	XXX	BIRTHS.CSV	MCO_XXX_20160211160145_BIRTHS.csv	0	131	0	100	100
2016_01	XXX	COMP_CVG.CSV	MCO_XXX_20160211160151_COMP_CVG.csv	0	30	0	100	100
2016_01	XXX	ENC_CERT.PDF	MCO_XXX_20160211160202_ENC_CERT.pdf	0				100
2016_01	XXX	ENC_PROV.CSV	MCO_XXX_20160211160228_ENC_PROV.csv	0	67	0	100	100
2016_01	XXX	EST_RECOV.CSV	MCO_XXX_20160211160238_EST_RECOV.csv	0			-1	100
2016_01	XXX	MCO_RPT.CSV	MCO_XXX_20160211160324_MCO_RPT.csv	0	16	0	100	100
2016_01	XXX	MNY_RECOV.CSV	MCO_XXX_20160211160336_MNY_RECOV.csv	0	170	3	98.23529412	98.23529412
2016_01	XXX	NB_RECON.CSV	MCO_XXX_20160211160346_NB_Recon.csv	0	5	0	100	100
2016_01	XXX	OTH_COVG.CSV	MCO_XXX_20160211160358_OTH_COVG.csv	0			-1	100
2016_01	XXX	PUMS.CSV	MCO_XXX_20160211160407_PUMS.csv	0	150	2	98.66666667	98.66666667
2016_01	XXX	RETURNED_ID.CSV	MCO_XXX_20160211160417_RETURNED_ID.csv	0	160	0	100	100
2016_01	XXX	WKR_COMP.CSV	MCO_XXX_20160211160425_WKR_COMP.csv	0			-1	100
2016_01	XXX	CALL_CENTER.CSV	MCO_XXX_20160212135920_CALL_CENTER.csv	0	1	0	100	100
2016_01	XXX	ASSESSMENTS.CSV	MCO_XXX_20160216124826_ASSESSMENTS.csv	0	50	0	100	100
2016_01	XXX	FC_ASSESSMENTS.CSV	MCO_XXX_20160216124913_FC_ASSESSMENTS.csv	0	5	0	100	100

MONTHLY_REPORTS | NOT_RECOGNIZED | MULTIPLE | APP_GRIEV | ASSESSMENTS | ASSESS_EXCEPTION

The last column in the worksheet shows the final score for the report. For reports with less than perfect scores, you may review the detailed information on the errors in the subsequent worksheets.

Not_Recognized Worksheet

The second tab (NOT_RECOGNIZED) shows report names that we do not accept – this could mean that a report was named incorrectly or a report is not part of the monthly submission.

Rpt_month	MCO	fname	Rpt_Name	Name_Valid	File_Format_Valid	Submit_dte	days
2016_01	XXX	MCO_XXX_20160211160120_ASSESSMENT.csv	ASSESSMENT.CSV		Yes	2/11/2016	-3
2016_01	XXX	MCO_XXX_20160211160311_FC_ASSESSMENT.csv	FC_ASSESSMENT.CSV		Yes	2/11/2016	-3

The report was named "ASSESSMENT.CSV" rather than "ASSESSMENTS.CSV"

MONTHLY_REPORTS | NOT_RECOGNIZED | MULTIPLE | APP_GRIEV | ASSESSMENTS | ASSESS_EXCEPTION

Multiple Worksheet

The third tab (MULTIPLE) contains the names of reports that you have corrected and resubmitted, so DMAS has multiple versions of that report.

MCO	fname	Rpt_Name	Name_Valid	File_Format_Valid	Submit_dte	submit_time	On_Time	no_of_working_days
XXX	MCO_XXX_20160212133934_BIRTHS.csv	BIRTHS.CSV	Yes	Yes	2/12/2016	133934	YES	-2
XXX	MCO_XXX_20160210143840_CALL_CENTER.csv	CALL_CENTER.CSV	Yes	Yes	2/10/2016	143840	YES	-4

MONTHLY_REPORTS | NOT_RECOGNIZED | **MULTIPLE** | APP_GRIEV | ASSESSMENTS | ASSESS_EXCEPTION

Detailed Errors Worksheets The remaining tabs provide details of the errors for each report. If a file has no errors, the rows on the tab will be blank. *Only records with errors are included in the error worksheet. When resubmitting a file with corrections, correct the error records and submit <u>all</u> records for the monthly report.*

Review the column with error codes ("Error_Code") to determine where the error(s) reside. Where an 'E' is present, its position represents the field (i.e., column) in the record that contains the error.

mbr_FirstName	mbr_LastName	mbr_ID	Third_Party	Amt_Recovered	file_num	Error_Code
FIRST	LASTNAME	000000000001	UNITED HEALTHCARE	342.7	3	12E45
SECOND	LASTNAME	000000000002	BCBS MARYLAND	102.7	3	12E45
THIRD	LASTNAME	000000000003	AETNA	72.8	3	12E45

CON ... RPT | **MNY_RECOV** | NB_RECON

In this example the 'E' is in the third position of the column – this refers to the third field in the report. he MCTM Field Descriptions to identify the name of the column and any specifications.

3.2.11.2 File Specifications

Field Description	Specifications
Member First Name	Must be 13 characters or less
Member Last Name	Must be 20 characters or less
Medicaid ID	Must be a valid Medicaid ID Format: 12 bytes with leading zeros
Third Party	Must be 50 characters or less
Amount Recovered	Must be 10 characters or less

3.2.11 Patient Pay Report – CCC PLUS Only

Method	Cardinal FTP
Format	Zip .zip file
File Name	SC##.MCO618_YYYYMMDDHHMMSS.ZIP
Schedule	Monthly on the last day of the month
Population	CCC+ Only

3.2.11.1 File Specifications

```
MCM618                                VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES                    REPORT NO:    MC-O-618
AS OF:MM/DD/CCYY                             MLTSS LONG TERM CARE PATIENT PAY                              PAGE NUMBER:    ZZ,ZZ9
RUN DATE: MM/DD/CCYY HH:MM


SERVICE VENDOR: 9999  PROVIDER:  9999999999   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX


MEMBER ID    MEMBER NAME                       BIRTHDATE  AID TPL      DATE OF       DISCHARGE   PP BEG DTE  PP END DTE  PP AMOUNT
                                                          CAT CODES  DEATH/DISCHARGE  DESTINATION

999999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY 999 XXXXX    _________     ___________ MM/DD/CCYY  MM/DD/CCYY  Z,ZZ9.99
                                                                                                 MM/DD/CCYY  MM/DD/CCYY  Z,ZZ9.99
999999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY 999 XXXXX    _________     ___________ MM/DD/CCYY  MM/DD/CCYY  Z,ZZ9.99
                                                                                                 MM/DD/CCYY  MM/DD/CCYY  Z,ZZ9.99
999999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY 999 XXXXX    _________     ___________ MM/DD/CCYY  MM/DD/CCYY  Z,ZZ9.99
                                                                                                 MM/DD/CCYY  MM/DD/CCYY  Z,ZZ9.99
999999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY 999 XXXXX    _________     ___________ MM/DD/CCYY  MM/DD/CCYY  Z,ZZ9.99
                                                                                                 MM/DD/CCYY  MM/DD/CCYY  Z,ZZ9.99
999999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY 999 XXXXX    _________     ___________ MM/DD/CCYY  MM/DD/CCYY  Z,ZZ9.99
                                                                                                 MM/DD/CCYY  MM/DD/CCYY  Z,ZZ9.99
999999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY 999 XXXXX    _________     ___________ MM/DD/CCYY  MM/DD/CCYY  Z,ZZ9.99
                                                                                                 MM/DD/CCYY  MM/DD/CCYY  Z,ZZ9.99
999999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY 999 XXXXX    _________     ___________ MM/DD/CCYY  MM/DD/CCYY  Z,ZZ9.99
                                                                                                 MM/DD/CCYY  MM/DD/CCYY  Z,ZZ9.99
999999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY 999 XXXXX    _________     ___________ MM/DD/CCYY  MM/DD/CCYY  Z,ZZ9.99
                                                                                                 MM/DD/CCYY  MM/DD/CCYY  Z,ZZ9.99
999999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY 999 XXXXX    _________     ___________ MM/DD/CCYY  MM/DD/CCYY  Z,ZZ9.99
                                                                                                 MM/DD/CCYY  MM/DD/CCYY  Z,ZZ9.99


   TOTAL MEMBERS FOR PROVIDER    9999999999    ZZ,ZZ9


            * * * * * * * C O N F I D E N T I A L    I N F O R M A T I O N   * * * * * * *

                                          *** END OF REPORT ***
```

3.2.11.2 Description

Includes active members who are in nursing facilities or who have a CCC Plus waiver. Data is reported for the current month, next month, and the previous six (6) months.

3.2.12 Capitation Patient Pay Discrepancy Report – CCC PLUS Only

Method	Cardinal FTP
Format	ZIP .zip file
File Name	SC##.CPO746_YYYYMMDDHHMMSS.ZIP
Schedule	Monthly - Run date is the 5th/6th of month for prior month
Population	CCC+ Only

3.2.12.1 File Specifications

```
CPR746                                VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES                    REPORT NO:    CP-O-746
AS OF: MM/DD/CCYY                       MLTSS CAPITATION PATIENT PAY DISCREPANCY REPORT                     PAGE NUMBER:        99
RUN DATE: MM/DD/CCYY HH:MM            AUDIT SERVICE MONTH RANGE: CCYY-MM THROUGH CCYY-MM

MCO:  XXXXXXXXX

                      LAST CHANGE                          DATE OF         PATIENT         CLAIM
          MEMBER          DATE             ICN            SERVICE          PAY        PATIENT PAY      DIFFERENCE
       XXX-XXXXXX-XXX    MM-DD-CCYY    XXXXXXX-X-XXXXXX-XX    MM-DD-CCYY     $ZZ,ZZ9.99-     $ZZ,ZZ9.99-    $Z,ZZZ,ZZ9.99-
       XXX-XXXXXX-XXX    MM-DD-CCYY    XXXXXXX-X-XXXXXX-XX    MM-DD-CCYY     $ZZ,ZZ9.99-     $ZZ,ZZ9.99-    $Z,ZZZ,ZZ9.99-
       XXX-XXXXXX-XXX    MM-DD-CCYY    XXXXXXX-X-XXXXXX-XX    MM-DD-CCYY     $ZZ,ZZ9.99-     $ZZ,ZZ9.99-    $Z,ZZZ,ZZ9.99-
       XXX-XXXXXX-XXX    MM-DD-CCYY    XXXXXXX-X-XXXXXX-XX    MM-DD-CCYY     $ZZ,ZZ9.99-     $ZZ,ZZ9.99-    $Z,ZZZ,ZZ9.99-
       XXX-XXXXXX-XXX    MM-DD-CCYY    XXXXXXX-X-XXXXXX-XX    MM-DD-CCYY     $ZZ,ZZ9.99-     $ZZ,ZZ9.99-    $Z,ZZZ,ZZ9.99-

                                                  AMOUNT
                                                -------------
                                    PATIENT PAY:          $Z,ZZZ,ZZ9.99-
                                    CLAIM PATIENT PAY:    $Z,ZZZ,ZZ9.99-
                                                -------------
                                    DIFFERENCE:           $Z,ZZZ,ZZ9.99-

                                          *** END OF REPORT ****
```

Report will identify the patient pay changes that have occurred during the reporting period.

3.3 Quarterly

3.3.1 Reinsurance

Method:	Cardinal FTP
Format:	Excel (.xlsx) file
File Name:	REINSURE_*yyyy*Q*n*_C*ontractorName*.xlsx where *yyyy*Q*n* is the reporting period state fiscal year and quarter. Example: 2021Q1 for reporting period July – Sept 2020.
Trigger:	Quarterly
Due Date:	Q1 – (Jul – Sep) Due by DMAS close of business on October 31st Q2 – (Oct – Dec) Due by DMAS close of business January 31st Q3 – (Jan – Mar) Due by DMAS close of business on April 30th Q4 – (Apr – Jun) Due by DMAS close of business on September 30th
Population	MEDALLION and CCC Plus
DMAS:	Provider Reimbursement Division

3.3.1.1 File Specifications

Field	Specifications
PAYER_CLAIM_ID	Unique MCO claim identification number (ICN/CCN) in the MCO Payment system. Format: CHAR(20) The same PAYER_CLAIM_ID cannot appear more than once in each file. If necessary, append line number for facility and medical claims to create a unique value. Required
EPS_TCN	Unique MCO Transaction Control Number (TCN) in DMAS Encounter system (EPS) associated to MCO PAYER_CLAIM_ID (without the claim line number) Format: CHAR(20) The same EPS_TCN can appear more than once. Required
CLAIM_LINE	Line number for facility and medical claims eligible for Pharmacy Reinsurance. Note: Combination of EPS_TCN with Claim Line is used to match the records in DMAS Encounter system (EPS). Required
FILL_DATE / FROM_DATE	Date prescription was filled (pharmacy) or drug was administered (medical and facility), Format: MM/DD/YYYY Must be a valid date. This date must be within the current contract year period. Required
DATE_PAID	Date claim paid. Used to calculate IBNR/trend estimates. Format: MM/DD/YYYY Must be a valid date. Must be greater than or equal to fill date / from date. Required
RECIP_ID	Member's Medicaid ID number. Format: Numeric 12 bytes with leading zeros. Must be a valid Medicaid ID number. Required
SSN	Member's social security number. Format: Numeric, 9 digits - 999999999 - No dashes. Required - Fill with all 9's if not available.

Field	Specifications
BIRTH	Member's birth date. Format: MM/DD/YYYY Required – Fill with 12/31/9999 if DOB is not available
SEX	Member's gender (as provided on 834) Format: CHAR(1) Valid Values: 'F' = female; 'M' = male; 'U' = unknown Required
CTY_CNTY	FIPS code of member's residence (as provided on 834) Format: CHAR(3) Must be valid Virginia city/county FIPS code Required – Fill with 999 if not available
ELIG_CAT	Member's aid category code at time of service (as provided on 834). Format: Numeric, three digits Must be a valid Virginia Medicaid/FAMIS aid category Required – Fill with '999' if not available
PROV_NPI	Pharmacy or servicing provider NPI or API number Format: Numeric, ten digits, leading zeros if necessary Required
PROV_TAXID	Provider tax ID Format: Numeric, nine digits Required - Fill with all 9's if not available.
BILLED_AMT	Billed Amount submitted to the MCO or PBM for the drug. Format: Numeric with 2 decimal places, no leading zeroes, no commas, and no dollar sign. Must be greater than zero. (Do not submit negative numbers.) Required
PAID_AMT	Amount Paid by the MCO for the drug – Include INGREDIENT COST and DISPENSING FEE. Format: Numeric with 2 decimal places, no leading zeroes, no commas, and no dollar sign. Must be greater than zero. (Do not submit negative numbers.) Required
COPAY_AMT	Co-pay collected from the member. Format: Numeric with 2 decimal places, no leading zeroes, no commas, and no dollar sign. May be equal to zero, but cannot be negative. Required
DISPENSE_FEE	Dispensing fee Format: Numeric with 2 decimal places, no leading zeroes, and no dollar sign. May be equal to zero, but cannot be negative. Required
BRAND_GEN	Format: CHAR(1) Brand/Generic indicator. Valid values are: 'B'=brand, 'G'=generic, 'U'=unknown Required
DRUG	Drug name Format: CHAR(50) Optional

Field	Specifications
DAW	Dispensed as written indicator. Format: CHAR(1) Valid values are: 0 = No product selection indicated (Default); 1 = Substitution not allowed by prescribing physician; 2 = Substitution allowed - patient requested product dispensed; 3 = Substitution allowed - pharmacist selected product dispensed; 4 = Substitution allowed -generic drug not in stock; 5 = Substitution allowed - brand drug dispensed as generic; 6 = Override; 7 = Substitution not allowed - brand drug mandated by law; 8 = Substitution allowed - generic drug not available in marketplace; 9 = Other Required
NDC	Must be a valid National drug code (NDC) Format: Numeric, 11 digits Required
PRESC_NUM	Prescription Number (Rx Number) Format: Numeric Required for NCPDP claims
THER_CLS	Standard therapeutic class code. Format: CHAR(2) Required - Fill with ‘99’ if not available.
REFILL	Indicates whether this drug claim is for a refill: Format: CHAR(1) Valid Values: ‘Y’ = refill; ‘N’ = not refill; ‘U’=unknown Required
SUB_CAP	Format: CHAR(1) Indicates whether claim is paid FFS or is a capitated service; Valid Values: 'F' =FFS, 'C' = Capitated Required
PROC_CD	HCPCS / CPT/ J-code used for medical claims. Format: Char(5) Situational based on claim type. Required when CLM_TYPE = ‘P’ or ‘I’. Required if NDC is not provided.
CLM_TYPE	Type of claim Format: Char(1) Valid values: N=pharmacy/NCPDP; P=professional/837P; I=institutional/ facility/ 837I Required

3.3.1.2 Requirements

As specified in the contract section referenced above.

Report only includes non-dual eligible members whose total Contractor payment amount for all drug costs for the current contract year is over the $175,000 threshold. Includes pharmacy, physician, and outpatient hospital costs.

Data submitted each quarter must be cumulative year-to-date. For example, if a member exceeds the threshold in the first quarter, then report all prescription drug costs associated with that member in each successive quarter along with any new prescription drug costs.

In order to be processed for reimbursement by DMAS, Contractor reinsurance requests must be submitted within five (5) business days of the due date specified for this deliverable.

Any submitted claim records that do not meet the specifications (editing criteria) specified for this deliverable will not be accepted and not considered for reimbursement.

4 System Interfaces

4.1 From MES to MCOs

4.1.1 Enrollment Roster (834)

Method:	ISS
Format:	EDI 834
File Name:	Per ISS File Naming Conventions
Schedule:	6th, 12th, 18th, and EOM
Population	CCC Plus and MEDALLION Separate Files

4.1.1.1 Description

For each month of coverage throughout the term of the Contract, the Department shall post an Enrollment Roster to DMAS' secure FTP EDI server using the X12 834 HIPAA compliant electronic data interchange (EDI) transaction set. These files will contain full member eligibility data (audit records) for member assignments to the Contractor. The 834 Enrollment Roster shall provide the Contractor with ongoing information about its active and disenrolled members. Unless otherwise notified by the Department, these files will be available on the 19th of the month and at the end of month.

Twice a month throughout the term of the Contract, the Department shall post an enrollment change file to DMAS' secure FTP EDI server using the 834 electronic data interchange (EDI) transaction set. These files will contain all changes to the Contractor's member eligibility data since the last 834 was produced. These changes will include "add" transactions (member is newly enrolled for the Contractor), "terminate" transactions (member is disenrolled or dropped from the Contractor), and "audit" information (any information that changed for the current member). Unless otherwise notified by the Department, these files will be available on the 6th and 13th of the month.

For access to the EDI Companion Guide, go to the Medicaid portal at the following link:

https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/Home/homepage/

Locate the EDI Support tab on the home page and click on EDI Companion Guides and then click on 834 – Enrollment/ Dis Enrollment to a Health Plan (5010).

General Guidance for interpreting the 834.

All CCC Plus members are pre-assigned on the 18th of the month with an effective date of the first day of the month following the immediately succeeding month. For the time period beginning with pre-assignment on the 18th of the month until the 18th of the following month, these members are considered to have a pending assignment status. During the pending assignment status of the member, there are no termination records (24-termination maintenance type code) sent to the plans when a member transfers to another plan.

Example: A member is assigned to MCO A on June 18. MCO A received a 21-add and a 30- audit maintenance type code on the mid-month 834 with an effective date of Aug 1. MCO A received a 30-audit maintenance type code on the Jun 30, end-of-the-month 834 with an effective date of Aug 1. The member calls enrollment broker to change to MCO B on July 3. On July 6, MCO B will receive a 21-add and a 30-audit maintenance type code on the weekly 834 on the 6th. MCO A will not receive any information on this member on either their weekly 834 on the 6th or the 13th. On the 18th 834 mid-month, MCO A will NOT receive a 30-Audit maintenance type code for this member. The absence of the

30-audit maintenance type code on the mid-month 834 should be interpreted by MCO A as terminated member.

Eligibility Changes reflected on the 834

Scenario 1. Add, Term and Audit received for the same plan and member on the same file.

Explanation: During normal eligibility processing in the changing of an Aid Category, there are instances where a member's CCC Plus benefit plan will end at the end of the month and a new CCC Plus benefit plan (in same health plan) will begin the first of the next month. Example -- end on 8/30/17 and begin on 9/1/17. In these instances, a 24 term record will be sent for the benefit plan termed on 8/30/17, as well as a 21 add record and 30-audit maintenance record for the new 9/1/17 benefit plan. This record scenario should be processed as continuous CCC Plus coverage with your plan.

Scenario 2. Multiple Audit records in the same file.

Explanation: The occurrence of multiple maintenance records can happen in instances of eligibility changes that result in a new eligibility line. Example using a 9/1/2017 834 -- one 30-audit maintenance record has a 9/1/2017 enroll and one has a 10/1/2017. Use only the audit maintenance record for the current month. In this example, you would use the 9/1/2017. Once you receive the October 834, you should now be back to one audit maintenance record and this one should have only the 10/1/2017 record.

4.1.1.2 Medicaid Expansions Aid Categories

Medicaid Expansion members are included on the existing 834 and 820 files. Medicaid Expansion members are on the 834 and 820 files with one of the aid category values below. These aid categories are effective 01/01/2019.

100 - Caretaker Adult, LE 100% FPL GT LIFC
101 - Caretaker Adult, GT 100% FPL
102 - Childless Adults, LE 100% FPL
103 - Childless Adults, GT 100% FPL

4.1.1.3 Medicaid Expansion Member 834 Data Examples

Medicaid Expansion members who are determined to be Medically Complex have a benefit loop of '01010100X'. Each member can have multiple benefit loops on the 834. The Medically Complex benefit loop is provided in addition to any existing benefit loops that the member may have for managed care, waiver, nursing home, etc.

For those members with a medically complex benefit, the Medically Complex information will be included on the 834 in the 2300 Health Coverage loop along with the other member benefit info. See examples of Medically Complex benefit information below:

Example #1:

```
HD*030**HMO*01140901~
DTP*348*D8*20190101~
AMT*P3*47100.2~
REF*17*103~
REF*1L*01~
HD*030**HMO*01010100X~
DTP*348*D8*20190101~
DTP*349*D8*99991231~
REF*1L*01~
REF*XX1*XP~
```

Example #2:

```
HD*030**HMO*01140901~
DTP*348*D8*20190101~
AMT*P3*47100.2~
REF*17*103~
REF*1L*01~
HD*030**HMO*01010100X~
DTP*348*D8*20190101~
DTP*349*D8*99991231~
REF*1L*01~
REF*XX1*X~
LX*1~
NM1*P3*2******SV*0247726596*72~
```

Medically Complex benefit data will not appear on the Medallion 834 since members transition to CCC Plus when they are determined to be Medically Complex.

4.1.1.4 Change Source Values

The REF XX1 segment on the 834 contains the 'Change Source' value for the Medically Complex benefit. Valid values are as follows:

ChgSrc	Description
X	Indicates a screening has been completed by an MCO or DMAS.
XP	Indicates that the member attested as Medically Complex on their eligibility application.
XA	Indicates Medical Complex benefit was 'auto-assigned' (e.g.,waiver member).
XG	Indicates member was formerly enrolled in GAP.

4.1.1.5 Identifying the MCO that Performed the MMHS

The Provider Information loop contains the MCO ID that performed the most recent screening (Loop 2310, NM109). Valid MCO ID values are shown below.

Provider	MCO Name
0247726596	CCC PLUS Aetna
0247726836	CCC PLUS Anthem
0247725432	CCC PLUS Magellan
0247719971	CCC PLUS Optima
0247725788	CCC PLUS United
0247726240	CCC PLUS Premier

Provider	MCO Name
0562425543	Medallion Aetna
0562425972	Medallion Anthem
0575325995	Medallion Magellan
0562427754	Medallion Optima
0575326118	Medallion United
0562425717	Medallion Premier

Note that the NM110 value on the Medically Complex provider segment (‘72’) is different than the NM110 value that is passed ('25') on the NM1 segment for other benefits such as managed care, waivers, EI, etc.

4.1.1.6 Additional 834 Information

For additional information about the content and format of the MCO 834, please refer to the Virginia Medicaid 834 Companion Guide located under the ‘EDI Support’ tab here:

www.virginiamedicaid.dmas.virginia.gov/wps/portal

4.1.2 Capitation Payment Remittance (820)

Method	ISS
Format	EDI 820
File Name	Per ISS File Naming Conventions
Schedule:	Weekly - Available on Mondays
Population:	CCC Plus and MEDALLION Separate Files

The 820 Capitation Payment file will list all of the members for whom the Contractor is being reimbursed in the current monthly payment cycle. For current month enrollments, the 820 is processed on the last Friday of the calendar month, and is available to the Contractor on the following Monday. The file includes individual member month detail. The 820 includes current and retroactive capitation payment adjustments.

