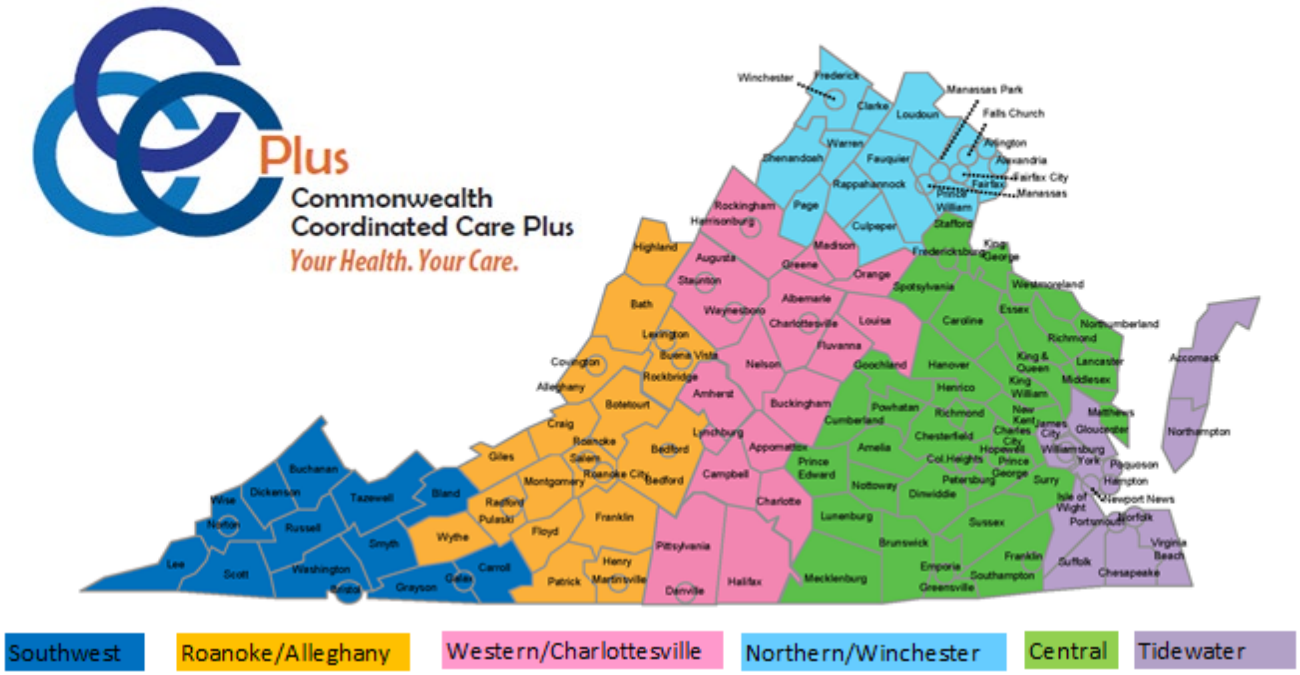
CCC Plus
Technical Manual



Virginia Department of Medical Assistance Services
Version 2.38

Table of Contents

Version Change Summary

Ver.	Description	Date
1.0	Added Version Change Summary and updated page numbering of Technical Manual.	6/21/17
1.0	Section 1.5.4.1: Added contract reference.	6/21/17
1.0	Section 2.1.3.1: Added delimiter to file format	6/21/17
1.0	Section 1.7.2: Added Marketing Fraud/Waste/Abuse report and updated page numbering of Technical Manual.	6/21/17
1.0	Section 1.6.5.2: Added reference to Program Integrity Activities Quarterly Report template.	6/29/17
1.0	Section 1.6.5.3: Updated reporting requirements.	6/29/17
1.0	Section 1.5.1: Drug Rebate Report changed from quarterly to annual. Reporting Quarter field added. Drug Rebate Report is now under section 1.6.1. Section numbers for other quarterly and annual reports updated accordingly.	7/5/17
1.0	Section 1.7.5.2: Added pre-payment review section to template for Notification of Provider Investigation.	7/10/17
1.0	Section 1.7.5.3: Modified requirements with regard to pre-payment review.	7/10/17
1.0	Section 1.5.1.2: Modified definition of sentinel event.	7/10/17
1.0	Section 1.6.2: Removed Health Insurer Fee report from manual. This report is not required for 2017. Section numbers of subsequently listed annual reports adjusted accordingly.	7/10/17
1.0	Section 1.4.5: Added city to Foster Care Barrier Report template.	7/24/17
1.0	Section 17.8.1: Changed submission method to “DMAS secure CCC Plus FTP server”	7/26/17
1.0	Section 1.4.2.2: Added field Service Auth Category	8/1/17
1.0	Section 1.4.8.2: Added field PUMS Pharmacy Contract Status	8/1/17
1.0	Section 1.7.1.2: Changed requirements to allow for reporting of multiple members.	8/8/17
1.0	Section 1.7.1.1: Changed “Excluded Member” report template option list for exclusion reasons.	8/10/17

Ver.	Description	Date
1.0	Section 1.7.1.1: Changed data format for Medicaid ID field on "Excluded Member" report template to numeric to prevent ID from displaying with scientific notation.	8/28/17
1.0	Section 1.4.1.2: Removed Substance Abuse Treatment Services from report specifications.	8/29/17
1.0	Section 1.4.1.3: Updated Requirements section with note regarding behavioral health appeals.	8/29/17
1.0	Section 1.4.2: Expanded title of report to define acronym ARTS.	8/29/17
1.0	Section 1.4.11: Added Addiction and Recovery Treatments Services (ARTS) Appeals & Grievances Summary report.	8/29/17
1.0	Section 1.7.1.1: Customized data format for Medicaid ID field on "Excluded Member" report template so that leading zeros will be displayed.	9/1/17
1.0	Section 1.4.12: Added Addiction and Recovery Treatment Services (ARTS) Call Center Statistics report.	9/1/17
1.0	Section 2.1.3.1: Updated method of delivery.	9/1/17
1.0	Section 1.6.1.2: Removed specifications for Drug Rebate Report pending their finalization.	9/6/17
1.0	Section 1.4.8.2: Modified specifications for PUMS Trigger Type, PUMS End Date and PUMS Pharmacy Contract Status.	9/6/17
1.0	Section 2.1.2: Corrected the dates in the chart for the Capitation Payment Remittance (820).	9/14/17
1.0	Section 1.5.2.2: Added reporting template CCCP_FIN_QTRLY	9/22/17
1.1	Section 1.7.1.1: Changed file name for report submission.	11/2/17
1.1	Section 1.4.13: Added Community Mental Health Rehabilitation Services (CMHRS) Service Authorizations and Registrations report.	11/2/17
1.1	Section 1.4.14: Added Community Mental Health Rehabilitation Services (CMHRS) Appeals & Grievances Summary report.	11/2/17
1.1	Section 1.4.15: Added Behavioral Health Call Center Statistics report.	11/2/17
1.1	Section 1.5.7: Modified Drug Rebate report specification and changed report from annual to quarterly.	11/2/17
1.1	Section 1.4.1.2: Added fields to Appeals & Grievances Summary report.	11/2/17
1.1	Section 1.4.16: Added Member Appeals report.	11/2/17
2.0	Section 1.2.4: Updated text.	1/16/18
2.0	Section 1.2.5: Updated text.	1/16/18
2.0	Section 1.2.6: Updated text.	1/16/18

Ver.	Description	Date
2.0	Section 1.5.7: Updated Drug Rebate Report specifications to enhance the clarity of the reporting requirements.	1/16/18
2/0	Section 1.7.8: Removed Closed Date from field list in specifications.	1/16/18
2.0	Section 1.5.9: Changed submission frequency to quarterly and moved from Monthly Reports to Quarterly Reports. The removal of this report from Monthly Reports altered other report numbers as follows: - 1.4.10 is now 1.4.9 - 1.4.11 is now 1.4.10 - 1.4.12 is now 1.4.11 - 1.4.13 is now 1.4.12 - 1.4.14 is now 1.4.13 - 1.4.15 is now 1.4.14 - 1.4.16 is now 1.4.15	1/19/18
2.0	Section 1.4.2: Replaced specifications with reference to ARTS Technical Manual.	1/19/18
2.0	Section 1.4.8: Replaced specifications with reference to ARTS Technical Manual.	1/19/18
2.0	Section 1.4.10: Replaced specifications with reference to ARTS Technical Manual.	1/19/18
2.0	Section 1.4.16: Added deliverable with reference to ARTS Technical Manual for specifications.	1/19/18
2.0	Section 1.4.17: Added deliverable with reference to ARTS Technical Manual for specifications.	1/19/18
2.0	Section 1.5.9: Changed file name used for submission.	1/19/18
2.0	Section 1.2: Changed normal maximum version update frequency for Technical Manual from monthly to quarterly.	1/21/18
2.0	Added Appendix A, “Core Performance Measure Reporting Requirements.”	1/21/18
2.0	Added Appendix B, "Waiver Assurance Measures.”	1/21/18
2.0	Section 1.5.8: Added deliverable.	1/21/18
2.1	Appendix A: Added table of contents	2/21/18
2.1	Appendix A – 1.41: Changed reporting frequency from semi-annual to annual.	2/21/18
2.1	Appendix A – 1.42: Changed reporting frequency from semi-annual to annual.	2/21/18
2.1	Appendix A – 1.43: Changed reporting frequency from semi-annual to annual.	2/21/18
2.1	Appendix A – 3.10: Changed reporting frequency from semi-annual to annual.	2/21/18
2.1	Section 1.6.7: Updated stop loss pricing and units for Medication Administration.	3/1/18

Ver.	Description	Date
2.1	Section 1.6.7: Changed reference to MCTM to CCC Plus Technical Manual	3/1/18
2.1	Appendix A – 1.14: Corrected specifications for numerators to count increases and decreases in authorized hours and not members. Added continuous enrollment requirement.	3/6/18
2.1	Appendix A – 1.15: Corrected specifications for numerator to count increases and decreases in authorized hours and not members. Added continuous enrollment requirement.	3/6/18
2.1	Section 1.5.6: Updated CLAIM_ID; combined FILL_DATE and FROM_DATE fields; eliminated STATUS; added CLM_TYPE; made allowance for COPAY to equal 0.	3/8/18
2.1	Section 1.5.7.3: Updated SharePoint link	3/9/18
2.1	Various sections: Added link to SharePoint site for all reporting templates referenced.	3/9/18
2.1	Section 1.4.12.2: Changed file format to Excel.	3/9/18
2.1	Section 1.4.13.2: Changed file format to Excel.	3/9/18
2.1	Section 1.4.15.2: Changed file format to Excel.	3/9/18
2.1	Section 1.4.14: Eliminated deliverable.	3/9/18
2.1	Sections 1.5.9: Changed submission frequency from quarterly to monthly. New section number is 1.4.18.	3/9/18
2.1	Sections 1.4.17: Changed submission frequency from quarterly to monthly.	3/9/18
2.1	Section 1.6.8: Added deliverable for value-based payment data collection.	3/10/18
2.1	Section 1.6.9: Added deliverable for value-based status.	3/10/18
2.1	Appendix A – 1.37: Changed reporting frequency from annual to semi-annual.	3/10/18
2.1	Section 1.4.17: Changed file naming convention.	4/19/18
2.1	Various sections: Updated all SharePoint links for new SharePoint platform.	4/19/18
2.1	Appendix A – 1.49: Changed continuous enrollment requirement.	4/19/18
2.1	Appendix A – 1.38: Changed due date.	4/30/18
2.1	Appendix A – 1.39: Changed due date.	4/30/18
2.1	Appendix A – 1.47: Changed due date.	4/30/18
2.1	Appendix A – 1.49: Changed due date.	4/30/18
2.1	Appendix A – 1.50: Changed due date.	4/30/18
2.1	Appendix A – 1.51: Changed due date.	4/30/18
2.1	Appendix A – 2.1: Changed due date.	4/30/18

Ver.	Description	Date
2.1	Appendix A – 2.2: Changed due date.	4/30/18
2.1	Appendix A – 2.4: Changed due date.	4/30/18
2.1	Appendix A – 2.5: Changed due date.	4/30/18
2.1	Appendix A – 2.6: Changed due date.	4/30/18
2.1	Appendix A – 2.7: Changed due date.	4/30/18
2.1	Appendix A – 2.13: Changed due date.	4/30/18
2.1	Appendix A – 4.1: Changed due date.	4/30/18
2.1	Appendix A – 4.3: Changed due date.	4/30/18
2.1	Appendix A – 1.44: Changed numerator to members with encounter; changed inclusion criteria for eligible population.	4/30/18
2.1	Appendix A – 1.2: Changed from semi-annual to annual reporting period.	4/30/18
2.1	Appendix A – 1.3: Replaced with HEDIS measure Identification of Alcohol and Other Drug Services.	4/30/18
2.1	Appendix A – 1.4: Replaced with HEDIS measure Follow-Up after Emergency Department Visit for Alcohol and Other Drug Dependence.	4/30/18
2.1	Appendix A – 1.41: Replaced with equivalent HEDIS measure.	4/30/18
2.1	Appendix A – 1.42: Replace with equivalent HEDIS measure.	4/30/18
2.1	Appendix A – 1.49: Added intake period and continuous enrollment period. Added further details for numerator and denominator. Added value sets.	4/30/18
2.1	Appendix A – 1.50: Changed due date for first submission to September 30, 2018.	4/30/18
2.1	Appendix A – 1.51: Changed due date for first submission to September 30, 2018.	4/30/18
2.1	Appendix A – 4.1: Added allowance for use of HRA to complete measure.	4/30/18
2.1	Appendix A – 1.43: Noted that measure is under review.	4/30/18
2.1	Appendix A – 2.4: Noted that measure is under review.	4/30/18
2.1	Appendix A – 3.10: Noted that measure is under review.	4/30/18
2.1	Appendix A: For each HEDIS measures, added requirement that plans must use a HEDIS certified vendor/auditor to complete the measure.	4/30/18
2.1	Section 1.7.10: New deliverable.	4/30/18
2.1	Section 1.5.4: Change name of reporting template.	4/30/18
2.1	Section 1.2: Changed location of Technical Manual from FTP server to SharePoint.	4/30/18

Ver.	Description	Date
2.1	Section 1.2.2.1: Added requirement that a blank report be submitted in the event that there is no data to report.	4/30/18
2.1	Section 1.4.18: Added deliverable.	4/30/18
2.1	Section 1.5.3: Changed name of report and added new reporting template.	4/30/18
2.1	Section 1.6.4: Noted that this report is under review.	4/30/18
2.1	Section 1.6.8: New deliverable.	4/30/18
2.1	Section 1.6.9: New deliverable.	4/30/18
2.1	Section 1.4.17: Moved deliverable to Other Reports section.	4/30/18
2.1	Section 1.7.9: Moved deliverable from Monthly section 1.4.17.	4/30/18
2.1	Section 1.7.10: New deliverable.	4/30/18
2.1	Section 2.1.1: Updated text.	4/30/18
2.1	Section 2.1.2: Updated text and sample remittance schedule.	4/30/18
2.1	Section 2.1.4: Added specifications.	4/30/18
2.1	Section 2.1.6: Added specifications.	4/30/18
2.1	Section 1.5.9: Added new deliverable.	4/30/18
2.2	Appendix A – 3.7: Changed invalid reference to NQF measure #2599 under "Notes – Additional Clarification" to NQF measure #0418.	9/4/18
2.2	Appendix A – 2.13: Corrected numerator to designate the number of discharges rather than the number of members.	9/4/18
2.2	Section 1.3.3: Added deliverable	9/4/18
2.2	Section 2.1.10: Added DMAS report	9/4/18
2.2	Section 1.5.10: Added deliverable	9/4/18
2.2	Section 1.4.18.2: Changed method of submission.	9/4/18
2.2	Section 1.4.13.2: Removed extra space preceding underscore in file name.	9/4/18
2.2	Section 2.1.4.2: Removed extra space preceding underscore in file name.	9/4/18
2.2	Section 2.1.5.2: Removed extra space preceding underscore in file name.	9/4/18
2.2	Section 2.1.9.2: Removed extra space preceding underscore in file name.	9/4/18
2.2	Section 1.5.2.2: Updated template used for report and revised due dates.	9/4/18
2.2	Section 1.7.5.2: Changed submission method.	9/4/18
2.2	Section 1.7.7.2: Changed submission method.	9/4/18
2.2	Section 1.7.2.1: Updated contract reference.	9/4/18

Ver.	Description	Date
2.2	Section 1.7.2.2: Changed submission method.	9/4/18
2.2	Section 1.7.3.2: Added specifications.	9/4/18
2.2	Section 1.4.11.1: Updated contract references.	9/4/18
2.2	Section 1.4.11.2: Replaced detailed specifications with reference to ARTS Technical Manual.	9/4/18
2.2	Section 1.4.16: Eliminated deliverable.	9/4/18
2.2	Section 1.5.7.2: Added "Total Rebate Amount Collected Year-to-Date"	9/4/18
2.2	Section 1.7.10.2: Added BillZieser@dmas.virginia.gov as destination for delivery.	9/4/18
2.2	Appendix A – 1.5: Replaced original measure description with HEDIS measure description.	9/4/18
2.2	Section 1.4.19: Added deliverable	9/4/18
2.2	Appendix A – 1.11: Added sampling option to measure specifications.	9/4/18
2.2	Appendix A – 1.12: Added sampling option to measure specifications.	9/4/18
2.2	Appendix A – 1.13: Added sampling option to measure specifications.	9/4/18
2.2	Appendix A – 1.45: Added note that this measure will be calculated by DMAS; no submission from plans will be required.	9/4/18
2.2	Appendix A – 1.1 through 1.9; 1.17 through 1.36; 1.40 through 1.42; 3.1 through 3.6; 3.8, 3.9, 3.11: Changed due date from June 30 to July 31 following the measurement year.	9/4/18
2.2	Appendix A – 1.2, 1.3, 1.4, 1.41 and 1.42: Eliminated submission requirement for partial measurement year 2017.	9/4/18
2.2	Appendix A – 1.43: Eliminated deliverable.	9/4/18
2.2	Appendix A – 1.10: Added sampling option to measure specifications.	9/4/18
2.2	Appendix A – 1.26: Added note indicating that first submission not due until 2020 due to continuous enrollment requirement.	9/4/18
2.2	Appendix A – 1.5.2.2: Changed due date for 2nd quarter report to August 15.	9/4/18
2.2	Section 1.4.5.2: Updated specifications.	9/4/18
2.2	Appendix A – 4.1: Added ICD-CM-10 code values for identifying members with newly diagnosed pressure ulcers.	9/4/18
2.2	Appendix A – 3.12: Added sampling option.	9/4/18
2.2	Appendix A – 2.6: Revised specifications. Removed note indicating that measure is under review.	9/4/18
2.2	Appendix A – 3.7: Added note that measure is under review.	9/4/18

Ver.	Description	Date
2.2	Appendix A – 1.52: Added deliverable.	9/4/18
2.3	Section 1.2.1: Made correction to FTP server description.	11/15/18
2.3	Section 1.4.12.2: Added Procedure Code Modifier.	11/15/18
2.3	Section 1.4.19: Noted that report is under review by DMAS.	11/15/18
2.3	Section 1.5.2.2: Changed file naming convention and due date for second quarter.	11/15/18
2.3	Section 1.5.2.2: Placed new report template on SharePoint	11/15/18
2.3	Section 1.5.2.3: Updated "Requirements" section.	11/15/18
2.3	Section 1.5.7.2: Added data element "Total Rebate Amount Invoiced to Date Since Start of Program."	11/15/18
2.3	Section 1.5.9: Added due dates per contract.	11/15/18
2.3	Section 1.5.10: Adjusted due dates to align with contract.	11/15/18
2.3	Section 1.6.4: Deliverable eliminated.	11/15/18
2.3	Section 1.6.10: Added deliverable.	11/15/18
2.3	Section 1.6.11: Added deliverable.	11/15/18
2.3	Section 1.6.12: Added deliverable.	11/15/18
2.3	Section 1.6.13: Added deliverable.	11/15/18
2.3	Section 1.6.14: Added deliverable.	11/15/18
2.3	Section 1.6.15: Added deliverable.	11/15/18
2.3	Section 1.6.16: Added deliverable.	11/15/18
2.3	Section 1.6.17: Added deliverable.	11/15/18
2.3	Section 1.6.18: Added deliverable.	11/15/18
2.3	Section 1.7.11: Added deliverable.	11/15/18
2.3	Section 1.7.2: Deliverable eliminated.	11/15/18
2.3	Appendix A – 1.1 - 1.9, 1.16 - 1.36, 1.40 – 1.42, 1.52, 3.1 – 3.6, 3.8, 3.9, 3.11: Removed condition limiting measure to non-dual eligible members and those dual eligible members whose Medicare coverage is managed by the same plan that manages their CCC Plus coverage.	11/15/18
2.3	Appendix A – 1.47: Added code value set for inpatient stay.	11/15/18
2.3	Appendix A – 1.49: Deleted Butrans and Belbuca from drug list.	11/15/18
2.3	Appendix A – 1.49: Added explanatory notes for surplus supplies.	11/15/18
2.3	Appendix A – 1.49: Added Sublocade to drug list.	11/15/18

Ver.	Description	Date
2.3	Appendix A – 1.49: Added footnote to drug list indicating that the dispensing date should be used as the treatment start date for Probuphine.	11/15/18
2.3	Appendix A – 2.2: Revised specifications. Added exclusions to eligible population. Added criteria for numerator under Notes.	11/15/18
2.3	Appendix A – 4.1: Added clarifying language to Denominator 2 description.	11/15/18
2.3	Appendix A – 4.1: Added CPT code values.	11/15/18
2.3	Appendix B – 2.7: Eliminated measure because it duplicated measure 2.1. Renumbered measures 2.8 through 2.13 (now 2.7 through 2.12).	11/15/18
2.4	Appendix A 1.45: Eliminated measure.	6/1/2019
2.4	Appendix A 1.47: Updated continuous enrollment requirement; eliminated inpatient stay value set.	6/1/2019
2.4	Appendix A 2.1: Added clarification to eligible population definition.	6/1/2019
2.4	Appendix A 2.6: Removed key performance indicator designation.	6/1/2019
2.4	Appendix A 2.7: Eliminated measure.	6/1/2019
2.4	Appendix A 3.12: Eliminated measure.	6/1/2019
2.4	Appendix B: Eliminated appendix.	6/1/2019
2.4	Section 1.3.3.1: Updated contract reference.	6/1/2019
2.4	Section 1.3.3.3: Updated requirements.	6/1/2019
2.4	Section 1.4.1.1: Updated contract references.	6/1/2019
2.4	Section 1.4.5.2: Updated specifications.	6/1/2019
2.4	Section 1.4.11: Eliminated deliverable.	6/1/2019
2.4	Section 1.4.12.2: Made Denial Reason a required field.	6/1/2019
2.4	Section 1.4.15.1: Updated contract references.	6/1/2019
2.4	Section 1.4.19: Eliminated note that indicated report was under review.	6/1/2019
2.4	Section 1.4.19.3: Added explanatory material to reporting requirements.	6/1/2019
2.4	Section 1.4.20: Moved deliverable from Other Reports (see 1.7.10) to Monthly Reports.	6/1/2019
2.4	Section 1.5.1.2: Added “Actions Taken by MCO” to specifications.	6/1/2019
2.4	Section 1.5.1.2: Changed file name for submission of deliverable.	6/1/2019
2.4	Section 1.5.2.2: Changed due date for April through June report to August 15.	6/1/2019
2.4	Section 1.5.3.1: Updated contract reference.	6/1/2019
2.4	Section 1.5.7.2: Made reporting template available on SharePoint; updated specifications to indicate reporting of collected rebate amount since start of	6/1/2019

Ver.	Description	Date
	program; eliminated invoiced amount since start of program; corrected format for prescription count (eliminated decimal point); updated submission method.	
2.4	Section 1.5.11: Added deliverable.	6/1/2019
2.4	Section 1.5.12: Added deliverable.	6/1/2019
2.4	Section 1.6.1.2: Added reference to reporting template on SharePoint.	6/1/2019
2.4	Section 1.6.2.2: Changed due date	6/1/2019
2.4	Section 1.6.3.2: Changed due date.	6/1/2019
2.4	Section 1.6.5.2: Changed due date	6/1/2019
2.4	Section 1.6.6.2: Changed due date.	6/1/2019
2.4	Section 1.6.9.2: Changed file name.	6/1/2019
2.4	Section 1.6.12: Moved report to Other Reports (see 1.7.12) and eliminated annual requirement.	6/1/2019
2.4	Section 1.6.19: Added deliverable.	6/1/2019
2.4	Section 1.6.20: Added deliverable.	6/1/2019
2.4	Section 1.6.21: Added deliverable.	6/1/2019
2.4	Section 1.7.10: Moved deliverable to Monthly Reports (see 1.4.20).	6/1/2019
2.4	Section 1.7.12: Moved deliverable to Other Reports from Annual Reports (was previously 1.6.12 under Annual Reports).	6/1/2019
2.4	Section 1.7.13: Added existing contract requirement to Technical Manual.	6/1/2019
2.4	Section 1.7.14: Added existing contract requirement to Technical Manual.	6/1/2019
2.4	Section 2.1.5.1: Changed file name.	6/1/2019
2.4	Section 2.1.9.1: Changed file name.	6/1/2019
2.4	Section 2.1.10.2: Updated reporting schedule.	6/1/2019
2.4	Section 2.1.10.4: Updated contact information.	6/1/2019
2.5	1.4.5.2: Updated specifications.	7/15/2019
2.5	Section 1.6.15.2: Changed due date.	7/15/2019
2.5	Section 1.6.15.3: Updated Requirements section.	7/15/2019
2.5	1.6.19.2: Changed due date to reference contract year rather than calendar year.	7/15/2019
2.5	1.6.22: Added deliverable.	7/15/2019
2.5	2.1.6: Changed name of report and added reference to ARTS Technical Manual for report specifications.	7/15/2019