4.1.2.1 Capitation Payment Remittance (820) – "Best Practices" in Reconciliation

- If the Contractor receives payment on the 820 file for a member not listed on the previous 834 enrollment file, the member is retroactively enrolled to the Contractor for the dates listed.
- If the Contractor receives a retraction of payment on the 820 file, the member is retroactively terminated for the dates listed.
- If a member is listed on the 834 enrollment file, but no payment is received for the member on the 820 file, the member should not be terminated. The Contractor must research the member on the DMAS eligibility website. If the member is no longer eligible on the website, the Contractor will terminate the member. However, if the member still is shown as active on the website, the member will not be terminated.

4.1.3 Provider PRSS PRN Full File

Method:	ISS
Format:	JSON
File Name:	Per ISS File Naming Conventions
Schedule:	Monthly on the first of the month
Population:	CCC PLUS and MEDALLION Separate files

4.1.3.1 Requirements

Refer to current versions of the PRSS documents stored on MCO MES SharePoint sites:

- Virginia Provider Network PRN File Guide
- PRSS Provider Code Value Descriptions
- VA Crosswalk Legacy PT SPEC Taxonomy (Published)
- MCO Configuration Working Document - Required Attachments

4.1.4 Provider PRSS PRN Daily Delta File

Method:	ISS
Format:	JSON
File Name:	Per ISS File Naming Conventions
Schedule:	Every weekday M-F
Population:	CCC PLUS and MEDALLION

4.1.4.1 Requirements

Future development.

4.1.5 MMHS Member Screening Data Response File (MCF196)

Method: ISS

Format: Fixed length file as specified below

File Name: Per ISS File Naming Conventions

Schedule: Generated in response to MCF195 submission from MCO

Population: CCC PLUS and MEDALLION

4.1.5.1 Requirements

- For each accepted MCF195 file submission, MES will provide a MCF196 response file.
- For each accepted record, DMAS will provide a response file record.
- The MCF196 is a variable length file. i.e., The CRLF occurs after the last value in each record, and may vary based on the number of Reject Code(s) for each record.

4.1.5.2 MCF196 Field Specifications

FIELD	TYPE	LEN	BEG	END	ADDITIONAL INFO
MCO Service Center	CHAR	4	1	4	
Member Last Name	CHAR	19	5	23	
Member First Name	CHAR	12	24	35	
Member Medicaid ID	CHAR	12	36	47	
Member MCO ID	CHAR	20	48	67	
Member Phone	CHAR	10	68	77	
Member PCP Name	CHAR	40	78	117	
Member PCP NPI	CHAR	10	118	127	
Screen Completed Date	CHAR	10	128	137	
Response Code	CHAR	4	138	141	See valid values below.
Reject Code 1	CHAR	4	142	145	Refer to MCF195 File Specifications for descriptions of field level edits.
Reject Code 2	CHAR	4	146	149	
Reject Code 3	CHAR	4	150	153	
Reject Code 4	CHAR	4	154	157	
Reject Code 5	CHAR	4	158	161	
Reject Code 6	CHAR	4	162	165	
Reject Code 7	CHAR	4	166	169	
Reject Code 8	CHAR	4	170	173	
Reject Code 9	CHAR	4	174	177	
Reject Code 10	CHAR	4	178	181	

4.1.5.3 Response Codes Returned on MCF196

Response codes indicate the disposition/ status of each record submitted by the MCO

Code	Response Code Description
0001	Transaction successful, member determined to be medically complex, medically complex benefit added.
0002	Transaction successful, member determined to be medically complex, medically complex benefit already exists.
0003	Transaction successful, member determined to be medically complex, not Medicaid expansion eligible, no medically complex benefit added.
0004	Transaction successful, member determined to be not medically complex, no Medically complex benefit exists.
0005	Transaction successful, member determined to be not medically complex, existing medically complex benefit ended.
0006	Transaction successful, member determined to be not medically complex, not Medicaid expansion eligible, no medically complex benefit added.
0007	Transaction successful, member determined to be not medically complex, existing medically complex benefit voided.
0008	Could not process due to multiple submissions from one or more MCOs
9999	Transaction rejected, the fields received are in error, refer to rejection codes for more information.

4.1.5.4 Reject Codes Returned on MCF196

Reject Codes correspond to the field edits documented in the MCF195 file specifications.

4.1.6 Maternity Kick Payment Detail

Method: ISS

Format:

File Name: Per ISS File Naming Conventions

Schedule:

Population: CCC PLUS and MEDALLION Separate Reports

4.1.6.1 Requirements

Future development

4.2 From MCO to MES

4.2.1 Encounter Data Certification

Method:	EPS Portal
Format:	Online
File Name:	N/A
Due Date:	See below
Population:	CCC PLUS and MEDALLION Reported Separately

4.2.1.1 Requirements

This process for the data submission certification is submitted and certified online via the Encounter Processing System (EPS) Portal.

4.2.2 Payment Cycle Data

Method:	EPS Portal
Format:	Online
File Name:	N/A
Schedule:	See below
Population:	CCC PLUS and MEDALLION Reported Separately

4.2.2.1 Requirements

This process for the MCO payment cycle submissions is done online via the Encounter Processing System (EPS) Portal.

4.2.3 Provider PRSS PRN File Network Participation Updates

Method:	ISS
Format:	JSON
File Name:	Per ISS File Naming Conventions
Due Date:	Daily M-F at MCO discretion
Population:	CCC PLUS and MEDALLION

4.2.3.1 Requirements

Refer to current versions of the PRSS documents stored on MCO MES SharePoint sites:

- Virginia Provider Network PRN File Guide
- PRSS Provider Code Value Descriptions
- VA Crosswalk Legacy PT SPEC Taxonomy

4.2.4 PRSS NPPR Out of Network Provider Add Files

Method:	ISS
Format:	JSON
File Name:	Per ISS File Naming Conventions
Trigger:	Daily M-F at MCO discretion
Population:	CCC PLUS and MEDALLION Reported Separately

4.2.4.1 Requirements

Refer to current versions of the PRSS documents stored on MCO MES SharePoint sites:

- Virginia Provider NPPR File Guide
- PRSS Provider Code Value Descriptions
- VA Crosswalk Legacy PT SPEC Taxonomy

4.2.5 MMHS Member Screening Data Update (MCF195)

Method:	ISS
Format:	Fixed Length file per specifications below
File Name:	Per ISS File Naming Conventions
Schedule:	Daily M-F at MCO discretion
Population:	CCC PLUS and MEDALLION

4.2.5.1 Requirements

Service center values on every MCF195 record must match the submitter's service center login/ folder. If the service center value on any record does not match, the entire file will be rejected (i.e., not accepted for processing). When this happens, the MCO will receive a 'ERR' file containing the following message: "***MCS file has been received, but rejected: At least one record has been found where the Service Center number does not correspond to the account used to submit the file."***

Upon acceptance of each submitted MCF195 file, the MCO will receive an Acknowledgement file containing the following message: "**MCS file has been received and delivered to MMIS."**

MCS files are processed on a daily basis, Monday - Friday. The daily batch process performs screening determination and takes one of the following actions:

- Reject record for one or more validity edits.
- Assign a new medically complex benefit for the member.
- End date the existing medically complex benefit for the member.
- Continue existing benefit for the member.

Prior to processing, all records from all MCOs are sorted by member and Screening Completed Date (descending). DMAS will process only one record for each member per day (latest Screening Completed Date). Additional records received for the same member will not be processed, and will display response code '0008' in the return file.

If the first record processed fails any field level edits, the remaining records for that member will not be processed.

DMAS will send a response file (MCF196) to the MCOs for all the records received and processed. Each record will be assigned a response code indicating the outcome of members' medically complex determination, and will report the Reject Code(s) for any failed field edit(s).

MCF195 File Specifications

Field	Type	Len	Beg	End	Nbr	R/O	Edits	Reject Code / Error Message
HEADER FIELDS								
Service Center	CHAR	4	1	4		REQ	Must match the SC# of the submitter ID folder.	If the service center value on any record does not match to submitter SC#, the entire file will be rejected.
Member Last Name	CHAR	19	5	23		REQ	Must be present, no other edit	9001 – INVALID LAST NAME
Member First Name	CHAR	12	24	35		REQ	Must be present, no other edit	9002 – INVALID FIRST NAME
Medicaid ID	CHAR	12	36	47		REQ	Must be entered and on file	9003 – INVALID MEDICAID ID
MCO Member ID	CHAR	20	48	67		OPT	No edits	
Member Phone	CHAR	10	68	77		OPT	If entered, must be numeric	9004 – INVALID PHONE NUMBER
Member PCP	CHAR	40	78	117		OPT	No edits	
Member PCP NPI	CHAR	10	118	127		OPT	No edits	
Screening Date	DATE	10	128	137		REQ	Must contain a valid date Date must be <= process date Format = MM/DD/YYYY	9005 – INVALID SCREENING DATE
MEDICALLY COMPLEX CLASSIFICATION FIELDS								
Social Screening Only	CHAR	1	138	138	H.1	OPT	Must be Y, N or space	9006 – INVALID VALUES IN HEADER FIELDS
Unable to Contact	CHAR	1	139	139	H.2	OPT		
Refused to Answer	CHAR	1	140	140	H.3	OPT		
Attestation Complete	CHAR	1	141	141	H.4	OPT		
Cancer	CHAR	1	142	142	1.1	COND	If responses for questions H.1, H.2 and H.3 are all space or N, classification question responses must be Y or N If any of the responses for questions H.1, H.2, H.3 are Y, classification question responses must be Y, N or space If any classification question responses are Y or N, all must be Y or N If responses for questions H.1, H.2 and H.3 are all space or N, classification question responses must be Y or N	9007 – INVALID VALUES IN CLASSIFICATION SECTION 1
COPD	CHAR	1	143	143	1.2	COND		
Diabetes	CHAR	1	144	144	1.3	COND		
Heart Disease	CHAR	1	145	145	1.4	COND		
HIV	CHAR	1	146	146	1.5	COND		
ESRD	CHAR	1	147	147	1.6	COND		
Parkinson's	CHAR	1	148	148	1.7	COND		
Sickle Cell	CHAR	1	149	149	1.8	COND		
Brain Injury	CHAR	1	150	150	1.9	COND		
Transplant	CHAR	1	151	151	1.1	COND		
Other Disabling	CHAR	1	152	152	1.11	COND		
Bathing	CHAR	1	153	153	2.1	COND		9008 - INVALID VALUES IN CLASSIFICATION SECTION 2
Dressing	CHAR	1	154	154	2.2	COND		
Eating	CHAR	1	155	155	2.3	COND		
Toileting	CHAR	1	156	156	2.4	COND		
Walking	CHAR	1	157	157	2.5	COND		
Alcoholism	CHAR	1	158	158	3.1	COND		9009 - INVALID VALUES IN CLASSIFICATION SECTION 3

Field	Type	Len	Beg	End	Nbr	R/O	Edits	Reject Code / Error Message
Bipolar	CHAR	1	159	159	3.2	COND	If any of the responses for questions H.1, H.2, H.3 are Y, classification question responses must be Y, N or space If any classification question responses are Y or N, all must be Y or N	
Depression	CHAR	1	160	160	3.3	COND		
Panic	CHAR	1	161	161	3.4	COND		
PTSD	CHAR	1	162	162	3.5	COND		
Psychotic	CHAR	1	163	163	3.6	COND		
Schizophrenia	CHAR	1	164	164	3.7	COND		
Addiction	CHAR	1	165	165	3.8	COND		
Other Mental Health	CHAR	1	166	166	3.9	COND		
Condition Prevents	CHAR	1	167	167	4	COND		9010 - INVALID VALUES IN CLASS SECTION 4
Learning	CHAR	1	168	168	5.1	COND		9011 - INVALID VALUES IN CLASSIFICATION SECTION 5
Listening	CHAR	1	169	169	5.2	COND		
Living Alone	CHAR	1	170	170	5.3	COND		
Decisions	CHAR	1	171	171	5.4	COND		
Self-Care	CHAR	1	172	172	5.5	COND		
Travel	CHAR	1	173	173	5.6	COND		
SOCIAL DETERMINANTS FIELDS								
Have Housing	CHAR	1	174	174	1.1	OPT	Must be Y, N or space	9012 – INVALID VALUES IN SOCIAL SECTION 1
Losing Housing	CHAR	1	175	175	1.2	OPT		
Living Others	CHAR	1	176	176	1.3	OPT		
Living Hotel	CHAR	1	177	177	1.4	OPT		
Living Shelter	CHAR	1	178	178	1.5	OPT		
Living Outside	CHAR	1	179	179	1.6	OPT		
Housing No Answer	CHAR	1	180	180	1.7	OPT		
Needs Food	CHAR	1	181	181	2.1	OPT		9013 – INVALID VALUES IN SOCIAL SECTION 2
Needs Medicine	CHAR	1	182	182	2.2	OPT		
Needs Utilities	CHAR	1	183	183	2.3	OPT		
Needs Clothing	CHAR	1	184	184	2.4	OPT		
Needs Child Care	CHAR	1	185	185	2.5	OPT		
Needs Phone	CHAR	1	186	186	2.6	OPT		
Needs Health Care	CHAR	1	187	187	2.7	OPT		
Needs No Answer	CHAR	1	188	188	2.8	OPT		
Times Emergency	NUM	2	189	190	3	OPT	Must be number 00-99 or space Must provide leading zeroes	9014 – INVALID VALUES IN SOCIAL SECTION 3

Field	Type	Len	Beg	End	Nbr	R/O	Edits	Reject Code / Error Message
Times Fallen	NUM	2	191	192	4	OPT	Must be number 00-99 or space Must provide leading zeroes	9015 – INVALID VALUES IN SOCIAL SECTION 4
Transport Medical	CHAR	1	193	193	5.1	OPT	Must be Y, N or space	9016 – INVALID VALUES IN SOCIAL SECTION 5
Transport Non-medical	CHAR	1	194	194	5.2	OPT		
Transport No Issue	CHAR	1	195	195	5.3	OPT		
Transport No Answer	CHAR	1	196	196	5.4	OPT		
Caretaker Child	CHAR	1	197	197	6.1	OPT		9017 – INVALID VALUES IN SOCIAL SECTION 6
Caretaker Adult	CHAR	1	198	198	6.2	OPT		
Schooling	NUM	1	199	199	7	OPT	Must be number 1-7 or space 1 = HIGH-SCHOOL-NO-DIPLOMA 2 = HIGH-SCHOOL-DIPLOMA 3 = COLLEGE-NO-DEGREE 4 = CERTF-AFTER-SCHOOL 5 = ASSOCIATE-DEGREE 6 = BACHELORS-DEGREE 7 = CHOSE-NO-ANSWER	9018 – INVALID VALUES IN SOCIAL SECTION 7
Work	NUM	1	200	200	8	OPT	Must be number 1-5 or space 1 = HAVE-PART-TM-JOB 2 = HAVE-FULL-TIME-JOB 3= NO-JOB-LOOKING-4-ONE 4 = NO-JOB-NOT-LOOKING 6 = CHOSE-NOT-TO-ANSWER	9019 – INVALID VALUES IN SOCIAL SECTION 8
Like job	CHAR	1	201	201	9.1	OPT	Must be Y, N or space	9020 – INVALID VALUES IN SOCIAL SECTION 9
No Full Time	NUM	1	202	202	9.2	OPT		
Greater 40 Hours	CHAR	1	203	203	9.3	OPT		
No Job Offer	CHAR	1	204	204	9.4	OPT		
Help Finding Job	CHAR	1	205	205	9.5	OPT		
Fear Relative Caregiver	NUM	1	206	206	10	OPT	Must be number 1-4 or space 1 = YES 2 = NO 3 = UNSURE 4 = CHOSE-NOT-TO ANSWER	9021 – INVALID VALUES IN SOCIAL SECTION 10
Unmet needs	CHAR	1	207	207	11	OPT	Must be Y, N or space	9022 – INVALID VALUES IN SOCIAL SECTION 11

Field	Type	Len	Beg	End	Nbr	R/O	Edits	Reject Code / Error Message
Coordinator Contact	NUM	1	208	208	12	OPT	Must be number 1-5 or space 1 = FROM-1-30DAYS 2 = FROM-31-60DAYS 3 = FROM-61-90DAYS 4 = FROM-91-120DAYS 5 = NOT-CONTACT	9023 – INVALID VALUES IN SOCIAL SECTION 12

5 Operational Business Processes

5.1 MCO Reporting of Incarcerated Members to DMAS

Population: CCC PLUS and MEDALLION

DMAS: Managed Care Operations

5.1.1.1 Description

- MCO completes the Incarcerated Member form within 48 hours of identification. All required fields must be submitted in order to be processed.
- MCO submits completed form to DMAS via the DMAS secure FTP server.
- After receiving the MCO form, the DMAS Managed Care Contract Monitor creates a case record in the HCS Case Tracking System and assigns to Enrollment Analyst.
- Enrollment Analyst contacts facility to confirm incarceration and dates.
- After confirming member incarceration, the Enrollment Analyst retroactively cancels the member's managed care benefit based effective with the day before the date of incarceration.
- As necessary, the Enrollment Analyst will exempt the member from future managed care enrollment.
- The DMAS Eligibility and Enrollment Unit (EEU) will notify the member, close Medicaid eligibility (advanced notice is not required for these individuals), and notify the appropriate DSS Supervisor and DSS Regional Eligibility Specialist of the case closure. EEU will also handle any appeals regarding the enrollee's Medicaid cancellation.
- If the recipient WAS incarcerated but has already been released by the time DMAS receives the information, or is to be released within the month in question, then no action will be taken to end the MCO enrollment or the Medicaid coverage. The case will be referred on to the DMAS Recipient Audit Unit (RAU) for follow-up on any claims/encounters paid during the period of incarceration.

5.2 Newborn Reconciliation

Population: CCC PLUS and MEDALLION

DMAS: Newborns

5.2.1.1 Description

The Cardinal Care Managed Care Contract requires the MCO to cover MCO (live birth) newborns for the birth month plus two additional months when the mother was enrolled in the MCO on the newborn's date of birth. The newborn reconciliation process provides an offline payment to the MCO for newborns when a capitation payment was not made through the MMIS on the 820 payment report. The reconciliation process occurs after the newborn turns age one.

The newborn MCO enrollment process updates the mother's MCO benefit on the newborn's ID. In order for this to occur, the mother's ID must be associated with the newborn ID in the MMIS. Once the association is made between the mother and the newborn, the MMIS will update the MCO benefit for the newborn and the capitation payment is made through the MMIS on the 820 payment report. DMAS utilizes your Live Birth report to identify these newborns to create the linkage and generate the payment through the MMIS 820 reimbursement process. Timely and accurately submission of the Live Birth report provides DMAS staff the opportunity to identify enrolled newborns and connect the mother ID allowing most payments to be made through the MMIS prior to the newborn turning age one. Once a newborn turns age one, the MMIS is not able to up the MCO benefit retroactively for the birth month+2.

There are some instances where even when the linkage is made between the mother and newborn, and the newborn has eligibility coverage in the MMIS that the MCO benefit is not updated for the newborn. The primary reason is that the newborn has other insurance (TPL) and MMIS edits will not allow managed care benefits to update with certain TPL coverages. Regardless if the MCO benefit is not updated on the newborn ID, the MCO is responsible for the newborn for the birth month+2 and payment will be processed through the reconciliation process.

Newborn Payment Calculation

For standardization and consistency, missing payments for the newborn reconciliation are calculated as follows:

- Newborn has eligibility in the MMIS:Payment is calculated using:
  - ❖ Newborn's MMIS AC for the month in which the payment is missing and
  - ❖ FIPS code for the Mother ID in the MMIS on newborn's DOB

- ❖ Newborn has no eligibility in the MMIS (Newborn ID not found):
  - ➢ DMAS will validate the live birth by verifying that an encounter was submitted by the MCO for the Mother ID for a live birth delivery
  - ➢ Payment is calculated using:
  - ❖ Mother ID's AC on Newborn DOB,
    - ⅄ If AC is Medicaid – AC 093 is used for payment,
    - ⅄ If AC is 005 or 009 (FAMIS) – AC 008 is used for payment,

- If AC is 007 (FAMIS) – AC 006 is used for payment

- FIPS code for Mother ID on the newborn DOB submitted by the MCO

A payment will not be processed for the following reasons:

- Newborn enrollment was cancelled for death and the date of death was in month prior to the birth month+2. Payment is made for partial month enrollment.
  - **Example:** DOB is 7/15/2012, date of death is 8/02/2012. The reconciliation process would issue a payment for 7/2012 and 8/2012 if a payment was not made by the MMIS. No payment is made for 9/2012.
  - Newborn changed MCOs after the BM1 and was enrolled in a different MCO for BM2 and/or BM3 Payment is not made for BM2 and/or BM3 to the MCO that the mother was enrolled in on the newborns DOB BM1.
  - **Example:** Mother was enrolled in MCO A on newborns DOB. Newborn enrolled in MCO A for BM1. Newborn/mother chose different MCO and was enrolled in MCO B for BM2 and BM3. No payment is made to MCO A for BM2 or BM3.
  - Mother ID submitted not enrolled in MCO on Newborn DOB
  - Newborn not enrolled in MMIS on DOB submitted. Newborn DOB submitted by MCO does not match MMIS DOB, month is different. MCO needs to resubmit on the correct monthly report.
  - Newborn ID not found in the MMIS and a paid encounter was not submitted by the MCO for a live birth delivery for the Mother ID.

- The MCO can submit a response and include the reference number for the paid live birth encounter in the comment field. DMAS will research the reference number and if the live birth is verified, correct the NB_Recon_Return_yyyymm to include the payment information. A new Certification form will be included to reflect the corrected offline payment amount.

-

Newborn Reconciliation Processing

The newborn reconciliation process consists of a monthly **NB_Recon_yyyymm** file submission from the MCO identifying newborns where a payment was not made on the MMIS 820 payment report. DMAS will validate the data submitted and return the **NB_Recon_Return_yyyymm** file to the MCO. The **Newborn Reconciliation Certification** is included with the return file. The Certification identifies the payment amount that will be processed for the MCO for newborns included on the reconciliation **NB_Recon_Return_yyyymm** file. The payment amount will be broken down into 2 payments, one for Medicaid and one for FAMIS and the total. Once the Certification is signed by the MCO and received by DMAS, the payment will be processed. The MCO will receive 2 checks one for the Medicaid amount and one for the FAMIS amount.

MCO Newborn Reconciliation File (NB_Recon_yyyymm)

- Report <u>all newborn live births</u> that occurred during the reporting period where payment was not received for the Birth Month (BM1), and/or Birth Month+1 (BM2), and/or Birth Month+2 (BM3).

DMAS Newborn Reconciliation Return File (NB_Recon_Return_yyyymm)

- DMAS will validate the report against MMIS enrollment and payment information and provide a return file to the MCO indicating that: (1) a payment was made by the MMIS,

(2) an Offline payment will be made with the calculated amount, or, (3) a payment will not be processed.

MCO Response to DMAS Newborn Reconciliation Return File (NB_Recon_Return_yyyymm)

- The MCO may submit a response file by email and include information in the MCO Comment field for any newborn where payment was not received. Information shall provide the reference number for the paid encounter submitted for the mother for the live birth so that DMAS can research and verify the delivery. Once DMAS has researched the information provided by the MCO, either a new DMAS Newborn Reconciliation Return File will be generated with the revised payment amount or an email response will be sent.
-

Newborn Reconciliation Payment

The Add pay will be processed when the signed Certification is received. 2 payments will be processed, one for the Medicaid payment amount and one for the FAMIS payment amount.

5.3 Capitation Reconciliation

Population: CCC PLUS and MEDALLION

DMAS:

5.3.1.1 Description

Future development

5.4 Performance Withhold Program

Population:	CCC PLUS and MEDALLION
DMAS:	VBP

5.4.1.1 Description

The PWP includes measures designed to evaluate Managed Care quality by setting performance standards and expectations for Contractors in key areas influencing member health and health outcomes. The PWP utilizes a financial incentive structure withholding a set percentage of the Contractor's PMPM capitation rate system payments that the Contractor can subsequently earn back based on performance attainment or improvement against the designated measures. By tying financial incentives to Contractor performance on designated quality measures, the PWP focuses performance attainment and improvement efforts on areas of high importance to members.

The Department contracts with its EQRO to implement the methodology for validation and performance assessment of all metrics included in the PWP. The Contractor is required to provide the EQRO full access to documentation, data, and other information the EQRO deems necessary to validate the Contractor's reported scores. The scoring structure and processes are distributed as part of the Cardinal Care Technical Manual and can also be found on the Department's VBP website.

The PWP withhold percentage is one percent (1%) of the Contractors' PMPM capitation rate system payments. Consistent with the methodology developed with the EQRO, the Department will determine the portion of the withhold each Contractor can earn back based on the extent to which the Contractor's performance compares favorably against benchmarks set for each measure.

PWP Measures

Indicator	Measure Specification Source	Required Reporting Method
*Asthma Admission Rate (per 100,000 Member Months [MM])**	AHRQ PQI	Administrative
Child and Adolescent Well-Care Visits—Total	HEDIS	Administrative
Childhood Immunization Status—Combination 3	HEDIS	Hybrid
*Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (per 100,000 MM)—Total**	CMS Adult Core Set	Administrative
Comprehensive Diabetes Care Composite— Blood Pressure Control for Patients With Diabetes—Total, Eye Exam for Patients With Diabetes—Total, HbA1c Control (<8.0%)—Total and *HbA1c Poor Control (>9.0%)—Total**[2]	HEDIS	Hybrid
Follow-Up After Emergency Department (ED) Visit for Alcohol and Other Drug (AOD) Abuse or Dependence—7-Day Follow-Up—Total and 30-Day Follow-Up— Total	HEDIS	Administrative
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*	HEDIS	Administrative

Indicator	Measure Specification Source	Required Reporting Method
*Heart Failure Admission Rate (per 100,000 MM)—Total**	CMS Adult Core Set	Administrative
Initiation and Engagement of Substance Use Disorder (SUD) Treatment—Initiation of SUD Treatment and *Engagement of SUD Treatment*	HEDIS	Administrative
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	HEDIS	Hybrid

The Department reserves the right to amend the measures included under the PWP composite in future years and may further amend performance thresholds associated with satisfactory performance, the withhold percentage, and other features necessary for implementation of the PWP at its discretion and will make any such changes to the PWP known to Contractors and the public through adjustments to the Cardinal Care Managed Care program Contract and PWP methodology documents posted on the Department's VBP website.

6 Appendix

6.1 Managed Care Aid Categories

Aid Cat	Description	CCC PLUS	Medallion
005	FAMIS MOMS-INC>133% FPL & INC<=166%	N/A	5,204
006	FAMIS Child under age 6, income >150% poverty AND <=200% poverty	N/A	15,427
007	FAMIS Child 6-19 years OLD, income >150% poverty AND <=200% poverty	N/A	53,081
008	FAMIS Child under age 6, income>133% poverty AND <=150% poverty	N/A	2,069
009	FAMIS Child 6-19 years OLD, income>133% poverty AND <=150% poverty	N/A	6,133
010	FAMIS DEEMED NEWBORN AT OR BELOW 150%FPL	N/A	2,288
011	C/N-SSI/QMB AGED	34,254	N/A
012	C/N-AG/QMB AGED	1,138	N/A
014	FAMIS DEEMED NEWBORN ABOVE 150% FPL	N/A	1,361
018	M/N-AGED NOT QMB	1,468	N/A
020	C/NNMP-INST/AGED	10,104	N/A
021	C/NNMP-QMB/AGED	293	N/A
022	C/NNMP-INST/AQMB	4,436	N/A
024	M/N-AGED SLMB PLUS	24	N/A
025	300% SSI AGED SLMB PLUS	3,836	N/A
028	M/N-AGED/DUAL ELIG	25	N/A
029	AGED POVERTY-RELATED GROUP	25,286	N/A
031	C/N-SSI/QMB BLIND	530	N/A
032	C/N-AG/QMB BLIND	4	N/A
038	M/N-BLIND NOT QMB	1	N/A
039	BLIND POVERTY-RELATED GROUP	111	N/A
040	C/NNMP-INST/BLIND	16	N/A
041	C/NNMP-QMB/BLIND	25	N/A
042	C/NNMP-INST/QMB	15	N/A
044	M/N-BLIND/DISABLED SLMB PLUS	244	N/A
045	300% SSI BLIND/DISABLED SLMB PLUS	2,436	N/A
048	M/N-BLIND/DUAL-ELG	1	N/A
049	DISABLED POVERTY-RELATED GROUP	13,705	N/A
051	C/N-SSI/QMB-DISAB	113,231	N/A
052	C/N-AG/QMB-DISAB	1,559	N/A
054	HOSPICE PATIENTS	3	N/A
058	M/N-DISAB/NOT-QMB	260	N/A
059	MEDICAID WORKS	45	N/A
060	C/NNMP-INST/DISAB	10,149	N/A
061	C/NNMP-QMB DISAB	2,468	N/A
062	C/NNMP-INST/DQMB	3,278	N/A
066	BCCPTA INDIVIDUAL	839	N/A
068	M/N-DISAB/DUAL-ELG	76	N/A
070	FORMER FOSTER CARE	82	2,003
072	C/NNMP-NON4E CHLD	337	9,055
076	C/N/NMP NON4E	51	5,661
081	C/NNMP-LIFC QMB	1,682	107,537

Aid Cat	Description	CCC PLUS	Medallion
082	C/NNMP-INST/CHILD	5	N/A
083	C/NNMP LIFC-UP	772	46,174
088	M/N-ADC	1	N/A
090	C/N-AFDC (TANF)	12	29,630
091	M/I-PREG.WOMN/CHLD	367	159,663
092	C/NNMP CHILD 6-19	476	391,138
093	C/NNMP-LT-1	39	66,973
094	CN/NMP CHILD 6-19 INC 100-133% FPL	76	92,817
100	CARETAKER ADULT, LE 100% FPL GT LIFC	3,360	83,971
101	CARETAKER ADULT, GT 100% FPL	2,061	66,330
102	CHILDLESS ADULTS, LE 100% FPL	46,099	332,799
103	CHILDLESS ADULTS, GT 100% FPL	6,806	70,062

Values as of 04/01/2022

6.2 Language Code Values

Code	Language
AA	Afar
AB	Abkhaz
AE	Avestan
AF	Afrikaans
AK	Akan
AM	Amharic
AN	Aragonese
AR	Arabic
AS	Assamese
AV	Avaric
AY	Aymara
AZ	Azerbaijani
BA	Bashkir
BE	Belarusian
BG	Bulgarian
BH	Bihari
BI	Bislama
BM	Bambara
BN	Bengali, Bangla
BO	Tibetan Standard, Tibetan, Central
BR	Breton
BS	Bosnian
CA	Catalan
CE	Chechen
CH	Chamorro
CO	Corsican
CR	Cree
CS	Czech
CU	Church Slavonic, Old Bulgarian
CV	Chuvash
CY	Welsh
DA	Danish
DE	German
DV	Divehi, Dhivehi, Maldivian
DZ	Dzongkha
EE	Ewe
EL	Greek (modern)
EN	English

Code	Language
EO	Esperanto
ES	Spanish
ET	Estonian
EU	Basque
FA	Persian (Farsi)
FF	Fula, Fulah, Pulaar, Pular
FI	Finnish
FJ	Fijian
FO	Faroese
FR	French
FY	Western Frisian
GA	Irish
GD	Scottish Gaelic, Gaelic
GL	Galician
GN	Guaraní
GU	Gujarati
GV	Manx
HA	Hausa
HE	Hebrew (modern)
HI	Hindi
HO	Hiri Motu
HR	Croatian
HT	Haitian, Haitian Creole
HU	Hungarian
HY	Armenian
HZ	Herero
IA	Interlingua
ID	Indonesian
IE	Interlingue
IG	Igbo
II	Nuosu
IK	Inupiaq
IO	Ido
IS	Icelandic
IT	Italian
IU	Inuktitut
JA	Japanese
JV	Javanese

Code	Language
KA	Georgian
KG	Kongo
KI	Kikuyu, Gikuyu
KJ	Kwanyama, Kuanyama
KK	Kazakh
KL	Kalaallisut, Greenlandic
KM	Khmer
KN	Kannada
KO	Korean
KR	Kanuri
KS	Kashmiri
KU	Kurdish
KV	Komi
KW	Cornish
KY	Kyrgyz
LA	Latin
LB	Luxembourgish, Letzeburgesch
LG	Ganda
LI	Limburgish, Limburgan, Limburger
LN	Lingala
LO	Lao
LT	Lithuanian
LU	Luba-Katanga
LV	Latvian
MG	Malagasy
MH	Marshallese
MI	Maori
MK	Macedonian
ML	Malayalam
MN	Mongolian
MR	Marathi (Mara?hi)
MS	Malay
MT	Maltese
MY	Burmese
NA	Nauruan
NB	Norwegian Bokmål
ND	Northern Ndebele

Code	Language
NE	Nepali
NG	Ndonga
NL	Dutch
NN	Norwegian Nynorsk
NO	Norwegian
NR	Southern Ndebele
NV	Navajo, Navaho
NY	Chichewa, Chewa, Nyanja
OC	Occitan
OJ	Ojibwe, Ojibwa
OM	Oromo
OR	Oriya
OS	Ossetian, Ossetic
PA	Panjabi, Punjabi
PI	Pali
PL	Polish
PS	Pashto, Pushto
PT	Portuguese
QU	Quechua
RC	Reunionese, Reunion Creole
RM	Romansh
RN	Kirundi
RO	Romanian
RU	Russian
RW	Kinyarwanda
SA	Sanskrit (Sa?sk?ta)
SC	Sardinian
SD	Sindhi
SE	Northern Sami
SG	Sango
SI	Sinhalese, Sinhala
SK	Slovak
SL	Slovene
SM	Samoan
SN	Shona
SO	Somali
SQ	Albanian
SR	Serbian
SS	Swati
ST	Southern Sotho

Code	Language
SU	Sundanese
SV	Swedish
SW	Swahili
TA	Tamil
TE	Telugu
TG	Tajik
TH	Thai
TI	Tigrinya
TK	Turkmen
TL	Tagalog
TN	Tswana
TO	Tonga (Tonga Islands)
TR	Turkish
TS	Tsonga
TT	Tatar
TW	Twi
TY	Tahitian
UG	Uyghur
UK	Ukrainian
UR	Urdu
UZ	Uzbek
VE	Venda
VI	Vietnamese
VO	Volapük
WA	Walloon
WO	Wolof
XH	Xhosa
YI	Yiddish
YO	Yoruba
ZA	Zhuang, Chuang
ZH	Chinese
ZU	Zulu

6.3 Requirement for Submission Upon Material Change

Where the Cardinal Care Contract or this Technical Manual require submission of a deliverable upon a 'material change' to such deliverable, the following definition of 'material change' applies:

A 'material change' is a change to the policy or procedure that:

(a) Alters the timeframes in which an activity or process is performed;

(b) Inserts or removes a level of review by the plan;

(c) Has the ability to negatively impact member's rights under the Contract or could cause Member harm;

(d) Has the ability to negatively impact provider's rights under the Contract; or

(e) Any other substantive change to member or provider facing materials.

A 'material change' would not include, for instance, a change to the name of the person performing a specific function, the numbering of the policy or procedure, or non-substantive grammatical changes.

6.4 Creating Comma Separated Value (CSV) File Using Excel

Comma-delimited files are text files in which data is separated by commas. Listed below are instructions on how to manually create .csv files from Excel.

- Open your Excel file in Excel.
- Choose ‘Save As’ from the Office button in the top upper left of the application window.
- Select ‘CSV (Comma Delimited) (*.csv)’ as the type.
- Enter the file name in the ‘File Name’ box.
- Click ‘Save’.

6.5 Inserting a PDF into a Word Document

These steps shall be used when submitting track changes version of documents and general Word documents. Insert the required submission form into the Word document to submit marketing materials as one submission for review.

1. Click **Insert** on the Toolbar
2. Select **Object**
3. Select **Text from File**
4. Select **Create from File**
5. Select **Browse** to select PDF document
6. Select **Insert**
7. Click **Ok** to insert into Word document

6.6 Medicaid Expansion Member Health Screening Form / Questions

MCO Member Health Screening

Header Fields

Member Last Name: _____
Member First Name: _____
*Member Medicaid ID #: _____
Member ID # (plan): _____
Member Contact/Phone: _____
Member Primary Care Provider: _____
Member Primary Care Provider NPI: _____
*Date Screening Completed: _____
(* fields will be validated and errors returned to plan for correction)

Unable to Contact Member	
Member Refused to Answer	
Member Complexity Attestation Completed	

PART 1- Medically Complex Classification Questions:

Question 1: Has a doctor, nurse, or health care provider told you that you had/have any of the following (**please check all applicable boxes**):

	Cancer (Active)
	COPD or Emphysema
	Diabetes
	Heart Disease, heart attack, heart failure (weak heart)
	HIV or AIDS
	Kidney Failure or End Stage Renal Disease (ESRD)
	Parkinson's Disease
	Sickle Cell Disease
	Stroke, Brain Injury or Spinal Injury
	Transplant or on a transplant wait list
	Other chronic (long term) disabling condition – **IF YES, Member Complexity Attestation must be completed**

Question 2: Do any of the chronic conditions you checked above impact your ability to do everyday things **AND** require you to receive assistance with any of the following (**please check all applicable boxes**):

	Bathing
	Dressing
	Eating
	Using the bathroom
	Walking

Question 3: Has a doctor, nurse or health care provider told you that you had/have any of the following (please check all applicable boxes):

	Alcoholism
	Bipolar Disorder or Mania
	Depression
	Panic Disorder
	Post-Traumatic Stress Disorder (PTSD)
	Psychotic Disorder
	Schizophrenia or Schizoaffective Disorder
	Substance Use Disorder or Addiction
	Other chronic (long term) mental health condition – **IF YES, Member Complexity Attestation must be completed**

Question 4: Do any of the conditions you selected above keep you from doing everyday things?

Yes	No

Question 5: Do you have an intellectual or developmental disability and require help with any of the following: (**please check all applicable boxes**):

	Learning or Problem-Solving
	Listening or Speaking
	Living on your own
	Making decisions about your health or well-being
	Self-Care (bathing, grooming, eating)
	Travel/Transportation (driving, taking the bus)

PART 2 - Social Determinants of Health and Health Risk Assessment Triage Questions:

QUESTION 1: What is your housing situation today?

	I have housing		
	Yes	No	I am worried about losing my housing
	I do not have housing (**check all that apply**)		
			Staying with others
			Living in a hotel
			Living in a shelter
			Living outside (on the street, on a beach, in a car, or in a park)
	I choose not to answer this question		

QUESTION 2(a): In the past **three (3) months**, did you worry whether your food would run out before you got money to buy more?

Yes	No

QUESTION 2(b): In the past **thirty (30) days**, have you or any family members you live with been **unable** to get any of the following when it was **really needed**? **Check all that apply.**

Yes	No	Prescription Drugs or Medicine
Yes	No	Utilities
Yes	No	Clothing
Yes	No	Child Care
Yes	No	Phone
Yes	No	Health Care (doctor appointment, mental health services, addiction treatment)
		I choose not to answer this question

QUESTION 3: How many times have you been in the Emergency Room or a hospital in the last 90 days for one of the conditions you listed earlier? _____ (enter number from 0-99)

QUESTION 4: How many times have you had a fall in the last 90 days and needed to visit a doctor, Emergency Room, or hospital because of the fall? _____ (enter number from 0-99) **(Adult Population Question)**

QUESTION 5: Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? **Check all that apply.**

	Yes it has kept me from medical appointment or from getting my medications
	Yes it has kept me from non-medical meetings, appointments, work, or from getting things that I need
	No
	I choose not to answer this question

QUESTION 6: Caregiver Status **(Adult Population Question)**

Yes	No	Do you live with at least one child under the age of 19, AND are you the main person taking care of this child?
Yes	No	Do you live with and are you the primary caretaker of an adult who requires assistance with bathing, dressing, walking, eating, or using the bathroom?

QUESTION 7: What is the highest level of school that you have finished? **(Adult Population Question)**

	Some high school but no diploma
	High school diploma or equivalency (GED)
	Some college but no degree
	Workforce Credential or Industry Certification after High School
	Associate's Degree
	Bachelor's Degree or higher
	I choose not to answer this question

QUESTION 8: Do you have a job? **(Adult Population Question)**

	I have a part-time or temporary job
	I have a full time job
	I do not have a job and am looking for one
	I do not have a job and I am not looking for one
	I choose not to answer this question

QUESTION 9: Do you like your current job? **(Adult Population Question)**

Yes	No	Yes, I like my job
Yes	No	I must work more than one job because I can't find a full time job
Yes	No	I work more than 40 hours per week at two or more part time jobs
Yes	No	I have been looking for a job for more than 3 months and I have not been offered a job
Yes	No	I would like help finding a job that I like more or pays more money

QUESTION 10: In the past year have you been afraid of your partner, ex-partner, family member, or caregiver (paid or unpaid)?

	Yes
	No
	Unsure
	I choose not to answer this question

QUESTION 11: Do you have other important health issues or needs that you would like to discuss with someone?

	Yes
	No

QUESTION 12: How soon do you want to be contacted by someone to discuss your health issues or needs?

	1-30 Days
	31-60 Days
	61-90 Days
	91-120 Days
	Do not contact me

6.7 Network Adequacy PT PS Taxonomy and Sub-Class

Use latest taxonomy values published by Washington Publishing Company.

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
020 Physician	060 Internal Medicine	Ltd	207RA0002X Adult Congenital Heart Disease		Adult Primary Care
020 Physician	060 Internal Medicine	Ltd	207KI0005X Clinical & Laboratory Immunology		Adult Primary Care
020 Physician	060 Internal Medicine	Ltd	207R00000X Internal Medicine		Adult Primary Care
020 Physician	060 Internal Medicine	Ltd	207RB0002X Obesity Medicine		Adult Primary Care
020 Physician	060 Internal Medicine	Ltd	207RC0000X Cardiovascular Disease		Adult Primary Care
020 Physician	060 Internal Medicine	Ltd	207RC0001X Clinical Cardiac Electrophysiology		Adult Primary Care
020 Physician	060 Internal Medicine	Ltd	207RC0200X Critical Care Medicine		Adult Primary Care
020 Physician	060 Internal Medicine	Ltd	207RE0101X Endocrinology, Diabetes & Metabolism		Adult Primary Care
020 Physician	060 Internal Medicine	Ltd	207RG0100X Gastroenterology		Adult Primary Care
020 Physician	060 Internal Medicine	Ltd	207RH0000X Hematology		Adult Primary Care
020 Physician	060 Internal Medicine	Ltd	207RH0002X Hospice and Palliative Medicine		Adult Primary Care
020 Physician	060 Internal Medicine	Ltd	207RH0003X Hematology & Oncology		Adult Primary Care
020 Physician	060 Internal Medicine	Ltd	207RH0005X Hypertension Specialist		Adult Primary Care
020 Physician	060 Internal Medicine	Ltd	207RI0001X Clinical & Laboratory Immunology		Adult Primary Care
020 Physician	060 Internal Medicine	Ltd	207RI0008X Hepatology		Adult Primary Care
020 Physician	060 Internal Medicine	Ltd	207RI0011X Interventional Cardiology		Adult Primary Care
020 Physician	060 Internal Medicine	Ltd	207RI0200X Infectious Disease		Adult Primary Care
020 Physician	060 Internal Medicine	Ltd	207RM1200X Magnetic Resonance Imaging (MRI)		Adult Primary Care
020 Physician	060 Internal Medicine	Ltd	207RN0300X Nephrology		Adult Primary Care
020 Physician	060 Internal Medicine	Ltd	207RP1001X Pulmonary Disease		Adult Primary Care
020 Physician	060 Internal Medicine	Ltd	207RR0500X Rheumatology		Adult Primary Care
020 Physician	060 Internal Medicine	Ltd	207RS0010X Sports Medicine		Adult Primary Care
020 Physician	060 Internal Medicine	Ltd	207RS0012X Sleep Medicine		Adult Primary Care
020 Physician	060 Internal Medicine	Ltd	207RT0003X Transplant Hepatology		Adult Primary Care
020 Physician	060 Internal Medicine	Ltd	207RX0202X Medical Oncology		Adult Primary Care
020 Physician	066 Pathology	Ltd	207ZM0300X Medical Microbiology		Adult Primary Care
023 Nurse Practitioner	309 Primary Care	Ltd	363LP2300X Primary Care		Primary Care Provider
020 Physician	560 Clinical Pharmacology	Ltd	208U00000X Clinical Pharmacology		Pharmacy
060 Pharmacy	168 Pharmacy Services	Ltd	333600000X Pharmacy		Pharmacy
060 Pharmacy	168 Pharmacy Services	Ltd	3336C0002X Clinic Pharmacy		Pharmacy
060 Pharmacy	168 Pharmacy Services	Ltd	3336C0003X Community/Retail Pharmacy		Pharmacy
060 Pharmacy	168 Pharmacy Services	Ltd	3336C0004X Compounding Pharmacy		Pharmacy
060 Pharmacy	168 Pharmacy Services	Ltd	3336H0001X Home Infusion Therapy Pharmacy		Pharmacy
060 Pharmacy	168 Pharmacy Services	Ltd	3336I0012X Institutional Pharmacy		Pharmacy
061 Pharmacy-Long Term Care	169 Unit Dose Pharmacy	Ltd	3336L0003X Long Term Care Pharmacy		Pharmacy
268 Pharmacist	268 Pharmacist	Ltd	183500000X Pharmacist		Pharmacy
268 Pharmacist	268 Pharmacist	Ltd	1835C0205X Critical Care - Pharmacist		Pharmacy

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
268 Pharmacist	268 Pharmacist	Ltd	1835G0303X Geriatric - Pharmacist		Pharmacy
268 Pharmacist	268 Pharmacist	Ltd	1835N0905X Nuclear - Pharmacist		Pharmacy
268 Pharmacist	268 Pharmacist	Ltd	1835N1003X Nutrition Support - Pharmacist		Pharmacy
268 Pharmacist	268 Pharmacist	Ltd	1835P0018X Pharmacist Clinician / Clinical Pharmacy Specialist		Pharmacy
268 Pharmacist	268 Pharmacist	Ltd	1835P0200X Pediatrics - Pharmacist		Pharmacy
268 Pharmacist	268 Pharmacist	Ltd	1835P1200X Pharmacotherapy		Pharmacy
268 Pharmacist	268 Pharmacist	Ltd	1835P1300X Psychiatric Pharmacist		Pharmacy
268 Pharmacist	268 Pharmacist	Ltd	1835P2201X Ambulatory Care Pharmacist		Pharmacy
268 Pharmacist	268 Pharmacist	Ltd	1835X0200X Oncology - Pharmacist		Pharmacy
268 Pharmacist	268 Pharmacist	Ltd	183700000X Pharmacy Technician		Pharmacy
020 Physician	067 Pediatrician	Ltd	2080C0008X Child Abuse Pediatrics		Pediatric Specialist
020 Physician	067 Pediatrician	Ltd	2080I0007X Clinical & Laboratory Immunology		Pediatric Specialist
020 Physician	067 Pediatrician	Ltd	2080N0001X Neonatal-Perinatal Medicine		Pediatric Specialist
020 Physician	067 Pediatrician	Ltd	2080P0008X Neurodevelopmental Disabilities		Pediatric Specialist
020 Physician	067 Pediatrician	Ltd	2080P0201X Pediatric Allergy/Immunology		Pediatric Specialist
020 Physician	067 Pediatrician	Ltd	2080P0202X Pediatric Cardiology		Pediatric Specialist
020 Physician	067 Pediatrician	Ltd	2080P0203X Pediatric Critical Care Medicine		Pediatric Specialist
020 Physician	067 Pediatrician	Ltd	2080P0204X Pediatric Emergency Medicine		Pediatric Specialist
020 Physician	067 Pediatrician	Ltd	2080P0206X Pediatric Gastroenterology		Pediatric Specialist
020 Physician	067 Pediatrician	Ltd	2080P0207X Pediatric Hematology-Oncology		Pediatric Specialist
020 Physician	067 Pediatrician	Ltd	2080P0208X Pediatric Infectious Diseases		Pediatric Specialist
020 Physician	067 Pediatrician	Ltd	2080P0210X Pediatric Nephrology		Pediatric Specialist
020 Physician	067 Pediatrician	Ltd	2080P0214X Pediatric Pulmonology		Pediatric Specialist
020 Physician	067 Pediatrician	Ltd	2080P0216X Pediatric Rheumatology		Pediatric Specialist
020 Physician	067 Pediatrician	Ltd	2080S0010X Sports Medicine		Pediatric Specialist
020 Physician	067 Pediatrician	Ltd	2080S0012X Sleep Medicine		Pediatric Specialist
020 Physician	067 Pediatrician	Ltd	2080T0002X Medical Toxicology		Pediatric Specialist
020 Physician	067 Pediatrician	Ltd	2080T0004X Pediatric Transplant Hepatology		Pediatric Specialist
020 Physician	260 Emergency Medicine	Ltd	207PP0204X Pediatric Emergency Medicine		Pediatric Primary Care
020 Physician	053 Family Practitioner	Ltd	207QA0000X Adolescent Medicine		Pediatric Primary Care
020 Physician	060 Internal Medicine	Ltd	207RA0000X Adolescent Medicine		Pediatric Primary Care
020 Physician	067 Pediatrician	Ltd	208000000X Pediatrics		Pediatric Primary Care
020 Physician	067 Pediatrician	Ltd	2080A0000X Adolescent Medicine		Pediatric Primary Care
020 Physician	067 Pediatrician	Ltd	2080B0002X Obesity Medicine		Pediatric Primary Care
020 Physician	067 Pediatrician	Ltd	2080P0205X Pediatric Endocrinology		Pediatric Primary Care
023 Nurse Practitioner	024 Pediatric	Ltd	363LP0200X Pediatric		Pediatric Primary Care
023 Nurse Practitioner	024 Pediatric	Ltd	363LP0222X Pediatrics, Critical Care		Pediatric Primary Care
356 Behavioral Health Clinic	141 Behavioral Health Clinic	Mod	261QM0855X Adolescent and Children Mental Health		Pediatric Behavioral Health
456 Behavioral Health Clinic	141 Behavioral Health Clinic	Mod	261QM0855X Adolescent and Children Mental Health		Pediatric Behavioral Health
020 Physician	053 Family Practitioner	Ltd	207QH0002X Hospice and Palliative Medicine		Other Specialist
020 Physician	067 Pediatrician	Ltd	2080H0002X Hospice and Palliative Medicine		Pediatric Specialist