Ver.	Description	Date
2.5	Appendix A 1.7: Eliminated measure.	7/15/2019
2.5	Appendix A 1.8: Eliminated measure.	7/15/2019
2.5	Appendix A 1.9: Eliminated measure.	7/15/2019
2.5	Appendix A 1.50: Eliminated measure.	7/15/2019
2.5	Appendix A 1.51: Eliminated measure.	7/15/2019
2.5	Appendix A 2.4: Eliminated measure.	7/15/2019
2.5	Appendix A 2.5: Eliminated measure.	7/15/2019
2.5	Appendix A 2.6: Eliminated measure.	7/15/2019
2.5	Appendix A 2.8: Eliminated measure.	7/15/2019
2.5	Appendix A 2.13: Eliminated unrelated CPT and HCPCS codes.	7/15/2019
2.5	Appendix A 3.10: Eliminated measure.	7/15/2019
2.5	Appendix A 4.2: Eliminated measure.	7/15/2019
2.6	Section 1.4.5.2: Added reference to template on SharePoint under Format.	8/16/2019
2.6	Section 1.4.12: Corrected file name (eliminated extra space following first underscore character).	8/16/2019
2.6	Section 1.4.18.2: Changed plan abbreviation for Optima to OPT to be consistent with NSRM.	8/16/2019
2.6	Section 1.4.21: Added deliverable.	8/16/2019
2.6	Section 1.5.12: Changed due date.	8/16/2019
2.6	Section 1.7.3.2: Changed file type from .csv to fixed-length text file. Also revised submission method, file name, trigger description and schedule.	8/16/2019
2.6	Section 1.7.3.3: Added text to Requirements section.	8/16/2019
2.6	Section 2.1.9: This deliverable has been eliminated. It was a duplication of 1.7.3 that was inadvertently placed under “DMAS Reports.”	8/16/2019
2.6	Appendix A 1.36: Deliverable has been eliminated.	8/16/2019
2.6	Appendix A 1.37: Updated reference to Adult Core Set specifications from 2018 to 2019. Specifications on SharePoint that are referenced have been updated.	8/16/2019
2.6	Appendix A 1.38: Updated reference to Adult Core Set specifications from 2018 to 2019. Specifications on SharePoint that are referenced have been updated.	8/16/2019
2.6	Appendix A 1.39: Updated reference to Adult Core Set specifications from 2018 to 2019. Specifications on SharePoint that are referenced have been updated.	8/16/2019

Ver.	Description	Date
2.6	Appendix A 1.40: Deliverable has been eliminated.	8/16/2019
2.7	Section 1.4.12.2: Updated specifications; also, see new reporting template on SharePoint.	11/30/2019
2.7	Section 1.4.15: Moved deliverable to "Other Reports" and changed to ad hoc report (see 1.7.15).	11/30/2019
2.7	Section 1.4.21.2: Clarified submission method.	11/30/2019
2.7	Section 1.5.2.2: Changed due dates.	11/30/2019
2.7	Section 1.5.4.3: Updated reporting requirements.	11/30/2019
2.7	Section 1.5.12: Clarified submission method.	11/30/2019
2.7	Section 1.5.12: Changed due date.	11/30/2019
2.7	Section 1.6.20.2: Changed due date.	11/30/2019
2.7	Section 1.6.22.2: Changed HICL SEQNO from 9-digit to 6-digit field.	11/30/2019
2.7	Section 1.7.8.2: Corrected file naming format (added underscore prior to contractor name).	11/30/2019
2.7	Section 1.7.15: Added deliverable previously described under 1.4.15 in Monthly Reports.	11/30/2019
2.7	Section 2.1.5.1: Updated specifications.	11/30/2019
2.7	Appendix A 1.10: Suspended measure.	11/30/2019
2.7	Appendix A 1.11: Suspended measure.	11/30/2019
2.7	Appendix A 1.12: Suspended measure.	11/30/2019
2.7	Appendix A 1.13: Suspended measure.	11/30/2019
2.7	Appendix A 1.14: Clarified reporting requirements for numerators.	11/30/2019
2.7	Appendix A 1.37: Updated reference to Adult Core Set to "most recent version … for the measurement year."	11/30/2019
2.7	Appendix A 1.38: Updated reference to Adult Core Set to "most recent version … for the measurement year."	11/30/2019
2.7	Appendix A 1.39: Updated reference to Adult Core Set to "most recent version … for the measurement year."	11/30/2019
2.7	Appendix A 3.7: Suspended measure.	11/30/2019
2.8	Section 1.2.5: Added description of Performance Withhold Program (renumbered original 1.2.5 and 1.2.6 to 1.2.6 and 1.2.7, respectively).	2/1/2020
2.8	Section 1.3.3: Updated reporting requirements making field 498 PY a mandatory field.	2/1/2020

Ver.	Description	Date
2.8	Section 1.4.1: Eliminated HCBS fields.	2/1/2020
2.8	Section 1.4.12: Corrected specification for the Number of Units Authorized field to require a value greater than or equal to zero.	2/1/2020
2.8	Section 1.4.19: Deliverable suspended.	2/1/2020
2.8	Section 1.4.21: Updated file specifications: Added: • MCO Response Time • Drug Product Name Submitted on Prior Authorization Request • Generic Name of Requested Product Removed: • Requested NDC of Drug • Other Service Categorization Description • Approved Service Categorization for Drug • Label Name • Urgent Indicator Updated requirements.	2/1/2020
2.8	Section 1.4.22: Added deliverable.	2/1/2020
2.8	Section 1.5: Changed file names of the following quarterly reports to include the year and quarter: 1.5.1, 1.5.2, 1.5.3, 1.5.4, 1.5.5, 1.5.6, 1.5.7, 1.5.8, 1.5.10, 1.5.12.	2/1/2020
2.8	Section 1.6.8: Eliminated deliverable (see 1.6.23).	2/1/2020
2.8	Section 1.6.9: Eliminated deliverable (see 1.6.23).	2/1/2020
2.8	Section 1.6.23: Added deliverable which combines retired deliverables 1.6.8 and 1.6.9.	2/1/2020
2.8	Appendix A 1.2: Added Performance Withhold Program designation to measure.	2/1/2020
2.8	Appendix A 1.4: Added Performance Withhold Program designation to measure.	2/1/2020
2.8	Appendix A 1.5: Added Performance Withhold Program designation to measure.	2/1/2020
2.8	Appendix A 1.5: Removed data element HbA1c control (<7.0%) from reporting requirements.	2/1/2020
2.8	Appendix A 1.14: Suspended measure.	2/1/2020

Ver.	Description	Date
2.8	Appendix A 1.15: Suspended measure.	2/1/2020
2.8	Appendix A 1.52: Added Performance Withhold Program designation to measure.	2/1/2020
2.8	Appendix B: Added new appendix containing Performance Withhold Program methodology.	2/1/2020
2.9	Section 1.3.4 Transportation Network Company (TNC) Report: Added deliverable.	6/4/2020
2.9	Section 1.4.5.2 Foster Care Barrier Report: Eliminated "FIPS code not correct or missing" from barrier categories; renumbered barrier categories beginning with '06' = In a facility/incarcerated.	6/4/2020
2.9	Section 1.4.20 Missed Trips: Changed due date of deliverable; corrected email address for submission.	6/4/2020
2.9	Section 1.4.21.2 Pharmacy Prior Authorization Report: Changed format for MCO response time.	6/4/2020
2.9	Section 1.5.1.2 Critical Incidents: Updated field specifications and added reference to new reporting template.	6/4/2020
2.9	Section 1.5.1.3 Critical Incidents: Added reference to section 1.7.8.3 Sentinel Event. Also added note regarding new standardized Critical Incident Report Form developed by DMAS.	6/4/2020
2.9	Section 1.5.2.2 Financial Report: Changed due dates for 1st and 2nd quarters.	6/4/2020
2.9	Section 1.5.6.2 Reinsurance: Updated specifications: • Changed CLAIM_ID to PAYER_CLAIM_ID and modified field specifications • Added EPS_TCN • Added CLAIM_LINE • Renamed PAID_DATE to DATE_PAID • Made NDC required • Added PRESC_NUM	6/4/2020
2.9	Section 1.5.11.2 Quality Improvement Team (QIT) Quarterly Report: Changed submission method to FTP.	6/4/2020
2.9	Section 1.6.2.2 Member Handbook: Changed due date.	6/4/2020
2.9	Section 1.6.5.2 Third Party Administrator (TPA) Firewall: Changed due date.	6/4/2020
2.9	Section 1.6.10.2 Marketing Plan: Changed due date.	6/4/2020
2.9	Section 1.6.11.2 Virginia ED Care Coordination Program Report: Changed due date.	6/4/2020

Ver.	Description	Date
2.9	Section 1.6.13.2 Formal Referral and Assistance Process for Homeless Members: Changed due date.	6/4/2020
2.9	Section 1.6.14.2 Wellness and Member Incentive Programs: Changed due date.	6/4/2020
2.9	Section 1.6.16.2 Expansion Enhanced Fraud Prevention Policies and Procedures: Changed due date.	6/4/2020
2.9	Section 1.6.18.2 Outreach to Pregnant Members who Qualify for Expansion Report: Changed due date.	6/4/2020
2.9	Section 1.6.20.2 CMS Annual Drug Utilization Review (DUR) Report: Changed due date.	6/4/2020
2.9	Section 1.6.21.2 Provider Preventable Conditions Summary Report: Changed due date to September 30.	6/4/2020
2.9	Section 1.6.23.2 Value Based-Payment (VBP) Data Collection Tool and Status Report: Corrected file type (changed from pdf to Excel)	6/4/2020
2.9	Section 1.6.24 Medical Loss Ratio (MLR) Report: Added deliverable.	6/4/2020
2.9	Section 1.6.25 Services for Justice-Involved Members Policies and Procedures: Added deliverable.	6/4/2020
2.9	Section 1.6.26 Quality Assessment & Performance Improvement (QAPI) Program: Added deliverable.	6/4/2020
2.9	Section 1.6.27 HEDIS Results: Added deliverable.	6/4/2020
2.9	Section 1.6.28 CAHPS Survey Results: Added deliverable.	6/4/2020
2.9	Section 1.6.29 Program Integrity Plan: Added deliverable.	6/4/2020
2.9	Section 1.7.7 Referral of Suspected Provider Fraud: Added note under Requirements section.	6/4/2020
2.9	Section 1.7.16 MCO DUR Board Minutes: Added deliverable.	6/4/2020
2.9	Section 1.7.17 Marketing and Member Materials: Added deliverable.	6/4/2020
2.9	Section 1.7.18 Outreach Event Materials: Added deliverable.	6/4/2020
2.9	Section 1.7.19 COVID-19 Provider and Member Materials Submission: Added deliverable.	6/4/2020
2.9	Section 1.7.20 Quality Improvement Plan (QIP) for New Plans: Added deliverable.	6/4/2020
2.9	Section 1.7.21 NCQA Accreditation Renewal: Added deliverable.	6/4/2020
2.9	Section 1.7.22 NCQA Accreditation Status Changes: Added deliverable.	6/4/2020
2.9	Section 1.7.23 Non-Emergency Medical Transportation (NEMT) Transportation Network Company (TNC) Project Plan: Added deliverable.	6/4/2020

Ver.	Description	Date
2.10	Section 1.2 Reporting Standards: Changed frequency of *CCC Plus Technical Manual* updates.	7/17/20
2.10	Section 1.4.5.4 Foster Care Barrier Report: Updated Requirements section: • Additional MCO Comments: made a required field for barrier categories 15 and 16 • First Name of Contact: changed barrier categories for which this field is required • Last Name of Contact: changed barrier categories for which this field is required • Area Code of Contact: changed barrier categories for which this field is required • Phone Number of Contact: changed barrier categories for which this field is required • Date of Contact Attempt: eliminated field • Date of First Contact Attempt: added field • Date of Second Contact Attempt: added field • Date of Third Contact Attempt: added field • Name of LDSS Agency: changed barrier categories for which this field is required • MCO Aware of New Location: changed barrier categories for which this field is required • Address Line 1: changed barrier categories for which this field is required • Address Line 2: changed barrier categories for which this field is required • City: changed barrier categories for which this field is required • State: changed barrier categories for which this field is required • Zip Code: changed barrier categories for which this field is required • Other Barrier: changed barrier category for which this field is required	7/17/20
2.10	1.5.1.2 Critical Incidents: Updated field specifications for Incident High-Level Description to align with report template: • Eliminated Incarceration • Changed Death to Sentinel Death	7/17/20
2.10	Section 1.5.1.2 Critical Incidents: Changed reference to reporting period year to reporting period fiscal year in description of File Name.	7/17/20
2.10	Section 1.5.2.2 Financial Report: Changed reference to reporting period year to reporting period fiscal year in description of File Name.	7/17/20
2.10	Section 1.5.3.2 Program Integrity Overpayment and Recovery Report: Changed reference to reporting period year to reporting period fiscal year in description of File Name.	7/17/20

Ver.	Description	Date
2.10	Section 1.5.4.2 Providers Failing Accreditation/Credentialing and Terminations: Changed reference to reporting period year to reporting period fiscal year in description of File Name.	7/17/20
2.10	Section 1.5.5.2 Rebalancing Activities: Changed reference to reporting period year to reporting period fiscal year in description of File Name.	7/17/20
2.10	Section 1.5.6.2 Reinsurance: Changed reference to reporting period year to reporting period fiscal year in description of File Name.	7/17/20
2.10	Section 1.5.7.2 Drug Rebate Report: Changed reference to reporting period year to reporting period fiscal year in description of File Name.	7/17/20
2.10	Section 1.5.8.2 ARTS Providers Failing Accreditation/Credentialing and Terminations: Changed reference to reporting period year to reporting period fiscal year in description of File Name.	7/17/20
2.10	Section 1.5.10.2 Fiscal Employer Agent Quarterly Payroll Review: Changed reference to reporting period year to reporting period fiscal year in description of File Name.	7/17/20
2.10	Section 1.5.12.2 Medication Therapy Management (MTM) Quarterly Report: Changed reference to reporting period year to reporting period fiscal year in description of File Name.	7/17/20
2.10	Section 1.6.30 Internal Controls Report: Added deliverable.	7/17/20
2.10	Section 1.7.24 Investigation Audit Report: Added deliverable	7/17/20
2.10	Section 1.7.25 Investigation Audit Report: Added deliverable	7/17/20
2.11	Section 1.5.11.2 Quality Improvement Team (QIT) Quarterly Report: Corrected file format designation for deliverable.	8/14/20
2.11	Section 1.6.19.2 Medication Therapy Management (MTM) Annual Report: Added note regarding due date for next submission.	8/14/20
2.11	Section 1.6.28.3 CAHPS Survey Results: Added submission format details.	8/14/20
2.11	Section 1.7.4.2 Network Deficiency and Exemption Request: Changed due date.	8/14/20
2.11	Appendix A 1.41: Updated abbreviated HEDIS report name.	8/14/20
2.12	Section 1.5.2.3 Financial Report: Updated specifications to align with most recent reporting template.	10/15/20
2.12	Section 1.5.9.2 ID/D Waiver Reports for the Department of Justice: Changed numbering of quarters to correspond to fiscal contract year.	10/15/20
2.12	Section 1.5.10.2 Fiscal Employer Agent Quarterly Payroll Review: Added due dates for submission of Payroll Review to DMAS.	10/15/20

Ver.	Description	Date
2.12	Section 1.5.11.2 Quality Improvement Team (QIT) Quarterly Report: Updated SharePoint Link to QIT report.	10/15/20
2.12	Section 1.5.13 Finished Review Report: Added deliverable –	10/15/20
2.12	Section 1.6.1.2 List of Subcontractors: Replaced due date which was relative to start of contract cycle with explicit due date of September 30.	10/15/20
2.12	Section 1.6.3.2 Organizational Charts: Replaced due date which was relative to start of contract cycle with explicit due date of September 30.	10/15/20
2.12	Section 1.6.21 Provider Preventable Conditions Summary Report: Suspended report	10/15/20
2.12	Section 1.6.22.2 Drug Formulary & Authorization Requirements: Corrected file extension (changed from .pdf to .xlsx).	10/15/20
2.12	Section 1.6.24.2 Medical Loss Ratio (MLR) Report: Corrected date range of reporting period for report due June 1, 2021.	10/15/20
2.12	Section 1.6.25.2 Services for Justice-Involved Members Policies and Procedures: Added Contractor name and date of submission to file name.	10/15/20
2.12	Section 1.6.26.2 Quality Assessment & Performance Improvement (QAPI) Program: Added Contractor name and date of submission to file name.	10/15/20
2.12	Section 1.6.27.2 HEDIS Results: Added Contractor name and date of submission to file name.	10/15/20
2.12	Section 1.6.28.2 CAHPS Survey Results: Added Contractor name and date of submission to file name.	10/15/20
2.12	Section 1.6.31 Internal Monitoring and Audit - Annual Plan: Added deliverable.	10/15/20
2.12	Section 1.7.1.1 Excluded Member: Corrected contract reference.	10/15/20
2.12	Section 1.7.24.2 Investigation Audit Report: Added Contractor name and date of submission to file name.	10/15/20
2.12	Appendix A 1.28: Added note indicating that measure is not part of IDSS submission because it is not standard for Medicaid. Added reference and link to report template on SharePoint.	10/15/20
2.12	Appendix A 3.4: Added note indicating that measure is not part of IDSS submission because it is not standard for Medicaid. Added reference and link to report template on SharePoint.	10/15/20
2.12	Appendix B: Replaced with revised Appendix B.	10/15/20
2.13	Section 1.2.5 on pg. 33 changed reference in Appendix A for Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)—Total from “1.5” to “1.39”.	11/17/20

Ver.	Description	Date
2.13	Section 1.2.5 on pg. 33 changed reference in Appendix A for Heart Failure Admission Rate (Per 100,000 Member Months)—Total from "1.5." to "1.38".	11/17/20
2.13	Section 1.3.3.3 added sentence, "All prior authorizations must be limited to a maximum approval duration of one year."	11/17/20
2.13	Section 1.3.5 Electronic Visit Verification (EVV) – added deliverable.	11/17/20
2.13	Section 1.4.5.4 changed all instances of 'use BLANK' to leave entry blank.	11/17/20
2.13	Section 1.5.1.2 Provided clarification to quarters within State Fiscal Year.	11/17/20
2.13	Section 1.5.2.2 Provided clarification to quarters within State Fiscal Year.	11/17/20
2.13	Section 1.5.3.2 Provided clarification to quarters within State Fiscal Year.	11/17/20
2.13	Section 1.5.4.2 Provided clarification to quarters within State Fiscal Year.	11/17/20
2.13	Section 1.5.5.2 Provided clarification to quarters within State Fiscal Year.	11/17/20
2.13	Section 1.5.6.2 Provided clarification to quarters within State Fiscal Year.	11/17/20
2.13	Section 1.5.7.2 Provided clarification to quarters within State Fiscal Year.	11/17/20
2.13	Section 1.5.8.2 Provided clarification to quarters within State Fiscal Year.	11/17/20
2.13	Section 1.5.10.2 Provided clarification to quarters within State Fiscal Year.	11/17/20
2.13	Section 1.5.12.2 Provided clarification to quarters within State Fiscal Year.	11/17/20
2.13	Section 1.5.13 added QMR to report name.	11/17/20
2.13	Section 1.5.14 Waiver Enrollees w/o PDN with HRAS Overdue 3 Months or Greater – added deliverable.	11/17/20
2.13	Section 1.6.30.3 added sentence to note, "Include attestation statement upon submission that indicates that this SOC 2 Report accounts for both Medallion 4.0 and CCC Plus Contract".	11/17/20
2.13	Section 1.7.21.2 changed DMAS: TBD to "Division of Quality & Population Health.	11/17/20
2.13	Section 1.7.22.2 changed DMAS: TBD to "Division of Quality & Population Health.	11/17/20
2.14	Section 1.3.5 Name changed from "Electronic Visit Verification (EVV) Report" to "Consumer-Directed Electronic Visit Verification (EVV) Report.	12/15/20
2.14	Section 1.3.5.2 File name changed to CD_EVV_Report_C*ontractorName_yyyymmdd.xlsx*	12/15/20
2.14	Section 1.3.5.2 Changed due date to read, "By close of business weekly or biweekly on Friday as approved by DMAS".	12/15/20

Ver.	Description	Date
2.14	Section 1.3.5.2 Replaced wording of "Sample Summary Report Format" with "Sample of a Summary Report Template that includes all Required EVV Fields".	12/15/20
2.14	Section 1.3.5.3 Added revised Sample Summary Report.	12/15/20
2.14	Section 1.3.5.3 Added list of Required EVV Fields.	12/15/20
2.14	Section 1.3.5.3 Added notes	12/15/20
2.14	Section 1.5.5.2 Data portion of the report has been eliminated. Narrative portion will still be required.	12/15/20
2.14	Section 1.5.10.2 File name change to CCCP_FEA_*agentname*_PAYROLL_REVIEW_*yyyyQn_ContractorName*.pdf	12/15/20
2.14	Section 1.5.10.2 Removed state fiscal quarters as report is based on a calendar year. Definition to calendar quarters added.	12/15/20
2.14	Section 1.5.10.2 Due dates reorganized to match calendar quarter. Actual due dates were not changed.	12/15/20
2.14	Section 1.5.13.2 Changed file name to CCCP_QMR_FRR_*ContractorName.yyyymmdd.xlsx*	12/15/20
2.14	Section 1.5.14.2 Updated Requirements to clarify the Report Requirements.	12/15/20
2.14	Section 2.1.7.2 Changed format from .txt to .zip.	12/15/20
2.14	Section 2.1.7.2 Changed file name from "TBD" to SC##.MCO618_YYYYMMDDHHMMSS.zip	12/15/20
2.14	Section 2.1.7.2 Changed schedule from "TBD" to "run last day of month".	12/15/20
2.14	Section 2.1.7.3 Changed "EDCD waiver" to "CCC Plus Waiver".	12/15/20
2.14	Section 2.1.7.3 Changed wording "the previous two (2) months" to "the previous six (6) months.	12/15/20
2.14	Section 2.1.8.2 Changed format for .txt to .zip	12/15/20
2.14	Section 2.1.8.2 Changed file name from "TBD" to "SC##.CPO746_YYYYMMDDHHMMSS.zip:"	12/15/20
2.14	Section 2.1.8.2 Changed schedule from "TBD" to run on the 5th/6th day of the month for prior month.	12/15/20
2,15	Section 1.3.3.2 Removed Hyperlink. Guidance remains the same.	1/15/21
2.15	Section 1.3.5.2 Updated file name to "CD_EVV_*agentname*_Report_*ContractorName.*yyyymmdd.xlsx	1/15/21
2.15	Section 1.4.8.1 Updated Contract Reference from "6.3.4" to "6.3.5"	1/15/21
2.15	Section 1.5.14.3 Added Clarifying Language "All information pertaining to an individual member should be reported on a single row of the report. Multiple	1/15/21

Ver.	Description	Date
	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.	
2.15	Section 1.5.14.3 Added Language to “K.” for clarification, “If there has been more than one successful contact, select the outcome that indicates the current state of the MCO’s efforts to complete the member’s initial HRA”.	1/15/21
2.15	Section 1.5.14. 3 Added Language to “O.” for clarification, “Include provider name along with date of contact attempt”.	1/15/21
2.15	Section 1.6.6 Changed destination from “Provider Reimbursement” to “Value Based Purchasing”.	1/15/21
2.15	Section 1.6.23 Changed destination from “Provider Reimbursement” to “Value Based Purchasing”.	1/15/21
2.15	Section 1.7.17 Added Member ID cards to Submission Type.	1/15/21
2.15	Section 1.7.17 Changed letter "E" from "Title of Documents" to add "Audience" deliverable with sub areas Members, Providers, and Potential members/public.	1/15/21
2.15	Section 1.7.17 Changed Letter "F" from "Add the marketing material as attachments to the email" to "Title Documents".	1/15/21
2.15	Section 1.7.17 Added letter "G" in order to continue to include deliverable “Add the marketing material as attachments to the email”.	1/15/21
2.16	Section 1.5.1.2 File Specifications - Field Description "MCO", added clarification by identifying valid values for field.	2/16/21
2.16	Section 1.5.1.2 File Specifications - Field Description "Year" was eliminated.	2/16/21
2.16	Section 1.5.1.2 File Specifications - Field Description "Qtr" was eliminated.	2/16/21
2.16	Section 1.5.1.2 File Specification - Field Description "Recipient Medicaid ID" changed to "Medicaid ID".	2/16/21
2.16	Section 1.5.1.2 File Specification - Field Description "Member Dually Eligible", added clarification by identifying valid values for field.	2/16/21
2.16	Section 1.5.1.2 File Specification - Field Description "Member Classification at Time of Incident", added values "CCC+ Waiver w/o PDN" and "CCC+ Waiver with PDN".	2/16/21
2.16	Section 1.5.1.2 File Specification - Field Description "Recipient DOB" changed to "Member DOB"	2/16/21
2.16	Section 1.5.1.2 File Specification - Field Description "Recipient Gender" changed to "Member Gender".	2/16/21

Ver.	Description	Date
2.16	Section 1.5.1.2 File Specification - Field Description "Member Gender", added clarification by identifying valid values for the field.	2/16/21
2.16	Section 1.5.1.2 File Specification - Field Description "Provider Name", changed word "event" to "incident" and removed "law enforcement contact or incarceration" language.	2/16/21
2.16	Section 1.5.1.2 File Specification - Field Description "Provider Type", added "Transportation" as a valid value.	2/16/21
2.16	Section 1.5.1.2 File Specification - Field Description "Incident Category", added the word "Incident" to "Quality of Care".	2/16/21
2.16	Section 1.5.1.2 File Specification - Field Description "Incident High-Level Description", added clarification language and values to provide the ability to identify more than one description of event if needed.	2/16/21
2.16	Section 1.5.1.2 File Specification - Field Description "Incident High-Level Description", removed "Law enforcement contact" from valid values.	2/16/21
2.16	Section 1.5.1.2 File Specification - Field Description "Source of Critical Incident Data", added clarifying language.	2/16/21
2.16	Section 1.5.1.3 Requirements, added clarifying language to "Quality of Care" and "Sentinel Event" sections.	2/16/21
2.16	Section 1.5.1.3 Requirements, added section "Other Critical Incidents" for clarification purposes.	2/16/21
2.16	Section 1.5.1.3 Requirements in Section "Reportable Critical Incident" the following incidents were removed "Law enforcement contact" and "Unexpected hospitalization".	2/16/21
2.16	Added New Deliverable 1.5.15 Community Mental Health Rehabilitation Services (CMHRS) Appeals Report.	2/16/21
2.16	Appendix A, 1.5 Comprehensive Diabetes Care within the measure description section the indicator “Medical Attention for Nephropathy” was removed.	2/16/21
2.16	Appendix A, 1.17 Medication Management for People with Asthma (MMA) Measure was Eliminated.	2/16/21
2.16	Appendix A, 3.1 Adult BMI Assessment Measure Eliminated.	2/16/21
2.17	Section 1.5.1.2 In the specifications column “Date Closed” language added, “Leave blank if case not closed”.	3/15/21
2.17	Section 1.5.15.3 Added clarifying language.	3/15/21
2.17	Section 1.7.3.3 Added DMAS Data Dictionary for reference purposes.	3/15/21
2.17	Appendix A, 1.37 Diabetes Short-Term Complication Admission Rate (PQI 01) – Measure changed from a semi-annual to an annual submission.	3/15/21