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
020 Physician	174 Medical Genetics	Ltd	207SC0300X Clinical Cytogenetics		Other Specialist
020 Physician	174 Medical Genetics	Ltd	207SG0201X Clinical Genetics, MD		Other Specialist
020 Physician	174 Medical Genetics	Ltd	207SG0202X Clinical Biochemical Genetics		Other Specialist
020 Physician	174 Medical Genetics	Ltd	207SG0203X Clinical Molecular Genetics		Other Specialist
020 Physician	174 Medical Genetics	Ltd	207SG0205X Ph.D. Medical Genetics		Other Specialist
020 Physician	360 Neuromusculoskeletal Med	Ltd	204R00000X Electrodiagnostic Medicine		Other Specialist
020 Physician	066 Pathology	Ltd	207SM0001X Molecular Genetic Pathology		Other Specialist
020 Physician	273 Transplant Surgery	Ltd	204F00000X Transplant Surgery		Other Specialist
020 Physician	059 Dermatologist	Ltd	207N00000X Dermatology		Other Specialist
020 Physician	059 Dermatologist	Ltd	207ND0101X MOHS-Micrographic Surgery		Other Specialist
020 Physician	059 Dermatologist	Ltd	207ND0900X Dermatopathology		Other Specialist
020 Physician	059 Dermatologist	Ltd	207NI0002X Clinical & Laboratory Dermatological Immunology		Other Specialist
020 Physician	059 Dermatologist	Ltd	207NP0225X Pediatric Dermatology		Pediatric Specialist
020 Physician	059 Dermatologist	Ltd	207NS0135X Procedural Dermatology		Other Specialist
020 Physician	260 Emergency Medicine	Ltd	207P00000X Emergency Medicine		Other Specialist
020 Physician	260 Emergency Medicine	Ltd	207PE0004X Emergency Medical Services		Other Specialist
020 Physician	260 Emergency Medicine	Ltd	207PE0005X Undersea and Hyperbaric Medicine		Other Specialist
020 Physician	260 Emergency Medicine	Ltd	207PH0002X Hospice and Palliative Medicine		Other Specialist
020 Physician	260 Emergency Medicine	Ltd	207PS0010X Sports Medicine		Other Specialist
020 Physician	260 Emergency Medicine	Ltd	207PT0002X Medical Toxicology		Other Specialist
020 Physician	053 Family Practitioner	Ltd	207Q00000X Family Medicine		Other Specialist
020 Physician	053 Family Practitioner	Ltd	207QB0002X Obesity Medicine		Other Specialist
020 Physician	053 Family Practitioner	Ltd	207QG0300X Geriatric Medicine		Other Specialist
020 Physician	053 Family Practitioner	Ltd	207QS0010X Sports Medicine		Other Specialist
020 Physician	053 Family Practitioner	Ltd	207QS1201X Sleep Medicine		Other Specialist
020 Physician	060 Internal Medicine	Ltd	207RA0001X Advanced Heart Failure and Transplant Cardiology		Other Specialist
020 Physician	061 Neurological Surgery	Ltd	207T00000X Neurological Surgery		Other Specialist
020 Physician	160 Nuclear Medicine	Ltd	207U00000X Nuclear Medicine		Other Specialist
020 Physician	160 Nuclear Medicine	Ltd	207UN0901X Nuclear Cardiology		Other Specialist
020 Physician	160 Nuclear Medicine	Ltd	207UN0902X Nuclear Imaging & Therapy		Other Specialist
020 Physician	160 Nuclear Medicine	Ltd	207UN0903X In Vivo & In Vitro Nuclear Medicine		Other Specialist
020 Physician	080 Oral Surgeon	Ltd	204E00000X Oral & Maxillofacial Surgery		Other Specialist
020 Physician	057 Anesthesiologist	Ltd	207L00000X Anesthesiology		Other Specialist
020 Physician	057 Anesthesiologist	Ltd	207LH0002X Hospice and Palliative Medicine		Other Specialist
020 Physician	057 Anesthesiologist	Ltd	207LP2900X Pain Medicine		Other Specialist
020 Physician	057 Anesthesiologist	Ltd	207LP3000X Pediatric Anesthesiology		Pediatric Specialist
020 Physician	062 Obstetrics and Gynecology	Ltd	207V00000X Obstetrics & Gynecology		Obstetrics & Gynecology
020 Physician	062 Obstetrics and Gynecology	Ltd	207VB0002X Obesity Medicine		Obstetrics & Gynecology
020 Physician	062 Obstetrics and Gynecology	Ltd	207VC0200X Critical Care Medicine		Obstetrics & Gynecology
020 Physician	062 Obstetrics and Gynecology	Ltd	207VE0102X Reproductive Endocrinology		Obstetrics & Gynecology

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
020 Physician	062 Obstetrics and Gynecology	Ltd	207VF0040X Female Pelvic Medicine and Reconstructive Surgery		Obstetrics & Gynecology
020 Physician	062 Obstetrics and Gynecology	Ltd	207VG0400X Gynecology		Obstetrics & Gynecology
020 Physician	062 Obstetrics and Gynecology	Ltd	207VH0002X Hospice and Palliative Medicine		Obstetrics & Gynecology
020 Physician	062 Obstetrics and Gynecology	Ltd	207VM0101X Maternal & Fetal Medicine		Obstetrics & Gynecology
020 Physician	062 Obstetrics and Gynecology	Ltd	207VX0000X Obstetrics		Obstetrics & Gynecology
020 Physician	062 Obstetrics and Gynecology	Ltd	207VX0201X Gynecologic Oncology		Obstetrics & Gynecology
010 Nursing Facility	010 Skilled Nursing Facility	Ltd	314000000X Skilled Nursing Facility		LTSS
010 Nursing Facility	010 Skilled Nursing Facility	Ltd	3140N1450X Nursing Care, Pediatric		LTSS
056 Waiver Services	562 Environmental Modifications	Ltd	171WH0202X Home Modifications Cost Only	99199	LTSS
056 Waiver Services	811 Consumer Directed Services	Ltd	171M00000X Case Manager/Service Facilitator	99509	LTSS
056 Waiver Services	662 Electronic Home-Based Supports	Ltd	333300000X Emergency Response System Companies	A9279	LTSS
056 Waiver Services	801 Adult Day Health Care	Ltd	261QA0600X Adult Day Care	S5102	LTSS
056 Waiver Services	811 Consumer Directed Services	Ltd	171M00000X Case Manager/Service Facilitator	S5109	LTSS
056 Waiver Services	813 Family & Caregiver Training	Ltd	251C00000X Day Training/Developmental Disability	S5111	LTSS
056 Waiver Services	811 Consumer Directed Services	Ltd	171M00000X Case Manager/Service Facilitator	S5116	LTSS
056 Waiver Services	822 Respite Care Services	Ltd	385H00000X Consumer Directed Respite Care	S5150	LTSS
056 Waiver Services	562 Environmental Modifications	Ltd	171WH0202X Home Modifications	S5165	LTSS
056 Waiver Services	834 Skilled Nursing Services	Ltd	251C00000X Day Training/Developmental Disability	S9123	LTSS
056 Waiver Services	834 Skilled Nursing Services	Ltd	251C00000X Day Training/Developmental Disability	S9124	LTSS
056 Waiver Services	835 Congregate Nursing	Ltd	251C00000X Day Training/Developmental Disability	T1000	LTSS
056 Waiver Services	835 Congregate Nursing	Ltd	251C00000X Day Training/Developmental Disability	T1001	LTSS
056 Waiver Services	163 Private Duty Nursing Services	Ltd	251J00000X Nursing Care	T1002	LTSS
056 Waiver Services	822 Respite Care Services	Ltd	385H00000X Private Duty Nursing Respite Care	T1002	LTSS
056 Waiver Services	834 Skilled Nursing Services	Ltd	251C00000X Day Training/Developmental Disability	T1002	LTSS
056 Waiver Services	163 Private Duty Nursing Services	Ltd	251J00000X Nursing Care	T1003	LTSS
056 Waiver Services	822 Respite Care Services	Ltd	385H00000X Private Duty Nursing Respite Care	T1003	LTSS
056 Waiver Services	834 Skilled Nursing Services	Ltd	251C00000X Day Training/Developmental Disability	T1003	LTSS
056 Waiver Services	822 Respite Care Services	Ltd	385H00000X Respite Care Agency	T1005	LTSS
056 Waiver Services	821 Personal Care Services	Ltd	3747P1801X Personal Care Agency	T1019	LTSS
056 Waiver Services	811 Consumer Directed Services	Ltd	171M00000X Case Manager/Service Facilitator	T1028	LTSS
056 Waiver Services	835 Congregate Nursing	Ltd	251C00000X Day Training/Developmental Disability	T1030	LTSS
056 Waiver Services	835 Congregate Nursing	Ltd	251C00000X Day Training/Developmental Disability	T1031	LTSS
056 Waiver Services	462 Assistive Technology	Ltd	225CA2400X Assistive Technology Practitioner	T1999	LTSS
056 Waiver Services	462 Assistive Technology	Ltd	225CA2500X Assistive Technology Practitioner	T1999	LTSS
062 Durable Medical Equipmnt	462 Assistive Technology	High	225CA2400X Assistive Technology Practitioner		LTSS
062 Durable Medical Equipmnt	462 Assistive Technology	High	225CA2500X Assistive Technology Supplier		LTSS
062 Durable Medical Equipmnt	462 Assistive Technology	Ltd	225CA2500X Assistive Technology Supplier		LTSS
062 Durable Medical Equipmnt	262 Durable Medical Equipment	High	332B00000X Durable Medical Equipment & Medical Supplies		LTSS
062 Durable Medical Equipmnt	262 Durable Medical Equipment	High	332BC3200X Customized Equipment		LTSS

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
062 Durable Medical Equipmnt	262 Durable Medical Equipment	High	332BD1200X Dialysis Equipment & Supplies		LTSS
062 Durable Medical Equipmnt	262 Durable Medical Equipment	High	332BN1400X Nursing Facility Supplies		LTSS
062 Durable Medical Equipmnt	262 Durable Medical Equipment	High	332BP3500X Parenteral & Enteral Nutrition		LTSS
062 Durable Medical Equipmnt	262 Durable Medical Equipment	High	332BX2000X Oxygen Equipment & Supplies		LTSS
062 Durable Medical Equipmnt	262 Durable Medical Equipment	High	335G00000X Medical Foods Supplier		LTSS
062 Durable Medical Equipmnt	362 Personal Emergency Response Services	High	333300000X Emergency Response System Companies		LTSS
062 Durable Medical Equipmnt	262 Durable Medical Equipment	High	171W00000X Contractor		LTSS
062 Durable Medical Equipmnt	262 Durable Medical Equipment	High	171WV0202X Vehicle Modifications		LTSS
063 Private Duty Nursing Srvcs	163 Private Duty Nursing Services	Ltd	251J00000X Nursing Care		LTSS
082 Emergency Medical Tech	185 Personal Emergency Response Attendant	Ltd	146D00000X Personal Emergency Response Attendant		LTSS
001 Hospital	001 Acute Care Hospital	Ltd	273R00000X Psychiatric Unit	Rev Code 0114	Hospital
001 Hospital	001 Acute Care Hospital	Ltd	273R00000X Psychiatric Unit	Rev Code 0124	Hospital
001 Hospital	001 Acute Care Hospital	Ltd	273R00000X Psychiatric Unit	Rev Code 0134	Hospital
001 Hospital	001 Acute Care Hospital	Ltd	273R00000X Psychiatric Unit	Rev Code 0144	Hospital
001 Hospital	001 Acute Care Hospital	Ltd	273R00000X Psychiatric Unit	Rev Code 0154	Hospital
001 Hospital	001 Acute Care Hospital	Ltd	273R00000X Psychiatric Unit	Rev Code 0204	Hospital
001 Hospital	002 State Mental Health Hospital for the Aged	Ltd	283Q00000X Psychiatric Hospital		Hospital
001 Hospital	009 Medical Surgery-Developmental Disability Hospital	Ltd	284300000X Special Hospital		Hospital
001 Hospital	012 Mental Health Long Stay Hospital	Ltd	283Q00000X Psychiatric Hospital		Hospital
001 Hospital	008 Mental Health Medical Surgery Hospital	Ltd	284300000X Special Hospital		Hospital
001 Hospital	192 Rehabilitation	Ltd	283X00000X Rehabilitation Hospital		Hospital
001 Hospital	001 Acute Care Hospital	Ltd	282NC0060X Critical Access		Hospital
001 Hospital	001 Acute Care Hospital	Ltd	282NC2000X Children		Hospital
001 Hospital	001 Acute Care Hospital	Ltd	282NR1301X Rural		Hospital
001 Hospital	001 Acute Care Hospital	Ltd	282NW0100X Women		Hospital
001 Hospital	001 Acute Care Hospital	Ltd	286500000X Military Hospital		Hospital
001 Hospital	001 Acute Care Hospital	Ltd	2865C1500X Community Health (Military Hospital)		Hospital
001 Hospital	001 Acute Care Hospital	Ltd	2865M2000X Military General Acute Care Hospital		Hospital
001 Hospital	001 Acute Care Hospital	Ltd	2865X1600X Military General Acute Care Hospital. Operational (Transportable)		Hospital
001 Hospital	005 Tuberculosis Hospital	Ltd	281P00000X Chronic Disease Hospital		Hospital
001 Hospital	301 Critical Care Hospital	Ltd	261QC0050X Critical Access Hospital		Hospital
001 Hospital	004 Long Stay Hospital	Ltd	282E00000X Long Term Care Hospital		Hospital
001 Hospital	001 Acute Care Hospital	Ltd	273100000X Epilepsy Unit - Hospital Units		Hospital
001 Hospital	001 Acute Care Hospital	Ltd	273Y00000X Rehabilitation Unit		Hospital

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
001 Hospital	001 Acute Care Hospital	Ltd	275N00000X Medicare Defined Swing Bed Unit		Hospital
001 Hospital	001 Acute Care Hospital	Ltd	276400000X Rehabilitation, Substance Use Disorder Unit		Hospital
001 Hospital	001 Acute Care Hospital	Ltd	281PC2000X Children		Hospital
001 Hospital	001 Acute Care Hospital	Ltd	282N00000X General Acute Care Hospital		Hospital
014 Rehabilitation Hospital	014 Rehabilitation Hospital	Ltd	261QA0900X Amputee		Hospital
014 Rehabilitation Hospital	014 Rehabilitation Hospital	Ltd	282J00000X Religious Nonmedical Health Care Institution		Hospital
014 Rehabilitation Hospital	014 Rehabilitation Hospital	Ltd	283X00000X Rehabilitation Hospital		Hospital
014 Rehabilitation Hospital	014 Rehabilitation Hospital	Ltd	283XC2000X Children		Hospital
020 Physician	460 Hospitalist	Ltd	208M00000X Hospitalist		Adult Primary Care
059 Home Health Agency	054 Hospital Based Home Health Agency	High	251E00000X Home Health		Hospital
042 Dental Medical	086 Dental Anesthesiology	Ltd	1223D0004X Dental Anesthesiology		Dental Medical
042 Dental Medical	083 Endodontist	Ltd	1223E0200X Endodontics		Dental Medical
042 Dental Medical	085 Oral Pathologist	Ltd	1223P0106X Oral Pathologist		Dental Medical
042 Dental Medical	180 Oral Surgeon	Ltd	1223S0112X Oral and Maxillofacial Surgery		Dental Medical
042 Dental Medical	180 Oral Surgeon	Ltd	1223X0008X Oral and Maxillofacial Radiology		Dental Medical
042 Dental Medical	082 Pedodontist	Ltd	1223P0221X Pediatric Dentistry		Pediatric Dental
041 Dental Clinic	041 Dental Clinic	Ltd	1223D0001X Dental Public Health		Dental Clinic
041 Dental Clinic	041 Dental Clinic	Ltd	261QD0000X Dental Clinic		Dental Clinic
041 Dental Clinic	041 Dental Clinic	Ltd	261QS0112X Oral and Maxillofacial Surgery		Dental Clinic
040 Dental	178 General Practice	Ltd	1223G0001X Dentist General Practice		Dental
040 Dental	086 Dental Anesthesiology	Ltd	1223D0004X Dental Anesthesiology		Dental
040 Dental	078 Dentist	Ltd	122300000X Dentist		Dental
040 Dental	078 Dentist	Ltd	1223G0001X General Practice		Dental
040 Dental	083 Endodontist	Ltd	1223E0200X Endodontics		Dental
040 Dental	085 Oral Pathologist	Ltd	1223P0106X Oral Pathologist		Dental
040 Dental	180 Oral Surgeon	Ltd	1223S0112X Oral and Maxillofacial Surgery		Dental
040 Dental	180 Oral Surgeon	Ltd	1223X0008X Oral and Maxillofacial Radiology		Dental
040 Dental	079 Orthodontist	Ltd	1223X0400X Orthodontics and Dentofacial Orthopedics		Dental
040 Dental	082 Pedodontist	Ltd	1223P0221X Pediatric Dentistry		Pediatric Dental
040 Dental	081 Periodontist	Ltd	1223P0300X Periodontics		Dental
040 Dental	084 Prosthodontist	Ltd	1223P0700X Prosthodontics		Dental
003 Private Inpatient Psychiatric Hospital	003 Private Inpatient Psychiatric Hospital	Ltd	283Q00000X Psychiatric Hospital	Rev code 0114	Behavioral Health
003 Private Inpatient Psychiatric Hospital	003 Private Inpatient Psychiatric Hospital	Ltd	283Q00000X Psychiatric Hospital	Rev code 0124	Behavioral Health
003 Private Inpatient Psychiatric Hospital	003 Private Inpatient Psychiatric Hospital	Ltd	283Q00000X Psychiatric Hospital	Rev code 0134	Behavioral Health
003 Private Inpatient Psychiatric Hospital	003 Private Inpatient Psychiatric Hospital	Ltd	283Q00000X Psychiatric Hospital	Rev code 0144	Behavioral Health

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
003 Private Inpatient Psychiatric Hospital	003 Private Inpatient Psychiatric Hospital	Ltd	283Q00000X Psychiatric Hospital	Rev code 0154	Behavioral Health
003 Private Inpatient Psychiatric Hospital	004 Private Inpatient Psychiatric Hospital	Ltd	283Q00000X Psychiatric Hospital	Rev code 0204	Behavioral Health
003 Private Inpatient Psychiatric Hospital	003 Private Inpatient Psychiatric Hospital	Ltd	283Q00000X Psychiatric Hospital		Behavioral Health
007 State MH Hospital (less than 21)	007 State Mental Health Hospital for less than 21	Ltd	283Q00000X Psychiatric Hospital		Behavioral Health
010 Nursing Facility	006 Skilled Nursing Facility- Mental Health	Ltd	284300000X Special Hospital		Behavioral Health
020 Physician	047 Substance Abuse - Anesthesiology	Ltd	207LA0401X Addiction Medicine		Behavioral Health
020 Physician	147 Substance Abuse - Family Medicine	Ltd	207QA0401X Addiction Medicine		Behavioral Health
020 Physician	247 Substance Abuse - Internal Medicine	Ltd	207RA0401X Addiction Medicine		Behavioral Health
020 Physician	067 Pediatrician	Ltd	2080P0006X Developmental – Behavioral Pediatrics		Pediatric Behavioral Health
020 Physician	447 Substance Abuse - Preventive Medicine	Ltd	2083A0300X Addiction Medicine		Behavioral Health
020 Physician	347 Substance Abuse - Psychiatry and Neurology	Ltd	2084P0802X Addiction Psychiatry		Behavioral Health
020 Physician	171 Psychiatry	Ltd	2084P0800X Psychiatry		Behavioral Health
020 Physician	171 Psychiatry	Ltd	2084A2900X Neurocritical Care		Behavioral Health
020 Physician	171 Psychiatry	Ltd	2084B0002X Obesity Medicine		Behavioral Health
020 Physician	171 Psychiatry	Ltd	2084B0040X Behavioral Neurology & Neuropsychiatry		Behavioral Health
020 Physician	171 Psychiatry	Ltd	2084D0003X Diagnostic Neuroimaging		Behavioral Health
020 Physician	171 Psychiatry	Ltd	2084E0001X Epilepsy		Behavioral Health
020 Physician	171 Psychiatry	Ltd	2084F0202X Forensic Psychiatry		Behavioral Health
020 Physician	171 Psychiatry	Ltd	2084H0002X Hospice and Palliative Medicine		Behavioral Health
020 Physician	171 Psychiatry	Ltd	2084N0008X Neuromuscular Medicine		Behavioral Health
020 Physician	171 Psychiatry	Ltd	2084N0400X Neurology		Behavioral Health
020 Physician	171 Psychiatry	Ltd	2084N0402X Neurology with Special Qualifications in Child Neurology		Behavioral Health
020 Physician	171 Psychiatry	Ltd	2084N0600X Clinical Neurophysiology		Behavioral Health
020 Physician	171 Psychiatry	Ltd	2084P0005X Neurodevelopmental Disabilities		Behavioral Health
020 Physician	171 Psychiatry	Ltd	2084P0015X Psychosomatic Medicine		Behavioral Health
020 Physician	171 Psychiatry	Ltd	2084P0301X Brain Injury Medicine		Behavioral Health
020 Physician	171 Psychiatry	Ltd	2084P0804X Child & Adolescent Psychiatry		Pediatric Behavioral Health
020 Physician	171 Psychiatry	Ltd	2084P0805X Geriatric Psychiatry		Behavioral Health
020 Physician	171 Psychiatry	Ltd	2084P2900X Pain Medicine		Behavioral Health
020 Physician	171 Psychiatry	Ltd	2084S0010X Sports Medicine		Behavioral Health

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
020 Physician	171 Psychiatry	Ltd	2084S0012X Sleep Medicine		Behavioral Health
020 Physician	171 Psychiatry	Ltd	2084V0102X Vascular Neurology		Behavioral Health
023 Nurse Practitioner	111 Psychiatric	Ltd	363LP0808X Psych/Mental Health		Behavioral Health
051 Clinics	210 ARTS-Office Based Opioid Treatment (OBAT)	Ltd	261QM2800X ARTS-Opioid Treatment Services – Individual Methadone	99211	Behavioral Health
051 Clinics	210 ARTS-Opioid Treatment Program (OTP)/ Medication Admin	Ltd	261QM2800X ARTS-Opioid Treatment Services – Individual Methadone	99211	Behavioral Health
051 Clinics	210 ARTS-Office Based Opioid Treatment (OBAT)	Ltd	261QM2800X ARTS-Opioid Treatment Services – Individual Methadone	99212	Behavioral Health
051 Clinics	210 ARTS-Opioid Treatment Program (OTP)/ Medication Admin	Ltd	261QM2800X ARTS-Opioid Treatment Services – Individual Methadone	99212	Behavioral Health
051 Clinics	210 ARTS-Office Based Opioid Treatment (OBAT)	Ltd	261QM2800X ARTS-Opioid Treatment Services – Individual Methadone	99213	Behavioral Health
051 Clinics	210 ARTS-Opioid Treatment Program (OTP)/ Medication Admin	Ltd	261QM2800X ARTS-Opioid Treatment Services – Individual Methadone	99213	Behavioral Health
051 Clinics	210 ARTS-Office Based Opioid Treatment (OBAT)	Ltd	261QM2800X ARTS-Opioid Treatment Services – Individual Methadone	99214	Behavioral Health
051 Clinics	210 ARTS-Opioid Treatment Program (OTP)/ Medication Admin	Ltd	261QM2800X ARTS-Opioid Treatment Services – Individual Methadone	99214	Behavioral Health
051 Clinics	210 ARTS-Office Based Opioid Treatment (OBAT)	Ltd	261QM2800X ARTS-Opioid Treatment Services – Individual Methadone	99215	Behavioral Health
051 Clinics	210 ARTS-Opioid Treatment Program (OTP)/ Medication Admin	Ltd	261QM2800X ARTS-Opioid Treatment Services – Individual Methadone	99215	Behavioral Health
051 Clinics	210 ARTS-Opioid Treatment Services – Individual	Ltd	261QM2800X ARTS-Opioid Treatment Services – Individual Methadone	H0004	Behavioral Health
051 Clinics	210 ARTS-Opioid Treatment Services – Group	Ltd	261QM2800X ARTS-Opioid Treatment Services – Individual Methadone	H0005	Behavioral Health
051 Clinics	210 ARTS-Opioid Treatment Services – Individual	Ltd	261QM2800X ARTS-Opioid Treatment Services – Individual Methadone	H0014	Behavioral Health
051 Clinics	210 ARTS-Opioid Treatment Program (OTP)/ Medication Admin	Ltd	261QM2800X ARTS-Opioid Treatment Services – Individual Methadone	H0020	Behavioral Health
077 Residential Treatment Facility	077 Residential Treatment Facility	Ltd	322D00000X Residential Treatment Facility, Emotionally Disturbed Children	Crisis	Pediatric Behavioral Health
077 Residential Treatment Facility	233 ARTS-ASAM 3.3-Residential Treatment-Adults	Ltd	320600000X Substance Abuse Rehabilitation Facility	H0010 Mod TG Rev Code 1002	Behavioral Health
077 Residential Treatment Facility	077 ARTS-ASAM 4.0-Residential Treatment-Adults Medically Monitored	Ltd	3245S0500X Substance Abuse Rehabilitation Facility, Children	H0011 Rev Code 1002	Behavioral Health
077 Residential Treatment Facility	077 Therapeutic Group Home (EPSDT)	Ltd	320800000X Community Based Residential Treatment Facility, Mental Health	H0019	Behavioral Health

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
077 Residential Treatment Facility	114 Therapeutic Group Home	Ltd	320800000X Community Based Residential Treatment Facility, Mental Health	H0020	Behavioral Health
077 Residential Treatment Facility	077 Residential Crisis Stabilization	Ltd	323P00000X Psychiatric Residential Treatment Facility	H2018	Behavioral Health
077 Residential Treatment Facility	133 ARTS-ASAM 3.1-Residential Treatment- Adult	Ltd	320600000X Substance Abuse Rehabilitation Facility	H2034	Behavioral Health
077 Residential Treatment Facility	229 ARTS-ASAM 3.1-Residential Treatment-Child	Ltd	3245S0500X Substance Abuse Rehabilitation Facility	H2034	Pediatric Behavioral Health
077 Residential Treatment Facility	132 ARTS-ASAM 3.7-Residential Treatment-Child	Ltd	3245S0500X Substance Abuse Rehabilitation Facility	H2036 Mod HA Rev Code 1002	Pediatric Behavioral Health
077 Residential Treatment Facility	135 ARTS-ASAM 3.5-Residential Treatment-Adults	Ltd	320600000X Substance Abuse Rehabilitation Facility	H0010 Mod HB Rev Code 1002	Behavioral Health
077 Residential Treatment Facility	232 ARTS-ASAM 3.5-Residential Treatment-Child	Ltd	3245S0500X Substance Abuse Rehabilitation Facility	H0010 Mod HA Rev Code 1002	Pediatric Behavioral Health
077 Residential Treatment Facility	136 ARTS-ASAM 3.7-Residential Treatment-Adults	Ltd	320600000X Substance Abuse Rehabilitation Facility	H2036 Mod HB Rev Code 1002	Behavioral Health
077 Residential Treatment Facility	077 ARTS-ASAM 3.7-Residential Treatment-Adults	Ltd	324500000X Substance Abuse Rehabilitation Facility	H2036 Rev Code 1002	Behavioral Health
077 Residential Treatment Facility	077 ARTS-ASAM 3.7-Residential Treatment-Adults	Ltd	3245S0500X Substance Abuse Rehabilitation Facility, Children	H2036 Rev Code 1002	Behavioral Health
156 Behavioral Health Services	903 Applied Behavioral Analysis (ABA)	Ltd	251S00000X Community/Behavioral Health	97151	Behavioral Health
156 Behavioral Health Services	903 Applied Behavioral Analysis (ABA)	Ltd	251S00000X Community/Behavioral Health	97152	Behavioral Health
156 Behavioral Health Services	903 Applied Behavioral Analysis (ABA)	Ltd	251S00000X Community/Behavioral Health	97153	Behavioral Health
156 Behavioral Health Services	903 Applied Behavioral Analysis (ABA)	Ltd	251S00000X Community/Behavioral Health	97154	Behavioral Health
156 Behavioral Health Services	903 Applied Behavioral Analysis (ABA)	Ltd	251S00000X Community/Behavioral Health	97156	Behavioral Health
156 Behavioral Health Services	903 Applied Behavioral Analysis (ABA)	Ltd	251S00000X Community/Behavioral Health	97157	Behavioral Health
156 Behavioral Health Services	903 Applied Behavioral Analysis (ABA)	Ltd	251S00000X Community/Behavioral Health	97158	Behavioral Health
156 Behavioral Health Services	903 Applied Behavioral Analysis (ABA)	Ltd	251S00000X Community/Behavioral Health	0362T	Behavioral Health
156 Behavioral Health Services	903 Applied Behavioral Analysis (ABA)	Ltd	251S00000X Community/Behavioral Health	0373T	Behavioral Health
156 Behavioral Health Services	914 ARTS-Case Management	Ltd	251S00000X Community/Behavioral Health	H0006	Behavioral Health
156 Behavioral Health Services	915 ARTS-ASAM 2.1-Intensive OP Services	Ltd	251S00000X Community/Behavioral Health	H0015	Behavioral Health

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
156 Behavioral Health Services	913 Mental Health Partial Hospitalization (MH-PHP)	Ltd	251S00000X Community/Behavioral Health	H0035	Behavioral Health
156 Behavioral Health Services	904 Assertive Community Treatment (ACT)	Ltd	251S00000X Community/Behavioral Health	H0040	Behavioral Health
156 Behavioral Health Services	906 Mental Health Skill Building	Ltd	251S00000X Community/Behavioral Health	H0046	Behavioral Health
156 Behavioral Health Services	920 Mobile Crisis Response	Ltd	251S00000X Community/Behavioral Health	H2011	Behavioral Health
156 Behavioral Health Services	905 Intensive In Home	Ltd	251S00000X Community/Behavioral Health	H2012	Behavioral Health
156 Behavioral Health Services	913 Mental Health Partial Hospitalization (MH-PHP)	Ltd	251S00000X Community/Behavioral Health	H2016	Behavioral Health
156 Behavioral Health Services	918 Therapeutic Day Treatment for Children	Ltd	251S00000X Community/Behavioral Health	H2016	Behavioral Health
156 Behavioral Health Services	909 Psychosocial Rehabilitation Services	Ltd	251S00000X Community/Behavioral Health	H2017	Behavioral Health
156 Behavioral Health Services	902 Functional Family Therapy	Ltd	251S00000X Community/Behavioral Health	H2019	Behavioral Health
156 Behavioral Health Services	905 Intensive In Home	Ltd	251S00000X Community/Behavioral Health	H2021	Behavioral Health
156 Behavioral Health Services	907 One on One Supports in Residential (EPSDT)	Ltd	251S00000X Community/Behavioral Health	H2027	Behavioral Health
156 Behavioral Health Services	903 Applied Behavioral Analysis (ABA)	Ltd	251S00000X Community/Behavioral Health	H2033	Behavioral Health
156 Behavioral Health Services	913 Mental Health Partial Hospitalization (MH-PHP)	Ltd	251S00000X Community/Behavioral Health	S0201	Behavioral Health
156 Behavioral Health Services	917 ARTS - Alcohol/SA Services Group Peer Support	Ltd	251S00000X Community/Behavioral Health	S9445	Behavioral Health
156 Behavioral Health Services	919 Mental Health Intensive Outpatient Services (MH-IOP)	Ltd	251S00000X Community/Behavioral Health	S9480	Behavioral Health
156 Behavioral Health Services	902 Community Crisis Stabilization	Ltd	251S00000X Community/Behavioral Health	S9482	Behavioral Health
156 Behavioral Health Services	921 23-Hour Observation	Ltd	251S00000X Community/Behavioral Health	S9485	Behavioral Health
156 Behavioral Health Services	916 ARTS - Alcohol/SA Services Individual Peer Support	Ltd	251S00000X Community/Behavioral Health	T1012	Behavioral Health
156 Behavioral Health Services	900 Case Management - Mental Health	Ltd	251B00000X Case Management	T1016	Behavioral Health
256 Behavioral Health Practitioner	101 School Psychologist	Ltd	103TS0200X School		Pediatric Behavioral Health
256 Behavioral Health Practitioner	176 Social Worker	Ltd	104100000X Social Worker		Behavioral Health
256 Behavioral Health Practitioner	176 Social Worker	Ltd	1041S0200X School		Behavioral Health
256 Behavioral Health Practitioner	474 Substance Abuse - Clinical Nurse Specialist	Ltd	163WA0400X Addiction (Substance Abuse Disorder)		Behavioral Health
256 Behavioral Health Practitioner	472 Substance Abuse - Licensed Clinical Social Worker	Ltd	1041C0700X Licensed Clinical Social Worker		Behavioral Health

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
256 Behavioral Health Practitioner	473 Substance Abuse - Marriage and Family Therapist	Ltd	106H00000X Marriage and Family Therapist (MFT)		Behavioral Health
256 Behavioral Health Practitioner	471 Substance Abuse - Psychologist	Ltd	103TA0400X Addiction Substance Use Disorder		Behavioral Health
256 Behavioral Health Practitioner	470 Substance Abuse- Licensed Professional Counselor	Ltd	101YA0400X Addiction (Substance Abuse Disorder)		Behavioral Health
256 Behavioral Health Practitioner	103 Substance Abuse Practitioner	Ltd	101YA0400X Addiction (Substance Abuse Disorder)		Behavioral Health
256 Behavioral Health Practitioner	104 Behavioral Analyst	Ltd	103K00000X Behavior Analyst		Behavioral Health
256 Behavioral Health Practitioner	104 Behavioral Analyst	Ltd	106E00000X Assistant Behavior Analyst		Behavioral Health
256 Behavioral Health Practitioner	104 Behavioral Analyst	Ltd	106S00000X Behavior Technician		Behavioral Health
256 Behavioral Health Practitioner	125 Clinical Psychologist	Ltd	103G00000X Clinical Neuropsychologist		Behavioral Health
256 Behavioral Health Practitioner	125 Clinical Psychologist	Ltd	103GC0700X Clinical Neuropsychologist - Psychology Services		Behavioral Health
256 Behavioral Health Practitioner	125 Clinical Psychologist	Ltd	103TC0700X Clinical Psychologist		Behavioral Health
256 Behavioral Health Practitioner	125 Clinical Psychologist	Ltd	103TH0100X Health Service		Behavioral Health
256 Behavioral Health Practitioner	076 Licensed Clinical Social Worker	Ltd	1041C0700X Licensed Clinical Social Worker		Behavioral Health
256 Behavioral Health Practitioner	021 Licensed Professional Counselor	Ltd	101Y00000X Counselor		Behavioral Health
256 Behavioral Health Practitioner	021 Licensed Professional Counselor	Ltd	101YM0800X Mental Health		Behavioral Health
256 Behavioral Health Practitioner	021 Licensed Professional Counselor	Ltd	101YP1600X Pastoral		Behavioral Health
256 Behavioral Health Practitioner	021 Licensed Professional Counselor	Ltd	101YP2500X Professional		Behavioral Health
256 Behavioral Health Practitioner	021 Licensed Professional Counselor	Ltd	101YS0200X School		Behavioral Health
256 Behavioral Health Practitioner	102 Marriage and Family Therapist	Ltd	106H00000X Marriage and Family Therapist (MFT)		Behavioral Health
256 Behavioral Health Practitioner	235 Poetry Therapist	Ltd	102X00000X Poetry Therapist		Behavioral Health
256 Behavioral Health Practitioner	204 Psychoanalyst	Ltd	102L00000X Psychoanalyst		Behavioral Health
256 Behavioral Health Practitioner	225 Psychologist	Ltd	103T00000X Psychologist		Behavioral Health

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
256 Behavioral Health Practitioner	225 Psychologist	Ltd	103TA0700X Adult Development and Aging		Behavioral Health
256 Behavioral Health Practitioner	225 Psychologist	Ltd	103TB0200X Cognitive and Behavior Therapy		Behavioral Health
256 Behavioral Health Practitioner	225 Psychologist	Ltd	103TC1900X Counseling		Behavioral Health
256 Behavioral Health Practitioner	225 Psychologist	Ltd	103TC2200X Clinical Child and Adolescent		Pediatric Behavioral Health
256 Behavioral Health Practitioner	225 Psychologist	Ltd	103TE1000X Educational (inactive) - Psychologist		Behavioral Health
256 Behavioral Health Practitioner	225 Psychologist	Ltd	103TE1100X Exercise and Sports		Behavioral Health
256 Behavioral Health Practitioner	225 Psychologist	Ltd	103TF0000X Family		Behavioral Health
256 Behavioral Health Practitioner	225 Psychologist	Ltd	103TF0200X Forensic		Behavioral Health
256 Behavioral Health Practitioner	225 Psychologist	Ltd	103TH0004X Health		Behavioral Health
256 Behavioral Health Practitioner	225 Psychologist	Ltd	103TM1700X Men & Masculinity - Psychologist		Behavioral Health
256 Behavioral Health Practitioner	225 Psychologist	Ltd	103TM1800X Mental Retardation and Developmental Disability		Behavioral Health
256 Behavioral Health Practitioner	225 Psychologist	Ltd	103TP0016X Prescribing (Medical)		Behavioral Health
256 Behavioral Health Practitioner	225 Psychologist	Ltd	103TP0814X Psychoanalysis		Behavioral Health
256 Behavioral Health Practitioner	225 Psychologist	Ltd	103TP2700X Psychotherapy - Psychologist		Behavioral Health
256 Behavioral Health Practitioner	225 Psychologist	Ltd	103TP2701X Group Psychotherapy		Behavioral Health
256 Behavioral Health Practitioner	225 Psychologist	Ltd	103TR0400X Rehabilitation		Behavioral Health
256 Behavioral Health Practitioner	225 Psychologist	Ltd	103TW0100X Women - Psychologist		Behavioral Health
256 Behavioral Health Services	Substance Use Care Coordination	Ltd	251S00000X Community/Behavioral Health	G9012	Behavioral Health
256 Behavioral Health Practitioner	134 Clinical Nurse Specialist	Ltd	364SP0807X Psych/Mental Health, Child & Adolescent		Pediatric Behavioral Health
256 Behavioral Health Practitioner	134 Clinical Nurse Specialist	Ltd	364SP0808X Psych/Mental Health		Behavioral Health
256 Behavioral Health Practitioner	134 Clinical Nurse Specialist	Ltd	364SP0809X Psych/Mental Health, Adult		Behavioral Health

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
256 Behavioral Health Practitioner	134 Clinical Nurse Specialist	Ltd	364SP0810X Psych/Mental Health, Child & Family		Behavioral Health
256 Behavioral Health Practitioner	134 Clinical Nurse Specialist	Ltd	364SP0811X Psych/Mental Health, Chronically Ill		Behavioral Health
256 Behavioral Health Practitioner	134 Clinical Nurse Specialist	Ltd	364SP0812X Psych/Mental Health, Community		Behavioral Health
256 Behavioral Health Practitioner	134 Clinical Nurse Specialist	Ltd	364SP0813X Psych/Mental Health, Geropsychiatric		Behavioral Health
456 Behavioral Health Clinic and Services	915 ARTS-ASAM 1- Psychotherapy	Mod	251S00000X ARTS - Community Based Mental Health	90832	Behavioral Health
456 Behavioral Health Clinic and Services	915 ARTS-ASAM 1-Psychotherapy	Mod	251S00000X ARTS - Community Based Mental Health	90833	Behavioral Health
456 Behavioral Health Clinic and Services	915 ARTS-ASAM 1- Psychotherapy	Mod	251S00000X ARTS - Community Based Mental Health	90834	Behavioral Health
456 Behavioral Health Clinic and Services	915 ARTS-ASAM 1-Psychotherapy	Mod	251S00000X ARTS - Community Based Mental Health	90836	Behavioral Health
456 Behavioral Health Clinic and Services	915 ARTS-ASAM 1- Psychotherapy	Mod	251S00000X ARTS - Community Based Mental Health	90837	Behavioral Health
456 Behavioral Health Clinic and Services	915 ARTS-ASAM 1-Psychotherapy	Mod	251S00000X ARTS - Community Based Mental Health	90838	Behavioral Health
456 Behavioral Health Clinic and Services	915 ARTS-ASAM 1-Psychotherapy	Mod	251S00000X ARTS - Community Based Mental Health	90846	Behavioral Health
456 Behavioral Health Clinic and Services	915 ARTS-ASAM 1-Psychotherapy	Mod	251S00000X ARTS - Community Based Mental Health	90847	Behavioral Health
456 Behavioral Health Clinic and Services	915 ARTS-ASAM 1-Psychotherapy	Mod	251S00000X ARTS - Community Based Mental Health	90853	Behavioral Health
456 Behavioral Health Clinic and Services	903 Applied Behavioral Analysis (ABA)	Mod	251S00000X Community/Behavioral Health	97151	Behavioral Health
456 Behavioral Health Clinic and Services	903 Applied Behavioral Analysis (ABA)	Mod	251S00000X Community/Behavioral Health	97152	Behavioral Health
456 Behavioral Health Clinic and Services	903 Applied Behavioral Analysis (ABA)	Mod	251S00000X Community/Behavioral Health	97153	Behavioral Health
456 Behavioral Health Clinic and Services	903 Applied Behavioral Analysis (ABA)	Mod	251S00000X Community/Behavioral Health	97154	Behavioral Health
456 Behavioral Health Clinic and Services	903 Applied Behavioral Analysis (ABA)	Mod	251S00000X Community/Behavioral Health	97156	Behavioral Health
456 Behavioral Health Clinic and Services	903 Applied Behavioral Analysis (ABA)	Mod	251S00000X Community/Behavioral Health	97157	Behavioral Health
456 Behavioral Health Clinic and Services	903 Applied Behavioral Analysis (ABA)	Mod	251S00000X Community/Behavioral Health	97158	Behavioral Health
456 Behavioral Health Clinic and Services	915 ARTS-ASAM 0.5-Screening and Brief Intervention (SBIRT)	Mod	251S00000X ARTS - Community Based Mental Health	99408	Behavioral Health

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
456 Behavioral Health Clinic and Services	915 ARTS-ASAM 0.6-Screening and Brief Intervention (SBIRT)	Mod	251S00000X ARTS - Community Based Mental Health	99409	Behavioral Health
456 Behavioral Health Clinic and Services	903 Applied Behavioral Analysis (ABA)	Mod	251S00000X Community/Behavioral Health	0362T	Behavioral Health
456 Behavioral Health Clinic and Services	903 Applied Behavioral Analysis (ABA)	Mod	251S00000X Community/Behavioral Health	0373T	Behavioral Health
456 Behavioral Health Clinic and Services	914 ARTS-Case Management	Mod	251S00000X Community/Behavioral Health	H0006	Behavioral Health
456 Behavioral Health Clinic and Services	915 Medication Assiste TX (MAT) Induction - Physician	Mod	251S00000X ARTS - Community Based Mental Health	H0014	Behavioral Health
456 Behavioral Health Clinic and Services	915 ARTS-ASAM 2.1-Intensive OP Services	Mod	251S00000X Community/Behavioral Health	H0015	Behavioral Health
456 Behavioral Health Clinic and Services	912 Mental Health Partial Hospitalization (MH-PHP)	Mod	251S00000X Community/Behavioral Health	H0035	Behavioral Health
456 Behavioral Health Clinic and Services	901 Functional Family Therapy	Mod	251S00000X Community/Behavioral Health	H0036	Behavioral Health
456 Behavioral Health Clinic and Services	904 Assertive Community Treatment (ACT)	Mod	251S00000X Community/Behavioral Health	H0040	Behavioral Health
456 Behavioral Health Clinic and Services	906 Mental Health Skill Building	Mod	251S00000X Community/Behavioral Health	H0046	Behavioral Health
456 Behavioral Health Clinic and Services	920 Mobile Crisis Response	Mod	251S00000X Community/Behavioral Health	H2011	Behavioral Health
456 Behavioral Health Clinic and Services	905 Intensive In Home	Mod	251S00000X Community/Behavioral Health	H2012	Behavioral Health
456 Behavioral Health Clinic and Services	918 Therapeutic Day Treatment for Children	Mod	251S00000X Community/Behavioral Health	H2016	Behavioral Health
456 Behavioral Health Clinic and Services	909 Psychosocial Rehabilitation Services	Mod	251S00000X Community/Behavioral Health	H2017	Behavioral Health
456 Behavioral Health Clinic and Services	902 Functional Family Therapy	Mod	251S00000X Community/Behavioral Health	H2019	Behavioral Health
456 Behavioral Health Clinic and Services	905 Intensive In Home	Mod	251S00000X Community/Behavioral Health	H2021	Behavioral Health
456 Behavioral Health Clinic and Services	907 One on One Supports in Residential (EPSDT)	Mod	251S00000X Community/Behavioral Health	H2027	Behavioral Health
456 Behavioral Health Clinic and Services	903 Applied Behavioral Analysis (ABA)	Mod	251S00000X Community/Behavioral Health	H2033	Behavioral Health
456 Behavioral Health Clinic and Services	913 Therapeutic Day Treatment/Partial Hospitalization for Adults	Mod	251S00000X Community/Behavioral Health	S0201	Behavioral Health
456 Behavioral Health Clinic and Services	917 ARTS - Alcohol/SA Services Group Peer Support	Mod	251S00000X Community/Behavioral Health	S9445	Behavioral Health

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
456 Behavioral Health Clinic and Services	919 Mental Health Intensive Outpatient Services (MH-IOP)	Mod	251S00000X Community/Behavioral Health	S9480	Behavioral Health
456 Behavioral Health Clinic and Services	902 Community Crisis Stabilization	Mod	251S00000X Community/Behavioral Health	S9482	Behavioral Health
456 Behavioral Health Clinic and Services	921 23-Hour Observation	Mod	251S00000X Community/Behavioral Health	S9485	Behavioral Health
456 Behavioral Health Clinic and Services	916 ARTS - Alcohol/SA Services Individual Peer Support	Mod	251S00000X Community/Behavioral Health	T1012	Behavioral Health
456 Behavioral Health Services	913 Mental Health Partial Hospitalization (MH-PHP)	Ltd	251S00000X Community/Behavioral Health	H2016	Behavioral Health
457 Behavioral Health Clinic and Services	916 Opioid Treatment Programb(OTP)/Medication Admin	Mod	251S00000X ARTS - Community Based Mental Health	99211	Behavioral Health
458 Behavioral Health Clinic and Services	917 Opioid Treatment Programb(OTP)/Medication Admin	Mod	251S00000X ARTS - Community Based Mental Health	99212	Behavioral Health
459 Behavioral Health Clinic and Services	918 Opioid Treatment Programb(OTP)/Medication Admin	Mod	251S00000X ARTS - Community Based Mental Health	99213	Behavioral Health
460 Behavioral Health Clinic and Services	919 Opioid Treatment Programb(OTP)/Medication Admin	Mod	251S00000X ARTS - Community Based Mental Health	99214	Behavioral Health
461 Behavioral Health Clinic and Services	920 Opioid Treatment Programb(OTP)/Medication Admin	Mod	251S00000X ARTS - Community Based Mental Health	99215	Behavioral Health
462 Behavioral Health Clinic and Services	921 Opioid Treatment Programb(OTP)/Medication Admin	Mod	251S00000X ARTS - Community Based Mental Health	H0020	Behavioral Health
463 Behavioral Health Clinic and Services	922 Office Based Opioid Treatment (OBAT)	Mod	251S00000X ARTS - Community Based Mental Health	99211	Behavioral Health
464 Behavioral Health Clinic and Services	923 Office Based Opioid Treatment (OBAT)	Mod	251S00000X ARTS - Community Based Mental Health	99212	Behavioral Health
465 Behavioral Health Clinic and Services	924 Office Based Opioid Treatment (OBAT)	Mod	251S00000X ARTS - Community Based Mental Health	99213	Behavioral Health
466 Behavioral Health Clinic and Services	925 Office Based Opioid Treatment (OBAT)	Mod	251S00000X ARTS - Community Based Mental Health	99214	Behavioral Health
467 Behavioral Health Clinic and Services	926 Office Based Opioid Treatment (OBAT)	Mod	251S00000X ARTS - Community Based Mental Health	99215	Behavioral Health
020 Physician	053 Family Practitioner	Ltd	207QA0505X Adult Medicine		Adult Primary Care
020 Physician	060 Internal Medicine	Ltd	207RG0300X Geriatric Medicine		Adult Primary Care
023 Nurse Practitioner	108 Geriatric	Ltd	363LG0600X Gerontology		Adult Primary Care
020 Physician	068 Physical Medicine & Rehabilitation	Ltd	208100000X Physical Medicine & Rehabilitation		
020 Physician	068 Physical Medicine & Rehabilitation	Ltd	2081N0008X Neuromuscular Medicine		
020 Physician	068 Physical Medicine & Rehabilitation	Ltd	2081P0004X Spinal Cord Injury Medicine		