Ver.	Description	Date
2.17	Appendix A, 1.38 Congestive Heart Failure Rate (PQI 08) – Measure changed from a semi-annual to an annual submission.	3/15/21
2.17	Appendix A, 1.39 COPD and Asthma in Older Adults Admission Rate (PQI 05) – Measure changed from a semi-annual to annual submission.	3/15/21
2.18	Section 1.4.12.2 File Specifications - updated specifications for field description "Denial Type".	4/15/21
2.18	Section 1.4.12.2 File Specifications - added new field description "Service Auth Urgency Type" with new specifications.	4/15/21
2.18	Section 1.4.12.2 File Specifications - added new field description "Service Auth Status" with new specifications.	4/15/21
2.18	Section 1.4.12.2 File Specifications - added new field description "Date Service Auth was Received by MCO or subcontractor" with new specifications.	4/15/21
2.18	Section 1.4.12.2 File Specifications - added new field description "Time Service Auth was Received by MCO or subcontractor" with new specifications.	4/15/21
2.18	Section 1.4.12.2 File Specifications - added new field description "Date Response sent to Provider" with new specifications.	4/15/21
2.18	Section 1.4.12.2 File Specifications - added new field description "Time Response sent to Provider" with new specifications.	4/15/21
2.18	Section 1.4.12.2 File Specifications - added new field description "MCO Response Time" with new specifications.	4/15/21
2.18	Section 1.4.12.2 File Specifications - added new field description "Resubmission Indicator" with new specifications.	4/15/21
2.18	Section 1.4.12.2 File Specification format changed from the use of an Excel template to a comma separated value (.csv) file.	4/15/21
2.18	Section 1.4.12.2 File Specification file name convention changed to reflect the use of a comma separated value (.csv) file.	4/15/21
2.18	Section 1.4.12.3 Requirements - corrected current language.	4/15/21
2.18	Section 1.4.22.3 - added language to the requirements section, “The Contractor shall add live-in attendants and overtime standardized reporting to the monthly scorecard”.	4/15/21
2.18	Section 2.1.6 - Corrected typo in title of report.	4/15/21
2.19	Section 1.3.3.3 – Added requirement “I” for clarification on service authorization durations.	5/17/21

Ver.	Description	Date
2.19	Section 1.4.12.2 - Updated time format in Field Description "MCO response time" from "hhhh/mm/ss" to "hhhh:mm:ss".	5/17/21
2.19	Section -1.5.1.2 - Year added as a new field with specification requirements.	5/17/21
2.19	Section 1.5.1.2 - Qrt added as new field with specification requirements.	5/17/21
2.19	Section 1.5.1.2 - Field Description name "Member Dually Eligible" was updated to "Member Dually Eligible?"	5/17/21
2.19	Section 1.5.1.2 - Field Description "Provider NPI" file specifications updates to "Leave Blank if no provider name entered".	5/17/21
2.19	Section 1.7.3.1 – Added contract reference.	5/17/21
2.19	Section 1.7.3.3 – Added Requirement: "Service authorizations must not exceed two (2) years in duration as defined by: • SA Auth from Date to SA Auth thru Date."	5/17/21
2.20	Section 1.4.18.2 - Name change Magellan to Molina	6/15/21
2.20	Section 1.5.1.2 - Name change Magellan to Molina	6/15/21
2.20	Section 1.5.6.1 - Updated contract reference 19.10.1 to 19.9.1 to correspondence with new contract reference in July 2021 contract release.	6/15/21
2.20	Section 1.6.24.1 - Updated contract reference 19.8 to 19.7 to correspondence with new contract reference in July 2021 contract release.	6/15/21
2.20	Section 1.6.30 - Name change Magellan to Molina	6/15/21
2.20	Section 2.1.10.3 - Name change Magellan to Molina	6/15/21
2.20	Section 2.1.10.4 - Name change Magellan to Molina	6/15/21
2.21	Section 1.5.4.1 - Added contract reference 8.5.6.3	7/15/21
2.21	Section 1.5.4.3 - Added update to Requirements - "This includes providers terminated from the MCO network".	7/15/21
2.21	Section 1.5.4.3 - Added requirement - "Ensure 5-digit zip code is included in (Address) Field".	7/15/21
2.21	Section 1.5.4.3 – Added requirement - "MCO must differentiate between those providers terminated with cause and those without cause".	7/15/21
2.21	Section 1.5.4 - Added requirement - "MCO must supply, for CHMRS & Behavioral Therapy Providers only, the number of Medicaid members the provider was serving prior to termination of the provider contract within the reporting template".	7/15/21
2.21	Section 1.5.14 Deliverable Suspended effective 6/15/2021	7/15/21

Ver.	Description	Date
2.21	Appendix A – All deliverable measures updated to provide clarification between Calendar Year and State Fiscal Year.	7/15/21
2.22	Section 1.3.3.3 - Updated Requirement "D".	8/16/21
2.22	Section 1.3.3.3 - Updated Requirement "E".	8/16/21
2.22	Section 1.7.4.2 - Updated method of delivery to utilize email as the format for delivery to DMAS.	8/16/21
2.22	Section 1.7.4.2 - Updated format to use template located in SharePoint.	8/16/21
2.23	Table of Content 1.6 Annual Reports updated to “1.6 Annual & Semi-Annual Reports”.	9/15/21
2.23	Section 1.4.12.2 – Updated procedure codes.	9/15/21
2.23	Section 1.5.15.2 - Updated specifications for field description "Procedure Code for Service Denied/Reduced".	9/15/21
2.23	Section 1.5.15.3 – Updated procedure codes	9/15/21
2.23	Section 1.6 – Updated title to “1.6 Annual & Semi-Annual Reports”.	9/15/21
2.23	Section 1.6.22.22 – Updated due dates to reflect a Semi-Annual Report as stated in contract.	9/15/21
2.24	Section 1.4.12.2 – Updated procedure codes based on Dec. 1 contract amendment.	11/15/21
2.24	Section 1.5.1.1 – Added contract reference to correspond with Dec. 1 contract amendment.	11/15/21
2.24	Section 1.5.1.2 – In field description “Member Classification at Time of Incident”, valid value “DD Waiver” added.	11/15/21
2.24	Section 1.5.1.2 - In field description “Incident High-Level Description”, valid values were updated.	11/15/21
2.24	Section 1.5.1.3 – Requirement added for clarification: “Included all critical incidents discovered by the contractor and/or reported to the contractor during the reporting period”.	11/15/21
2.24	Section 1.5.1.3 – Requirement added to clarify which member’s critical incidents reports should include.	11/15/21
2.24	Section 1.5.1.3 – Requirement added to ensure that member classification is identified at time of incident.	11/15/21
2.24	Section 1.5.1.3 – Sentinel Event definition updated to correspond with Dec. 1 contract amendment definition.	11/15/21
2.24	Section 1.5.1.3 – Updated reportable critical incident list.	11/15/21

Ver.	Description	Date
2.24	Section 1.5.1.3 – Provided clarification for the role of the model Critical Incident Report form.	11/15/21
2.24	Section 1.5.6 – Deliverable had been moved to DMAS reports. See 2.1.11	11/15/21
2.24	Section 1.5.15 – Updated procedure codes based on Dec. 1 contract amendment.	11/15/21
2.24	Section 1.7.8 – Updated contract reference to correspond with Dec. 1 contract amendment.	11/15/21
2.24	Section 1.7.8.2 – Added new field description "Member classification at Time of Incident".	11/15/21
2.24	Section 1.7.8.3 – Added clarification that all sentinel events shall be reported for all CCCPlus program members.	11/15/21
2.24	Section 1.7.8.3 – Added clarification that state that all Sentinel Events are Critical Incidents.	11/15/21
2.24	Section 1.7.8.3 – Sentinel event definition updated to correspond with Dec.1 contract amendment definition.	11/15/21
2.24	Section 1.7.8.3 – Provided definition of "Sentinel Death".	11/15/21
2.24	Section 1.7.8.3 – Replaced "Severe Injury" with "Serious Injury" and updated definition.	11/15/21
2.24	Section 1.7.8.3 – Updated example events that are considered sentinel events.	11/15/21
2.24	Section 2.1.11 – 2.1.11 replaced report 1.5.6.	11/15/21
2.25	Section 1.4.12.2 - Updated procedure code chart to include effective dates.	12/15/21
2.25	Section 1.4.12.2 - Added chart to identify procedure codes that have expired or have been converted.	12/15/21
2.25	Section 1.4.12.3 - Updated requirements to provide clarification to include all EBH, CMHRS, and targeted case management in report.	12/15/21
2.25	Section 1.5.15.3 - Updated procedure code chart to include effective dates.	12/15/21
2.25	Section 1.5.15.3 - Added chart to identify procedure codes that have expired or have been converted.	12/15/21
2.26	Section 1.4.12.2 Updated "Codes expired or converted" chart to provide clarification.	1/18/22
2.26	Section 1.5.15.3 Updated "Codes expired or converted" chart to provide clarification.	1/15/22
2.27	Section 2.1.11.1 Contract reference updated from 19.9.1 to 19.8.1	2/15/22
2.27	Section 2.1.11.2 Updated to reflect that reports are generated by DMAS.	2/15/22

Ver.	Description	Date
2.27	Section 2.1.11.3 Threshold for drug cost updated from $175,000 to $200,000 in accordance with the SFY Contract 2022	2/15/22
2.27	Appendix C "Managed Care Aid Categories" added.	2/15/22
2.28	Section 1.5.14 Deliverable Eliminated effective 4/15/2022	4/15/22
2.28	Section 2.1.10 Deliverable Eliminated effective 4/15/2022	4/15/22
2.29	Section 1.7.3 Deliverable eliminated effective 4/29/2022.	
2.29	Section 1.7.5.2 Updated method of submission to mcopideliverables@dmas.virginia.gov	5/16/22
2.29	Section 1.7.7.2 Updated method of submission to mcopideliverables@dmas.virginia.gov	5/16/22
2.29	Section 1.7.25.2 Updated method of submission to mcopideliverables@dmas.virginia.gov	5/16/22
2.29	Section 2.1.5 Deliverable eliminated effective 4/29/2022.	5/16/22
2.30	Section 1.5.16 Deliverable added	6/15/22
2.30	Section 1.7.26 Deliverable added	6/15/22
2.31	Section 1.4.3 Deliverable eliminated effective 8/15/2022.	8/15/2022
2.31	Section 1.4.4 Deliverable eliminated effective 8/15/2022.	8/15/2022
2.31	Section 1.4.6 Deliverable eliminated effective 8/15/2022.	8/15/2022
2.31	Section 1.4.7 Deliverable eliminated effective 8/15/2022.	8/15/2022
2.31	Section 1.4.9 Deliverable eliminated effective 8/15/2022.	8/15/2022
2.31	Section 1.6.22.2 Updated File Specifications.	8/15/2022
2.31	Section 1.7.5.2 Updated typo in email address.	8/15/2022
2.32	Section 1.3.5 Changed from a weekly to monthly report (1.4.23)	9/15/2022
2.32	Section 1.4.23 Weekly report (1.3.5) change to monthly report	9/15/2022
2.32	Section 1.4.23.2 Updated file specifications	9/15/2022
2.32	Section 1.4.23.3 Updated Requirements to remove "Live in" related fields	9/15/2022
2.32	Section 1.5.14 Reinstated deliverable 8/23/2022, first report due 10/10/2022	9/15/2022
2.32	Section 1.5.14.3 Updated Requirement language.	9/15/2022
2.33	Section 1.4.12.2 Community Stabilization (S9482) has been changed from registration to service authorization.	10/14/2022
2.33	Section 1.4.20 Updated Method.	10/14/2022

Ver.	Description	Date
2.33	Section 1.5.15.3 Community Stabilization (S9482) has been changed from registration to a service authorization.	10/14/2022
2.33	Section 1.6.6.2 Updated method.	10/14/2022
2.33	Section 1.6.6.2 Updated Requirements	10/14/2022
2.34	Section 1.6.32 Added new deliverable "CMS Managed Care Program Annual Report"	11/15/2022
2.34	Section 2.1.7.2 Updated method of delivery.	11/15/2022
2.34	Section 2.1.7.2 Updated file name.	11/15/2022
2.34	Section 2.1.8.2 Updated method of delivery.	11/15/2022
2.34	Section 2.18.2 Updated file name.	11/15/2022
2.34	Section 2.1.1 Updated link for the EDI Companion Guide.	11/15/2022
2.35	Section 1.6.23.1 Updated requirements.	12/15/2022
2.35	Section 1.6.24.2 Updated file specifications for submission to be an .xlsx file.	12/15/2022
2.36	Section 1.6.22.2 Updated trigger and due date.	2/15/2023
2.37	Section 1.4.24 Added new deliverable "Renewal Outreach Stats Report"	5/18/2023
2.37.2	Updated Section 1.4.24	5/22/2023
2.38	Section 1.5.16.3 Updated Requirements	8/15/2023
2.38	Deliverable 1.7.9 "Addiction and Recovery Treatment Services (ARTS) Provider Network Change Affecting Member Access to Care" - Eliminated	8/15/2023

Version Release Dates

Version	Release Date
1.0	9/22/2017
1.1	11/6/2017
2.0	1/22/2018
2.1	5/1/2018
2.2	9/5/2018
2.3	11/15/2018
2.4	6/1/2019
2.5	7/15/2019
2.6	8/16/2019
2.7	11/30/2019
2.8	2/1/2020
2.9	6/4/2020
2.10	7/17/2020
2.11	8/14/2020
2.12	10/15/2020
2.13	11/17/2020
2.14	12/15/2020
2.15	1/15/2021
2.16	2/16/2021
2.17	3/15/2021
2.18	4/15/2021
2.19	5/17/2021
2.20	6/15/2021
2.21	7/15/2021
2.22	8/16/2021
2.23	9/15/2021
2.24	11/15/2021
2.25	12/15/2021

2.26	1/18/2022
2.27	2/15/2022
2.28	4/15/2022
2.29	5/16/2022
2.30	6/15/2022
2.31	8/15/2022
2.32	9/15/2022
2.33	10/14/2022
2.34	11/15/2022
2.35	12/15/2022
2.36	2/15/2023
2.37	5/18/2023
2.37.2	5/22/2023
2.38	8/15/2023

1 Contractor Deliverables

1.1 Introduction

The Commonwealth Coordinated Care Plus (CCC Plus) Program is Virginia's managed long-term services and supports (MLTSS) program aimed at providing an integrated health services delivery program, including home and community based services (HCBS), institutional-based services, behavioral health services, and acute and primary care services, through capitated Medicaid managed care plans.

The purpose of this manual is to provide contracted Medicaid managed care plans with a common understanding of the data they are required to report and to ensure a high level of accuracy in the data reported while reducing the need to correct and resubmit data.

1.2 Reporting Standards

DMAS **strongly recommends** 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 reporting 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 will be required to correct and re-submit deliverables as necessary to comply with the reporting requirements set forth in this document. All reporting manual reporting requirements are required at the contract level, unless otherwise indicated.

Please note:

> The source of truth for the functionality, scheduling, and data specifications of all system files included in this reporting manual (e.g., Medical Transition Report, 834, and 820), 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, and companion guides in which they were originally described. Where there is any conflict between this manual and those original sources, CCC Plus health plans must comply with the original sources. A diligent effort will be made by DMAS to keep the *CCC Plus Technical Manual* aligned with those sources.

Updated versions of the *CCC Plus Technical Manual* will ordinarily be released once a month on or about the 15th of the month. Updated manuals will be made available to the Contractors via email. They will also be posted to both the CCC Plus Health Plans Common/Sharing Documentation folder on SharePoint and the Virginia Medicaid CCC Plus website. The version number of the manual will be incremented with each new release. All updates for a given release will be documented in the Version Change Summary section of the manual.

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

1.2.1 DMAS secure CCC Plus FTP server

DMAS has established a secure FTP server to facilitate transfer of files with the Contractors. Each Contractor has their own secure login and dedicated folders on the DMAS report server. Each Contractor can have one and only one login/account. The login account for new Contractors will be set up as part of the Department's standard implementation process for new Contractors, usually one to two months prior to "go live."

Within the Contractor's CCC Plus folder, there are two subfolders: TO-DMAS and FROM-DMAS. Any CCC Plus files sent from DMAS to the Contractor will be in the FROM-DMAS folder. Any CCC Plus files the Contractor is submitting to DMAS should be placed in the TO-DMAS folder. The server is swept daily at 6:00 PM EST/EDT, and any files in the TO-DMAS folder are moved to DMAS' local intranet server for user retrieval.

1.2.2 Deliverable Monitoring and Compliance

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

1.2.2.1 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.

1.2.2.2 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.

1.2.3 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’.

1.2.4 Quality Performance Measure Reporting

DMAS has selected quality performance measures that align with federal, state, and CCC Plus quality improvement aims and priorities. These measures cover the following performance domains:

1. Enhanced member experience and engagement for person- and family-centered care
2. Better quality of care
3. Maintain or improve population health
4. Reduce per capita costs

See Appendix A of this manual for quality performance measure specifications.

1.2.5 Performance Withhold Program

The Department introduced the Performance Withhold Program (PWP) to reinforce value-based payment principles by setting performance standards and expectations for Contractors in key areas influencing Member health and health outcomes. 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. This effort also aligns with the Virginia Medicaid focus areas by including measures pertaining to behavioral health and chronic conditions.

PWP Measures

Measure Indicator	Appendix A Measure Number	Measure Specification Source	Required Reporting Method
Behavioral Health			
Follow-Up After Emergency Department (ED) Visit for Alcohol and Other Drug (AOD) Abuse or Dependence—7-Day Follow-Up—Total	1.4	HEDIS	Administrative
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total	1.4	HEDIS	Administrative
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total	1.52	HEDIS	Administrative
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total	1.52	HEDIS	Administrative
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Total	1.2	HEDIS	Administrative
Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Total	1.2	HEDIS	Administrative
Chronic Conditions			
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing	1.5	HEDIS	Hybrid
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)	1.5	HEDIS	Hybrid
Comprehensive Diabetes Care—HbA1c Control (<8.0%)	1.5	HEDIS	Hybrid
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	1.5	HEDIS	Hybrid
Comprehensive Diabetes Care—Medical Attention for Nephropathy	1.5	HEDIS	Hybrid
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	1.5	HEDIS	Hybrid
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)—Total	1.39	CMS Adult Core Set	Administrative
Heart Failure Admission Rate (Per 100,000 Member Months)—Total	1.38	CMS Adult Core Set	Administrative

A general description of each PWP measure, along with a reference to detailed external specifications, can be found in Appendix A.

See Appendix B for a detailed description of both the scoring methodology that will be used to evaluate the Contractor's performance on PWP measures and the calculations that will be used to determine the portion of the withhold amount that the Contractor will receive on the basis of that performance.

1.2.6 HCBS Waiver Assurance Reporting

Under CMS Medicaid Home and Community-Based Services HCBS waiver requirements, DMAS is required to report on a set of requirements known as the HCBS waiver assurances. The six assurance domains are as follows: 1) Level of Care; 2) Service Plan; 3) Qualified Providers; 4) Health and Welfare; 5) Financial Accountability; and 6) Administrative Authority.

DMAS has authorized the CCC Plus health plans to conduct waiver quality management reviews (QMR) to collect and report data to CMS. The waiver quality assurances are identified in the CCC Plus 1915 C Waiver application. This review process will be closely supervised by DMAS, with experienced DMAS staff conducting quality assurance reviews of a sample of QMRs performed by the CCC Plus health plans each quarter. CCC Plus health plans are required by DMAS to follow all DMAS waiver quality assurance procedures and protocols as identified in the CCC Plus Waiver Technical Guide, located on SharePoint.

QMRs focus on the development and implementation of the plan of care. Reviewers determine if the plan is person centered, based on the assessment, and if it addresses the individual's needs and personal goals. Provider documentation of services is reviewed to determine if services were delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan. The provider's personnel records are reviewed to confirm that only qualified staff are delivering services. QMR details are discussed with the provider at an exit conference during the review and are further explained in a letter sent to the provider.

1.2.7 Dashboards Reporting

To enable DMAS to conduct frequent and intensive contract monitoring and compliance assessments, CCC Plus health plans will be required to report current contract status, progress, and deliverables via dashboards. Dashboards can be at the contract level or can address a component of the contract, targeting a specific DMAS program such as Addictions Recovery and Treatment Services (ARTS). Dashboard data elements will include, but are not limited to, enrollment, care management status, grievances and appeals, claim processing, authorization processing, utilization data, call center statistics, provider training activities, and member outreach activities. Plans will be supplied the dashboard reporting templates and instructions in a separate document and are expected to report data accurately, completely, and within prescribed timeliness standards for ongoing dashboard submissions.

1.3 Weekly Reports

1.3.1 Department Provider File To Support Member Enrollment Assignment and Encounter Processing

1.3.1.1 Contract Reference: *16.9.4.2*

For this MMIS system related report, please use and comply with information shared thus far through the CCC Plus Systems email distribution list or your “Systems Documentation” SharePoint folder.

1.3.2 Enrollment Broker Provider File

1.3.2.1 Contract Reference: *16.9.4.2*

For this MMIS system related report, please use and comply with information shared thus far through the CCC Plus Systems email distribution list or your “Systems Documentation” SharePoint folder.

1.3.3 Pharmacy Prior Authorizations - NCPDP Transfer Standard - To DMAS *(Last required report submission is 4/15/2022. The report will be eliminated effectively following the 4/15/2022 submission.*

1.3.3.1 Contract Reference *3.2.21*

1.3.3.2 File Specifications

Method:	DMAS secure FTP server (GoAnywhere)
Format:	Must conform to the NCPDP Prior Authorization Transfer Standard Implementation Guide version 22.
File Name:	SRVAUTH_*xxxx*_NCPDP22_*yyyymmdd*.txt Where *xxxx* is the MCO's service center ID and y*yyymmdd* is the date of submission
Trigger:	Weekly
Due Date:	By 6PM each Monday
DMAS:	CMO / Pharmacy Team

1.3.3.3 Requirements

A. Submissions must conform to all requirements as documented in the *NCPDP Prior Authorization Transfer Standard Implementation Guide version 22*.

B. In the NCPDP Prior Authorization Transfer Standard Implementation Guide Version 22

1. All fields labeled M- Mandatory must be completed.
2. Field A21, SUBGROUP ID (position 58), is considered **mandatory** NOT situational. The MCO **must** include the MCO's service center ID for every detail record provided.
3. Field 498-PY, PRIOR AUTHORIZATION ID ASSIGNED (position 254), is considered **mandatory** NOT situational. The MCO **must** include the prior authorization ID assigned for every detail record provided.

C. For every detail record provided, Service authorization data provided in this file will be distributed to the member's new MCO when there is a change in the member's MCO/program, in order to ensure continuity of care. DMAS will collect and distribute this service authorization data to the member's new MCO.

D. All prior authorizations must be limited to a maximum approval duration of one year.

E. Each weekly file must contain ALL active and appropriate SAs that were created or modified since the last submission to DMAS.

F. For the incoming file name, xxxx is equal to the MCO's Service Center ID that is generating the file.

G. If the plan has no weekly PA files to submit, the plan will submit a zero file using the appropriate header and trailer format.

H. If the MCO does not submit their weekly file by Monday at 6pm, the plan will combine two (2) weeks of prior authorization requests and submit the following Monday. DMAS can only process 1 file per week from each plan.

I. Service authorizations must not exceed one (1) year in duration. The SA End Date will extend no more than (1) year beyond the latest of the following dates:

- SA Create Date
- SA Effective Date
- SA Update Date

1.3.3.4 Examples

Refer to *NCPDP Prior Authorization Transfer Standard Implementation Guide version 22* for examples.

1.3.3.5 Scoring Criteria

N/A

1.3.4 Transportation Network Company (TNC) Report

1.3.4.1 Contract Reference: *N/A*

1.3.4.2 File Specifications

Method:	Send as email attachment to cccplus@dmas.virginia.gov and Bill.Zieser@dmas.virginia.gov. See additional cc destinations on instructions tab of report template.
Format:	Use TNC Weekly Report template which can be found on SharePoint.
File Name:	DMAS TNC Weekly - y*yyy mm-dd ContractorName.xlsx* where *mm-dd* is the month and day of the Friday on which the reporting week ended
Trigger:	Weekly
Due Date:	By 12:00 noon on the Wednesday following the Saturday through Friday reporting period (or 12:00 noon on Thursday if a holiday intervenes following the end of the reporting period).
DMAS:	Transportation Unit

1.3.4.3 Requirements

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 should also be cumulative for all reporting periods.

See the instructions tab of the TNC Weekly Report template provided by DMAS for further details.