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
020 Physician	068 Physical Medicine & Rehabilitation	Ltd	2081P0010X Pediatric Rehabilitation Medicine		
020 Physician	068 Physical Medicine & Rehabilitation	Ltd	2081S0010X Sports Medicine		
015 Intermediate Care Facility	015 Intermediate Care Facility	Ltd	313M00000X Nursing Facility/Intermediate Care Facility		
015 Intermediate Care Facility	192 Rehabilitation	Ltd	313M00000X Nursing/Intermediate Care Facility		
020 Physician	060 Internal Medicine	Ltd	207K00000X Allergy and Immunology		
020 Physician	060 Internal Medicine	Ltd	207KA0200X Allergy		
020 Physician	060 Internal Medicine	Ltd	207RA0201X Allergy & Immunology		
256 Behavioral Health Practitioner	234 Clinical Nurse Services	Ltd	364S00000X Clinical Nurse Specialist		
256 Behavioral Health Practitioner	234 Clinical Nurse Services	Ltd	364SA2100X Acute Care		
256 Behavioral Health Practitioner	234 Clinical Nurse Services	Ltd	364SA2200X Adult Health		
256 Behavioral Health Practitioner	234 Clinical Nurse Services	Ltd	364SC1501X Community Health/Public Health		
256 Behavioral Health Practitioner	234 Clinical Nurse Services	Ltd	364SE0003X Emergency		
256 Behavioral Health Practitioner	234 Clinical Nurse Services	Ltd	364SF0001X Family Health		
256 Behavioral Health Practitioner	234 Clinical Nurse Services	Ltd	364SG0600X Gerontology		
256 Behavioral Health Practitioner	234 Clinical Nurse Services	Ltd	364SH0200X Home Health		
256 Behavioral Health Practitioner	234 Clinical Nurse Services	Ltd	364SL0600X Long-Term Care		
256 Behavioral Health Practitioner	234 Clinical Nurse Services	Ltd	364SM0705X Medical-Surgical		
256 Behavioral Health Practitioner	234 Clinical Nurse Services	Ltd	364SN0000X Neonatal		
256 Behavioral Health Practitioner	234 Clinical Nurse Services	Ltd	364SP0200X Pediatrics		
256 Behavioral Health Practitioner	234 Clinical Nurse Services	Ltd	364SP1700X Perinatal (CNS)		
256 Behavioral Health Practitioner	234 Clinical Nurse Services	Ltd	364SP2800X Perioperative (CNS)		
256 Behavioral Health Practitioner	234 Clinical Nurse Services	Ltd	364SW0102X Women's Health		
256 Behavioral Health Practitioner	234 Clinical Nurse Services	Ltd	364SX0200X Oncology		

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
256 Behavioral Health Practitioner	234 Clinical Nurse Services	Ltd	364SC0200X Critical Care Medicine (CNS)		
256 Behavioral Health Practitioner	234 Clinical Nurse Services	Ltd	364SC2300X Chronic Care (CNS)		
256 Behavioral Health Practitioner	234 Clinical Nurse Services	Ltd	364SE1400X Ethics (CNS)		
256 Behavioral Health Practitioner	234 Clinical Nurse Services	Ltd	364SH1100X Holistic (CNS)		
256 Behavioral Health Practitioner	234 Clinical Nurse Services	Ltd	364SI0800X Informatics (CNS)		
256 Behavioral Health Practitioner	234 Clinical Nurse Services	Ltd	364SN0800X Neuroscience (CNS)		
256 Behavioral Health Practitioner	234 Clinical Nurse Services	Ltd	364SR0400X Rehabilitation (CNS)		
256 Behavioral Health Practitioner	234 Clinical Nurse Services	Ltd	364SS0200X School (CNS)		
256 Behavioral Health Practitioner	234 Clinical Nurse Services	Ltd	364ST0500X Transplantation (CNS)		
256 Behavioral Health Practitioner	234 Clinical Nurse Services	Ltd	364SX0106X Occupational Health (CNS)		
256 Behavioral Health Practitioner	234 Clinical Nurse Services	Ltd	364SX0204X Oncology, Pediatrics (CNS)		
001 Hospital	119 Early Intervention Case Management	Ltd	251B00000X Case Management		
001 Hospital	116 Early Intervention Services	Ltd	252Y00000X Early Intervention Provider Agency		
010 Nursing Facility	413 Christian Science Facility	Ltd	282J00000X Christian Science Sanitarium		
010 Nursing Facility	413 Christian Science Facility	Ltd	317400000X Christian Science Facility		
010 Nursing Facility	513 Custodial Care Facility	Ltd	311Z00000X Custodial Care Facility		
010 Nursing Facility	513 Custodial Care Facility	Ltd	311ZA0620X Adult Care Home		
010 Nursing Facility	016 Intermediate Care Facility - Mental Health	Ltd	310500000X Intermediate Care Facility, Mental Illness		
010 Nursing Facility	192 Rehabilitation	Ltd	313M00000X Nursing/Intermediate Care Facility		
010 Nursing Facility	013 Alzheimer Center (Dementia Center)	Ltd	311500000X Alzheimer Center (Dementia Center)		
014 Rehabilitation Hospital	116 Early Intervention Services	Ltd	252Y00000X Early Intervention Provider Agency		
017 Intermediate Care Facility - Developmental Disability	017 Intermediate Care Facility - Developmental Disability	Ltd	315P00000X Intermediate Care Facility, Intellectual or Developmental Disability		
019 Comprehensive Outpatient Rehabilitation Facility	139 Comprehensive Outpatient Rehabilitation Facility	Mod	261QR0401X Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF)		
019 Comprehensive Outpatient Rehabilitation Facility	139 Comprehensive Outpatient Rehabilitation Facility	Mod	261QR0404X Rehabilitation, Cardiac Facilities		

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
019 Comprehensive Outpatient Rehabilitation Facility	139 Comprehensive Outpatient Rehabilitation Facility	Mod	261QR0405X Rehabilitation, Substance Use Disorder		
020 Physician	124 Intern	Ltd	390200000X Student, Health Care		
020 Physician	071 Neurology	Ltd	2084P0800X Psychiatry		
020 Physician	360 Neuromusculoskeletal Medicine	Ltd	204C00000X Neuromusculoskeletal Medicine, Sports Medicine		
020 Physician	360 Neuromusculoskeletal Medicine	Ltd	204D00000X Neuromusculoskeletal Medicine & OMM		
020 Physician	068 Physical Medicine and Rehabilitation	Ltd	208VP0000X Pain Medicine		
020 Physician	068 Physical Medicine and Rehabilitation	Ltd	208VP0014X Interventional Pain Medicine		
020 Physician	063 Ophthalmology	Ltd	207W00000X Ophthalmology		
020 Physician	063 Ophthalmology	Ltd	207WX0009X Glaucoma Specialist		
020 Physician	063 Ophthalmology	Ltd	207WX0107X Retina Specialist		
020 Physician	063 Ophthalmology	Ltd	207WX0108X Uveitis and Ocular Inflammatory Disease		
020 Physician	063 Ophthalmology	Ltd	207WX0109X Neuro-ophthalmology		
020 Physician	063 Ophthalmology	Ltd	207WX0110X Pediatric Ophthalmology and Strabismus Specialist		
020 Physician	063 Ophthalmology	Ltd	207WX0120X Cornea and External Diseases Specialist		
020 Physician	063 Ophthalmology	Ltd	207WX0200X Ophthalmic Plastic and Reconstructive Surgery		
020 Physician	347 Substance Abuse - Psychiatry and Neurology	Ltd	2084A0401X Addiction Medicine		
020 Physician	075 Urology	Ltd	208800000X Urology		
020 Physician	075 Urology	Ltd	2088F0040X Female Pelvic Medicine and Reconstructive Surgery		
020 Physician	075 Urology	Ltd	2088P0231X Pediatric Urology		
020 Physician	074 Cardiothoracic Surgery	Ltd	208G00000X Cardiothoracic Surgery		
020 Physician	058 Colon & Rectal Surgery	Ltd	208C00000X Colon & Rectal Surgery		
020 Physician	056 General Practice	Ltd	208D00000X General Practice		
020 Physician	173 General Surgeon	Ltd	208600000X Surgery		
020 Physician	173 General Surgeon	Ltd	2086H0002X Hospice and Palliative Medicine		
020 Physician	173 General Surgeon	Ltd	2086S0102X Surgical Critical Care		
020 Physician	173 General Surgeon	Ltd	2086S0105X Surgery of the Hand		
020 Physician	173 General Surgeon	Ltd	2086S0120X Pediatric Surgery		
020 Physician	173 General Surgeon	Ltd	2086S0127X Trauma Surgery		
020 Physician	173 General Surgeon	Ltd	2086S0129X Vascular Surgery		
020 Physician	173 General Surgeon	Ltd	2086X0206X Surgical Oncology		
020 Physician	071 Neurology	Ltd	2084A2900X Neurocritical Care		
020 Physician	071 Neurology	Ltd	2084B0002X Obesity Medicine		
020 Physician	071 Neurology	Ltd	2084B0040X Behavioral Neurology & Neuropsychiatry		
020 Physician	071 Neurology	Ltd	2084D0003X Diagnostic Neuroimaging		

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
020 Physician	071 Neurology	Ltd	2084E0001X Epilepsy		
020 Physician	071 Neurology	Ltd	2084F0202X Forensic Psychiatry		
020 Physician	071 Neurology	Ltd	2084H0002X Hospice and Palliative Medicine		
020 Physician	071 Neurology	Ltd	2084N0008X Neuromuscular Medicine		
020 Physician	071 Neurology	Ltd	2084N0400X Neurology		
020 Physician	071 Neurology	Ltd	2084N0402X Neurology with Special Qualifications in Child Neurology		
020 Physician	071 Neurology	Ltd	2084N0600X Clinical Neurophysiology		
020 Physician	071 Neurology	Ltd	2084P0005X Neurodevelopmental Disabilities		
020 Physician	071 Neurology	Ltd	2084P0015X Psychosomatic Medicine		
020 Physician	071 Neurology	Ltd	2084P0301X Brain Injury Medicine		
020 Physician	071 Neurology	Ltd	2084P0804X Child & Adolescent Psychiatry		
020 Physician	071 Neurology	Ltd	2084P0805X Geriatric Psychiatry		
020 Physician	071 Neurology	Ltd	2084P2900X Pain Medicine		
020 Physician	071 Neurology	Ltd	2084S0010X Sports Medicine		
020 Physician	071 Neurology	Ltd	2084S0012X Sleep Medicine		
020 Physician	071 Neurology	Ltd	2084V0102X Vascular Neurology		
020 Physician	064 Orthopedic Surgeon	Ltd	207X00000X Orthopedic Surgery		
020 Physician	064 Orthopedic Surgeon	Ltd	207XP3100X Pediatric Orthopedic Surgery		
020 Physician	064 Orthopedic Surgeon	Ltd	207XS0106X Hand Surgery		
020 Physician	064 Orthopedic Surgeon	Ltd	207XS0114X Adult Reconstructive Orthopedic Surgery		
020 Physician	064 Orthopedic Surgeon	Ltd	207XS0117X Orthopedic Surgery of the Spine		
020 Physician	064 Orthopedic Surgeon	Ltd	207XX0004X Foot and Ankle Surgery		
020 Physician	064 Orthopedic Surgeon	Ltd	207XX0005X Sports Medicine		
020 Physician	064 Orthopedic Surgeon	Ltd	207XX0801X Orthopedic Trauma		
020 Physician	065 Otolaryngology	Ltd	207Y00000X Otolaryngology		
020 Physician	065 Otolaryngology	Ltd	207YP0228X Pediatric Otolaryngology		Pediatric Specialist
020 Physician	065 Otolaryngology	Ltd	207YS0012X Sleep Medicine		
020 Physician	065 Otolaryngology	Ltd	207YS0123X Facial Plastic Surgery		
020 Physician	065 Otolaryngology	Ltd	207YX0007X Plastic Surgery within the Head & Neck		
020 Physician	065 Otolaryngology	Ltd	207YX0602X Otolaryngic Allergy		
020 Physician	065 Otolaryngology	Ltd	207YX0901X Otology & Neurotology		
020 Physician	065 Otolaryngology	Ltd	207YX0905X Otolaryngology/Facial Plastic Surgery		
020 Physician	066 Pathology	Ltd	207ZB0001X Blood Banking & Transfusion Medicine		
020 Physician	066 Pathology	Ltd	207ZC0006X Clinical Pathology		
020 Physician	066 Pathology	Ltd	207ZC0008X Clinical Informatics		
020 Physician	066 Pathology	Ltd	207ZC0500X Cytopathology		
020 Physician	066 Pathology	Ltd	207ZD0900X Dermatopathology		
020 Physician	066 Pathology	Ltd	207ZF0201X Forensic Pathology		
020 Physician	066 Pathology	Ltd	207ZH0000X Hematology		
020 Physician	066 Pathology	Ltd	207ZI0100X Immunopathology		

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
020 Physician	066 Pathology	Ltd	207ZN0500X Neuropathology		
020 Physician	066 Pathology	Ltd	207ZP0007X Molecular Genetic Pathology		
020 Physician	066 Pathology	Ltd	207ZP0101X Anatomic Pathology		
020 Physician	066 Pathology	Ltd	207ZP0102X Anatomic Pathology & Clinical Pathology		
020 Physician	066 Pathology	Ltd	207ZP0104X Chemical Pathology		
020 Physician	066 Pathology	Ltd	207ZP0105X Clinical Pathology/Laboratory Medicine		
020 Physician	066 Pathology	Ltd	207ZP0213X Pediatric Pathology		
020 Physician	068 Physical Medicine & Rehabilitation	Ltd	2081H0002X Hospice and Palliative Medicine		
020 Physician	068 Physical Medicine & Rehabilitation	Ltd	2081P0301X Brain Injury Medicine		
020 Physician	068 Physical Medicine & Rehabilitation	Ltd	2081P2900X Pain Medicine		
020 Physician	069 Plastic Surgery	Ltd	208200000X Plastic Surgery		
020 Physician	069 Plastic Surgery	Ltd	2082S0099X Plastic Surgery Within the Head and Neck		
020 Physician	069 Plastic Surgery	Ltd	2082S0105X Surgery of the Hand		
020 Physician	069 Plastic Surgery	Ltd	2086S0122X Plastic and Reconstructive Surgery		
020 Physician	070 Preventive Medicine	Ltd	2083A0100X Aerospace Medicine		
020 Physician	070 Preventive Medicine	Ltd	2083B0002X Obesity Medicine		
020 Physician	070 Preventive Medicine	Ltd	2083C0008X Clinical Informatics		
020 Physician	070 Preventive Medicine	Ltd	2083P0011X Undersea and Hyperbaric Medicine		
020 Physician	070 Preventive Medicine	Ltd	2083P0500X Preventive Medicine/Occupational Environmental Medicine		
020 Physician	070 Preventive Medicine	Ltd	2083P0901X Public Health & General Preventive Medicine		
020 Physician	070 Preventive Medicine	Ltd	2083S0010X Sports Medicine		
020 Physician	070 Preventive Medicine	Ltd	2083T0002X Medical Toxicology		
020 Physician	070 Preventive Medicine	Ltd	2083X0100X Occupational Medicine		
020 Physician	072 Radiology	Ltd	2085B0100X Body Imaging		
020 Physician	072 Radiology	Ltd	2085D0003X Diagnostic Neuroimaging		
020 Physician	072 Radiology	Ltd	2085H0002X Hospice and Palliative Medicine		
020 Physician	072 Radiology	Ltd	2085N0700X Neuroradiology		
020 Physician	072 Radiology	Ltd	2085N0904X Nuclear Radiology		
020 Physician	072 Radiology	Ltd	2085P0229X Pediatric Radiology		
020 Physician	072 Radiology	Ltd	2085R0001X Radiation Oncology		
020 Physician	072 Radiology	Ltd	2085R0202X Diagnostic Radiology		
020 Physician	072 Radiology	Ltd	2085R0203X Therapeutic Radiology		
020 Physician	072 Radiology	Ltd	2085R0204X Vascular & Interventional Radiology		
020 Physician	072 Radiology	Ltd	2085R0205X Radiological Physics		
020 Physician	072 Radiology	Ltd	2085U0001X Diagnostic Ultrasound		
020 Physician	057 Anesthesiologist	Ltd	207LC0200X Critical Care Medicine		

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
022 Treatment Foster Care Case Management	222 Treatment Foster Care Case Management	Ltd	171M00000X Case Manager/Care Coordinator		
022 Treatment Foster Care Case Management	222 Treatment Foster Care Case Management	Ltd	251B00000X Case Management		
022 Treatment Foster Care Case Management	222 Treatment Foster Care Case Management	Ltd	253J00000X Foster Care Agency		
023 Nurse Practitioner	112 Certified Nurse Midwife	Ltd	367A00000X Advanced Practice Midwife		
023 Nurse Practitioner	243 Certified Registered Nurse Anesthetist	Ltd	367500000X Nurse Anesthetist, Certified Registered		
023 Nurse Practitioner	310 School	Ltd	363LS0200X School		
023 Nurse Practitioner	547 Substance Abuse - Nurse Practitioner	Ltd	363LC1500X Community Health		
023 Nurse Practitioner	022 Women's Health	Ltd	363LW0102X Women's Health		
023 Nurse Practitioner	023 Family	Ltd	363LF0000X Family		
023 Nurse Practitioner	109 Neonatal	Ltd	363LN0000X Neonatal		
023 Nurse Practitioner	109 Neonatal	Ltd	363LN0005X Neonatal, Critical Care		
023 Nurse Practitioner	313 Nurse Practitioner	Ltd	363L00000X Nurse Practitioner		
023 Nurse Practitioner	311 Obstetrics/Gynecology	Ltd	363LX0001X Obstetrics/Gynecology		
023 Nurse Practitioner	312 Occupational Health	Ltd	363LX0106X Occupational Health		
023 Nurse Practitioner	308 Perinatal	Ltd	363LP1700X Perinatal		
023 Nurse Practitioner	110 Acute Care	Ltd	363LA2100X Acute Care		
023 Nurse Practitioner	110 Acute Care	Ltd	363LC0200X Critical Care Medicine		
023 Nurse Practitioner	107 Adult	Ltd	363LA2200X Adult Health		
026 Chiropractor	126 Chiropractor	Ltd	111N00000X Chiropractor		
026 Chiropractor	126 Chiropractor	Ltd	111NI0013X Independent Medical Examiner		
026 Chiropractor	126 Chiropractor	Ltd	111NI0900X Internist		
026 Chiropractor	126 Chiropractor	Ltd	111NN0400X Neurology		
026 Chiropractor	126 Chiropractor	Ltd	111NN1001X Nutrition		
026 Chiropractor	126 Chiropractor	Ltd	111NP0017X Pediatric Chiropractor		
026 Chiropractor	126 Chiropractor	Ltd	111NR0200X Radiology		
026 Chiropractor	126 Chiropractor	Ltd	111NR0400X Rehabilitation		
026 Chiropractor	126 Chiropractor	Ltd	111NS0005X Sports Physician		
026 Chiropractor	126 Chiropractor	Ltd	111NT0100X Thermography		
026 Chiropractor	126 Chiropractor	Ltd	111NX0100X Occupational Health		
026 Chiropractor	126 Chiropractor	Ltd	111NX0800X Orthopedic		
030 Podiatrist	030 Podiatrist	Ltd	213E00000X Podiatrist		
030 Podiatrist	030 Podiatrist	Ltd	213EG0000X General Practice		
030 Podiatrist	030 Podiatrist	Ltd	213EP0504X Public Medicine		
030 Podiatrist	030 Podiatrist	Ltd	213EP1101X Primary Podiatric Medicine		
030 Podiatrist	030 Podiatrist	Ltd	213ER0200X Radiology		
030 Podiatrist	030 Podiatrist	Ltd	213ES0000X Sports Medicine		

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
030 Podiatrist	030 Podiatrist	Ltd	213ES0103X Foot & Ankle Surgery		
030 Podiatrist	030 Podiatrist	Ltd	213ES0131X Foot Surgery		
031 Optometrist	031 Optometrist	Ltd	152W00000X Optometrist		
031 Optometrist	031 Optometrist	Ltd	152WC0802X Corneal and Contact Management		
031 Optometrist	031 Optometrist	Ltd	152WL0500X Low Vision Rehabilitation		
031 Optometrist	031 Optometrist	Ltd	152WP0200X Pediatrics		
031 Optometrist	031 Optometrist	Ltd	152WS0006X Sports Vision		
031 Optometrist	031 Optometrist	Ltd	152WV0400X Vision Therapy		
031 Optometrist	031 Optometrist	Ltd	152WX0102X Occupational Vision		
036 Baby Care	036 Care Coordination	Ltd	171M00000X Case Manager/Care Coordinator		
036 Baby Care	039 Homemaker Services	Ltd	376J00000X Homemaker Services		
036 Baby Care	037 Nutritional Services	Ltd	133NN1002X Nutrition, Education-Dietary & Nutritional Services Provider		
036 Baby Care	038 Patient Education	Ltd	251B00000X Case Management		
036 Baby Care	237 Registered Dietician	Ltd	133V00000X Registered Dietician		
038 Hearing Aid Specialist	238 Hearing Aid Specialist	Ltd	237600000X Hearing Aid Fitter		
038 Hearing Aid Specialist	238 Hearing Aid Specialist	Ltd	332S00000X Hearing Aid Equipment		
039 Therapists	343 Speech and Language Therapy	Ltd	231HA2500X Assistive Technology Supplier		
039 Therapists	343 Speech and Language Therapy	Ltd	2355A2700X Audiology Assistant		
039 Therapists	343 Speech and Language Therapy	Ltd	2355S0801X Speech-Language Assistant		
039 Therapists	343 Speech and Language Therapy	Ltd	237700000X Hearing Instrument Specialist		
039 Therapists	043 Speech-Language Pathologist	Ltd	235Z00000X Speech-Language Pathology		
039 Therapists	045 Occupational Therapist	Ltd	225X00000X Occupational Therapist		
039 Therapists	145 Occupational Therapy	Ltd	224Z00000X Occupational Therapy Assistant		
039 Therapists	145 Occupational Therapy	Ltd	224ZE0001X Environmental Modification (OT Assistant)		
039 Therapists	145 Occupational Therapy	Ltd	224ZF0002X Feeding, Eating & Swallowing (OT Assistant)		
039 Therapists	145 Occupational Therapy	Ltd	224ZL0004X Low Vision		
039 Therapists	145 Occupational Therapy	Ltd	224ZR0403X Driving and Community Mobility		
039 Therapists	145 Occupational Therapy	Ltd	225XE0001X Environmental Modification - (Occupational Therapy)		
039 Therapists	145 Occupational Therapy	Ltd	225XE1200X Ergonomics		
039 Therapists	145 Occupational Therapy	Ltd	225XF0002X Feeding, Eating & Swallowing - (Occupational Therapy)		
039 Therapists	145 Occupational Therapy	Ltd	225XG0600X Gerontology - (Occupational Therapy)		
039 Therapists	145 Occupational Therapy	Ltd	225XH1200X Hand		
039 Therapists	145 Occupational Therapy	Ltd	225XH1300X Human Factors - (Occupational Therapy)		
039 Therapists	145 Occupational Therapy	Ltd	225XL0004X Low Vision		
039 Therapists	145 Occupational Therapy	Ltd	225XM0800X Mental Health		
039 Therapists	145 Occupational Therapy	Ltd	225XN1300X Neurorehabilitation		
039 Therapists	145 Occupational Therapy	Ltd	225XP0019X Physical Rehabilitation		
039 Therapists	145 Occupational Therapy	Ltd	225XP0200X Pediatrics		

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
039 Therapists	145 Occupational Therapy	Ltd	225XR0403X Driving and Community Mobility - (Occupational Therapy)		
039 Therapists	154 Physical Therapist	Ltd	225100000X Physical Therapist		
039 Therapists	254 Physical Therapy	Ltd	2251C2600X Cardiopulmonary		
039 Therapists	254 Physical Therapy	Ltd	2251E1200X Ergonomics		
039 Therapists	254 Physical Therapy	Ltd	2251E1300X Electrophysiology, Clinical		
039 Therapists	254 Physical Therapy	Ltd	2251G0304X Geriatrics		
039 Therapists	254 Physical Therapy	Ltd	2251H1200X Hand		
039 Therapists	254 Physical Therapy	Ltd	2251H1300X Human Factors		
039 Therapists	254 Physical Therapy	Ltd	2251N0400X Neurology		
039 Therapists	254 Physical Therapy	Ltd	2251P0200X Pediatrics		
039 Therapists	254 Physical Therapy	Ltd	2251S0007X Sports		
039 Therapists	254 Physical Therapy	Ltd	2251X0800X Orthopedic		
039 Therapists	254 Physical Therapy	Ltd	225200000X Physical Therapy Assistant		
039 Therapists	339 Rehabilitation	Ltd	225400000X Rehabilitation Practitioner		
039 Therapists	339 Rehabilitation	Ltd	225C00000X Rehabilitation Counselor		
039 Therapists	339 Rehabilitation	Ltd	225CA2500X Assistive Technology Supplier		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	221700000X Art Therapist		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	222Q00000X Developmental Therapist		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	224Y00000X Clinical Exercise Physiologist		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	225700000X Massage Therapist		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	225B00000X Pulmonary Function Technologist		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	226000000X Recreational Therapist Assistant		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	226300000X Kinesiotherapist		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	227800000X Respiratory Therapist, Certified		

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	2278C0205X Critical Care		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	2278E0002X Emergency Care - (Respiratory Therapist)		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	2278E1000X Educational - (Respiratory Therapist)		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	2278G0305X Geriatric Care - (Respiratory Therapist)		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	2278G1100X General Care - (Respiratory Therapist)		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	2278H0200X Home Health		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	2278P1004X Pulmonary Diagnostics		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	2278P1005X Pulmonary Rehabilitation = (Respiratory Therapist)		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	2278P1006X Pulmonary Function Technologist - (Respiratory Therapist)		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	2278P3800X Palliative/Hospice		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	2278P3900X Neonatal/Pediatrics -(Respiratory Therapist)		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	2278P4000X Patient Transport -(Respiratory Therapist)		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	2278S1500X SNF/Subacute Care - (Respiratory Therapist)		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	227900000X Respiratory Therapist, Registered		

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	2279C0205X Critical Care - (Respiratory Therapist)		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	2279E0002X Emergency Care - (Respiratory Therapist)		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	2279E1000X Educational - (Respiratory Therapist)		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	2279G0305X Geriatric Care - (Respiratory Therapist)		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	2279G1100X General Care - (Respiratory Therapist)		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	2279H0200X Home Health		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	2279P1004X Pulmonary Diagnostics		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	2279P1005X Pulmonary Rehabilitation - (Respiratory Therapist)		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	2279P1006X Pulmonary Function Technologist - (Respiratory Therapist)		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	2279P3800X Palliative/Hospice - (Respiratory Therapist)		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	2279P3900X Neonatal/Pediatrics (Respiratory Therapist)		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	2279P4000X Patient Transport - (Respiratory Therapist)		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	2279S1500X SNF/Subacute Care		
039 Therapists	239 Respiratory, Developmental, Rehabilitative and Restorative Service Providers	Ltd	229N00000X Anaplastologist		

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163W00000X Registered Nurse		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WA0400X Registered Nurse (Addiction Substance Use Disorder)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WA2000X Registered Nurse (Administrator)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WC0200X Registered Nurse (Critical Care)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WC1400X College Health - (RN) Nursing Service Provider		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WC1500X Registered Nurse (Community Health)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WC1600X Registered Nurse (Continuing Education/Staff Development)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WC2100X Continence Care - (RN) Nursing Service Provider		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WC3500X Cardiac Rehabilitation - (RN) Nursing Service Provider		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WD0400X Registered Nurse (Diabetic Educator)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WD1100X Dialysis, Peritoneal - (RN) Nursing Service Provider		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WE0003X Registered Nurse (Emergency)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WE0900X Enterostomal Therapy - (RN) Nursing Service Provider		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WG0000X Registered Nurse (General Practice)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WG0100X Registered Nurse (Gastroenterology)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WG0600X Registered Nurse (Gerontology)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WH0200X Registered Nurse (Home Health)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WH0500X Registered Nurse (Hemodialysis)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WH1000X Registered Nurse (Hospice)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WI0500X Infusion Therapy - (RN) Nursing Service Provider		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WI0600X Registered Nurse (Infection Control)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WL0100X Registered Nurse (Lactation Consultant)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WM0102X Registered Nurse (Maternal Newborn)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WM0705X Registered Nurse (Medical-Surgical)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WM1400X Nurse Massage Therapist (NMT) - (RN) Nursing Service Provider		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WN0002X Registered Nurse (Neo-natal Intensive Care)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WN0003X Neonatal, Low-Risk - (RN) Nursing Service Provider		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WN0300X Registered Nurse (Nephrology)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WN0800X Registered Nurse (Neuroscience)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WN1003X Nutrition Support - (RN) Nursing Service Provider		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WP0000X Registered Nurse (Pain Management)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WP0200X Registered Nurse (Pediatrics)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WP0218X Pediatric Oncology - (RN) Nursing Service Provider		

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WP0807X Psychiatric/Mental Health, Child & Adolescent		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WP0808X Registered Nurse (Psychiatric/Mental Health)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WP0809X Registered Nurse (Psychiatric/Mental Health, Adult)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WP1700X Registered Nurse (Perinatal)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WP2201X Registered Nurse (Ambulatory Care)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WR0006X Registered Nurse (First Assistant)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WR0400X Registered Nurse (Rehabilitation)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WR1000X Registered Nurse (Reproductive Endocrinology/Infertility)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WS0121X Registered Nurse (Plastic Surgery)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WS0200X Registered Nurse (School)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WU0100X Registered Nurse (Urology)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WW0000X Registered Nurse (Wound Care)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WW0101X Registered Nurse (Women's Health Care, Ambulatory Care)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WX0002X Obstetric, High-Risk - (RN) Nursing Service Provider		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WX0003X Registered Nurse (Obstetrics, Inpatient)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WX0106X Occupational Health - (RN) Nursing Service Provider		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WX0200X Registered Nurse (Oncology)		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WX0601X Otorhinolaryngology & Head-Neck - (RN) Nursing Service Provider		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WX0800X Orthopedic - (RN) Nursing Service Provider		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WX1100X Ophthalmic - (RN) Nursing Service Provider		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	163WX1500X Ostomy Care - (RN) Nursing Service Provider		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	164W00000X Licensed Practical Nurse		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	164X00000X Licensed Vocational Nurse		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	167G00000X General Practice - (RN) Nursing Service Provider		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	374700000X Technician		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	374U00000X Home Health Aide		
043 Nursing Service Providers	143 Nursing Service Providers	Ltd	376K00000X Nurse's Aide		
043 Nursing Service Providers	143 Anesthesiologist Assistant	Ltd	367H00000X Anesthesiologist Assistant		
044 Audiologist	044 Audiology	Ltd	231H00000X Audiologist		
044 Audiologist	044 Audiology	Ltd	231HA2400X Assistive Technology Practitioner		
045 Specialist/Technician	245 Specialist/Technician	Ltd	132700000X Dietary Manager		
045 Specialist/Technician	245 Specialist/Technician	Ltd	133N00000X Nutritionist		
045 Specialist/Technician	245 Specialist/Technician	Ltd	133VN1004X Nutrition, Pediatric		
045 Specialist/Technician	245 Specialist/Technician	Ltd	133VN1005X Nutrition, Renal		
045 Specialist/Technician	245 Specialist/Technician	Ltd	133VN1006X Nutrition, Metabolic		

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
045 Specialist/Technician	245 Specialist/Technician	Ltd	136A00000X Dietetic Technician, Registered		
045 Specialist/Technician	245 Specialist/Technician	Ltd	170100000X Medical Genetics, Ph.D. Medical Genetics		
045 Specialist/Technician	245 Specialist/Technician	Ltd	170300000X Genetic Counselor, PHD		
045 Specialist/Technician	245 Specialist/Technician	Ltd	171100000X Acupuncturist		
045 Specialist/Technician	245 Specialist/Technician	Ltd	171R00000X Interpreter		
045 Specialist/Technician	245 Specialist/Technician	Ltd	172M00000X Mechanotherapist		
045 Specialist/Technician	245 Specialist/Technician	Ltd	172P00000X Naprapath		
045 Specialist/Technician	245 Specialist/Technician	Ltd	172V00000X Community Health Worker		
045 Specialist/Technician	245 Specialist/Technician	Ltd	173000000X Legal Medicine		
045 Specialist/Technician	245 Specialist/Technician	Ltd	173C00000X Reflexologist		
045 Specialist/Technician	245 Specialist/Technician	Ltd	173F00000X Sleep Specialist, PHD		
045 Specialist/Technician	245 Specialist/Technician	Ltd	1744G0900X Graphics Designer (Technologist)		
045 Specialist/Technician	245 Specialist/Technician	Ltd	1744R1102X Research Study		
045 Specialist/Technician	245 Specialist/Technician	Ltd	1744R1103X Research Data Abstracter/Coder (Specialist/Technologist)		
045 Specialist/Technician	245 Specialist/Technician	Ltd	174H00000X Health Educator		
045 Specialist/Technician	245 Specialist/Technician	Ltd	174M00000X Veterinarian		
045 Specialist/Technician	245 Specialist/Technician	Ltd	174MM1900X Veterinarian-Medical Research		
045 Specialist/Technician	245 Specialist/Technician	Ltd	174N00000X Lactation Consultant, Non-RN		
045 Specialist/Technician	245 Specialist/Technician	Ltd	174V00000X Clinical Ethicist		
045 Specialist/Technician	245 Specialist/Technician	Ltd	175F00000X Naturopath		
045 Specialist/Technician	245 Specialist/Technician	Ltd	175L00000X Homeopath		
045 Specialist/Technician	245 Specialist/Technician	Ltd	175M00000X Midwife, Lay		
045 Specialist/Technician	245 Specialist/Technician	Ltd	176P00000X Funeral Director		
045 Specialist/Technician	245 Specialist/Technician	Ltd	202C00000X Independent Medical Examiner		
045 Specialist/Technician	245 Specialist/Technician	Ltd	202K00000X Phlebology		
045 Specialist/Technician	245 Specialist/Technician	Ltd	209800000X Legal Medicine		
045 Specialist/Technician	245 Specialist/Technician	Ltd	224900000X Mastectomy Fitter		
045 Specialist/Technician	245 Specialist/Technician	Ltd	224L00000X Pedorthist		
045 Specialist/Technician	245 Specialist/Technician	Ltd	225500000X Specialist/Technologist		
045 Specialist/Technician	245 Specialist/Technician	Ltd	2255A2300X Athletic Trainer		
045 Specialist/Technician	245 Specialist/Technician	Ltd	2255R0406X Rehabilitation, Blind (Specialist/Technologist)		
045 Specialist/Technician	245 Specialist/Technician	Ltd	225600000X Dance Therapist - (Specialist/Technologist)		
045 Specialist/Technician	245 Specialist/Technician	Ltd	225800000X Recreation Therapist - (Specialist/Technologist)		
045 Specialist/Technician	245 Specialist/Technician	Ltd	225A00000X Music Therapist - (Specialist/Technologist)		
045 Specialist/Technician	245 Specialist/Technician	Ltd	225CX0006X Rehabilitation Counselor (Specialist/Technologist)		
045 Specialist/Technician	245 Specialist/Technician	Ltd	235500000X Specialist/Technologist		
045 Specialist/Technician	245 Specialist/Technician	Ltd	242T00000X Perfusionist		
045 Specialist/Technician	245 Specialist/Technician	Ltd	243U00000X Radiology Practitioner Assistant		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246Q00000X Specialist, Technology-Pathology		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246QB0000X Blood Banking - (Specialist/Technologist)		

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
045 Specialist/Technician	245 Specialist/Technician	Ltd	246QC1000X Chemistry - (Specialist/Technologist)		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246QC2700X Cytotechnologist		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246QH0000X Hematology		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246QH0401X Hemapheresis Practitioner - (Specialist/Technologist)		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246QH0600X Histology - (Specialist/Technologist)		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246QI0000X Immunology - (Specialist/Technologist)		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246QL0900X Laboratory Management - (Specialist/Technologist)		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246QL0901X Laboratory Management, Diplomate - (Specialist/Technologist)		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246QM0706X Medical Technologist - (Specialist/Technologist)		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246QM0900X Microbiology		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246R00000X Technician, Pathology		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246RH0600X Histology		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246RM2200X Medical Technician		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246RP1900X Phlebotomy		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246W00000X Technician, Cardiology		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246X00000X Specialist/Technologist Cardiovascular		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246XC2901X Cardiovascular Invasive Specialist		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246XC2903X Vascular Specialist		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246XS1301X Sonography		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246Y00000X Specialist/Technologist, Health Information		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246YC3301X Coding Specialist, Hospital Based		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246YC3302X Coding Specialist, Physician Office Based		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246YR1600X Registered Record Administrator		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246Z00000X Specialist/Technologist, Other		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246ZA2600X Art, Medical		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246ZB0301X Biomedical Engineering		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246ZB0302X Biomedical Photographer		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246ZB0500X Biochemist		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246ZB0600X Biostatistician		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246ZC0007X Surgical Assistant		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246ZE0500X EEG		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246ZE0600X Electroneurodiagnostic		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246ZG0701X Graphics Methods		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246ZG1000X Geneticist, Medical (PhD)		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246ZI1000X Illustration, Medical		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246ZN0300X Nephrology		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246ZS0410X Surgical Technologist		
045 Specialist/Technician	245 Specialist/Technician	Ltd	246ZX2200X Orthopedic Assistant		

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
045 Specialist/Technician	245 Specialist/Technician	Ltd	247000000X Technician, Health Information		
045 Specialist/Technician	245 Specialist/Technician	Ltd	2470A2800X Assistant Record Technician		
045 Specialist/Technician	245 Specialist/Technician	Ltd	247100000X Radiologic Technologist		
045 Specialist/Technician	245 Specialist/Technician	Ltd	2471B0102X Bone Densitometry - (Radiologic Technologist)		
045 Specialist/Technician	245 Specialist/Technician	Ltd	2471C1101X Cardiovascular-Interventional Technology		
045 Specialist/Technician	245 Specialist/Technician	Ltd	2471C1106X Cardiac-Interventional Technology - (Radiologic Technologist)		
045 Specialist/Technician	245 Specialist/Technician	Ltd	2471C3401X Computed Tomography - (Radiologic Technologist)		
045 Specialist/Technician	245 Specialist/Technician	Ltd	2471C3402X Radiography - (Radiologic Technologist)		
045 Specialist/Technician	245 Specialist/Technician	Ltd	2471M1202X Magnetic Resonance Imaging		
045 Specialist/Technician	245 Specialist/Technician	Ltd	2471M2300X Mammography - (Radiologic Technologist)		
045 Specialist/Technician	245 Specialist/Technician	Ltd	2471N0900X Nuclear Medicine Technology		
045 Specialist/Technician	245 Specialist/Technician	Ltd	2471Q0001X Quality Management - (Radiologic Technologist)		
045 Specialist/Technician	245 Specialist/Technician	Ltd	2471R0002X Radiation Therapy		
045 Specialist/Technician	245 Specialist/Technician	Ltd	2471S1302X Sonography		
045 Specialist/Technician	245 Specialist/Technician	Ltd	2471V0105X Vascular Sonography		
045 Specialist/Technician	245 Specialist/Technician	Ltd	2471V0106X Vascular-Interventional Technology - (Radiologic Technologist)		
045 Specialist/Technician	245 Specialist/Technician	Ltd	247200000X Technician, Other		
045 Specialist/Technician	245 Specialist/Technician	Ltd	2472B0301X Biomedical Engineering - (technician - other)		
045 Specialist/Technician	245 Specialist/Technician	Ltd	2472D0500X Darkroom - (technician - other)		
045 Specialist/Technician	245 Specialist/Technician	Ltd	2472E0500X EEG - (technician - other)		
045 Specialist/Technician	245 Specialist/Technician	Ltd	2472R0900X Renal Dialysis		
045 Specialist/Technician	245 Specialist/Technician	Ltd	2472V0600X Veterinary - (technician - other)		
045 Specialist/Technician	245 Specialist/Technician	Ltd	247ZC0005X Clinical Laboratory Director, Non-physician		
045 Specialist/Technician	245 Specialist/Technician	Ltd	251V00000X Voluntary or Charitable		
045 Specialist/Technician	245 Specialist/Technician	Ltd	251X00000X Supports Brokerage		
045 Specialist/Technician	245 Specialist/Technician	Ltd	374K00000X Religious Nonmedical Practitioner		
045 Specialist/Technician	245 Specialist/Technician	Ltd	374T00000X Religious Nonmedical Nursing Personnel		
045 Specialist/Technician	245 Specialist/Technician	Ltd	376G00000X Nursing Home Administrator		
045 Specialist/Technician	245 Specialist/Technician	Ltd	405300000X Prevention Professional		
046 Hospice	046 Hospice	Mod	251G00000X Hospice Care, Community Based		
046 Hospice	046 Hospice	Mod	315D00000X Hospice, Inpatient		
048 Dental Clinic Medical	041 Dental Clinic	Ltd	1223D0001X Dental Public Health		
048 Dental Clinic Medical	041 Dental Clinic	Ltd	261QD0000X Dental Clinic		
048 Dental Clinic Medical	041 Dental Clinic	Ltd	261QS0112X Oral and Maxillofacial Surgery		
049 Ambulatory Surgical Center	249 Ambulatory Surgical Center	Ltd	261QA0005X Ambulatory Family Planning Facility		
049 Ambulatory Surgical Center	249 Ambulatory Surgical Center	Ltd	261QA1903X Ambulatory Surgical		

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
049 Ambulatory Surgical Center	249 Ambulatory Surgical Center	Ltd	261QE0800X Endoscopy		
049 Ambulatory Surgical Center	249 Ambulatory Surgical Center	Ltd	261QL0400X Lithotripsy		
049 Ambulatory Surgical Center	249 Ambulatory Surgical Center	Ltd	261QM1101X Military and U.S. Coast Guard Ambulatory Procedure		
049 Ambulatory Surgical Center	249 Ambulatory Surgical Center	Ltd	261QM1102X Military Outpatient Operational (Transportable) Component		
049 Ambulatory Surgical Center	249 Ambulatory Surgical Center	Ltd	261QM1103X Military Ambulatory Procedure Visits Operational (Transportable)		
049 Ambulatory Surgical Center	249 Ambulatory Surgical Center	Ltd	261QM1300X Multi-Specialty		
049 Ambulatory Surgical Center	249 Ambulatory Surgical Center	Ltd	261QM2500X Medical Specialty		
049 Ambulatory Surgical Center	249 Ambulatory Surgical Center	Ltd	261QP2400X Prison Health		
049 Ambulatory Surgical Center	249 Ambulatory Surgical Center	Ltd	261QR0800X Recovery Care		
049 Ambulatory Surgical Center	249 Ambulatory Surgical Center	Ltd	261QR1100X Research		
049 Ambulatory Surgical Center	249 Ambulatory Surgical Center	Ltd	261QS0132X Ophthalmologic Surgery		
051 Clinics	153 Rural Health Clinic	Ltd	261QR1300X Rural Health		
051 Clinics	217 Sleep Disorder	Ltd	261QS1200X Sleep Disorder Diagnostic		
051 Clinics	216 Student Health	Ltd	261QS1000X Student Health		
051 Clinics	271 Substance Abuse Clinic	Ltd	261QR0405X Rehabilitation, Substance Use Disorder		
051 Clinics	219 Urgent Care	Ltd	261QU0200X Urgent Care		
051 Clinics	220 Veterans Affair	Ltd	261QV0200X VA-Veterans Affairs		
051 Clinics	324 Augmentative Communication	Ltd	261QA3000X Augmentative Communication		
051 Clinics	223 Birthing	Ltd	261QB0400X Birthing		
051 Clinics	321 Clinic/Center	Ltd	261Q00000X Clinic/Center		
051 Clinics	325 Corporate Health	Ltd	261QC1800X Corporate Health		
051 Clinics	202 Developmental Disabilities	Ltd	261QD1600X Developmental Disabilities		
051 Clinics	203 Emergency Care	Ltd	261QE0002X Emergency Care		
051 Clinics	205 Family Planning, Non-Surgical	Ltd	261QF0050X Family Planning, Non-Surgical		
051 Clinics	052 Federally Qualified Health Center	Ltd	261QF0400X Federally Qualified Health Center (FQHC)		
051 Clinics	052 Federally Qualified Health Center	Ltd	261QP0904X Public Health, Federal		
051 Clinics	052 Federally Qualified Health Center	Ltd	261QR0405X Rehabilitation, Substance Use Disorder		

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
051 Clinics	206 Genetics	Ltd	261QG0250X Genetics		
051 Clinics	151 Health Department Clinic	Ltd	261QC1500X Community Health		
051 Clinics	151 Health Department Clinic	Ltd	261QH0100X Health Service		
051 Clinics	151 Health Department Clinic	Ltd	261QP0905X Public Health State or Local Clinic		
051 Clinics	151 Health Department Clinic	Ltd	261QR0405X Rehabilitation - Substance Use Disorder		
051 Clinics	207 Infusion Therapy	Ltd	261QI0500X Infusion Therapy		
051 Clinics	209 Magnetic Resonance Imaging	Ltd	261QM1200X Magnetic Resonance Imaging (MRI)		
051 Clinics	211 Medically Fragile Infants and Children Day Care	Ltd	261QM3000X Medically Fragile Infants and Children Day Care		
051 Clinics	326 Migrant Health	Ltd	261QM1000X Migrant Health		
051 Clinics	208 Military Outpatient	Ltd	261QM1100X Military/U.S. Coast Guard Outpatient		
051 Clinics	221 Oncology	Ltd	261QX0200X Oncology		
051 Clinics	221 Oncology	Ltd	261QX0203X Oncology, Radiation		
051 Clinics	214 Pain	Ltd	261QP3300X Pain		
051 Clinics	212 Podiatric	Ltd	261QP1100X Podiatric		
051 Clinics	213 Primary Care	Ltd	261QP2300X Primary Care		Primary Care Provider
051 Clinics	215 Radiology	Ltd	261QR0200X Radiology		
051 Clinics	215 Radiology	Ltd	261QR0206X Radiology, Mammography		
051 Clinics	215 Radiology	Ltd	261QR0207X Radiology, Mobile Mammography		
051 Clinics	050 Renal Dialysis Clinic	Ltd	261QE0700X End-Stage Renal Disease (ESRD) Treatment		
051 Clinics	323 Ambulatory Fertility Facility	Ltd	261QA0006X Ambulatory Fertility Facility		
056 Waiver Services	807 Community Coaching	Ltd	251C00000X Day Training/Developmental Disability	97127	
056 Waiver Services	826 Therapeutic Consultation (professional)	Ltd	251C00000X Day Training/Developmental Disability	97139	
056 Waiver Services	814 Group Day Support Services	Ltd	251C00000X Day Training/Developmental Disability	97150	
056 Waiver Services	827 Therapeutic Consultation (non-professional)	Ltd	251C00000X Day Training/Developmental Disability	97530	
056 Waiver Services	819 In-Home Support Services and Customized In-Home Support Services	Ltd	253Z00000X In Home Support Care/General	97535	
056 Waiver Services	807 Community Coaching	Ltd	251C00000X Day Training/Developmental Disability	97537	
056 Waiver Services	831 Non-emergency Transportation	Ltd	251C00000X Day Training/Developmental Disability	A0090	
056 Waiver Services	831 Non-emergency Transportation	Ltd	251C00000X Day Training/Developmental Disability	A0110	
056 Waiver Services	831 Non-emergency Transportation	Ltd	251C00000X Day Training/Developmental Disability	A0120	
056 Waiver Services	820 Peer Mentor Supports	Ltd	251C00000X Day Training/Developmental Disability	H0038	
056 Waiver Services	825 Supported Living Residential Tier 1-4 and/or Customized Supported Living Residential	Ltd	251C00000X Day Training/Developmental Disability	H0043	

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
056 Waiver Services	819 In-Home Support Services and Customized In-Home Support Services	Ltd	253Z00000X In Home Support Care/General	H2014	
056 Waiver Services	809 Community Guide	Ltd	251C00000X Day Training/Developmental Disability	H2015	
056 Waiver Services	815 Group Home Residential and Customized Group Home Residential	Ltd	251C00000X Day Training/Developmental Disability	H2022	
056 Waiver Services	818 Individual Supported Employment	Ltd	251C00000X Day Training/Developmental Disability	H2023	
056 Waiver Services	816 Group Supported Employment	Ltd	251C00000X Day Training/Developmental Disability	H2024	
056 Waiver Services	829 Workplace Assistive Services	Ltd	251C00000X Day Training/Developmental Disability	H2025	
056 Waiver Services	810 Companion Services	Ltd	372600000X Adult Companion	S5136	
056 Waiver Services	806 Community Based Crisis Support (non-professionals and professionals)	Ltd	251C00000X Day Training/Developmental Disability	S9484	
056 Waiver Services	804 Case Management (State Plan Option)	Ltd	163WC0400X Case Management	T1017	
056 Waiver Services	823 Shared Living	Ltd	251C00000X Day Training/Developmental Disability	T1020	
056 Waiver Services	803 Benefits Planning	Ltd	251C00000X Day Training/Developmental Disability	T1023	
056 Waiver Services	807 Community Coaching	Ltd	251C00000X Day Training/Developmental Disability	T2013	
056 Waiver Services	815 Group Home Residential and Customized Group Home Residential	Ltd	251C00000X Day Training/Developmental Disability	T2016	
056 Waiver Services	808 Community Engagement Tier 1-4	Ltd	251C00000X Day Training/Developmental Disability	T2021	
056 Waiver Services	814 Group Day Support Services	Ltd	251C00000X Day Training/Developmental Disability	T2025	
056 Waiver Services	817 Independent Living Support Services - Tier 1 -4	Ltd	373H00000X Day Training/Habitation Specialist	T2032	
056 Waiver Services	824 Sponsored Residential and Customized Sponsored Residential	Ltd	251C00000X Day Training/Developmental Disability	T2033	
056 Waiver Services	805 Center Based Crisis Support (non-professionals and professionals)	Ltd	251C00000X Day Training/Developmental Disability	T2034	
056 Waiver Services	806 Community Based Crisis Support (non-professionals and professionals)	Ltd	251C00000X Day Training/Developmental Disability	T2034	
056 Waiver Services	812 Crisis Support Services (non-professional and professionals)	Ltd	251C00000X Day Training/Developmental Disability	T2034	
056 Waiver Services	828 Transition Services	Ltd	251C00000X Day Training/Developmental Disability	T2038	
056 Waiver Services	810 Companion Services	Ltd	372600000X Adult Companion	Y0070	
056 Waiver Services	802 Assisted Living	Ltd	3104A0630X Assisted Living, Behavioral Disturbances		