1.3.5 Consumer-Directed Electronic Visit Verification (EVV) Report

Report moved to 1.4 monthly reports see report 1.4.23

1.4 Monthly Reports

1.4.1 Appeals & Grievances Summary

1.4.1.1 Contract Reference: *15.2, 15.3, 15.7*

1.4.1.2 File Specifications

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

Authorization Requests Denied/Limited (reduced)	Cannot be blank/spaces
Other Services – Benefit Denial or Limitation (Member Appeal)	Value must be ≥ 0 Cannot be blank/spaces
Other Services – Benefit Denial or Limitation (Provider Appeal)	Value must be ≥ 0 Cannot be blank/spaces
Benefit Denial or Limitation – Other (Appeal)	Value must be ≥ 0 Cannot be blank/spaces
Contractor Administrative Issue (Member Appeal)	Value must be ≥ 0 Cannot be blank/spaces
Contractor Administrative Issue (Provider Appeal)	Value must be ≥ 0 Cannot be blank/spaces
Provider Enrollment (Provider Appeal)	Value must be ≥ 0 Cannot be blank/spaces
Transportation (Member Appeal)	Value must be ≥ 0 Cannot be blank/spaces
Transportation (Provider Appeal)	Value must be ≥ 0 Cannot be blank/spaces
Other (Member Appeal)	Value must be ≥ 0 Cannot be blank/spaces
Other (Provider Appeal)	Value must be ≥ 0 Cannot be blank/spaces
Total Number of Adverse Actions (Member and Provider)	Value must be ≥0 Cannot be blank spaces
Total Standard Member Appeals Resolved Timely	Value must be ≥ 0 Cannot be blank/spaces
Total Standard Member Appeals Resolved Untimely	Value must be ≥ 0 Cannot be blank/spaces
Total Standard Extended Member Appeals Resolved Timely	Value must be ≥0 Cannot be blank/spaces
Total Standard Extended Member Appeals Resolved Untimely	Value must be ≥0 Cannot be blank/spaces
Total Expedited Member Appeals Resolved Timely	Value must be ≥0 Cannot be blank/spaces
Total Expedited Member Appeals Resolved Untimely	Value must be ≥0 Cannot be blank/spaces
Total Appeals Resolved At End Of Reporting Period	Value must be ≥0 Cannot be blank/spaces
Total Appeals Resolved – Fully Favorable	Value must be ≥ 0 Cannot be blank/spaces
Total Appeals Resolved – Partially Favorable	Value must be ≥ 0 Cannot be blank/spaces
Total Appeals Resolved - Unfavorable	Value must be ≥ 0 Cannot be blank/spaces
Total Appeals Going to State Fair Hearing	Value must be ≥ 0 Cannot be blank/spaces
Total New Appeals	Value must be ≥ 0 Cannot be blank/spaces
Total Active Appeals At End Of Reporting Period	Value must be ≥ 0 Cannot be blank/spaces

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

Method: DMAS secure CCC Plus FTP server

Format: Excel (.xlsx) file

File Name: CCCP_APP_GRIEV_C*ontractorName_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.

DMAS: CCC Plus Quality Analyst

1.4.1.3 Requirements

As specified in the contract section referenced above.

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 category.

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

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

1.4.1.4 Examples

N/A

1.4.1.5 Scoring Criteria

Number of rows with one or more errors (as defined in the file specifications) divided by the total number of rows submitted.

1.4.2 Addiction and Recovery Treatment Services (ARTS) Service Authorizations and Registrations

1.4.2.1 Contract Reference: *17.1*

1.4.2.2 File Specifications

For report specifications and submission requirements, see the most recent version of the ARTS Technical Manual posted on the CCC Plus program website under CCC Plus Information for Health Plans.

1.4.3 Comprehensive Health Coverage *(Eliminated effective 8/15/2022)*

1.4.3.1 Contract Reference: *12.4.12.3*

1.4.3.2 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
Other Carrier Name	Must be 50 characters or less
Policy Number	Must be 15 characters or less
Eff Date	Must be a valid date Format: mm/dd/yyyy
End Date	Must be a valid date Format: mm/dd/yyyy

Method: DMAS secure CCC Plus FTP server

Format: Excel (.xlsx) file

File Name: CCCP_COMP_CVG_C*ontractorName_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.

DMAS: Third Party Liability Unit

1.4.3.3 Requirements

As specified in the contract section referenced above.

Include any other member health insurance coverage that is identified during the reporting month.

When multiple coverages are present for a member, enter each type of coverage on a separate line for that member.

1.4.3.4 Examples

None

1.4.3.5 Scoring Criteria

Number of rows with one or more errors (as defined in the file specifications) divided by the total number of rows submitted.

1.4.4 Estate Recoveries *(Eliminated effective 8/15/2022)*

1.4.4.1 Contract Reference: *12.4.12.2*

1.4.4.2 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
Date of Death (Member Over Age 55)	Must be a valid date Format: mm/dd/yyyy

Method: DMAS secure CCC Plus FTP server

Format: Excel (.xlsx) file

File Name: CCCP_EST_RECOV_C*ontractorName_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.

DMAS: Third Party Liability Unit

1.4.4.3 Requirements

As specified in the contract section referenced above.

Member must be over the age of 55 at time of death.

1.4.4.4 Examples

None

1.4.4.5 Scoring Criteria

Number of rows with one or more errors (as defined in the file specifications) divided by the total number of rows submitted.

1.4.5 Foster Care Barrier Report

1.4.5.1 Contract Reference: *4.18.1*

1.4.5.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
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. Numeric fields shall not include commas, dollar signs, or other extraneous characters. Do not include a header row in .csv files.
File Name:	CCCP_BARRIER_C*ontractorName_yyyymm*.csv (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.
DMAS:	Special Populations Unit

1.4.5.3 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.

1.4.5.4 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
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
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)
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').

Field Description	Specifications
	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'.
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

Field Description	Specifications
	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.

1.4.5.5 Examples

None

1.4.5.6 Scoring Criteria

Number of rows with one or more error (as defined in the File Specifications) divided by the Total number of rows submitted.

1.4.6 Money Recovered *(Eliminated effective 8/15/2022)*

1.4.6.1 Contract Reference: *N/A*

1.4.6.2 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 Name	Must be 50 characters or less
Amount Recovered	Amount recovered from third party.

Method: DMAS secure CCC Plus FTP server

Format: Excel (.xlsx) file

File Name: CCCP_MNY_RECOV_C*ontractorName_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.

DMAS: Third Party Liability Unit

1.4.6.3 Requirements

Member must be enrolled under CCC Plus.

1.4.6.4 Examples

None

1.4.6.5 Scoring Criteria

Number of rows with one or more errors (as defined in the file specifications) divided by the total number of rows submitted.

1.4.7 Other Coverage *(Eliminated effective 8/15/2022)*

1.4.7.1 Contract Reference: *12.4.12*

1.4.7.2 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
Other Coverage Type	Must be 2 characters or less Valid Values: CA, LI, CS, PI, TI, NA
If reporting Injury or Trauma - date	Must be a valid date Format: mm/dd/yyyy

Method: DMAS secure CCC Plus FTP server

Format: Excel (.xlsx) file

File Name: CCCP_OTH_COVG_C*ontractorName_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.

DMAS: Third Party Liability Unit

1.4.7.3 Requirements

As specified in the contract section referenced above.

Use the following codes: CA = Casualty; LI = Liability; CS = Child Support; PI = Personal Injury; TI = Trauma Injury; NA = Not Available

Provide one-time member trauma injury reporting per trauma date. Do not report ongoing member trauma injury.

1.4.7.4 Examples

NONE

1.4.7.5 Scoring Criteria

Number of rows with one or more errors (as defined in the file specifications) divided by the total number of rows submitted.

1.4.8 Patient Utilization Management and Safety (PUMS) Program Members

1.4.8.1 Contract Reference: *6.3.4*

1.4.8.2 File Specifications

For report specifications and submission requirements, see the most recent version of the ARTS Technical Manual posted on the CCC Plus program website under CCC Plus Information for Health Plans.

1.4.9 Workers' Compensation *(Eliminated effective 8/15/2022)*

1.4.9.1 Contract Reference: *12.4.12.1*

1.4.9.2 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
Other Carrier Name	Must be 50 characters or less
Other Carrier Policy Number	Must be 15 characters or less
Policy Effective Date	MM/DD/YYYY
Policy End Date	MM/DD/YYYY

Method: DMAS secure CCC Plus FTP server

Format: Excel (.xlsx) file

File Name: CCCP_WKR_COMP_C*ontractorName_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.

DMAS: Third Party Liability Unit

1.4.9.3 Requirements

As specified in the contract section referenced above.

When multiple coverages are present for a member, enter each type of coverage on a separate line for that member.

1.4.9.4 Examples

None

1.4.9.5 Scoring Criteria

Number of rows with one or more errors (as defined in the file specifications) divided by the total number of rows submitted.

1.4.10 Addiction and Recovery Treatment Services (ARTS) Appeals & Grievances Summary

1.4.10.1 Contract Reference: *17.1*

1.4.10.2 File Specifications

For report specifications and submission requirements, see the most recent version of the ARTS Technical Manual posted on the CCC Plus program website under CCC Plus Information for Health Plans.

1.4.11 Addiction and Recovery Treatment Services (ARTS) Call Center Statistics (Eliminated)

Deliverable eliminated.

1.4.12 Community Mental Health Rehabilitation Services (CMHRS) Service Authorizations and Registrations

Effective 1/1/2018

1.4.12.1 Contract Reference: *4.2.2, 6.2.5.2*

1.4.12.2 File Specifications

Field Description	Specifications
Medicaid ID	• Must be a valid Medicaid ID • Format: 12 bytes with leading zeros
Service Auth Category	Valid Values are: • Adult • Child under 21
Service Auth ID	Unique identifier for service authorization.
Type	• 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	• 15 Minute • Hour • Day • Week • Month • Unit • Other
Frequency Requested	• Day • Bi-Weekly • Week • Month • Year • Other • None
Number of Units Authorized	Numeric. Must be greater than or equal to zero.
Unit Approved Qualifier	• 15 Minute • Hour • Day • Week • Month • Unit • Other

Field Description	Specifications
Frequency Approved	• Day • Bi-Weekly • Week • Month • Year • Other • None
Denial Type	• Required • 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 'A" (approved) or 'P' (pending)
Denial Reason	• Administrative • Medical Necessity
Service Auth Urgency Type	• Required • Must use one of the following identifiers • 'E' = Expedited (Urgent SA Request) • 'N" = Non-Urgent (Standard SA Request)
Service Auth Status	• Required • Must use one of the following one character valid values: • 'A' = Approved ➢ Approved = Approved for full/requested amount • 'D' = Denied ➢ Denied = Denied for full/requested, 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 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)
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 • '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)

Method: DMAS secure CCC Plus FTP server

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. Numeric fields shall not include commas, dollar signs, or other extraneous characters. Do not include a header row in .csv files.

File Name: CCCP_CMHRS_SA_C*ontractorName_yyyymm*.csv (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.

DMAS: Managed Care Operations

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	A	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

Service Name	Proc. Code	Initial Request	Contd. Stay Request	Effective Date
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

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 H0035 (no modifier) converted 07/01/21 to MH-Partial Hospitalization Program
Intensive Community Treatment (ICT)	H0039	Expired 6/30/2021 Converted 07/01/21 to DD Waiver Community Crisis (May see on MTR)
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 Non-DD Waiver	H2019	Expired 11/30/2021 Converted 12/1/2021 to DD Waiver Crisis Intervention (May see on MTR)

Behavioral Therapy Assessment	H0032 UA	Expired 11/30/2021

1.4.12.3 Requirements

Include all EBH, CMHRS and Targeted Case Management service authorizations and registrations that **were approved/denied/pended during the previous calendar month."**

1.4.12.4 Examples

None

1.4.12.5 Scoring Criteria

None

1.4.13 Community Mental Health Rehabilitation Services (CMHRS) Appeals & Grievances Summary

Effective 1/1/2018

1.4.13.1 Contract Reference: *4.2.2, 6.2.5.2*

1.4.13.2 File Specifications

Field Description	Provider Specifications	Member Specifications
CMHRS Authorization Requests Received	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
CMHRS Authorization Requests Denied/Limited (reduced)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
CMHRS Appeals Open/Received	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total CMHRS Appeals Resolved This Month	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total CMHRS Appeals Carried Forward	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total CMHRS Appeals Resolved Prior Month	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
CMHRS Grievances	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces

Method: DMAS secure CCC Plus FTP server

Format: Excel (.xlsx)

File Name: CCCP_CMHRS_APP_GRIEV _C*ontractorName_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.

DMAS: Managed Care Contract Monitor

1.4.13.3 Requirements

Include only CMHRS appeals and grievances in this report.

Provider & Member Appeals:

- Total from members includes appeals submitted by a provider on behalf of a member.
- Total from providers includes only appeals submitted by a provider on behalf of the provider.

Total Carried Forward: Report only the number of appeals carried forward from the previous month that were still unresolved at the beginning of the reporting period.

Provider & Member Grievances: Only report on grievances received this month. Do not report any grievances carried forward from prior month(s). Report Provider and Member grievances separately.

Note: CMHRS appeals should also be included within the behavioral health category in the general Appeals & Grievances Summary report (1.4.1) while CMHRS grievances should be included in the overall grievance totals in that same report.

1.4.13.4 Examples

None

1.4.13.5 Scoring Criteria

None

1.4.14 Behavioral Health Call Center Statistics (Eliminated)

Deliverable eliminated effective 3/1/2018.

1.4.15 Member Appeals

Deliverable moved to “Other Reports” for ad hoc reporting only upon request (see 1.7.15)

1.4.16 Addiction and Recovery Treatment Services (ARTS) Provider Network File (Eliminated)

Deliverable eliminated.

1.4.17 Addiction and Recovery Treatment Services (ARTS) Provider Network Change Affecting Member Access to Care (See Other Reports)

This report was moved to the Other Reports section.

1.4.18 Provider Network File

1.4.18.1 Contract Reference: *16.9.4.2*

1.4.18.2 File Specifications

Please see the CCC Plus Network Submission Requirements Manual (NSRM) on the DMAS website for details.

Method:	Reference submission requirements in NSRM
Format:	Excel (.xlsx) file
File Name:	The file name should be composed of the Contractor's abbreviated name + month and year of the submission + NS + xlsx in the form XXXmmyyyyNS.xlsx. Example: AET062018NS.xlsx for the file submitted in June 2018 by Aetna. Use the following plan name abbreviations: AET: Aetna ANT: Anthem MCC: Molina Complete Care OPT: Optima UHC: United Health Care VAP: Virginia Premier
Trigger:	Monthly
Due Date:	By close of business on the 20th calendar day of the month following the reporting month.
DMAS:	Integrated Care

1.4.18.3 Requirements

As specified in the contract section referenced above.

1.4.18.4 Examples

None

1.4.18.5 Scoring Criteria

None

1.4.19 LTSS Service Reductions, Suspensions and Terminations – Suspended effective 2/1/2020

1.4.19.1 Contract Reference: *6.2.14*

1.4.19.2 File Specifications

Field Description	Specifications
Recipient Last Name	Recipient last name
Recipient First Name	Recipient first name
Medicaid ID	Format: 12 digits including leading zeros
Change in Services	Enter one of the following changes: - Reduction - Suspension - Termination
Date of Service Reduction, Suspension or Termination	Format: mmddyyyy

Method: DMAS secure CCC Plus FTP server

Format: Excel (.xlsx) file

File Name: CCCP_LTSS_SERVICE_CHANGES_C*ontractorName_yyyymm*.xlsx (where *yyyymm* is the reporting period month)

Trigger: Monthly

Due Date: *No submission is required until further notice.*

DMAS: CCC Plus Quality Analyst

1.4.19.3 Requirements

Reduction of services: Include all instances of a member's services being reduced by the MCO for any period of time.

Suspension of services: Do not include suspension of services for hospitalization or other circumstances where regulations or policy require services to be suspended. Include all other suspensions of services by the MCO for any period of time.

Termination of services: Include all terminations of services performed by the MCO. Do not include those terminations that are a result of the termination of the CCC Plus Waiver.

1.4.19.4 Examples

None

1.4.19.5 Scoring Criteria

None

1.4.20 Missed Trips

1.4.20.1 Contract Reference: *4.10.27*

1.4.20.2 File Specifications

Method:	Send as email attachment to CCCPlusReporting@dmas.virginia.gov and copy Bill.Zieser@dmas.virginia.gov Nicki.Taylor@dmas.virginia.gov michele.anderson@dmas.virginia.gov aaron.moore@dmas.virginia.gov
Format:	Use the reporting template located on SharePoint.
File Name:	CCCP_MISSED_TRIPS_C*ontractorName_mmddyy-mmddyy*.xlsx (where *mmddyy-mmddyy* is the reporting period) Example: CCCP_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.
DMAS:	Integrated Care Division

1.4.20.3 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.

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.

1.4.20.4 Examples

None

1.4.20.5 Scoring Criteria

None

1.4.21 Pharmacy Prior Authorization Report

1.4.21.1 Contract Reference: *18.2.3.3*

1.4.21.2 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 twelve 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)
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 • Format = 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.

Method: DMAS secure CCC Plus FTP server (place in "To DMAS" Monthly folder – do not place in Pharmacy folder)

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. Numeric fields shall not include commas, dollar signs, or other extraneous characters. Do not include a header row in .csv files.

File Name: CCCP_PA_REPORT_C*ontractorName_yyyymm*.csv

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.

The first submission of this report is due October 15, 2019 for the September reporting period.

DMAS: Pharmacy Unit

1.4.21.3 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 by the requestor to the MCO, 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.

1.4.21.4 Examples

None

1.4.21.5 Scoring Criteria

None

1.4.22 Fiscal/Employer Agent (F/EA) Scorecard

1.4.22.1 Contract Reference: *4.7.6*

1.4.22.2 File Specifications

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
DMAS:	Office of Community Living

1.4.22.3 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.

1.4.22.4 Examples

None

1.4.22.5 Scoring Criteria

None

1.4.23 Consumer-Directed Electronic Visit Verification (EVV) Report

1.4.23.1 Contract Reference 4.7.6.6

1.4.23.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Excel (.xlsx) file
File Name:	Per existing arrangement with DMAS
Trigger:	Monthly
Due Date:	By close of business on the 20th calendar day of the month
DMAS:	Office of Community Living

1.4.23.3 Requirements

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:

1. Unduplicated Active Attendant Total for the pay period
2. EVV Mobile App w/GPS attendants
3. EVV Mobile App w/GPS shifts
4. EVV-IVR Attendants
5. EVV-IVR Shifts
6. EVV – Mobile App w/GPS Edited Attendants (edited within 15 minutes of shift entry)
7. EVV – Mobile App w/GPS Edited Shifts (edited within 15 minutes of shift entry)
8. EVV – IVR Edited Attendants (edited within 15 minutes of shift entry)
9. EVV – IVR Edited Shifts (edited within 15 minutes of shift entry)
10. EVV – Mobile App w/GPS adjusted more than 15 minutes after shift entry - Attendants
11. EVV – Mobile App w/GPS adjusted more than 15 minutes after shift entry - Shifts
12. EVV – IVR adjusted more than 15 minutes after shift entry - Attendants
13. EVV – IVR adjusted more than 15 minutes after shift entry – Shifts
14. EVV - Mobile App w/o GPS Attendants
15. EVV - Mobile App w/o GPS Shifts
16. Manual - Web Portal Attendants
17. Manual - Web Portal Shifts
18. Manual – IVR attendants
19. Manual – IVR shifts
20. Distinct Total of Attendants using IVR
21. All IVR shifts
22. Distinct Total of Attendants using mobile app
23. All Mobile App Shifts
24. All EVV Compliant Shifts
25. EVV Compliance Percentage = (All EVV compliant shifts/ Total Shifts)*100
26. All EVV Non-Compliant Shifts
27. EVV Non-Compliant Shift Percentage = (All EVV non-compliant shifts/ Total Shifts)*100
28. 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.

2. EVV attendants (mobile app w/GPS)
3. EVV shifts (mobile app w/GPS)
4. EVV-IVR attendants
5. EVV-IVR shifts

6. EVV – Mobile App w/GPS Edited Attendants (edited within 15 minutes of shift entry)
7. EVV – Mobile App w/GPS Edited Shifts (edited within 15 minutes of shift entry)
8. EVV – IVR Edited Attendants (edited within 15 minutes of shift entry)
9. 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.

10 EVV – Mobile App w/GPS adjusted more than 15 minutes after shift entry - Attendants
11. EVV – Mobile App w/GPS adjusted more than 15 minutes after shift entry - Shifts
12. EVV – IVR adjusted more than 15 minutes after shift entry - Attendants
13. EVV – IVR adjusted more than 15 minutes after shift entry – Shifts
14. EVV - Mobile App w/o GPS Attendants
15. EVV - Mobile App w/o GPS Shifts
16. Manual - Web Portal Attendants
17. Manual - Web Portal Shifts
18. Manual – IVR attendants
19. Manual – IVR shifts

1.4.24 Renewal and Closure Outreach Report

1.4.24.1 Contract Reference: 2.14

1.4.24.2 File Specifications

Method:	Email to the following recipients: Mariam.Siddiqui@dmas.virginia.gov peter.sokol@dmas.virginia.gov
Format:	Excel (.xlsx) file – see report template on SharePoint
File Name:	Renewal_Outreach_C*ontractorName_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
DMAS:	Director's Office

1.4.24.3 Requirements

Report outreach activities collectively for CCC Plus and Medallion 4.0 members. There is no need to report separate totals for each program. Although this deliverable is listed in both the CCC Plus and Medallion 4.0 technical manuals, it is only necessary to submit one report to the email addresses indicated above.

1.4.24.4 Examples

None

1.4.24.5 Scoring Criteria

None

1.5 Quarterly Reports

1.5.1 Critical Incidents

1.5.1.1 Contract Reference: *17.3, 17.3.2*

1.5.1.2 File Specifications

Field Description	Specifications
MCO	Valid Values: • Aetna • Anthem • Molina • Optima • United HealthCare • Virginia Premier
Year	Format = mm/dd/yyyy
Qrt	Valid Values: • 1 • 2 • 3 • 4
Medicaid ID	Must be a valid Medicaid ID Format = 12 digits with any leading zeros included
Member Dually Eligible?	Valid Value: • Yes • No
Member Classification at Time of Incident	Select one of the following values from the drop-down list in template: • CCC+ Waiver w/o PDN • CCC+ Wavier with PDN • DD Waiver • Emerging Vulnerable • Minimal Need • Nursing Facility Other Vulnerable
Member DOB	Format = mm/dd/yyyy
Member Gender	Valid Values: • M • F • Other
Date of Event	Format = mm/dd/yyyy
Date Closed	Format = mm/dd/yyyy

Field Description	Specifications
	Leave blank if case not yet closed.
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
Provider Type	Valid Values: • HCBS • Hospital • Inpatient behavioral health facility • Nursing facility • PCP • Specialist • Transportation • Other • Not Applicable
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 description 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

Field Description	Specifications
	• Sentinel death • Serious injury • Theft • Other
Incident Detailed Description	Detailed description of incident
Cause of Death	Cause of death if applicable; "N/A" if not applicable
Actions Taken by MCO	Detailed description of actions taken
Date of Initiation of MCO Actions	Format: mm/dd/yyyy
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

Method: DMAS secure MLTSS FTP server

Format: Use the reporting template located on SharePoint.

File Name: CCCP_CRITICAL_INCIDENTS_*yyyy*Q*n*_C*ontractorName.xlsx*

where *yyyy*Q*n* is the reporting period state fiscal year and quarter.

For example: 2021Q1 for the first quarter of fiscal year 2021

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.

DMAS: TBD

1.5.1.3 Requirements

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

Critical incidents are reported for members that experience an incident while in nursing facilities, inpatient behavioral health or HCBS setting (e.g. an adult day care center, a members' home or any other community-based settings). It shall include reporting for CCCPlus waiver members.

Member classification at time of incident must be identified as one of the following: CCC+ Waiver w/o PDN, CCC+ Waiver with PDN, DD Waiver, Emerging Vulnerable, Minimal Need, Nursing Facility or Other Vulnerable.

A critical incident is defined as any actual, or alleged, event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety, or well-being of a member.

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

> *Quality of Care:* 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 patient's 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 1.7.8.3 under Sentinel Event in this manual for a more detailed description of sentinel events.
>
> *Other Critical Incidents:* An event or situation that creates a significant risk to the physical or mental health, safety, or well-being 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.

1.5.1.4 Examples

None

1.5.1.5 Scoring Criteria

None

1.5.2 Financial Report

1.5.2.1 Contract Reference: *19.1.3*

1.5.2.2 File Specifications

Method: DMAS secure CCC Plus FTP server

Format: Use the reporting template located on SharePoint.

File Name: FIN_QTRLY_*yyyy*Q*n*_C*ontractorName*.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: July thru September report is due November 30
October thru December report is due March 15
January thru March report is due May 31
April thru June report is due August 31

DMAS: Provider Reimbursement Division

1.5.2.3 Requirements

As specified by contract and additional guidance provided by DMAS Provider Reimbursement Division. The MCO Financial Report template 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 FTP as specified above. Do not submit any hardcopy files to DMAS.

The new Template has the following reporting requirements:

1) Report Operations By Line Of Business
   i) Medallion 3.0 Medicaid (Title XIX)
   ii) FAMIS + FAMIS MOMS SCHIP (Title XXI)
   iii) Medallion 4.0 Medicaid (Title XIX)
   iv) Commonwealth Coordinated Care Plus (CCC+) Non-Expansion
   v) Commonwealth Coordinated Care Plus (CCC+) Expansion
   vi) DSNP
   vii) Medicare Advantage
   viii) All Other Lines of Business

2) Revenue

3) Expenditures - By DMAS Rate Book Service Categories

4) Directed Payments

5) Plan Specific Enhanced Benefits.

Each Quarter's Operations by Line of Business are to be reported in the appropriate tab included in this template. Amounts reported for each quarter should be for that quarter only (i.e. not cumulative). Amounts reported in any quarter should not be included in any subsequent quarter.

To categorize expenditures by rate book service categories, please follow the detailed information presented on the tab "Service Categories Detail". This tab lists details and hierarchy information which is further explained in the tabs that follow.
.

1.5.2.4 Examples

None

1.5.2.5 Scoring Criteria

None

1.5.3 Program Integrity Overpayment and Recovery Report

1.5.3.1 Contract Reference: *14.10*

1.5.3.2 File Specifications

Method: DMAS secure CCC Plus FTP server

Format: Use the reporting template located on SharePoint

File Name: CCCP_PI_ACTIV*_yyyyQn_ContractorName*.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 last calendar day of the month following the end of the reporting quarter.