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
056 Waiver Services	116 Early Intervention Services	Ltd	252Y00000X Early Intervention Provider Agency		
057 Outpatient Rehabilitation Facility	116 Early Intervention Services	Ltd	252Y00000X Early Intervention Provider Agency		
057 Outpatient Rehabilitation Facility	157 Outpatient Rehabilitation Facility	Ltd	261QH0700X Hearing and Speech		
057 Outpatient Rehabilitation Facility	157 Outpatient Rehabilitation Facility	Ltd	261QP2000X Physical Therapy		
057 Outpatient Rehabilitation Facility	157 Outpatient Rehabilitation Facility	Ltd	261QR0400X Rehabilitation		
057 Outpatient Rehabilitation Facility	157 Outpatient Rehabilitation Facility	Ltd	261QR0401X Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF)		
057 Outpatient Rehabilitation Facility	157 Outpatient Rehabilitation Facility	Ltd	261QX0100X Occupational Medicine		
059 Home Health Agency	116 Early Intervention Services	High	252Y00000X Early Intervention Provider Agency		
059 Home Health Agency	055 Non-Hospital Based Home Health Agency	High	251E00000X Home Health		
060 Pharmacy	269 Home Infusion	Ltd	251F00000X Home Infusion		
060 Pharmacy	168 Pharmacy Services	Ltd	332000000X Military/U.S. Coast Guard Pharmacy		
060 Pharmacy	168 Pharmacy Services	Ltd	332100000X Department of Veterans Affairs (VA) Pharmacy		
060 Pharmacy	168 Pharmacy Services	Ltd	332800000X Indian Health Service/Tribal/Urban Indian Health (I/T/U) Pharmacy		
060 Pharmacy	168 Pharmacy Services	Ltd	3336M0002X Mail Order Pharmacy		
060 Pharmacy	168 Pharmacy Services	Ltd	3336M0003X Managed Care Organization Pharmacy		
060 Pharmacy	168 Pharmacy Services	Ltd	3336N0007X Nuclear Pharmacy		
060 Pharmacy	168 Pharmacy Services	Ltd	3336S0011X Specialty Pharmacy		
061 Pharmacy-Long Term Care	322 Long Term Care Pharmacy Non-Unit Dose	Ltd	332900000X Non-Pharmacy Dispensing Site		
062 Durable Medical Equipment	562 Environmental Modifications	High	171WH0202X Home Modifications		
063 Private Duty Nursing Services	116 Early Intervention Services	Ltd	252Y00000X Early Intervention Provider Agency		
064 Prosthetic and Orthotics	264 Prosthetic and Orthotics	High	174400000X Specialist		
064 Prosthetic and Orthotics	264 Prosthetic and Orthotics	High	1744P3200X Prosthetics Case Management		
064 Prosthetic and Orthotics	264 Prosthetic and Orthotics	High	222Z00000X Orthotist		
064 Prosthetic and Orthotics	264 Prosthetic and Orthotics	High	224P00000X Prosthetist		
064 Prosthetic and Orthotics	264 Prosthetic and Orthotics	High	225000000X Orthotic Fitter		
064 Prosthetic and Orthotics	264 Prosthetic/Orthotic Services	High	335E00000X Prosthetic/Orthotic Supplier		
070 Laboratory Services	498 Dental Laboratory	Mod	292200000X Dental Laboratory (Dental)		
070 Laboratory Services	098 Independent Laboratory	Mod	291U00000X Clinical Medical Laboratory		
070 Laboratory Services	398 Military Clinical Medical Laboratory	Mod	291900000X Military Clinical Medical Laboratory		

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
070 Laboratory Services	298 Physiological Laboratory	Mod	293D00000X Physiological Laboratory		
071 Diagnostic and Imaging Centers	198 Diagnostic and Imaging Centers	Mod	261QR0208X Radiology, Mobile		
071 Diagnostic and Imaging Centers	198 Diagnostic and Imaging Centers	Mod	335V00000X Portable X-ray and/or Other Portable Diagnostic Imaging Supplier		
072 Local Education Agency	051 School Based Clinic/Practitioner	Ltd	251300000X Local Education Agency		
072 Local Education Agency	025 Special Ed - Nursing Services	Ltd	251300000X Local Education Agency		
072 Local Education Agency	028 Special Ed - Occupational Therapy	Ltd	251300000X Local Education Agency		
072 Local Education Agency	019 Special Ed - Personal Care Services	Ltd	251300000X Local Education Agency		
072 Local Education Agency	027 Special Ed - Physical Therapy	Ltd	251300000X Local Education Agency		
072 Local Education Agency	026 Special Ed - Psych Services	Ltd	251300000X Local Education Agency		
072 Local Education Agency	029 Special Ed - Speech/Language Therapy	Ltd	251300000X Local Education Agency		
072 Local Education Agency	020 Special Ed - Transportation	Ltd	251300000X Local Education Agency		
072 Local Education Agency	018 Special ED- Audiologist	Ltd	251300000X Local Education Agency		
077 Residential Treatment Facility	077 Substance Abuse	Ltd	323P00000X Psychiatric Residential Treatment Facility		
077 Residential Treatment Facility	077 Residential Treatment Facility	Ltd	320600000X Residential Treatment Facility, Developmental Disabilities		
077 Residential Treatment Facility	077 Residential Treatment Facility	Ltd	320700000X Residential Treatment Facility, Physical Disabilities		
077 Residential Treatment Facility	077 Residential Treatment Facility	Ltd	320800000X Community Based Residential Treatment Facility, Mental Illness		
077 Residential Treatment Facility	077 Residential Treatment Facility	Ltd	320900000X Community Based Residential Treatment, Mental Retardation and/or Developmental Disabilities		
077 Residential Treatment Facility	132 ARTS-ASAM 3.7-Residential Treatment-Child	Ltd	320600000X Residential Treatment Facility, Mental Retardation and/or Developmental Disabilities		Pediatric Behavioral Health
080 Emergency Transportation	251 Water Transportation	Mod	3416S0300X Water Transport		
080 Emergency Transportation	251 Water Transportation	Mod	3418M1130X Military or U.S. Coast Guard Ambulance, Water Transport		
080 Emergency Transportation	149 Neonatal Ambulance	Mod	3416L0300X Land Transport		
080 Emergency Transportation	121 Air Transport	Mod	3416A0800X Air Transport		
080 Emergency Transportation	121 Air Transport	Mod	3418M1120X Military or U.S. Coast Guard Ambulance, Air Transport		
080 Emergency Transportation	121 Air Transport	Mod	344800000X Air Carrier		
080 Emergency Transportation	201 Ambulance	Mod	341600000X Ambulance		
080 Emergency Transportation	201 Ambulance	Mod	3416L0300X Land Transport		
080 Emergency Transportation	201 Ambulance	Mod	341800000X Military/US Coast Guard Transport		

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
080 Emergency Transportation	201 Ambulance	Mod	3418M1110X Military/US Coast Guard Ground Transportation		
081 Non-Emergency Transportation	404 Secured Van	Ltd	343800000X Secured Medical Transport (VAN)		
081 Non-Emergency Transportation	409 Stretcher Van/Wheelchair	Ltd	3416L0300X Land Transport		
081 Non-Emergency Transportation	403 Taxi	Ltd	344600000X Taxi		
081 Non-Emergency Transportation	405 Train	Ltd	347D00000X Train		
081 Non-Emergency Transportation	406 Transportation Broker	Ltd	347C00000X Private Vehicle		
081 Non-Emergency Transportation	402 Van	Ltd	343900000X Non-emergency Medical Transport (VAN)		
081 Non-Emergency Transportation	412 Volunteer Driver	Ltd	251V00000X Voluntary or Charitable		
081 Non-Emergency Transportation	408 Bus/Mass Transit	Ltd	347B00000X Bus		
081 Non-Emergency Transportation	410 Private Vehicle - Gas Reimbursement	Ltd	347C00000X Private Vehicle		
081 Non-Emergency Transportation	411 Registered Driver	Ltd	172A00000X Driver		
082 Emergency Medical Technician	184 Emergency Medical Technician (Basic)	Ltd	146N00000X Emergency Medical Technician (Basic)		
082 Emergency Medical Technician	183 Emergency Medical Technician (Intermediate)	Ltd	146M00000X Emergency Medical Technician (Intermediate)		
082 Emergency Medical Technician	182 Emergency Medical Technician (Paramedic)	Ltd	146L00000X Emergency Medical Technician (Paramedic)		
083 NEMT-Ground Ambulance	407 NEMT-Ground Ambulance	Mod	341600000X Ambulance		
083 NEMT-Ground Ambulance	407 NEMT-Ground Ambulance	Mod	3418M1130X Military or U.S. Coast Guard Ambulance, Water Transport		
104 Program for All Inclusive Care for Elderly	113 Full PACE (Program for All Inclusive Care for Elderly)	Ltd	251T00000X Program for All-Inclusive Care for the Elderly (PACE) Provider Organization		
105 Certified Professional Midwife	105 Certified Professional Midwife	Ltd	176B00000X Midwife		
105 Certified Professional Midwife	105 Certified Professional Midwife	Ltd	367A00000X Advance Practice Midwife		
107 Administration	329 CCC	Ltd	302R00000X Health Maintenance Organization		
107 Administration	319 CCC Plus	Ltd	302R00000X Health Maintenance Organization		
107 Administration	317 Medallion 3	Ltd	302R00000X Health Maintenance Organization		
107 Administration	318 Medallion 4	Ltd	302R00000X Health Maintenance Organization		
108 Early Intervention	116 Early Intervention Services	Ltd	252Y00000X Early Intervention Provider Agency		

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
117 Doula	717 Doula	High	374J00000X Doula		
120 Physician Assistant	120 Physician Assistant	Ltd	363A00000X Physician Assistant		
120 Physician Assistant	120 Physician Assistant	Ltd	363AM0700X Medical		
120 Physician Assistant	120 Physician Assistant	Ltd	363AS0400X Surgical Technologist		
130 Podiatry Assistant	330 Podiatry Assistant	Ltd	211D00000X Assistant, Podiatric - (Podiatry)		
141 Military Healthcare Provider	241 Military Healthcare Provider	Ltd	171000000X Military Health Care Provider		
141 Military Healthcare Provider	241 Military Healthcare Provider	Ltd	1710I1002X Independent Duty Corpsman		
141 Military Healthcare Provider	241 Military Healthcare Provider	Ltd	1710I1003X Independent Duty Medical Technicians - Military Health Provider		
156 Behavioral Health Services	900 Mental Health- Case Management	Ltd	251B00000X Case Management	H0023	Behavioral Health
156 Behavioral Health Services	908 Mental Health Peer Recovery Support Services/Individual	Ltd	175T00000X Peer Specialist	H0024	
156 Behavioral Health Services	908 Mental Health Peer Recovery Support Services/Group	Ltd	175T00000X Peer Specialist	H0025	
231 Optician	231 Optician	Ltd	156F00000X Technician/Technologist		
231 Optician	231 Optician	Ltd	156FC0800X Contact Lens		
231 Optician	231 Optician	Ltd	156FC0801X Contact Lens Fitter		
231 Optician	231 Optician	Ltd	156FX1100X Ophthalmic		
231 Optician	231 Optician	Ltd	156FX1101X Ophthalmic Assistant		
231 Optician	231 Optician	Ltd	156FX1201X Optometric Assistant		
231 Optician	231 Optician	Ltd	156FX1202X Optometric Technician		
231 Optician	231 Optician	Ltd	156FX1700X Ocularist		
231 Optician	231 Optician	Ltd	156FX1800X Optician		
231 Optician	231 Optician	Ltd	156FX1900X Orthoptist		
331 Optical Clinic	331 Optical Clinic	Ltd	332H00000X Eyewear Supplier		
356 Behavioral Health Clinic	141 Behavioral Health Clinic	Mod	261QM0801X Mental Health (Including Community Mental Health Center)		
356 Behavioral Health Clinic	141 Behavioral Health Clinic	Mod	261QM0850X Adult Mental Health		
456 Behavioral Health Clinic	141 Behavioral Health Clinic	Mod	261QM0801X Mental Health (Including Community Mental Health Center)		
456 Behavioral Health Clinic	141 Behavioral Health Clinic	Mod	261QM0850X Adult Mental Health		
456 Behavioral Health Clinic and Services	908 Mental Health Peer Recovery Support Services/Individual	Mod	175T00000X Peer Specialist	H0024	
456 Behavioral Health Clinic and Services	908 Mental Health Peer Recovery Support Services/Group	Mod	175T00000X Peer Specialist	H0025	
573 Public Health Agency	033 Center for Independent Living Skills (CILS)	Ltd	251K00000X Public Health or Welfare		

Provider Type	Provider Specialty	Risk	Taxonomy	SubClass	Critical Provider Category
573 Public Health Agency	131 Community Services Board (CSB)	Ltd	251K00000X Public Health or Welfare		
573 Public Health Agency	034 Department of Social Services (DSS)	Ltd	251K00000X Public Health or Welfare		
573 Public Health Agency	130 Area Agency on Aging (AAA)	Ltd	251K00000X Public Health or Welfare		
700 Meals	701 Home Delivered Meals	Ltd	332U00000X Home Delivered Meals		
700 Meals	700 Meals	Ltd	174200000X Meals		
701 Lodging	702 Lodging	Ltd	177F00000X Lodging		
703 Blood Bank	703 Blood Bank	Ltd	331L00000X Blood Bank		
704 Eye Bank	704 Eye Bank	Ltd	332G00000X Eye Bank		
990 Group Practice	990 Single & Multi-Specialty Group	Ltd	193200000X Multi-Specialty		
990 Group Practice	990 Single & Multi-Specialty Group	Ltd	193400000X Single Specialty		

6.8 Provider Taxonomy Crosswalk for Cardinal Enrollment Broker File

Only the following provider taxonomy code values will be accepted and loaded to the Maximus provider database. The Maximus provider search function does not include provider types that are not relevant to member MCO selection.

Maximus Type	Taxonomy
Behavioral Health Therapists and Counselors	101Y00000X, 101YA0400X, 101YM0800X, 101YP1600X, 101YP2500X, 101YS0200X, 102L00000X, 102X00000X, 103G00000X, 103GC0700X, 103K00000X, 103T00000X, 103TA0400X, 103TA0700X, 103TB0200X, 103TC0700X, 103TC1900X, 103TC2200X, 103TE1000X, 103TE1100X, 103TF0000X, 103TF0200X, 103TH0004X, 103TH0100X, 103TM1700X, 103TM1800X, 103TP0016X, 103TP0814X, 103TP2700X, 103TP2701X, 103TR0400X, 103TS0200X, 103TW0100X, 104100000X, 1041C0700X, 1041S0200X, 106H00000X
Chiropractor	111N00000X, 111NI0013X, 111NI0900X, 111NN0400X, 111NN1001X, 111NP0017X, 111NR0200X, 111NR0400X, 111NS0005X, 111NT0100X, 111NX0100X, 111NX0800X
Dietary and Nutritional Providers	132700000X, 133N00000X, 133NN1002X, 133V00000X, 133VN1004X, 133VN1005X, 133VN1006X, 136A00000X
Eye Wear Supplier	332H00000X
Hospitals	273100000X, 273R00000X, 273Y00000X, 275N00000X, 276400000X, 281P00000X, 281PC2000X, 282E00000X, 282J00000X, 282N00000X, 282NC0060X, 282NC2000X, 282NR1301X, 282NW0100X, 283Q00000X, 283X00000X, 283XC2000X, 284300000X, 286500000X, 2865C1500X, 2865M2000X, 2865X1600X, 287300000X
Laboratories	291900000X, 291U00000X, 292200000X, 293D00000X
Nursing and Custodial Facilities	310400000X, 3104A0625X, 3104A0630X, 310500000X, 311500000X, 311Z00000X, 311ZA0620X, 313M00000X, 314000000X, 3140N1450X, 315D00000X, 315P00000X, 317400000X
Occupational, Physical and Respiratory Therapists	224Z00000X, 224ZE0001X, 224ZF0002X, 224ZL0004X, 224ZR0403X, 225000000X, 225100000X, 2251C2600X, 2251E1200X, 2251E1300X, 2251G0304X, 2251H1200X, 2251H1300X, 2251N0400X, 2251P0200X, 2251S0007X, 2251X0800X, 225200000X, 225400000X, 225500000X, 2255A2300X, 2255R0406X, 225600000X, 225700000X, 225800000X, 225A00000X, 225B00000X, 225C00000X, 225CA2400X, 225CA2500X, 225CX0006X, 225X00000X, 225XE0001X, 225XE1200X, 225XF0002X, 225XG0600X, 225XH1200X, 225XH1300X, 225XL0004X, 225XM0800X, 225XN1300X, 225XP0019X, 225XP0200X, 225XR0403X, 226000000X, 226300000X, 227800000X, 2278C0205X, 2278E0002X, 2278E1000X, 2278G0305X, 2278G1100X, 2278H0200X, 2278P1004X, 2278P1005X, 2278P1006X, 2278P3800X, 2278P3900X, 2278P4000X, 2278S1500X, 227900000X, 2279C0205X, 2279E0002X, 2279E1000X, 2279G0305X, 2279G1100X, 2279H0200X, 2279P1004X, 2279P1005X, 2279P1006X, 2279P3800X, 2279P3900X, 2279P4000X, 2279S1500X, 229N00000X
Pharmacy	183500000X, 1835C0205X, 1835G0000X, 1835G0303X, 1835N0905X, 1835N1003X, 1835P0018X, 1835P0200X, 1835P1200X, 1835P1300X, 1835P2201X, 1835X0200X, 183700000X, 333600000X, 3336C0002X, 3336C0003X, 3336C0004X, 3336H0001X, 3336I0012X, 3336L0003X, 3336M0002X, 3336M0003X, 3336N0007X, 3336S0011X

Maximus Type	Taxonomy
Physician Assistants and Nurse Practitioners	363A00000X, 363AM0700X, 363AS0400X, 363L00000X, 363LA2100X, 363LA2200X, 363LC0200X, 363LC1500X, 363LF0000X, 363LG0600X, 363LN0000X, 363LN0005X, 363LP0200X, 363LP0222X, 363LP0808X, 363LP1700X, 363LP2300X, 363LS0200X, 363LW0102X, 363LX0001X, 363LX0106X, 364S00000X, 364SA2100X, 364SA2200X, 364SC0200X, 364SC1501X, 364SC2300X, 364SE0003X, 364SE1400X, 364SF0001X, 364SG0600X, 364SH0200X, 364SH1100X, 364SI0800X, 364SL0600X, 364SM0705X, 364SN0000X, 364SN0800X, 364SP0200X, 364SP0807X, 364SP0808X, 364SP0809X, 364SP0810X, 364SP0811X, 364SP0812X, 364SP0813X, 364SP1700X, 364SP2800X, 364SR0400X, 364SS0200X, 364ST0500X, 364SW0102X, 364SX0106X, 364SX0200X, 364SX0204X, 367500000X, 367A00000X, 367H00000X
Physicians - Obstetrics and Gynecology	207V00000X, 207VB0002X, 207VC0200X, 207VE0102X, 207VF0040X, 207VG0400X, 207VH0002X, 207VM0101X, 207VX0000X, 207VX0201X
Physicians - Pediatrics	208000000X, 2080A0000X, 2080B0002X, 2080C0008X, 2080H0002X, 2080I0007X, 2080N0001X, 2080P0006X, 2080P0008X, 2080P0201X, 2080P0202X, 2080P0203X, 2080P0204X, 2080P0205X, 2080P0206X, 2080P0207X, 2080P0208X, 2080P0210X, 2080P0214X, 2080P0216X, 2080S0010X, 2080S0012X, 2080T0002X, 2080T0004X
Physicians - Primary Care	207Q00000X, 207QA0000X, 207QA0401X, 207QA0505X, 207QB0002X, 207QG0300X, 207QH0002X, 207QS0010X, 207QS1201X, 207R00000X, 207RA0000X, 207RA0001X, 207RA0201X, 207RA0401X, 207RB0002X, 207RC0000X, 207RC0001X, 207RC0200X, 207RE0101X, 207RG0100X, 207RG0300X, 207RH0000X, 207RH0002X, 207RH0003X, 207RH0005X, 207RI0001X, 207RI0008X, 207RI0011X, 207RI0200X, 207RM1200X, 207RN0300X, 207RP1001X, 207RR0500X, 207RS0010X, 207RS0012X, 207RT0003X, 207RX0202X, 208D00000X

Maximus Type	Taxonomy
Specialty Physicians	193200000X, 193400000X, 202C00000X, 202K00000X, 204C00000X, 204D00000X, 204E00000X, 204F00000X, 204R00000X, 207K00000X, 207KA0200X, 207KI0005X, 207L00000X, 207LA0401X, 207LC0200X, 207LH0002X, 207LP2900X, 207LP3000X, 207N00000X, 207ND0101X, 207ND0900X, 207NI0002X, 207NP0225X, 207NS0135X, 207P00000X, 207PE0004X, 207PE0005X, 207PH0002X, 207PP0204X, 207PS0010X, 207PT0002X, 207SC0300X, 207SG0201X, 207SG0202X, 207SG0203X, 207SG0205X, 207SM0001X, 207T00000X, 207U00000X, 207UN0901X, 207UN0902X, 207UN0903X, 207W00000X, 207WX0200X, 207X00000X, 207XP3100X, 207XS0106X, 207XS0114X, 207XS0117X, 207XX0004X, 207XX0005X, 207XX0801X, 207Y00000X, 207YP0228X, 207YS0012X, 207YS0123X, 207YX0007X, 207YX0602X, 207YX0901X, 207YX0905X, 207ZB0001X, 207ZC0006X, 207ZC0008X, 207ZC0500X, 207ZD0900X, 207ZF0201X, 207ZH0000X, 207ZI0100X, 207ZM0300X, 207ZN0500X, 207ZP0007X, 207ZP0101X, 207ZP0102X, 207ZP0104X, 207ZP0105X, 207ZP0213X, 208100000X, 2081H0002X, 2081N0008X, 2081P0004X, 2081P0010X, 2081P0301X, 2081P2900X, 2081S0010X, 208200000X, 2082S0099X, 2082S0105X, 2083A0100X, 2083B0002X, 2083C0008X, 2083P0011X, 2083P0500X, 2083P0901X, 2083S0010X, 2083T0002X, 2083X0100X, 2084A0401X, 2084B0002X, 2084B0040X, 2084D0003X, 2084F0202X, 2084H0002X, 2084N0008X, 2084N0400X, 2084N0402X, 2084N0600X, 2084P0005X, 2084P0015X, 2084P0301X, 2084P0800X, 2084P0802X, 2084P0804X, 2084P0805X, 2084P2900X, 2084S0010X, 2084S0012X, 2084V0102X, 2085B0100X, 2085D0003X, 2085H0002X, 2085N0700X, 2085N0904X, 2085P0229X, 2085R0001X, 2085R0202X, 2085R0203X, 2085R0204X, 2085R0205X, 2085U0001X, 208600000X, 2086H0002X, 2086S0102X, 2086S0105X, 2086S0120X, 2086S0122X, 2086S0127X, 2086S0129X, 2086X0206X, 208800000X, 2088F0040X, 2088P0231X, 208C00000X, 208G00000X, 208M00000X, 208U00000X, 208VP0000X, 208VP0014X, 209800000X, 211D00000X, 213E00000X, 213EG0000X, 213EP0504X, 213EP1101X, 213ER0200X, 213ES0000X, 213ES0103X, 213ES0131X, 261Q00000X, 261QA0005X, 261QA0006X, 261QA0600X, 261QA0900X, 261QA1903X, 261QA3000X, 261QB0400X, 261QC0050X, 261QC1500X, 261QC1800X, 261QD0000X, 261QD1600X, 261QE0002X, 261QE0700X, 261QE0800X, 261QF0050X, 261QF0400X, 261QG0250X, 261QH0100X, 261QH0700X, 261QI0500X, 261QL0400X, 261QM0801X, 261QM0850X, 261QM0855X, 261QM1000X, 261QM1100X, 261QM1101X, 261QM1102X, 261QM1103X, 261QM1200X, 261QM1300X, 261QM2500X, 261QM2800X, 261QM3000X, 261QP0904X, 261QP0905X, 261QP1100X, 261QP2000X, 261QP2300X, 261QP2400X, 261QP3300X, 261QR0200X, 261QR0206X, 261QR0207X, 261QR0208X, 261QR0400X, 261QR0401X, 261QR0404X, 261QR0405X, 261QR0800X, 261QR1100X, 261QR1300X, 261QS0112X, 261QS0132X, 261QS1000X, 261QS1200X, 261QU0200X, 261QV0200X, 261QX0100X, 261QX0200X, 261QX0203X
Speech, Language and Hearing Providers	231H00000X, 231HA2400X, 231HA2500X, 235500000X, 2355A2700X, 2355S0801X, 235Z00000X, 237600000X, 237700000X

6.9 Other Documentation and Resources

Manual	Subject Area	Location
Virginia Provider Network PRN File Guide	PRSS	
Virginia Provider NPPR File Guide	PRSS	
PRSS Provider Code Value Descriptions	PRSS	
VA Crosswalk Legacy PT SPEC Taxonomy	PRSS	
VA Enrollment Attachments	PRSS	
834 Enrollment Roster EDI Companion Guide	EDI	
820 Payment Detail EDI Companion Guide	EDI	
Cardinal Care Managed Care Encounters Technical Manual	Encounters	
837I Companion Guide	Encounters / EDI	
837P Companion Guide	Encounters / EDI	
EPS Business Rules For External Audience	Encounters	
CRMS_MCO_Technical Manual_Version	CRMS	
MCO MTR Specifications	CRMS	