DMAS: Program Integrity Division

1.5.3.3 Requirements

As specified in the contract section referenced above. Include all components as specified by the contract.

1.5.3.4 Examples

None

1.5.3.5 Scoring Criteria

None

1.5.4 Providers Failing Accreditation/Credentialing and Terminations

1.5.4.1 Contract Reference: 8.4.10, 8.5.6.3

1.5.4.2 File Specifications

Method: DMAS secure CCC Plus FTP server

Format: Use the reporting template located on SharePoint

File Name: CCCP_PRV_CRED_*yyyy*Q*n*_*ContractorName*.xlsx

where *yyyy*Q*n* is the reporting state period 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 end of the reporting quarter.

DMAS: Program Integrity Division

1.5.4.3 Requirements

Report all providers who have failed to meet accreditation/credentialing standards, been denied application or have been terminated during the reporting quarter. This includes providers terminated from the MCO network.

MCO must supply, for CHMRS & Behavioral Therapy Providers only, the number of Medicaid members the provider was serving prior to termination of the provider contract within the reporting template.

- Include all terminations the MCO received from DMAS during the reporting quarter.
- Include all terminated providers regardless of PAR or NON-PAR status.
- Ensure 5-digit zip code is included in “Address” field.
- MCO must differentiate between those providers terminated with cause and those without cause.

1.5.4.4 Examples

None

1.5.4.5 Scoring Criteria

None

1.5.5 Rebalancing Activities

1.5.5.1 Contract Reference: *17.1*

1.5.5.2 File Specifications

Narrative report is required.

Method:	DMAS secure CCC Plus FTP server
Format:	Adobe .pdf file
File Name:	CCCP_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:	Quarterly
Due Date:	By close of business on the last calendar day of the month following the end of the reporting quarter.
DMAS:	CMT

1.5.5.3 Requirements

As specified in the contract section referenced above.

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.

1.5.5.4 Examples

None

1.5.5.5 Scoring Criteria

None

1.5.6 Reinsurance

This deliverable has been moved to DMAS Reports. See 2.1.11

1.5.7 Drug Rebate Report

1.5.7.1 Contract Reference: *19.2*

1.5.7.2 File Specifications

Field Description	Specifications
Drug Classification Source	Must be one of the following values: 1) Market Basket *For common core formulary drug classes defined in DMAS market basket* 2) AHFS *For AHFS Pharmacologic-Therapeutic classifications* 3) SSDC *Sole Source Drug Category (SSDC) is used for drug classes that contain only one drug product*
Drug Classification	E.g., antipsychotics, hepatitis C agents, etc. *Note: For AHFS drug classifications, use the tier 3 drug description if it exists; otherwise, use the lowest tier description available in a given drug classification hierarchy.*
Prescription count for each drug classification	Format 999
Total rebate amount invoiced during the reporting quarter for each drug classification	Format 999.99
Total rebate amount collected to date since the start of the program for each drug classification	Format 999.99
Total rebate amount invoiced during the reporting quarter for all drug classifications combined	Format 999.99
Total rebate amount collected on all prescriptions since the start of the program	Format 999.99

Method: DMAS secure CCC Plus FTP server (place in “To DMAS” Quarterly folder – do not place in Pharmacy folder)

Format: Use the reporting template located on SharePoint

File Name: CCCP_DRUG_REBATE_*yyyy*Q*n*_*ContractorName*.xlsx

where *yyyy*Q*n* is the reporting period state fiscal year and quarter.

For example: 2021Q1 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: Due 45 days following the end of the reporting quarter.

DMAS: Pharmacy Unit

1.5.7.3 Requirements

This report is not limited to drug classes on the Common Core Formulary. Plans must report all drug rebates collected including those on physician administered drugs and Medicare Part-B crossovers managed through POS claims processing.

Total rebate amount collected on all prescriptions since the start of the program: The Contractor shall report all rebates collected on drugs or devices dispensed to Medicaid Members from pharmaceutical manufacturers, distributors or any other source since the start of the plan's participation in the CCC Plus program through the end of the reporting quarter.

See the Market Basket list for DMAS drug classifications on SharePoint.

1.5.7.4 Examples

None.

1.5.7.5 Scoring Criteria

None.

1.5.8 ARTS Providers Failing Accreditation/Credentialing and Terminations

1.5.8.1 Contract Reference: *8.4.10*

1.5.8.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Use the reporting template located on SharePoint.
File Name:	CCCP_ARTS_PRV_CRED_*yyyy*Q*n*_C*ontractorName*.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 end of the reporting quarter.
DMAS:	Program Integrity Division

1.5.8.3 Requirements

Report all ARTS providers who have failed to meet accreditation/credentialing standards, been denied application (including terminated providers), and/or have had program integrity-related and adverse benefit determination.

1.5.8.4 Examples

None.

1.5.8.5 Scoring Criteria

None.

1.5.9 ID/D Waiver Reports for the Department of Justice

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

1.5.9.1 Contract Reference: *4.10.28*

1.5.9.2 File Specifications:

Method:	DMAS secure CCC Plus FTP server
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
DMAS:	Transportation Unit

1.5.9.3 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

1.5.9.4 Examples

None.

1.5.9.5 Scoring Criteria

None.

1.5.10 Fiscal Employer Agent Quarterly Payroll Review

1.5.10.1 Contract Reference: *4.7.6.9*

1.5.10.2 File Specifications

Method: DMAS secure CCC Plus FTP server

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

1.5.10.3 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.

1.5.10.4 Examples

None

1.5.10.5 Scoring Criteria

None

1.5.11 Quality Improvement Team (QIT) Quarterly Report

1.5.11.1 Contract Reference: *10.9*

1.5.11.2 File Specifications

Method: DMAS secure CCC Plus FTP server

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:

Reporting Period	Due Date
Jan 1 – Mar 31	Apr 30
Apr 1 – Jun 30	Jul 31
Jul 1 – Sep 30	Oct 31
Oct 1 – Dec 31	Jan 31

DMAS: Quality Improvement Specialist
Division of Integrated Care

1.5.11.3 Requirements

See the *CCC Plus Waiver QMR Technical Guide* for specific reporting requirements.

1.5.11.4 Examples

None

1.5.11.5 Scoring Criteria

None

1.5.12 Medication Therapy Management (MTM) Quarterly Report

1.5.12.1 Contract Reference: *4.8.4*

1.5.12.2 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

Method: DMAS secure CCC Plus FTP server (place in "To DMAS" Quarterly folder – do not place in Pharmacy folder)

Format: Excel (.xlsx) file

File Name: MTM_QTRLY_*yyyy*Q*n*_C*ontractorName*.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 end of the reporting quarter.

DMAS: Pharmacy Unit

1.5.12.3 Requirements

As specified in the contract section referenced above.

1.5.12.4 Examples

None

1.5.12.5 Scoring Criteria

None

1.5.13 QMR Finished Review Report

1.5.13.1 Contract Reference: 10.9

1.5.13.2 File Specifications

Method: DMAS secure CCC Plus FTP server

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:

Reporting Period	Due Date
Jan 1 – Mar 31	Apr 30
Apr 1 – Jun 30	Jul 31
Jul 1 – Sep 30	Oct 31
Oct 1 – Dec 31	Jan 31

DMAS: Quality Improvement Specialist
Division of Integrated Care

1.5.13.3 Requirements

See the *CCC Plus Waiver QMR Technical Guide* for specific reporting requirements.

1.5.13.4 Examples

None

1.5.13.5 Scoring Criteria

None

1.5.14 Waiver Enrollees w/o PDN with HRAs Overdue 3 months or Greater – Reinstated 8/23/2022 first report due 10/10/2022

1.5.14.1 Contract Reference: *5.7.1, 5.16.7*

1.5.14.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Use the reporting template located on SharePoint.
File Name:	Overdue_HRAReport_C*ontractorName_yyyyQn.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 10th of the month following the end of the reporting quarter.
DMAS:	Contract Monitoring Team

1.5.14.3 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+ 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 HRA. 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 <u>all</u> 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

1.5.15 Community Mental Health Rehabilitation Services (CMHRS) Appeals Report

1.5.15.1 Contract Reference: *4.2.2, 6.2.5.2*

1.5.15.2 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, U7,U8) H0035 H0036 H0040 H0046 H2011 H2012 H2016 (U7, 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

Method: DMAS secure CCC Plus FTP server

Format: Excel (.xlsx)

File Name: CCCP_CMHRS_APPEALS _C*ontractorName_yyyyQN*.xlsx
where *yyyyQN* is the reporting period state fiscal year and quarter.

For example: 2021Q3 for reporting period January -March 2021.

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

DMAS: Division of Integrated Care

1.5.15.3 Requirements

Report the following totals separately for each CMRHS 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 CMHRS appeals filed during the reporting period.

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

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

Appeals in Progress: the total number of CMHRS 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	A	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

Service Name	Proc. Code	Initial Request	Contd. Stay Request	Effective Date
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

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 H0035 (no modifier) converted 07/01/21 to MH-Partial Hospitalization Program
Intensive Community Treatment (ICT)	H0039	Expired 6/30/2021 Converted 07/01/21 to DD Waiver Community Crisis (May see on MTR)
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 Non-DD Waiver	H2019	Expired 11/30/2021 Converted 12/1/2021 to DD Waiver Crisis Intervention (May see on MTR)
Behavioral Therapy Assessment	H0032 UA	Expired 11/30/2021

1.5.15.4 Examples

None

1.5.15.5 Scoring Criteria

None

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

1.5.16.1 Contract Reference 8.4.6

1.5.16.2 File Specifications

Method: DMAS secure CCCPlus FTP server

Format: Use the IES Quarterly Reporting Template located on 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: CCCPlus Only

DMAS: Integrated Care

1.5.16.3 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.

1.6 Annual & Semi-Annual Reports

1.6.1 List of Subcontractors

1.6.1.1 Contract Reference: *7.1*

1.6.1.2 File Specifications

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 Care Coordination LTSS Services Other Providers

Method: DMAS secure CCC Plus FTP server

Format: Use the reporting template located on SharePoint

File Name: CCCP_SUBCONTRACT_C*ontractorName_yyyymmdd*.xlsx

where *yyyymmdd* is the date of submission

Trigger: Annually and prior to any changes

Due Date:
- September 30
- 30 calendar days prior to implementation of any changes

DMAS: Integrated Care Division

1.6.1.3 Requirements

As specified in the contract section referenced above.

Report should utilize form available from DMAS CCC Plus web site 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.

1.6.1.4 Examples

N/A

1.6.1.5 Scoring Criteria

None

1.6.2 Member Handbook

1.6.2.1 Contract Reference: *11.11.5*

1.6.2.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Adobe .pdf file
File Name:	CCCP_MBR_HNDBK_C*ontractorName_yyyymmdd*.pdf where *yyyymmdd* is the date of submission
Trigger:	- Annual - Upon revision - Upon request
Due Date:	- September 30 - 60 calendar days prior to printing (new or revised) - Within 10 business days of receipt of DMAS request
DMAS:	Contract Monitoring Team

1.6.2.3 Requirements

The Contractor shall submit a copy of the revised member handbook to the department for approval 60 calendar days prior to planned printing. The updated handbook must address changes in policies through submission of a cover letter identifying sections that have changed and/or red-lined showing the before and after language. See contract section referenced above for further details.

1.6.2.4 Examples

None

1.6.2.5 Scoring Criteria

None

1.6.3 Organizational Charts

1.6.3.1 Contract Reference: *14.6*

1.6.3.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Adobe .pdf file
File Name:	CCCP_ORG_CHART_C*ontractorName_yyyymmdd*.pdf
	where *yyyymmdd* is the date of submission
Trigger:	Annual
Due Date:	September 30
DMAS:	Integrated Care Division

1.6.3.3 Requirements

As specified in the contract section referenced above. Reported changes should include both structural changes and key staff changes.

1.6.3.4 Examples

None

1.6.3.5 Scoring Criteria

None

1.6.4 Program Integrity Activities Annual Summary (Eliminated)

Deliverable eliminated.

1.6.5 Third Party Administrator (TPA) Firewall

1.6.5.1 Contract Reference: *7.1*

1.6.5.2 File Specifications

Method:	Email: CCCPlusReporting@dmas.virginia.gov
Format:	N/A
File Name:	N/A
Trigger:	- Negotiation of TPA contract - Amendment of TPA contract - Annual
Due Date:	- 10 days prior to execution of TPA contract with Contractor - 10 days prior to amendment of TPA contract with Contractor - At least 60 days prior to signing of contract between the Contractor and DMAS and annually thereafter on September 30
DMAS:	Information Management Division

1.6.5.3 Requirements

As specified in the contract section referenced above.

The Contractor must provide demonstrable assurances of adequate physical and virtual firewalls whenever utilizing a Third Party Administrator (TPA) for services including, but not limited to, those referenced in contract section 7.1, and when there is a change in an existing or new TPA relationship. Assurances must include an assessment, performed by an independent contractor/third party, that demonstrates proper interconnectivity with the Department and that firewalls meet or exceed the industry standard. Contractors and TPAs must provide assurances that all service level agreements with the Department will be met or exceeded. Contractor staff must be solely responsible to the single health plan entity contracted with the Department.

1.6.5.4 Examples

N/A

1.6.5.5 Scoring Criteria

None

1.6.6 Value Based Payment Plan

1.6.6.1 Contract Reference: *13.2*

1.6.6.2 File Specifications

Method:	OVBP/DMAS will distribute, by secure mail, to each contractor a pre populated template at least 60 days prior to the due date. CONTRACTOR will submit through DMAS secure CCC Plus FTP server.
Format:	Adobe .pdf file
File Name:	CCCP_VBP_ANNUAL_PLAN_C*ontractorName_yyyymmdd*.pdf where *yyyymmdd* is the date of submission
Trigger:	Annual
Due Date:	January 1
DMAS:	Value Based Purchasing

1.6.6.3 Requirements

As specified in the contract section referenced above (i.e. Contractor Annual VBP Plan). Submission must include all components referenced in the contract section “Contractor Annual 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.

A generic Annual Plan template is located on SharePoint.

1.6.6.4 Examples

None

1.6.6.5 Scoring Criteria

None

1.6.7 Addiction Recovery and Treatment Services (ARTS) Stop Loss (Eliminated)

Deliverable eliminated effective 10/1/2018.

1.6.8 Value-Based Payment (VBP) Data Collection Tool (Eliminated)

See 1.6.23

1.6.9 Value-Based Payment (VBP) Status Report (Eliminated)

See 1.6.23

1.6.10 Marketing Plan

1.6.10.1 Contract Reference: *11.12.1.1*

1.6.10.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Adobe .pdf file.
File Name:	MKTG_PLAN_C*ontractorName_yyyymmdd*.pdf
	where *yyyymmdd* is the date of submission
Trigger:	Annual
Due Date:	September 30
	Thirty days prior to implementation of any changes
DMAS:	Integrated Care

1.6.10.3 Requirements

The Contractor shall annually submit a complete marketing plan to the Department for informational purposes. Any changes to the marketing plan shall be submitted to the Department for approval prior to use.

1.6.10.4 Examples

None

1.6.10.5 Scoring Criteria

None

1.6.11 Virginia ED Care Coordination Program Report

1.6.11.1 Contract Reference: *5.12*

1.6.11.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Adobe .pdf file
File Name:	EDCC_C*ontractorName_yyyymmdd*.pdf where *yyyymmdd* is the date of submission
Trigger:	Annual
	Upon revision
	Upon request
Due Date:	September 30
	Within five business days of revision
	Within ten business days of request
DMAS:	TBD

1.6.11.3 Requirements

The Contractor shall describe activities supporting appropriate utilization of hospital emergency room services. These activities include the use of incentives the Contractor provides for primary care practices that provide night and weekend hours and same-day appointments; advanced levels of care management for those exhibiting high utilization of emergency services; and use of the ED Care Coordination encounter alerts and shared care coordination plans by MCO care coordinators to identify frequent ED utilizers and address their needs.

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.

1.6.11.4 Examples

None

1.6.11.5 Scoring Criteria

None

1.6.12 MCO Member Health Screening (MMHS) Policies and Procedures

This report has been moved to Other Reports. See 1.7.12.

1.6.13 Formal Referral and Assistance Process for Homeless Members

1.6.13.1 Contract Reference: *5.7.5*

1.6.13.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Adobe .pdf file
File Name:	REF_HMLSS_C*ontractorName_yyyymmdd*.pdf where *yyyymmdd* is the date of submission
Trigger:	Annual
Due Date:	Within 120 calendar days of the contract effective date (5/1/2019) and annually thereafter on September 30
	Within five business days of revision
	Within ten business days of request
DMAS:	TBD

1.6.13.3 Requirements

The Contractor shall develop formal referral and assistance processes and procedures in its existing case management programs that identify homeless members enrolled in the Contractor's managed care program and provide them with information and referrals to local shelters and other community based homeless aid programs services provided in every region of the state. The Contractor shall submit a report to DMAS within 120 days of the effective date of this Contract and annually that identifies these community-based homeless support services by city/county, provides details of the formal referral relationships established and describes how the Contractor will make face to face contact with its homeless members.

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.

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

1.6.13.4 Examples

None

1.6.13.5 Scoring Criteria

None

1.6.14 Wellness and Member Incentive Programs

1.6.14.1 Contract Reference: *10.13*

1.6.14.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Adobe .pdf file
File Name:	MBR_WELL_C*ontractorName_yyyymmdd*.pdf where *yyyymmdd* is the date of submission
Trigger:	Annual Upon revision
Due Date:	On September 30 of each year and 30 calendar days prior to implementation of any changes
DMAS:	TBD

1.6.14.3 Requirements

The Contractor shall describe the activities supporting health and wellness initiatives to include healthy behavior incentives to encourage Members to take an active role in their health. Examples of healthy behavior activities include engagement in disease management programs, performance of best-practice preventive measures such as flu shots, participating in smoking cessation programs, etc.

1.6.14.4 Examples

None

1.6.14.5 Scoring Criteria

None

1.6.15 Social Determinants of Health Policies and Procedures

1.6.15.1 Contract Reference: *10.14*

1.6.15.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Adobe .pdf file. See SDOH Policies and Procedures template on SharePoint.
File Name:	SDOH_RPT_C*ontractorName_yyyymmdd*.pdf
	where *yyyymmdd* is the date of submission
Trigger:	Annual
Due Date:	September 30
	Within five (5) business days of revision
	Within ten (10) business days of request
DMAS:	TBD

1.6.15.3 Requirements

Focus areas: Employment, Food Security, Housing Stability for all CCC Plus populations.

1. Policies and procedures on programs and partnerships established to identify, address and track members at risk of housing, job, or food insecurity.

2. Policies and procedures on current care coordination efforts being made to identify, address, and track member access to housing services, job training, and food security.

3. Provide to the Department in pdf format Care Coordination training materials, to include social determinants of health policies and procedures surrounding employment, food, and housing. If the Care Coordination training materials are different under CCC Plus versus Medallion 4.0, please specify those differences.

1.6.15.4 Examples

None

1.6.15.5 Scoring Criteria

None

1.6.16 Expansion Enhanced Fraud Prevention Policies and Procedures

1.6.16.1 Contract Reference: *10.17*

1.6.16.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Adobe .pdf file
File Name:	MEDEX_EFP_C*ontractorName_yyyymmdd*.pdf where *yyyymmdd* is the date of submission
Trigger:	Annual
	Upon revision
	Upon request
Due Date:	September 30
	Within five (5) business days of revision
	Within ten (10) business days of request
DMAS:	TBD

1.6.16.3 Requirements

Enhanced fraud prevention policies and procedures must be submitted to the Department on an annual basis and upon revision (or request).

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.

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

1.6.16.4 Examples

None

1.6.16.5 Scoring Criteria

None

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

1.6.17.1 Contract Reference: *11.12.8.1*

1.6.17.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
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

1.6.17.3 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.

1.6.17.4 Examples

None

1.6.17.5 Scoring Criteria

None

1.6.18 Outreach to Pregnant Members who Qualify for Expansion Report

1.6.18.1 Contract Reference: *11.12.8.2*

1.6.18.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Adobe .pdf file
File Name:	MEDEX_PREG_C*ontractorName_yyyymmdd*.pdf where *yyyymmdd* is the date of submission
Trigger:	Annual
	Upon revision
	Upon request
Due Date:	September 30
	Within 5 business days of revision
	Within 10 business days of request
DMAS:	TBD

1.6.18.3 Requirements

The Contractor shall assist pregnant members who are two months postpartum and who are not in a Medicaid expansion aid category with assistance in transitioning to a Medicaid expansion aid category. The Contractor shall develop policies and procedures to assist members to assure that their newborn children get enrolled in Medicaid.

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.

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

1.6.18.4 Examples

None

1.6.18.5 Scoring Criteria

None

1.6.19 Medication Therapy Management (MTM) Annual Report

1.6.19.1 Contract Reference: *4.8.4*

1.6.19.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Adobe .pdf file
File Name:	MTM_ANNUAL_C*ontractorName_yyyymmdd*.pdf where *yyyymmdd* is the date of submission
Trigger:	Annual
Due Date:	45 days after the end of the contract year *Note: No report is due for the partial contract year of January 2020 – June 2020. The 2021 report will cover six quarters: January 2020 – June 2021.*
DMAS:	Pharmacy Unit

1.6.19.3 Requirements

Submit a free-form outcome report identifying positive changes in drug therapies and potential cost savings.

1.6.19.4 Examples

None

1.6.19.5 Scoring Criteria

None

1.6.20 CMS Annual Drug Utilization Review (DUR) Report

1.6.20.1 Contract Reference: *4.8.7*

1.6.20.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Adobe .pdf file
File Name:	DUR_CMS _C*ontractorName_yyyymmdd*.pdf where *yyyymmdd* is the date of submission
Trigger:	Annual
Due Date:	August 15
DMAS:	Pharmacy Unit

1.6.20.3 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 http://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.

1.6.20.4 Examples

None

1.6.20.5 Scoring Criteria

None

1.6.21 Provider Preventable Conditions Summary Report – Suspended

1.6.21.1 Contract Reference: *12.4.13*

1.6.21.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Adobe .pdf file
File Name:	PPC_SUM_RPT _C*ontractorName_yyyymmdd*.pdf where *yyyymmdd* is the date of submission
Trigger:	Annual
Due Date:	SUSPENDED
DMAS:	Integrated Care

1.6.21.3 Requirements

As specified in the contract section referenced above.

1.6.22 Drug Formulary & Authorization Requirements

1.6.22.1 Contract Reference: *4.8.1.1*

1.6.22.2 File Specifications

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

Method: DMAS secure CCC Plus FTP server

Format: Excel (.xlsx) file

File Name: FORMULARY _C*ontractorName_yyyymmdd*.xlsx
where *yyyymmdd* is the date of submission

Trigger: Prior to implementation.

After full pharmacy coding files.

Upon revisions.

Due Date: 60 calendar days prior to implementation.

60 days after a full pharmacy coding files is provided by DMAS.

45 calendar days prior to the effective date of the changes.

DMAS: Pharmacy Unit

1.6.22.3 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 CCC Plus 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 "common core" formulary will not apply to dual eligible Members who have a pharmacy benefit covered by a Medicare Part D plan.

The Contractor's form ulary must be developed and reviewed at least 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. The Contractor shall submit changes for review and approval via email at least forty-five (45) calendar days prior to the effective date of the change. The Department will respond within fifteen (15) calendar days.

1.6.23 Value Based-Payment (VBP) Data Collection Tool and Status Report

1.6.23.1 Contract Reference: *13.3, 13.4*

1.6.23.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Use the reporting template located on SharePoint.
File Name:	CCCP_HCPLAN_STATUS_RPT_TOOL_C*ontractorName_yyyymmdd*.xlsx
	where *yyyymmdd* is the date of submission
Trigger:	Annual
Due Date:	April 1 following end of reporting year
DMAS:	Value Based Purchasing

1.6.23.3 Requirements

As specified in the contract section referenced above (i.e. Contractor Annual VBP Status Report). Submission must include all components referenced in the contract section “Contractor Annual 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.

A generic Annual Plan template is located on SharePoint.

1.6.23.4 Examples

None

1.6.23.5 Scoring Criteria

None

1.6.24 Medical Loss Ratio (MLR) Report

1.6.24.1 Contract Reference: *19.7*

1.6.24.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Use the reporting template located on SharePoint.
File Name:	CCCP_MLR_RPT_C*ontractorName_yyyymmdd*.xlsx
	where *yyyymmdd* is the date of submission
Trigger:	Annual
Due Date:	June 1, 2021 for the reporting period January 1, 2020 through June 30, 2020
	June 1 following the report fiscal year thereafter
DMAS:	Provider Reimbursement

1.6.24.3 Requirements

See contract reference.

1.6.25 Services for Justice-Involved Members Policies and Procedures

1.6.25.1 Contract Reference: *5.15.6*

1.6.25.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Adobe PDF
File Name:	JUST_SVC_C*ontractorName_yyyymmdd*.pdf where *yyyymmdd* is the date of submission
Trigger:	Annual Upon Revision Upon Request
Due Date:	September 30 Within five (5) business days of revision Within ten (10) business days of request

1.6.25.3 Requirements

The Contractor shall collaborate with the Department to develop policies and procedures for the screening and provision of care for Medicaid Members who have been identified as recently released from a correctional facility or local/regional jail. These policies and procedures should address the following: 1) assisting the Member with accessing care and/or community supports as needed; 2) partnering with community resources to facilitate referral networks; and 3) developing reports that include methods for identifying and removing barriers to care and addressing additional needs expressed by the Member.

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.

1.6.26 Quality Assessment & Performance Improvement (QAPI) Program

1.6.26.1 Contract Reference: *10.4*

1.6.26.2 *File Specifications*

Method:	DMAS secure CCC Plus FTP server
Format:	Adobe PDF
File Name:	QAPI_PLAN_C*ontractorName_yyyymmdd*.pdf where *yyyymmdd* is the date of submission
Trigger:	Annual
Due Date:	July 31st
DMAS:	Office of Quality and Population Health

1.6.26.3 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. 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.

1.6.27 HEDIS Results

1.6.27.1 Contract Reference: *10.6*

1.6.27.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Excel file
File Name:	HEDIS_C*ontractorName_yyyymmdd*.xlsx where *yyyymmdd* is the date of submission
Trigger:	Annual
Due Date:	July 31
DMAS:	Office of Quality and Population Health

1.6.27.3 Requirements

Include the full locked Interactive Data Submission System (IDSS) file.

1.6.28 CAHPS Survey Results

1.6.28.1 Contract Reference: *10.6*

1.6.28.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Excel or PDF file
File Name:	CAHPS_C*ontractorName_yyyymmdd*.xlsx or CAHPS_C*ontractorName_yyyymmdd*.pdf where *yyyymmdd* is the date of submission
Trigger:	Annual
Due Date:	July 31
DMAS:	Office of Quality and Population Health

1.6.28.3 Requirements

As specified in the contract, including all detailed survey results. The results for Adults, Children and Children with Chronic Conditions shall be combined into one file for submission – using either separate tabs if an Excel file or separate sections if a PDF file.

1.6.29 Program Integrity Plan

1.6.29.1 Contract Reference: *14.2*

1.6.29.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Adobe PDF file
File Name:	CCCP_PI_PLAN_C*ontractorName_yyyymmdd*.pdf where *yyyymmdd* is the date of submission
Trigger:	Annual Upon Revision Upon Request
Due Date:	September 30 Within 5 business days of revision Within 10 business days of receiving a request from DMAS
DMAS:	Program Integrity Division

1.6.29.3 Requirements

The Contractor shall develop a written program integrity plan specific to the CCC Plus program. The program integrity plan must define how the Contractor will adequately identify and report suspected fraud, waste and abuse by Members, by network providers, by subcontractors and by the Contractor.

The Virginia Medicaid Program Integrity Plan must be submitted annually. The Plan must include the Contractor PI Lead and contact information. The PI plan must also include the following elements:

1) PI Staffing Organizational chart, to include the full-time equivalency of each staff (estimated weekly hours or percentage of work time) dedicated to PI;
2) A listing of the health plan PI contractors (unless proprietary);
3) A process to act as or sub-contract with a Contractor for Recovery Audit purposes; and,
4) A plan with set goals and objectives and describe the processes involved including data mining, software, audit findings for the Virginia Medicaid.

All fraudulent activities or other program abuses shall be subject to the laws and regulations of the Commonwealth of Virginia and/or Federal government.

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 business days of that request.

1.6.30 Internal Controls Report

1.6.30.1 Contract Reference: *19.4*

1.6.30.2 File Specifications

Method: DMAS secure CCC Plus FTP server

Format: Adobe PDF file

File Name: *xxxx*_SOC_2_*yyyymmdd*.pdf
where *xxxx* is the service center ID and *yyyymmdd* is the date of submission

Service Center ID	MCO
1014	Aetna Better Health of Virginia
1015	HealthKeepers, Inc.
1016	Molina
1017	Optima Health Community Care
1018	United Healthcare Community Plan
1019	Virginia Premier Health Plan, Inc.

Trigger: Annual

Due Date: Within 30 days of completion of report and no later than June 1

DMAS: Procurement and Contract Management Division

1.6.30.3 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 SOC 2 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.

Note: The same report will cover internal controls for both CCC Plus and Medallion 4.0. Include attestation statement upon submission that indicates that this SOC 2 Report accounts for both Medallion 4.0 and CCC Plus Contract.

1.6.31 Internal Monitoring and Audit - Annual Plan

1.6.31.1 Contract Reference: *14.2.3*

1.6.31.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	As Specified by the MCO
File Name:	PI_MONITOR_AUDIT_PLAN__C*ontractorName_yyyymmdd*.pdf where *yyyymmdd* is the date of submission
Trigger:	Annual
	Upon Revision
	Upon Request
Due Date:	December 31st of each year
	Within five (5) business days of revision
	Within ten (10) business days of request
DMAS:	Program Integrity Division

1.6.31.3 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.

Examples

None

Scoring Criteria

None

1.6.32 CMS Managed Care Program Annual Report

1.6.32.1 Contract Reference 16.3

1.6.32.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Use the Reporting Template located on SharePoint
File Name:	CCCP_MCPAR_*ContractorName_yyyymmdd.xlsx*
	Where *yyyymmdd* is the date of submission
Trigger:	Annual
Due Date:	September 30th
DMAS:	Integrated Care Policy Team

1.6.32.3 Requirements

See reporting template provided by DMAS for instruction. Report only grievance and appeals data that was resolved during the reporting period July 1, 2022 through December 31, 2022, or as of the last effective date of the FY23 CCCPlus contract as directed by the department.

One template may be completed for both the CCC Plus and the Medallion program. Data must be separated according to each program and not be combined.

The template will need to be submitted individually to each program's preferred method of delivery.

1.7 Other Reports

1.7.1 Excluded Member

1.7.1.1 Contract Reference: *3.2.10*

1.7.1.2 File Specifications

Method:	DMAS secure CCC Plus FTP server (place in “Other” folder under “To-DMAS”)
Format:	Use the reporting template located on SharePoint.
File Name:	CCCP_EXCLUDED_C*ontractorName_yyyymmdd*.xlsx where *yyyymmdd* is the date of submission
Trigger:	Identification of excluded member
Due Date:	Within 2 business days of learning that member meets one or more exclusion criteria
DMAS:	TBD

1.7.1.3 Requirements

As specified in the contract section referenced above. Multiple members may be included in each individual report submitted.

1.7.1.4 Examples

None

1.7.1.5 Scoring Criteria

None

1.7.2 Marketing Fraud/Waste/Abuse (Eliminated)

Deliverable eliminated effective 11/15/2018.

1.7.3 Medical Transition Report Service Authorizations *(Deliverable eliminated 4/29/2022).*

1.7.3.1 Contract Reference: *3.2.2, 6.2 (July 1, 2021)*

1.7.3.2 File Specifications

Field	Length	Start Pos	End Pos	Description/Comments	Required Field
SA-SVC-CTR	4	1	4	MMIS EDI Service Center	Yes
SA-RUN-DATE	8	5	12	Run Date – MMDDYYYY	Yes
SA-MCO-API	10	13	22	Plan (MCO) Number – MMIS API Number (Generating Plan)	Yes
SA-REC-TYPE	1	23	23	Record Type – S (Service Authorization)	No
SA-SOURCE-CODE	1	24	24	Source Code - M (Managed Care)	No
SA-MCO-BNFT-BEG-DATE	8	25	32	N/A - (This is populated by MMIS for the Receiving Plan)	No
SA-MEMBER-ID	12	33	44	Member Medicaid ID	Yes
SA-MEMBER-LAST-NM	20	45	64	Member Last Name	Yes
SA-MEMBER-FIRST-NM	12	65	76	Member First Name	Yes
SA-MEMBER-MIDDLE-NM	1	77	77	Member Middle Initial	Yes
SA-MEMBER-DOB	8	78	85	Member Birth Date – MMDDYYYY	Yes
SA-MEMBER-GENDER	1	86	86	Member Gender	Yes
SA-MEMBER-RACE	1	87	87	Member Race Code	No
SA-MEMBER-FIPS	3	88	90	Member Locality	No
SA-MEMBER-AID-CAT	3	91	93	Program Aid Category	No
SA-MEMBER-EXCP-IND	2	94	95	Level of Care/Exception Indicator	Yes
SA-TYPE	4	96	99	Service Authorization Type (see DMAS Data Element Dictionary)	Yes
SA-SRV-PROV-NPI-API	10	100	109	Servicing Provider ID – NPI or API	Yes
SA-SRV-PROV-NAME	40	110	149	Servicing Provider Name	Yes
SA-PRIM-DIAG	7	150	156	Diagnosis Code – ICD-9 or ICD-10	Yes
SA-PROC-CODE	11	157	167	Procedure Code – HCPCS, CPT, NDC, or Pseudo Code	Yes
SA-PROC-MOD-1	2	168	169	Procedure Code Modifier 1	Yes
SA-PROC-MOD-2	2	170	171	Procedure Code Modifier 2	Yes
SA-PROC-MOD-3	2	172	173	Procedure Code Modifier 3	Yes
SA-PROC-MOD-4	2	174	175	Procedure Code Modifier 4	Yes
SA-NBR	20	176	195	Service Authorization (SA) Number	Yes
SA-AUTH-FROM-DATE	8	196	203	Authorized From Date of Service – MMDDYYYY	Yes
SA-AUTH-THRU-DATE	8	204	211	Authorized Through Date of Service - MMDDYYYY	Yes

Field	Length	Start Pos	End Pos	Description/Comments	Required Field
SA-AUTH-UNIT	6	212	217	Authorized Units	Yes
SA-AUTH-AMT	16	218	233	Authorized Amount if applicable for SA services	Yes
SA-USED-UNITS	6	234	239	Used Units	Yes
SA-M-D-AUTH-TYPE	1	240	240	Medical/Drug Authorization Type – M = Medical, D = Drug	Yes
SA-FREQ-DAYS-SUP	5	241	245	Authorized Frequency/Days Supply – If MP_AUTH_TYPE = M, value is Frequency: BW Bi-Weekly; DY Daily; HR Hourly; MO Monthly; QR Quarterly; WK Weekly; YR Yearly; and, FY Fiscal Year. If MP_AUTH_TYPE = D, value is Days Supply	Yes
SA-SRC-SYSTEM-ID	20	246	265	The source system identifier number other than the SA Number	No
SA-EPSDT-IND	1	266	266	Y = EPSDT Related, N = Not EPSDT Related	No
SA-FILLER	32	267	298	Filler - Use first 4 characters to populate health plans' MMIS EDI Service Center	Yes
Total Record Length	298				

Method	Submit file to /Distribution/EDI/*SC##*/To-VAMMIS/Claims where *SC##* is the MCO's service center number
Format	Fixed-length text file (zipped)
File Name	MCF622*_yyyymmdd-xxxxxx*.txt where *yyyymmdd-xxxxxx* is a date-time stamp (the time format is left to the MCO's discretion)
Trigger	Termination of CCC Plus coverage for one or more members
Schedule	As needed – could be daily
DMAS	MMIS

1.7.3.3 Requirements

A plan-to-plan MTR provides service authorizations to the new MCO for members changing MCOs or to Magellan and KePRO if the member is dropping into FFS. The required fields are suggestions to the MCOs for better data quality, but there is currently no editing of the data in this file.

Service authorizations must not exceed two (2) years in duration as defined by:

- SA Auth from Date to SA Auth thru Date.

DMAS Data Element Dictionary- Services Authorization Type

SA-Type	Service
0300	Organ Transplant Services
0302	Surgical Procedures
0303	Prosthetic Services
0304	Medical Device Services/Maintenance
1020	Specialized Care/Long Stay Hospital
0204	Outpatient Rehabilitation Services
0500	Outpatient Home Health Services
0450	Outpatient MRI
0451	Outpatient CAT Scan
0452	Outpatient PET Scan
0400	Inpatient Hospital Medical/Surgical Services
0200	Intensive Inpatient Rehabilitation Services (to include out of state)
0100	Outpatient Durable Medical Equipment (DME) and Supplies
0092	EPSDT Orthotics/DME Services; EPSDT Chiropractic; EPSDT Hearing Aid Services; EPSDT Assistive Technology Services
0090	EPSDT Private Duty Nursing
0098	EPSDT MCO Carve Out – Private Duty Nursing – In the School
0091	EPSDT Personal Care/Attendant Care
0960	Technology Waiver
0902	Developmental Disabilities
0900	Elderly & Disabled Waiver With Consumer Direction

1.7.3.4 Examples

None

1.7.3.5 Scoring Criteria

None

1.7.4 Network Deficiency and Exemption Request

1.7.4.1 Contract Reference: *8.3*

1.7.4.2 File Specifications

Method:	Send as email attachment to CCCPlusReporting@dmas.virginia.gov.
Format:	Use the reporting template located in SharePoint.
File Name:	CCCP_NETWORK_DEF_C*ontractorName_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 5 business days of identification of deficiency
DMAS:	CMT

1.7.4.3 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

1.7.4.4 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.

1.7.4.5 Scoring Criteria

None

1.7.5 Notification of Provider Investigation

1.7.5.1 Contract Reference: *14.9, 14.14.1*

1.7.5.2 File Specifications

Method:	Send as email attachment to mcopideliverables@dmas.virginia.gov
Format:	Use the reporting template located on SharePoint.
File Name:	CCCP_PROV_INV_C*ontractorName_yyyymmdd*.pdf
	where *yyyymmdd* is the date of submission
Trigger:	Discovery of possible fraud, waste, or abuse
Due Date:	Within 48 hours of discovery of possible fraud, waste, or abuse.
DMAS:	Program Integrity Division

1.7.5.3 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.

1.7.5.4 Examples

None

1.7.5.5 Scoring Criteria

None

1.7.6 Other Coverage Claims History

1.7.6.1 Contract Reference: *12.4.12*

1.7.6.2 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

Method: To be determined by the Contractor

Format: Excel (.xlsx) file

File Name: CCCP_CLAIM_HIST_C*ontractorName*.yyyymmddxlsx

where *yyyymmdd* is the date of submission

Trigger: Upon request

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

DMAS: Third Party Liability Unit

1.7.6.3 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.

1.7.7 Referral of Suspected Provider Fraud

1.7.7.1 Contract Reference: *14.9*

1.7.7.2 File Specifications

Method:	Send as email attachment to mcopideliverables@dmas.virginia.gov.
Format:	Use the reporting template located on SharePoint.
File Name:	CCCP_PROV_FRAUD_C*ontractorName_yyyymmdd*.pdf
	where *yyyymmdd* is the date of submission
Trigger:	Evidence of fraudulent activity
Due Date:	Within 48 hours of discovery of evidence of fraudulent activity.
DMAS:	Program Integrity Division

1.7.7.3 Requirements

Note: 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.

1.7.7.4 Examples

None

1.7.7.5 Scoring Criteria

None

1.7.8 Sentinel Event

1.7.8.1 Contract Reference: *17.3, 17.3.1*

1.7.8.2 File Specifications

Field Description	Specifications
Recipient Last Name	Recipient Last Name
Recipient First Name	Recipient First Name
Recipient Medicaid ID	Must be a valid Medicaid ID Format: 12 digits with leading zeros
Member Dually Eligible	Y = Yes, N = No
Member Classification at Time of Incident	Valid Values: • CCC+ Waiver w/o PDN • CCC+ Waiver with PDN • DD Waiver • Emerging Vulnerable • Minimal Need • Nursing Facility • Other Vulnerable
Recipient DOB	mm/dd/yyyy
Recipient Gender	M or F
Date of Event	mm/dd/yyyy
Provider - Hospital	Hospital name (or N/A)
Provider - PCP or Specialist	PCP or specialist name (or N/A)
Provider - Nursing Facility	Nursing facility name (or N/A)
Provider - Inpatient Behavioral Health Facility	Inpatient behavioral health facility name (or N/A)
Provider – HCBS	HCBS provider name (or N/A)
Provider - Other	Other provider name (or N/A)
Event High-Level Description	Brief description of event (e.g., sexual assault)
Event Detailed Description	Narrative description of event
Cause of Death	Cause of death if applicable
Source of Event Data	
Contact Name	Name of person who can be contacted for further information about the incidents reported.
Contact Phone Number	Phone number of person who can be contacted for further information about the incidents reported. Include area code.

	Format: (999) 999-9999
Contact E-mail	E-mail address of person who can be contacted for further information about the incidents reported.

Method	DMAS secure CCC Plus FTP server (place in “Other” folder under “To-DMAS”)
Format	Excel (.xlsx) file
File Name	CCCP_SENTINEL_C*ontractorName*.*yyyymmdd*.xlsx
	where *yyyymmdd* is the date of submission
Trigger	Identification by the Contractor of any member sentinel event.
Due Date	Within 24 hours of identification.
DMAS	TBD

1.7.8.3 Requirements

Sentinel events shall be reported for all CCCPlus Program Members.

Sentinel events are a sub-category of Critical Incidents. Therefore, they shall also be reported on the 1.5.1 Quarterly Critical Incident report according to date of discovery.

A **sentinel event** is 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 treated or monitored by a medical professional at the time of the incident) or serious physical or psychological injury, or the risk thereof.

- Unexpected “Sentinel” Death (e.g. suicide, intrapartum maternal death, death of full-term infant, or any other death that is unrelated to the natural course of patient’s illness or underlying condition).
- Serious injury – An event that specifically includes loss of limb or function that leads to permanent or severe temporary harm.

An event is also considered sentinel if it is one of the following:

- Discharge of an infant to the wrong family
- Abduction of a member while receiving care, treatment, or services.
- Any elopement that is an unauthorized departure of a patient from a staffed around-the-clock care setting (including the ED) leading to the death, permanent harm, or severe temporary harm of the patient

- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a member receiving care, treatment, or services while on site at the organization.

- Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the organization

- Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure.

- Unintended retention of a foreign object in a patient after an invasive procedure, including surgery.

- Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)

- Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose

- Fire, flame, or unanticipated smoke, or heat exposure occurring during an episode of member care.

- Severe maternal morbidity (not primarily related to the natural course of the Member's illness or underlying condition) when it reaches a patient and results in permanent harm or severe temporary harm.

1.7.8.4 Examples

None

1.7.8.5 Scoring Criteria

None

1.7.9 Addiction and Recovery Treatment Services (ARTS) Provider Network Change Affecting Member Access to Care (Eliminated 8/15/2023)

1.7.10 Missed Trips

Moved to Monthly Reports (see 1.4.20)

1.7.11 MCO Member Health Screening (MMHS)

1.7.11.1 Contract Reference: *5.2.2*

1.7.11.2 File Specifications

Method:	Submit via Conduent portal
Format:	See MMHS manual
File Name:	See MMHS manual
Trigger:	Completion of MMHS Third instance of inability to contact Member Refusal of Member to participate
Due Date:	Within five (5) business days of the date on which the screening was completed, upon the third instance of inability to contact the Member, or the date on which the Member refused to participate
DMAS:	Conduent

1.7.11.3 Requirements

Follow the instructions provided in separate MMHS manual. The MMHS will consist of a header section and a two-part questionnaire as follows:

Document 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: _____

Unable to Contact Member	
Member Refused to Answer	
Member Complexity Attestation Completed	

(* fields will be validated and errors returned to plan for correction)

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 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 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

1.7.11.4 Examples

None

1.7.11.5 Scoring Criteria

None

1.7.12 MCO Member Health Screening (MMHS) Policies and Procedures

1.7.12.1 Contract Reference: *5.16.3*

1.7.12.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Adobe .pdf file
File Name:	MMHS_POLICY_C*ontractorName_yyyymmdd*.pdf where *yyyymmdd* is the date of submission
Trigger:	Upon revision
	Upon request
Due Date:	Within five business days of revision
	Within ten business days of request
DMAS:	TBD

1.7.12.3 Requirements

The Contractor's MMHS policies and procedures shall describe all of the following required elements:

1) The identification strategy, administrative claims data when available, and other sources of information that are used to prioritize the timeframes for when and how initial MMHS's are conducted for each Member.

2) When the stratification is conducted.

3) The qualifications of the personnel conducting the MMHS.

4) How the Contractor determines if Members, are capable of participating in the MMHS process and how authorized representatives, family Members and caregivers are involved in the MMHS process when appropriate.

5) How the Contractor will provide Communication/Interpreter Services as described in *Communication / Interpreter Assistance*.

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.

1.7.12.4 Examples

None

1.7.12.5 Scoring Criteria

None

1.7.13 Provider Termination

1.7.13.1 Contract Reference: *8.5.6.2*

1.7.13.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Adobe .pdf file
File Name:	PROV_TERM_C*ontractorName_yyyymmdd*.pdf where *yyyymmdd* is the date of submission
Trigger:	see Requirements below
Due Date:	see Requirements below
DMAS:	TBD

1.7.13.3 Requirements

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

1) 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 of 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;
2) In advance of, as soon as possible, 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 (see *Certification of Network Adequacy,* Section 8.3 of the CCC Plus Contract);
3) As soon as possible and within forty-eight (48) hours for suspected or actual fraud or abuse per Section 14.10 of the CCC Plus Contract;
4) Immediately, 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 (see *Provider Credentialing,* Section 8.4.10 of the CCC Plus Contract).

1.7.13.4 Examples

None

1.7.13.5 Scoring Criteria

None

1.7.14 Level of Care Review

1.7.14.1 Contract Reference: *4.7.2.3.1*

1.7.14.2 File Specifications

Method:	Virginia Medicaid Web Portal
Format:	see Requirements below
File Name:	N/A
Trigger:	see Requirements below
Due Date:	see Requirements below
DMAS:	TBD

1.7.14.3 Requirements

Level of Care (LOC) reviews shall be completed 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 shall initiate a LOC review at any time the Contractor's (Care Coordinator) assessment indicates that the Member may not meet the CCC Plus Waiver criteria.

LOC Reviews shall be conducted using the *Level of Care Review Instrument* (LOCERI) also known as the DMAS 99 Series Form. The Contractor shall enter all required information for the LOCERI electronically using the Virginia Medicaid Web Portal; LOC review tab. The *Level of Care User Guide and Tutorial*, is available on the Virginia Medicaid Web Portal, Provider Resources tab, at: https://www.virginiamedicaid.dmas.virginia.gov.

1.7.14.4 Examples

None

1.7.14.5 Scoring Criteria

None

1.7.15 Member Appeals

1.7.15.1 Contract Reference: *15.1, 15.3*

1.7.15.2 File Specifications

Field Description	Specifications
Recipient Last Name	Recipient last name
Recipient First Name	Recipient first name
Medicaid ID	Format: 12 digits including leading zeros
Appeal Type	Enter one of the following appeal types: - Behavioral Health Services - EPSDT Services - HCBS Services - Institutional Services - Pharmacy Services - Specialty Services - Transportation - MCO Administrative Issue - Other
File Date	Format: mmddyyyy
Decision Due Date	Format: mmddyyyy
Extended	Y or N
Decision Date	Format: mmddyyyy (blank if decision pending)
Result	Values: - MCO - Appellant - Partial - N/A (if decision pending)

Method: DMAS secure CCC Plus FTP server

Format: Excel (.xlsx) file

File Name: CCCP_ MEMBER_APPEALS_C*ontractorName_yyyymm*.xlsx (where *yyyymm* is the reporting period month)

Trigger: Upon request

Due Date: Within 5 business days of request

DMAS: CCC Plus Quality Analyst

1.7.15.3 Requirements

For the reporting period designated by DMAS:

- Report all appeals either previously opened and carried forward into the reporting period or opened during the reporting period. The appeal type indicates either the type of service for which benefits were limited or denied or other circumstance to which the appeal relates.

- Report the decision date and result for all appeals closed during the reporting period. If an appeal is still open at the end of the reporting period, leave the decision date blank and enter N/A for the result.

1.7.15.4 Examples

None

1.7.15.5 Scoring Criteria

None

1.7.16 MCO DUR Board Minutes

1.7.16.1 Contract Reference: 4.8.7

1.7.16.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Adobe PDF
File Name:	DUR_MTG.pdf
Trigger:	MCO DUR Board Meeting
Due Date:	Within 30 days of meeting
DMAS:	Pharmacy Team

1.7.16.3 Requirements

As specified in contract.

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

Minutes shall not contain any PHI (redact PHI).

1.7.17 Marketing and Member Materials

1.7.17.1 Contract Reference: 11.12.1.2

1.7.17.2 File Specifications

Method:	MCO's Marketing Materials (Log) folder on DMAS SharePoint site
Format:	Unspecified
File Name:	Unspecified
Trigger:	Development of new or revised marketing or member materials
Due Date:	N/A
DMAS:	Integrated Care

1.7.17.3 Requirements

Steps to follow for submitting marketing and member materials for approval:

1. Health Plans upload materials to their Share Point Marketing folder labeled: Marketing Materials (Log).
2. Health Plans then send an email to the marketing box to submit the request for review to cccpmarketing@dmas.virginia.gov
3. For a single request, In the email please include:
    a. Requested by:
        i. Name of who is requesting approval
    b. Submission Category:
        i. New submission—Not previously submitted to DMAS
        ii. Revised—MCO has updated a previously approved material, include a redline version or summary of changes.
        iii. Re-Submit—MCO is responding to questions/concerns from DMAS reviewer.
    c. Submission Method:
        i. Standard
        ii. Expedited
        iii. Withdrawn
    d. Submission Type:
        i. Letter
        ii. Brochure/Flyer/Postcard
        iii. Survey/Survey Materials
        iv. Handbook/Manual
        v. Social media/website/text/email
        vi. Press release
        vii. Newsletter
        viii. Advertisement
        ix. Member ID Cards

x. Other

e. Audience
    i. Members
    ii. Providers
    iii. Potential members/public
f. Title of Document/s
g. Add the marketing material as attachments to the email.

4. For multiple material requests, please use the blank submission form and attach it to the email being sent to the marketing box along with attached documents.
5. This will be forwarded to a designated reviewer with whom you will have contact with if there are any questions or concerns.

Materials are reviewed within 30 days from when DMAS is notified by email.

1.7.18 Outreach Event Materials

1.7.18.1 Contract Reference: 11.12.1.3

1.7.18.2 File Specifications

Method:	MCO's Marketing Materials (Log) folder on DMAS SharePoint site
Format:	Unspecified
File Name:	Unspecified
Trigger:	Planned outreach event
Due Date:	Two weeks prior to event date
DMAS:	Integrated Care

1.7.18.3 Requirements

Steps to follow for submitting outreach event materials for approval:

1. Health Plans upload outreach events to their Share Point Marketing folder labeled: Marketing Materials (Log).
2. Health Plans then send an email to the marketing box to submit the request for review to cccpmarketing@dmas.virginia.gov with the subject line saying OUTREACH EVENTS
3. In the email please include the Excel Submission form with all of the fields completed.

Any submission for outreach events needs to be submitted to DMAS at least two (2) weeks prior to the event date.

Outreach Events are reviewed within two (2) weeks from when DMAS is notified by email.

1.7.19 COVID-19 Provider and Member Materials Submission

1.7.19.1 Contract Reference: N/A

1.7.19.2 File Specifications

Method:	Email (see details under “Requirements” below)
Format:	Unspecified
File Name:	Unspecified
Trigger:	Production of member and provider communications with medical information related to COVID-19
Due Date:	N/A
DMAS:	Chief Medical Office

1.7.19.3 Requirements

DMAS requires that all member and provider communications with medical information related to COVID-19 be reviewed and approved by our Chief Medical Office.

1. Submit your medical CCC Plus COVID-19 materials directly to the Chief Medical Office team member, Talisha Sheppard, at talisha.sheppard@dmas.virginia.gov with a cc to Tammy Whitlock at tammy.whitlock@dmas.virginia.gov and CCCPmarketing@dmas.virginia.gov
2. Please include **MCO Review** in the subject line of your email.
3. Please attach **all** documents you want for review in the email.

CCC Plus provider materials related to COVID-19 processes and procedures should be sent to CCCPmarketing@dmas.virginia.gov

1.7.20 Quality Improvement Plan (QIP) for New Plans

1.7.20.1 Contract Reference: *10.4*

1.7.20.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Adobe PDF
File Name:	QAPI_PLAN.pdf
Trigger:	New health plan contracted with CCC Plus
Due Date:	At least sixty (60) days before the first membership file is provided to MCO

1.7.20.3 Requirements

The new contractor shall submit a plan that adhere to Element A: Quality 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.

1.7.21 NCQA Accreditation Renewal

1.7.21.1 Contract Reference: *10.19*

1.7.21.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Adobe PDF
File Name:	NCQA_RENEW.pdf
Trigger:	NCQA Accreditation Assessment or Renewal
Due Date:	Within 30 calendar days after NCQA notification to the MCO
DMAS:	Division of Quality & Population Health

1.7.21.3 Requirements

Must include all components as specified in the contract.

1.7.22 NCQA Accreditation Status Changes

1.7.22.1 Contract Reference: *10.19*

1.7.22.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Adobe PDF
File Name:	NCQA_ACRED.pdf
Trigger:	Notification by NCQA of Change in MCO's Accreditation Status
Due Date:	Within 10 calendar days after NCQA notification
DMAS:	Division of Quality & Population Health

1.7.22.3 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 3 years.

1.7.23 Non-Emergency Medical Transportation (NEMT) Transportation Network Company (TNC) Project Plan

1.7.23.1 Contract Reference: *4.10*

1.7.23.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Adobe PDF
File Name:	NEMT_TNC_Project_Plan.pdf
Trigger:	Startup of new TNC
Due Date:	60 days prior to startup of TNC
DMAS:	Transportation Unit

1.7.23.3 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 CCC Plus 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.

1.7.24 Investigation Audit Report

1.7.24.1 Contract Reference: *14.2.3.2*

1.7.24.2 File Specifications

Method:	DMAS secure CCC Plus FTP server
Format:	Adobe PDF
File Name:	CCCP_PI_INVESTIGATION_AUDIT_C*ontractorName_yyyymmdd*.pdf where *yyyymmdd* is the date of submission
Trigger:	Conclusion of a completed FWA investigation
Due Date:	Conclusion of a completed FWA investigation and as determined via communication with Program Integrity division
DMAS:	Program Integrity

1.7.24.3 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 Section 14.0 of the contract, final resolution shall include, at a minimum, repayment of any identified overpayments.

1.7.25 Notice of Suspected Recipient Fraud or Misconduct

1.7.25.1 Contract Reference: *14.9*

1.7.25.2 File Specifications

Method:	Send as email attachment to mcopideliverables@dmas.virginia.gov
Format:	Use the reporting template located on SharePoint
File Name:	CCCP_RECIP_FRAUD_*ContractorName*_yyyymmdd.pdf
	where yyyymmdd is the date of submission
Trigger:	Evidence of fraudulent activity
Due Date:	Within 48 hours of discovery of evidence of fraudulent activity
DMAS:	Program Integrity Division

1.7.25.3 *Requirements*

Note: 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.

1.7.26 Individual Experience Policies and Procedures

1.7.26.1 Contract Reference: *8.4.6*

1.7.26.2 File Specifications

Method:	DMAS secure CCCPlus Server
Format:	Adobe.pdf file
File Name:	CCCP_IES_POLICY_*ContractorName_yyyymmdd.xlsx*
	where *yyyymmdd* 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:	CCCPlus Only
DMAS:	Integrated Care

1.7.26.3 *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 DMAS Reports

2.1 Reports Generated by DMAS

The following reports are prepared by DMAS and sent to the Contractors.

DMAS has established a secure FTP server for transfer of files with the Contractors, and each Contractor has its own secure login. All DMAS reports will be transmitted via DMAS' secure FTP server and should be picked up by the Contractor.

The Department will notify the Contractor in a timely manner of any changes to the reporting requirements. Changes may be communicated via memo or electronically.

2.1.1 Enrollment Roster (834)

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 MES Home page at the following link:

https://vamedicaid.dmas.virginia.gov/

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.

2.1.2 Capitation Payment Remittance (820)

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.

Capitation Payment Remittance (820) Schedule

(2018 Sample shown below):

CAPITATION 820 RUN	CAPITATION 820 AVAILABILITY	CAPITATION CHECK DATE
Friday	Monday	Friday
01/26/2018	01/29/2018	02/02/2018
02/23/2018	02/26/2018	03/02/2018
03/30/2018	04/02/2018	04/06/2018
04/27/2018	04/30/2018	05/04/2018
05/25/2018	05/28/2018	06/01/2018
06/29/2018	07/02/2018	07/06/2018
07/27/2018	07/30/2018	08/03/2018
08/31/2018	09/03/2018	09/07/2018
09/28/2018	10/01/2018	10/05/2018
10/26/2018	10/29/2018	11/02/2018
11/30/2018	12/03/2018	12/07/2018
12/28/2018	12/31/2019	01/04/2019

820 Schedule following first Reconciliation

CAPITATION 820 RUN	CAPITATION 820 AVAILABILITY	CAPITATION CHECK DATE
Quarter	Monday	Friday
1Q – 01/05	01/08/2018	01/12/2018
2Q – 04/05	04/09/2018	04/13/2018
3Q – 07/05	07/09/2018	07/13/2018
4Q – 10/05	10/08/2018	10/12/2018

820 Schedule following second Reconciliation

CAPITATION 820 RUN	CAPITATION 820 AVAILABILITY	CAPITATION CHECK DATE
Quarter	Monday	Friday
1Q – 01/11	01/15/2018	01/19/2018
2Q – 04/11	04/16/2018	04/20/2018
3Q – 07/11	07/16/2018	04/20/2018
4Q – 10/11	10/15/2018	10/19/2018

2.1.2.1 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.

2.1.3 Provider File

2.1.3.1 Contract Reference: *TBD*

2.1.3.2 File Specifications

Field Description	Specifications
PROV	PROVIDER NUMBER
LICENSE	PROVIDER LICENSE NUMBER
PROVBASE	PROVIDER BASE ID
CITY_CNTY	PROVIDER LOCALITY CODE
PROVIDERNAME	PROVIDER NAME
PATTN	PAYTO ATTENTION LINE
PADDR	PAYTO ADDRESS LINE
PCITY	PAYTO CITY
PSTATE	PAYTO STATE
PZIP5	PAYTO ZIP
SATTN	SVC ATTENTION LINE
SADDR	SVC ADDRESS LINE
SCITY	SVC CITY
SSTATE	SVC STATE
SZIP5	SVC ZIP
SOPHONE	SVC OFFICE PHONE NUMBER
IRS_NO	IRS NO.
PCPIND	PCP IND
P_PROG01	PROVIDER PROGRAM CODE 01
BEGDT01C	ELIG BEGIN DATE CURRENT 01
ENDDT01C	ELIG END DATE CURRENT 01
CAN_RN01	CANCEL REASON 01
BEGDT011	PRIOR1 BEGIN DATE 01
ENDDT011	PRIOR1 END DATE 01
CANRN011	PRIOR1 CANCEL REASON 01
BEGDT012	PRIOR2 BEGIN DATE 01
ENDDT012	PRIOR2 END DATE 01
CANRN012	PRIOR2 CANCEL REASON 01
P_PROG02	PROVIDER PROGRAM CODE 02
BEGDT02C	ELIG BEGIN DATE CURRENT 02
ENDDT02C	ELIG END DATE CURRENT 02
CAN_RN02	CANCEL REASON 02
BEGDT021	PRIOR1 BEGIN DATE 02
ENDDT021	PRIOR1 END DATE 02
CANRN021	PRIOR1 CANCEL REASON 02

Field Description	Specifications
BEGDT022	PRIOR2 BEGIN DATE 02
ENDDT022	PRIOR2 END DATE 02
CANRN022	PRIOR2 CANCEL REASON 02
P_PROG03	PROVIDER PROGRAM CODE 03
BEGDT03C	ELIG BEGIN DATE CURRENT 03
ENDDT03C	ELIG END DATE CURRENT 03
CAN_RN03	CANCEL REASON 03
BEGDT031	PRIOR1 BEGIN DATE 03
ENDDT031	PRIOR1 END DATE 03
CANRN031	PRIOR1 CANCEL REASON 03
BEGDT032	PRIOR2 BEGIN DATE 03
ENDDT032	PRIOR2 END DATE 03
CANRN032	PRIOR2 CANCEL REASON 03
P_PROG04	PROVIDER PROGRAM CODE 04
BEGDT04C	ELIG BEGIN DATE CURRENT 04
ENDDT04C	ELIG END DATE CURRENT 04
CAN_RN04	CANCEL REASON 04
BEGDT041	PRIOR1 BEGIN DATE 04
ENDDT041	PRIOR1 END DATE 04
CANRN041	PRIOR1 CANCEL REASON 04
BEGDT042	PRIOR2 BEGIN DATE 04
ENDDT042	PRIOR2 END DATE 04
CANRN042	PRIOR2 CANCEL REASON 04
P_PROG05	PROVIDER PROGRAM CODE 05
BEGDT05C	ELIG BEGIN DATE CURRENT 05
ENDDT05C	ELIG END DATE CURRENT 05
CAN_RN05	CANCEL REASON 05
BEGDT051	PRIOR1 BEGIN DATE 05
ENDDT051	PRIOR1 END DATE 05
CANRN051	PRIOR1 CANCEL REASON 05
BEGDT052	PRIOR2 BEGIN DATE 05
ENDDT052	PRIOR2 END DATE 05
CANRN052	PRIOR2 CANCEL REASON 05
CLS_TP1	PROVIDER CLASS TYPE 1
CLS_BEG1	PROVIDER CLASS TYPE 1 BEGIN DATE
CLS_END1	PROVIDER CLASS TYPE 1 END DATE.
CLS_RN1	PROVIDER CLASS TYPE 1 REASON CODE.
CLS_TP2	PROVIDER CLASS TYPE 2
CLS_BEG2	PROVIDER CLASS TYPE 2 BEGIN DATE
CLS_END2	PROVIDER CLASS TYPE 2 END DATE.

Field Description	Specifications
CLS_RN2	PROVIDER CLASS TYPE 2 REASON CODE.
CLS_TP3	PROVIDER CLASS TYPE 3
CLS_BEG3	PROVIDER CLASS TYPE 3 BEGIN DATE
CLS_END3	PROVIDER CLASS TYPE 3 END DATE.
CLS_RN3	PROVIDER CLASS TYPE 3 REASON CODE.
SPC_CDE1	SPECIALTY CODE 1
SPC_BEG1	PROV SPEC CDE 1 BEGIN DATE
SPC_END1	PROV SPEC CDE 1 END DATE
SPC_CDE2	SPECIALTY CODE 2
SPC_BEG2	PROV SPEC CDE 2 BEGIN DATE
SPC_END2	PROV SPEC CDE 2 END DATE
SPC_CDE3	SPECIALTY CODE 3
SPC_BEG3	PROV SPEC CDE 3 BEGIN DATE
SPC_END3	PROV SPEC CDE 3 END DATE
SPC_CDE4	SPECIALTY CODE 4
SPC_BEG4	PROV SPEC CDE 4 BEGIN DATE
SPC_END4	PROV SPEC CDE 4 END DATE
SPC_CDE5	SPECIALTY CODE 5
SPC_BEG5	PROV SPEC CDE 5 BEGIN DATE
SPC_END5	PROV SPEC CDE 5 END DATE
NPI_ID	NPI_ID (add leading zeroes)
NPI_API	NPI_API
AGREECDE	INDEFINITE AGREEMENT CODE

Method	DMAS SharePoint site
Format	Text .txt file delimited by ";"
File Name	CCCP_PROVIDER_yyyymm.txt (where mm is the reporting period month)
Trigger	Monthly
Schedule	Generated around the 6th of the month, but may vary based on data availability
DMAS	Integrated Care SAS Team

2.1.3.3 Description

This report lists all Medicaid fee-for-service providers and those providers enrolled in one or more of the Contractor networks. Report includes those providers who are currently enrolled and those whose enrollment ended within the past 2 years. This file does not specify which providers may not be accepting new Medicaid patients.

2.1.4 Medical Transition Report Claims

2.1.4.1 Contract Reference: 3.2.21

2.1.4.2 File Specifications

Field Description	Specifications
SA-SVC-CTR	MMIS EDI Service Center
FILLER	System Generated
SA-RUN-DATE	Run Date – MMDDYYYY System Generated
FILLER	System Generated
SA-MCO-API	Plan (MCO) Number – MMIS API Number
FILLER	System Generated
SA-REC-TYPE	Record Type – C (Claim) - System Generated
FILLER	System Generated
SA-SOURCE-CODE	B = Behavioral Health, C = CD Services, F = MMIS, M= Managed Care - System Generated
FILLER	System Generated
SA-MCO-BNFT-BEG-DATE	Member CCC Plus MCO Begin Date – MMDDYYYY
FILLER	System Generated
SA-MEMBER-ID	Member ID
FILLER	System Generated
SA-MEMBER-LAST-NM	Member Last Name
FILLER	System Generated
SA-MEMBER-FIRST-NM	Member First Name
FILLER	System Generated
SA-MEMBER-MIDDLE-NM	Member Middle Initial
FILLER	System Generated
SA-MEMBER-DOB	Member Birth Date – MMDDYYYY
FILLER	System Generated
SA-MEMBER-GENDER	Member Gender
FILLER	System Generated
SA-MEMBER-RACE	Member Race Code
FILLER	System Generated
SA-MEMBER-FIPS	Member Locality
FILLER	System Generated
SA-MEMBER-AID-CAT	Program Aid Category

Field Description	Specifications
FILLER	System Generated
SA-MEMBER-EXCP-IND	Level of Care/Exception Indicator
FILLER	System Generated
SA-TYPE	Claim Type Identifier
FILLER	System Generated
SA-SRV-PROV-NPI-API	Servicing Provider ID – NPI or API
FILLER	System Generated
SA-SRV-PROV-NAME	Servicing Provider Name
FILLER	System Generated
CLM-SRV-PROV-CLASS-TYPE	Servicing Provider Class Type
FILLER	System Generated
CLM-SRV-PROV-SPEC	Servicing Provider Specialty Code – Default 000
FILLER	System Generated
CLM-FROM-DOS	From Date of Service – MMDDYYYY
FILLER	System Generated
CLM-THRU-DOS	Through Date of Service – MMDDYYYY
FILLER	System Generated
CLM-PRIM-DAIG	Primary Diagnosis – ICD-9 or ICD-10
FILLER	System Generated
CLM-PROC-CODE	Procedure Code – HCPCS or CPT
FILLER	System Generated
CLM-PROC-MOD-1	Procedure Code Modifier 1
FILLER	System Generated
CLM-PROC-MOD-2	Procedure Code Modifier 2
FILLER	System Generated
CLM-PROC-MOD-3	Procedure Code Modifier 3
FILLER	System Generated
CLM-PROC-MOD-4	Procedure Code Modifier 4
FILLER	System Generated

Field Description	Specifications
CLM-NDC	Pharmacy NDC
FILLER	System Generated
CLM-PRINC-PROC	Principle Procedure Code – ICD-9 or ICD-10
FILLER	System Generated
CLM-ICD-VER-DTRM	ICD Version Indicator – 9 = ICD-9, 0 = ICD-10
FILLER	System Generated
CLM-UNITS	Units/Quantity – 7 positions with 3 decimal places.
FILLER	System Generated
CLM-REFILL-CD	Refill Code
FILLER	System Generated
CLM-SA-NBR	Service Authorization Number – Made up of Combined DE2498 and DE2499
FILLER	System Generated
CLM-PRESCRIPT-NO	Prescription Number
FILLER	System Generated
CLM-ICN	Source Internal Control Number – Claim Number ID – Made up of Combined DE2477, DE2478, DE2434 and DE2480
FILLER	System Generated
CLM-BILL-TYPE	Facility Bill Type
FILLER	System Generated
CLM-POS	Place of Service
FILLER	System Generated
CLM-PRESC-PROV	Prescribing Provider – NPI or API
FILLER	System Generated
CLM-ORP-PROV	Ordering/Referring/Prescribing – NPI or API
FILLER	System Generated
CLM-EPSDT-IND	Y = EPSDT Related, N = Not EPSDT Related
FILLER	System Generated

Method	DMAS secure CCC Plus server
Format	Delimited .csv text file (zipped)
File Name	MCF621D_yyyymmdd-xxxxxx.csv
Trigger	Weekly
Schedule	Generated 6th, 13th, 19th, and EOM, but may vary
DMAS	MMIS

2.1.4.3 Description

This report contains all claims paid or encounters processed in the past 24 months from the Eligibility Begin date for the member.

2.1.5 Medical Transition Report Service Authorization (*Deliverable eliminated 4/29/2022).*

Contract Reference: 3.2.21

2.1.5.1 File Specifications

Field	Length	Start Pos	End Pos	Description/Comments	Required Field
SA-SVC-CTR	4	1	4	MMIS EDI Service Center	Yes
SA-RUN-DATE	8	5	12	Run Date – MMDDYYYY	Yes
SA-MCO-API	10	13	22	Plan (MCO) Number – MMIS API Number (Generating Plan)	Yes
SA-REC-TYPE	1	23	23	Record Type – S (Service Authorization)	No
SA-SOURCE-CODE	1	24	24	Source Code - M (Managed Care)	No
SA-MCO-BNFT-BEG-DATE	8	25	32	N/A - (This is populated by MMIS for the Receiving Plan)	No
SA-MEMBER-ID	12	33	44	Member Medicaid ID	Yes
SA-MEMBER-LAST-NM	20	45	64	Member Last Name	Yes
SA-MEMBER-FIRST-NM	12	65	76	Member First Name	Yes
SA-MEMBER-MIDDLE-NM	1	77	77	Member Middle Initial	Yes
SA-MEMBER-DOB	8	78	85	Member Birth Date – MMDDYYYY	Yes
SA-MEMBER-GENDER	1	86	86	Member Gender	Yes
SA-MEMBER-RACE	1	87	87	Member Race Code	No
SA-MEMBER-FIPS	3	88	90	Member Locality	No
SA-MEMBER-AID-CAT	3	91	93	Program Aid Category	No
SA-MEMBER-EXCP-IND	2	94	95	Level of Care/Exception Indicator	Yes
SA-TYPE	4	96	99	Service Authorization Type (see DMAS Data Element Dictionary)	Yes
SA-SRV-PROV-NPI-API	10	100	109	Servicing Provider ID – NPI or API	Yes
SA-SRV-PROV-NAME	40	110	149	Servicing Provider Name	Yes
SA-PRIM-DIAG	7	150	156	Diagnosis Code – ICD-9 or ICD-10	Yes
SA-PROC-CODE	11	157	167	Procedure Code – HCPCS, CPT, NDC, or Pseudo Code	Yes
SA-PROC-MOD-1	2	168	169	Procedure Code Modifier 1	Yes
SA-PROC-MOD-2	2	170	171	Procedure Code Modifier 2	Yes
SA-PROC-MOD-3	2	172	173	Procedure Code Modifier 3	Yes
SA-PROC-MOD-4	2	174	175	Procedure Code Modifier 4	Yes
SA-NBR	20	176	195	Service Authorization (SA) Number	Yes
SA-AUTH-FROM-DATE	8	196	203	Authorized From Date of Service – MMDDYYYY	Yes
SA-AUTH-THRU-DATE	8	204	211	Authorized Through Date of Service - MMDDYYYY	Yes

Field	Length	Start Pos	End Pos	Description/Comments	Required Field
SA-AUTH-UNIT	6	212	217	Authorized Units	Yes
SA-AUTH-AMT	16	218	233	Authorized Amount if applicable for SA services	Yes
SA-USED-UNITS	6	234	239	Used Units	Yes
SA-M-D-AUTH-TYPE	1	240	240	Medical/Drug Authorization Type – M = Medical, D = Drug	Yes
SA-FREQ-DAYS-SUP	5	241	245	Authorized Frequency/Days Supply – If MP_AUTH_TYPE = M, value is Frequency: BW Bi-Weekly; DY Daily; HR Hourly; MO Monthly; QR Quarterly; WK Weekly; YR Yearly; and, FY Fiscal Year. If MP_AUTH_TYPE = D, value is Days Supply	Yes
SA-SRC-SYSTEM-ID	20	246	265	The source system identifier number other than the SA Number	No
SA-EPSDT-IND	1	266	266	Y = EPSDT Related, N = Not EPSDT Related	No
SA-FILLER	32	267	298	Filler - Use first 4 characters to populate health plans' MMIS EDI Service Center	Yes
Total Record Length	298				

Method	DMAS secure CCC Plus server
Format	Delimited .csv text file (zipped)
File Name	MCF622B_yyyymmdd-xxxxxx.csv
Trigger	Weekly
Schedule	Generated 6th, 13th, 19th, and EOM, but may vary
DMAS	MMIS

2.1.5.2 Description

A full MTR report is created when a member moves from one CCC Plus MCO to another and contains the past two years of claims and encounters as well as the service authorizations for the previous 6 months of service. An interim MTR is created when there has been a change to the member's active service authorizations since the last MTR is created.

2.1.6 Monthly Patient Utilization Management and Safety (PUMS) Member Plan Transfer Report

See Addiction and Recovery Treatment Services (ARTS) Technical Manual for report specifications.

2.1.7 Patient Pay Report

2.1.7.1 Contract Reference: *TBD*

2.1.7.2 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   XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

MEMBER ID    MEMBER NAME                              BIRTHDATE  AID TPL      DATE OF       DISCHARGE    PP BEG DTE   PP END DTE   PP AMOUNT
                                                                 CAT CODES  DEATH/DISCHARGE DESTINATION

999999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY 999 XXXXX    __________     ____________ MM/DD/CCYY   MM/DD/CCYY  Z,ZZ9.99
                                                                                                MM/DD/CCYY   MM/DD/CCYY  Z,ZZ9.99
999999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY 999 XXXXX    __________     ____________ MM/DD/CCYY   MM/DD/CCYY  Z,ZZ9.99
                                                                                                MM/DD/CCYY   MM/DD/CCYY  Z,ZZ9.99
999999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY 999 XXXXX    __________     ____________ MM/DD/CCYY   MM/DD/CCYY  Z,ZZ9.99
                                                                                                MM/DD/CCYY   MM/DD/CCYY  Z,ZZ9.99
999999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY 999 XXXXX    __________     ____________ MM/DD/CCYY   MM/DD/CCYY  Z,ZZ9.99
                                                                                                MM/DD/CCYY   MM/DD/CCYY  Z,ZZ9.99
999999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY 999 XXXXX    __________     ____________ MM/DD/CCYY   MM/DD/CCYY  Z,ZZ9.99
                                                                                                MM/DD/CCYY   MM/DD/CCYY  Z,ZZ9.99
999999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY 999 XXXXX    __________     ____________ MM/DD/CCYY   MM/DD/CCYY  Z,ZZ9.99
                                                                                                MM/DD/CCYY   MM/DD/CCYY  Z,ZZ9.99
999999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY 999 XXXXX    __________     ____________ MM/DD/CCYY   MM/DD/CCYY  Z,ZZ9.99
                                                                                                MM/DD/CCYY   MM/DD/CCYY  Z,ZZ9.99
999999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY 999 XXXXX    __________     ____________ MM/DD/CCYY   MM/DD/CCYY  Z,ZZ9.99
                                                                                                MM/DD/CCYY   MM/DD/CCYY  Z,ZZ9.99
999999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  MM/DD/CCYY 999 XXXXX    __________     ____________ MM/DD/CCYY   MM/DD/CCYY  Z,ZZ9.99
                                                                                                MM/DD/CCYY   MM/DD/CCYY  Z,ZZ9.99
999999999999 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  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 ***
```

Method	DMAS Secure ISS MFT
Format	Zip .zip file
File Name	MMIS_SC##_PATPAY_M_YYYYMMDD_HHMMSS-UTC Time Offset.Zip
Trigger	Monthly on the last day of the month
Schedule	Run last day of month
DMAS	Conduent

2.1.7.3 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.

2.1.8 Capitation Patient Pay Discrepancy Report

2.1.8.1 Contract Reference: *TBD*

2.1.8.2 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 ****
```

Method	DMAS secure ISS MFT
Format	ZIP .zip file
File Name	MMIS_SC##_MTHPPY_M_YYYYMMDD_HHMMSS-UTCTimeOffset.zip
Trigger	Monthly
Schedule	Run date is the 5th/6th of month for prior month
DMAS	Conduent

2.1.8.3 Description

Report will identify the patient pay changes that have occurred during the reporting period.

2.1.9 Medical Transition Report Service Authorizations Plan to Plan

See section 1.7.3

2.1.10 *Pharmacy* Prior Authorizations - NCPDP Transfer Standard - From DMAS *(Last report will be generated on 4/15/2022. This report will be eliminated effective immediately following the generation of the 4/15/2022 report)*

2.1.10.1 Contract Reference *3.2.21*

2.1.10.2 File Specifications

Method	DMAS secure FTP server (GoAnywhere)
Format	NCPDP Prior Authorization Transfer Standard Implementation Guide version 22
File Name	MCO_xxxx_NCPDP22_yyyymmdd.txt
Schedule	Within 2 business days after 834 eligibility file delivery (MCO contacts provided to DMAS will be notified via email upon delivery of file).
DMAS	CMO / Pharmacy Team

2.1.10.3 Description

File will conform to all requirements as documented in the *NCPDP Prior Authorization Transfer Standard Implementation Guide version 22*.

DMAS generates this file based on the prior authorization data received from the member's previous MCO and/or the FFS PBM. This file only includes members who are currently enrolled with the MCO. If there is no PA data to deliver, DMAS will send a zero report to the plan.

For each detail record provided, the originator/source MCO service center ID is provided in the 'SUBGROUP ID' (A21) field (position 58). Service Center crosswalk:

Srvc Ctr	Program	Managed Care Organization
1001	Medallion 3	Optima Family Care
1002	Medallion 3	Aetna Better Health
1003	Medallion 3	Virginia Premier Health Plan
1004	Medallion 3	Anthem HealthKeepers Plus
1008	Medallion 3	InTotal Health
1010	Medallion 3	Kaiser Foundation Health Plan
1014	CCC Plus	Aetna Better Health of Virginia
1015	CCC Plus	HealthKeepers, Inc.
1016	CCC Plus	Molina Complete Care of Virginia
1017	CCC Plus	Optima Health Plan
1018	CCC Plus	United Healthcare Community Plan
1019	CCC Plus	Virginia Premier Health Plan, Inc.
1044	Medallion 4	Aetna Better Health
1045	Medallion 4	HealthKeepers, Inc.
1046	Medallion 4	Molina
1047	Medallion 4	Optima Health Plan
1048	Medallion 4	United HealthCare
1049	Medallion 4	Virginia Premier Health Plan, Inc.
1078	FFS	Molina

2.1.10.4 MCO to MCO Contact Information

MCO Contact Information – Technical Issue			
Plan Name	**Contact Name**	**Email**	**Phone Number**
Aetna	Venkat Velapakam	VelapakamV@aetna.com	321-303-0982
Anthem	Monique Ransom	Monique.Ransom@anthem.com	757-473-2737 ext 1061281432
Molina		MCCVA_CCCPlus@magellanhealth.com	
Optima	Calvin Allen	CXALLEN@sentara.com	757-252-8184
United	Jeremy D Bell	jeremy.bell@optum.com	972.836.0957
Virginia Premier	Samuel Sarquah	Samuel.sarquah@vapremier.com	804-819-5151ext. 55471
Molina FFS	Pete Benyah	PEBenyah@magellanhealth.com	804.548.0193

MCO Contact Information – Data Integrity Issue			
Plan Name	**Contact Name**	**Email**	**Phone Number**
Aetna	Marcus Hunt	HuntM2@AETNA.com	860-900-4536
Anthem	Sandy Seekamp	sandy.seekamp@anthem.com	(386) 410-3810
Molina	Rob Berringer	berringerr@magellanhealth.com	804.762.6119
Optima	Calvin Allen	CXALLEN@sentara.com	757-252-8184
United	Rajeev Verma	rajeev.verma@uhc.com	952 202 2947
Virginia Premier	Crystal May	Crystal.may@vapremier.com	804-819-5151ext. 55077
Molina FFS	Tim Wilford	tlwilford@magellanhealth.com	804-548-0423

2.1.11 Reinsurance

2.1.11.1 Contract Reference: *19.8.1*

2.1.11.2 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.
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

Field	Specifications
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.

Field	Specifications
CLM_TYPE	Type of claim Format: Char(1) Valid values: N=pharmacy/NCPDP; P=professional/837P; I=institutional/ facility/ 837I Required

Method: DMAS secure CCC Plus FTP server

Format: Excel (.xlsx) file

File Name: CCCP_REINSURE_*yyyy*Q*n*_C*ontractorName*.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

Schedule: Q1 – (Jul – Sep) Generated on October 31st
Q2 – (Oct – Dec) Generated on January 31st
Q3 – (Jan – Mar) Generated on April 30th
Q4 – (Apr – Jun) Generated on September 30th

DMAS: Provider Reimbursement Division

2.1.11.3 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 $200,000 threshold. Includes pharmacy, physician, and outpatient hospital 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.

2.1.11.4 Examples

None

2.1.11.5 Scoring Criteria

None

Appendix A

CCC Plus
Core Performance Measure Reporting Requirements

Contents

Introduction to Appendix A

Each measure listed in this appendix pertains to one of the following four categories of quality performance:

1. Access, Disease Management and Service Utilization
2. Care Management and Transition Coordination
3. Prevention, Healthy Living and Aging Well
4. Member Safety, Satisfaction and Quality of Life

The first digit of each measure number (1-4) indicates the category of quality performance targeted by that measure.

The measure steward is identified for each measure listed in this appendix. Any questions concerning those measures stewarded by DMAS, or questions that are not fully addressed by specifications from any other measure source, should be directed to the CCCPlusReporting@dmas.virginia.gov mailbox.

All HEDIS measure reporting must be done through a HEDIS certified vendor/auditor.

Certain measures only apply to that portion of a plan's member population consisting of non-dual eligible members and dual eligible members whose CCC Plus health plan also serves as their Medicare managed care health plan. This restriction is noted wherever applicable.

Where indicated for individual measures, use the reporting template supplied by DMAS to report the measure results. Separate templates are available for monthly, quarterly, semi-annual and annual measures. Instructions for the submission of measure results are provided within the reporting template. All templates are located on SharePoint.

1.1 Adults' Access to Preventive/ Ambulatory Health Services

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year.

Measure Description

The percentage of members 20 years and older who had an ambulatory or preventive care visit.

Notes – Additional Clarification

Follow HEDIS specifications for measure AAP. Plans must use a HEDIS certified vendor/auditor to complete this measure.

This measure is a key performance indicator.

1.2 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year.

Measure Description

The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following.

- Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
- Engagement of AOD Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

Endorsed by NQF as measure #0004.

Notes – Additional Clarification

Follow HEDIS specifications for measure IET. Plans must use a HEDIS certified vendor/auditor to complete this measure.

This measure is both a key performance indicator and a Performance Withhold Program measure.

1.3 Identification of Alcohol and Other Drug Services

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year.

Measure Description

This measure summarizes the number and percentage of members with an alcohol and other drug (AOD) claim who received the following chemical dependency services during the measurement year:

- Any service.
- Inpatient.
- Intensive outpatient or partial hospitalization.
- Outpatient or ED.

Notes – Additional Clarification

Follow HEDIS specifications for measure IAD. Plans must use a HEDIS certified vendor/auditor to complete this measure.

This measure is a key performance indicator.

1.4 Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year.

Measure Description

The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) dependence, who had a follow up visit for AOD. Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit.
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit.

Notes – Additional Clarification

Follow HEDIS specifications for measure FUA. Plans must use a HEDIS certified vendor/auditor to complete this measure.

This measure is both a key performance indicator and a Performance Withhold Program measure.

1.5 Comprehensive Diabetes Care

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year.

Measure Description

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1c (HbA1c) testing.
- HbA1c poor control (>9.0%).
- HbA1c control (<8.0%).
- Eye exam (retinal) performed.
- BP control (<140/90 mm Hg).

Notes – Additional Clarification

Follow HEDIS specifications for measure CDC. Plans must use a HEDIS certified vendor/auditor to complete this measure.

This measure is both a key performance indicator and a Performance Withhold Program measure.

1.6 Controlling High Blood Pressure

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year.

Measure Description

The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.

Endorsed by NQF as measure #0018.

Notes – Additional Clarification

Follow HEDIS specifications for measure CBP. Plans must use a HEDIS certified vendor/auditor to complete this measure.

This measure is a key performance indicator.

1.7 Medication Reconciliation Post-Discharge (Measure eliminated effective 7/15/19)

1.8 Care for Older Adults: Medication Review (Measure eliminated effective 7/15/19)

1.9 Advance Care Plan (Measure eliminated effective 7/15/19)

1.10 Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment - *Measure suspended effective 11/30/2019*

Measure Steward: AMA

Frequency: Annual (Based on Calendar Year)

Due Date: *This measure is under review. No submission is required until further notice.*

Measure Description

Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.

Endorsed by NQF as measure #1365.

Notes – Additional Clarification

Follow specifications on the National Quality Forum website for measure #1365.

This measure will only apply to non-dual eligible members and dual eligible members whose CCC Plus health plan also serves as their Medicare managed care health plan.

Plans may use the sampling methodology described at the end of this appendix to determine the eligible population based on a diagnosis of major depressive disorder.

Use the reporting template supplied by DMAS for submitting measure results. Instructions for submission are included within the template.

Additional guidance from CMS (from ECQI Resource Center):

The specific type and magnitude of the suicide risk assessment is intended to be at the discretion of the individual clinician and should be specific to the needs of the patient. At a minimum, suicide risk assessment should evaluate:

1. Risk (e.g., age, sex, stressors, comorbid conditions, hopelessness, impulsivity) and protective factors (e.g., religious belief, concern not to hurt family) that may influence the desire to attempt suicide.

2. Current severity of suicidality

3. Most severe point of suicidality in episode and lifetime

Low burden tools to track suicidal ideation and behavior such as the Columbia-Suicidal Severity Rating Scale can also be used.

A suicide risk assessment should be performed at every visit for major depressive disorder during the measurement period.

This measure is an episode-of-care measure; the level of analysis for this measure is every visit for major depressive disorder during the measurement period. For example, at every visit for MDD, the patient should have a suicide risk assessment.

Use of a standardized tool or instrument to assess suicide risk will meet numerator performance.

1.11 Dementia: Cognitive Assessment - *Measure suspended effective 11/30/2019*

Measure Steward: Physician Consortium for Performance Improvement (PCPI)

Frequency: Annual (Based on Calendar Year)

Due Date: *This measure is under review. No submission is required until further notice.*

Measure Description

Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period.

Endorsed by NQF as measure #2872.

Notes – Additional Clarification

See *Dementia Performance Measurement Sets* available on the PCPI website for specifications. Refer to measure #2: Cognitive Assessment. These specifications are also available on SharePoint.

Plans may use the sampling methodology described at the end of this appendix to determine the eligible population based on a diagnosis of dementia.

This measure will only apply to non-dual eligible members and dual eligible members whose CCC Plus health plan also serves as their Medicare managed care health plan.

Use the reporting template supplied by DMAS for submitting measure results. Instructions for submission are included within the template.

1.12 Dementia: Functional Status Assessment - *Measure suspended effective 11/30/2019*

Measure Steward: American Academy of Neurology

Frequency: Annual (Based on Calendar Year)

Due Date: *This measure is under review. No submission is required until further notice.*

Measure Description

Percentage of patients with dementia for whom an assessment of functional status was performed at least once in the last 12 months.

See American Academy of Neurology for specifications.

Notes – Additional Clarification

See *Dementia Management: Quality Measurement Assessment Update* available on the American Academy of Neurology website for specifications. Refer to "Functional Status Assessment for Patients with Dementia." These specifications are also available on SharePoint.

Plans may use the sampling methodology described at the end of this appendix to determine the eligible population based on a diagnosis of dementia.

This measure will only apply to non-dual eligible members and dual eligible members whose CCC Plus health plan also serves as their Medicare managed care health plan.

Use the reporting template supplied by DMAS for submitting measure results. Instructions for submission are included within the template.

1.13 Dementia: Staging of Dementia - *Measure suspended effective 11/30/2019*

Measure Steward: American Academy of Neurology

Frequency: Annual (Based on Calendar Year)

Due Date: *This measure is under review. No submission is required until further notice.*

Measure Description

Percentage of members, regardless of age, with a diagnosis of dementia whose severity of dementia was classified as mild, moderate or severe at least once within a 12-month period.

Notes – Additional Clarification

This measure was formerly stewarded by the American Medical Association (AMA). A copy of the AMA specifications excerpted from the AMA's *Dementia Performance Measurement Set* (2011) is available from the American Academy of Neurology at this link. These specifications are also available on SharePoint.

Plans may use the sampling methodology described at the end of this appendix to determine the eligible population based on a diagnosis of dementia.

This measure will only apply to non-dual eligible members and dual eligible members whose CCC Plus health plan also serves as their Medicare managed care health plan.

Use the reporting template supplied by DMAS for submitting measure results. Instructions for submission are included within the template.

1.14 Personal Care and Respite Care Services with Increase or Decrease in Authorized Hours - *Measure suspended effective 2/1/2020*

Measure Steward: DMAS

Frequency: Monthly

Due Date: *This measure is under review. No submission is required until further notice.*

Measure Description

Members enrolled in the CCC Plus waiver who experienced an increase or decrease in authorized hours for personal care or respite care services during the reporting period.

Eligible population

Members who were authorized personal care services, respite care services, or both, throughout the reporting period.

Continuous enrollment: Enrolled in CCC Plus waiver for entire reporting period.

Denominators

Denominator 1:

Members who were authorized personal care services throughout the reporting period.

Denominator 2:

Members who were authorized respite care services throughout the reporting period.

Numerators

Numerator 1:

Total number of increases in personal care service hours during the reporting period. Report the number of increases and not the number of hours by which services were increased or the number of members for whom services were increased.

Numerator 2:

Total number of decreases in personal care service hours during the reporting period. Report the number of decreases and not the number of hours by which services were decreased or the number of members for whom services were decreased.

Numerator 3:

Total number of increases in respite care service hours during the reporting period. Report the number of increases and not the number of hours by which services were increased or the number of members for whom services were increased.

Numerator 4:

Total number of decreases in respite care service hours during the reporting period. Report the number of decreases and not the number of hours by which services were decreased or the number of members for whom services were decreased.

Notes – Additional Clarification

In order to identify any change in authorized hours coinciding with the first day of the reporting period, plans must look at the number of hours authorized as of the end of the previous month.

Include all changes during the reporting period (inclusive of the first day of the reporting period) for each individual member when counting the number of increases and decreases in authorized hours. All increases and decreases for an individual member are to be counted.

A member going from zero authorized hours to any number of authorized hours does not count as an increase in hours.

Use the reporting template supplied by DMAS for submitting measure results. Instructions for submission are included within the template.

1.15 Increase or Decrease in Private Duty Nursing for CCC Plus Waiver Technology Assisted Level of Care - *Measure suspended effective 2/1/2020*

Measure Steward**:** DMAS

Frequency: Monthly

Due Date: *This measure is under review. No submission is required until further notice.*

Measure Description

Members enrolled in the CCC Plus waiver for technology assisted services who experienced either an increase or a decrease in authorized hours for private duty nursing during the reporting period.

Eligible population

Members who were authorized private duty nursing throughout the reporting period.

Continuous enrollment: Enrolled in CCC Plus waiver for entire reporting period.

Denominator

Eligible population.

Numerators

Numerator 1:

Total increases in authorized service hours for private duty nursing during the reporting period for members of the eligible population.

Numerator 2:

Total decreases in authorized service hours for private duty nursing during the reporting period for members of the eligible population.

Notes – Additional Clarification

In order to identify any change in authorized hours coinciding with the first day of the reporting period, plans must look at the number of hours authorized as of the end of the previous month.

Include all changes during the reporting period (inclusive of the first day of the reporting period) for each individual member when counting the number of increases and decreases in authorized hours. All increases and decreases for an individual member are to be counted.

A member going from zero authorized hours to any number of authorized hours does not count an increase in hours.

Use the reporting template supplied by DMAS for submitting measure results. Instructions for submission are included within the template.

1.16 Asthma Medication Ratio

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year.

Measure Description

The percentage of patients 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

Endorsed by NQF as measure #1800.

Notes – Additional Clarification

Follow HEDIS specifications for measure AMR. Plans must use a HEDIS certified vendor/auditor to complete this measure.

1.17 Medication Management for People with Asthma (Measure eliminated 2/16/21).

1.18 Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year.

Measure Description

The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.

Endorsed by NQF as measure #0058.

Notes – Additional Clarification

Follow HEDIS specifications for measure AAB. Plans must use a HEDIS certified vendor/auditor to complete this measure.

1.19 Pharmacotherapy Management of COPD Exacerbation

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year

Measure Description

This measure assesses the percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter on or between January 1–November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported:

1) Dispensed a systemic corticosteroid within 14 days of the event.

2) Dispensed a bronchodilator within 30 days of the event.

Endorsed by NQF as measure #0549.

Notes – Additional Clarification

Follow HEDIS specifications for measure PCE. Plans must use a HEDIS certified vendor/auditor to complete this measure.

1.20 Use of Imaging Studies for Low Back Pain

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year

Measure Description

The percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis.

Endorsed by NQF as measure #0052.

Notes – Additional Clarification

Follow HEDIS specifications for measure LBP. Plans must use a HEDIS certified vendor/auditor to complete this measure.

1.21 Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year

Measure Description

The percentage of patients 18–64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year.

Endorsed by NQF as measure #1933.

Notes – Additional Clarification

Follow HEDIS specifications for measure SMC. Plans must use a HEDIS certified vendor/auditor to complete this measure.

1.22 Inpatient Utilization—General Hospital/ Acute Care

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year

Measure Description

This measure summarizes utilization of acute inpatient care and services in the following categories:

- Total inpatient
- Maternity
- Surgery
- Medicine

Notes – Additional Clarification

Follow HEDIS specifications for measure IPU. Plans must use a HEDIS certified vendor/auditor to complete this measure.

1.23 Ambulatory Care - Emergency Department (ED) Visits

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year

Measure Description

For members 18 years of age and older, the risk-adjusted ratio of observed to expected emergency department (ED) visits during the measurement year.

Notes – Additional Clarification

Follow HEDIS specifications for measure AMB. Calculate for ED visits only. Plans must use a HEDIS certified vendor/auditor to complete this measure.

This measure is a key performance indicator.

1.24 Mental Health Utilization

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year

Measure Description

The number and percentage of members receiving the following mental health services during the measurement year:

- Any service
- Inpatient
- Intensive outpatient or partial hospitalization
- Outpatient or ED

Notes – Additional Clarification

Follow HEDIS specifications for measure MPT. Plans must use a HEDIS certified vendor/auditor to complete this measure.

1.25 Plan All-Cause Readmissions

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year

Measure Description

For patients 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Endorsed by NQF as measure #1768.

Notes – Additional Clarification

Follow HEDIS specifications for measure PCR. Plans must use a HEDIS certified vendor/auditor to complete this measure.

This measure is a key performance indicator.

1.26 Antidepressant Medication Management

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year

The first submission of this measure will not be due until 2020 due to the continuous enrollment requirement.

Measure Description

The percentage of patients 18 years of age and older with a diagnosis of major depression and were treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported:

1) Effective Acute Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks).

2) Effective Continuation Phase Treatment. The percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).

Endorsed by NQF as measure #0105.

Notes – Additional Clarification

Follow HEDIS specifications for measure AMM. Plans must use a HEDIS certified vendor/auditor to complete this measure.

This measure is a key performance indicator.

1.27 Follow-Up after Hospitalization for Mental Illness

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year

Measure Description

The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported:

1. The percentage of discharges for which the patient received follow-up within 30 days of discharge

2. The percentage of discharges for which the patient received follow-up within 7 days of discharge.

Endorsed by NQF as measure #0576.

Notes – Additional Clarification

Follow HEDIS specifications for measure FUH. Plans must use a HEDIS certified vendor/auditor to complete this measure.

This measure is a key performance indicator.

1.28 Use of High-Risk Medications in the Elderly

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year

Measure Description

Two rates will be reported for the dispensing of high-risk medication:

1. The percentage of members 66 years of age and older who had at least one dispensing event for a high-risk medication.

2. The percentage of members 66 years of age and older who had at least two dispensing events for the same high-risk medication.

For both rates, a lower rate represents better performance.

Notes – Additional Clarification

Follow HEDIS specifications for measure DAE. Plans must use a HEDIS certified vendor/auditor to complete this measure.

Because this measure is not standard for Medicaid, it is not part of the IDSS submission. Report this measures using the report template located on SharePoint.

This measure is a key performance indicator.

1.29 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year

Measure Description

Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months).

Endorsed by NQF as measure #1879.

Notes – Additional Clarification

Follow HEDIS specifications for measure SAA. Plans must use a HEDIS certified vendor/auditor to complete this measure.

1.30 Children and Adolescents' Access to Primary Care Practitioners

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year

Measure Description

The percentage of members 12 months–19 years of age who had a visit with a PCP. Four separate percentages will be reported:

1. Children 12–24 months who had a visit with a PCP during the measurement year.
2. Children 25 months–6 years who had a visit with a PCP during the measurement year.
3. Children 7–11 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.
4. Adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.

Notes – Additional Clarification

Follow HEDIS specifications for measure CAP. Plans must use a HEDIS certified vendor/auditor to complete this measure.

1.31 Adolescent Well-Care Visits

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year

Measure Description

The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Notes – Additional Clarification

Follow HEDIS specifications for measure AWC. Plans must use a HEDIS certified vendor/auditor to complete this measure.

1.32 Well-Child Visits in the First 15 Months of Life

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year

Measure Description

The percentage of children 15 months old who had the recommended number of well-child visits with a PCP during their first 15 months of life.

Endorsed by NQF as measure #1392.

Notes – Additional Clarification

Follow HEDIS specifications for measure W15. Plans must use a HEDIS certified vendor/auditor to complete this measure.

1.33 Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year

Measure Description

The percentage of children 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.

Endorsed by NQF as measure #1516.

Notes – Additional Clarification

Follow HEDIS specifications for measure W34. Plans must use a HEDIS certified vendor/auditor to complete this measure.

1.34 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year

Measure Description

The percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.

Notes – Additional Clarification

Follow HEDIS specifications for measure APP. Plans must use a HEDIS certified vendor/auditor to complete this measure.

1.35 Metabolic Monitoring for Children and Adolescents on Antipsychotics

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year

Measure Description

The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.

Notes – Additional Clarification

Follow HEDIS specifications for measure APM. Plans must use a HEDIS certified vendor/auditor to complete this measure.

1.36 Use of Multiple Concurrent Antipsychotics in Children and Adolescents (Measure Eliminated effective 8/1/2019)

This measure (HEDIS measure APC) has been retired. No submission to DMAS is required after July 31, 2019.

1.37 Diabetes Short-Term Complication Admission Rate (PQI 01)

Measure Steward: AHRQ

Frequency: Annual (Based on Calendar Year)

Due Date: March 31st following the measurement year.

Measure Description

Number of inpatient hospital admissions for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 beneficiary months for beneficiaries age 18 and older.

Endorsed by NQF as measure #0272.

Notes – Additional Clarification

Refer to the PQI 01 specifications in the most recent version of the *Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)* for the measurement year. For your convenience, these specifications, along with the value set for diabetes diagnoses codes (see table PQI01-A in 2019-Adult-PQI-Codes.xlsx), are available on SharePoint. Please ensure that you are using the most recent specifications and codes for this measure.

This measure will only apply to non-dual eligible members and dual eligible members whose CCC Plus health plan also serves as their Medicare managed care health plan.

Use the reporting template supplied by DMAS for submitting measure results. Instructions for submission are included within the template.

This measure is a key performance indicator.

1.38 Congestive Heart Failure Rate (PQI 08)

Measure Steward: AHRQ

Frequency: Annual (Based on Calendar Year)

Due Date: March 31st following the measurement year.

Measure Description

Number of inpatient hospital admissions for heart failure per 100,000 beneficiary months for beneficiaries age 18 and older.

Endorsed by NQF as measure #0277.

Notes – Additional Clarification

Refer to the PQI 08 specifications in the most recent version of the *Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)* for the measurement year. For your convenience, these specifications, along with related value sets (see tables PQI08-A and PQI08-C in 2019-Adult-PQI-Codes.xlsx), are available on SharePoint. Please ensure that you are using the most recent specifications and codes for this measure.

This measure will only apply to non-dual eligible members and dual eligible members whose CCC Plus health plan also serves as their Medicare managed care health plan.

Use the reporting template supplied by DMAS for submitting measure results. Instructions for submission are included within the template.

This measure is a key performance indicator.

1.39 COPD and Asthma in Older Adults Admission Rate (PQI 05)

Measure Steward: AHRQ

Frequency: Annual (Based on Calendar Year)

Due Date: March 31st following the measurement year.

Measure Description

Number of inpatient hospital admissions for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 beneficiary months for beneficiaries age 40 and older.

Endorsed by NQF as measure #0275.

Notes – Additional Clarification

Refer to the PQI 05 specifications in the most recent version of the *Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)* for the measurement year. For your convenience, these specifications, along with related value sets (see tables PQI05-A, PQI05-B and PQI05-D in 2019-Adult-PQI-Codes.xlsx), are available on SharePoint. Please ensure that you are using the most recent specifications and codes for this measure.

This measure will only apply to non-dual eligible members and dual eligible members whose CCC Plus health plan also serves as their Medicare managed care health plan.

Use the reporting template supplied by DMAS for submitting measure results. Instructions for submission are included within the template.

This measure is a key performance indicator.

1.40 Annual Monitoring for Patients on Persistent Medications (Measure Eliminated effective 8/1/2019)

This measure (HEDIS measure MPM) has been retired. No submission to DMAS is required after July 31, 2019.

1.41 Use of Opioids at High Dosage

Measure Steward: NCQA (adapted from Pharmacy Quality Alliance measure)

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year.

Measure Description

For members 18 years of and older, the rate per 1,000 receiving prescription opioids for >= 15 days during the measurement year at a high dosage (average morphine equivalent dose [MED] > 120 mg).

Notes – Additional Clarification

Follow HEDIS specifications for measure HDO. Plans must use a HEDIS certified vendor/auditor to complete this measure.

This measure is a key performance indicator.

1.42 Use of Opioids from Multiple Providers

Measure Steward: NCQA (adapted from Pharmacy Quality Alliance measure)

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year

Measure Description

For members 18 years and older, the rate per 1,000 receiving prescription opioids for >= 15 days during the measurement year who received opioids from multiple providers.

Notes – Additional Clarification

Follow HEDIS specifications for measure UOP. Plans must use a HEDIS certified vendor/auditor to complete this measure.

This measure is a key performance indicator.

1.43 Use of Opioids at High Dosage and from Multiple Providers in Persons without Cancer (Measure eliminated effective 9/1)

1.44 Outpatient Behavioral Health Encounter in the Last 12 months for Population with Behavioral Health Condition

Measure Steward: DMAS (Based on Calendar Year)

Frequency: Annual

Due Date: N/A

Note: DMAS will calculate this measure. No submission is required.

Measure Description

Outpatient behavioral health encounters, including both mental health and substance abuse services, during the measurement year for members with a behavioral health condition.

Eligible population

Members who received mental health or substance abuse services at any time during the 12 months prior to the start of the measurement year.

Note: For measurement year 2018, the eligible population will consist of members who received mental health or substance abuse services at any time between August 1, 2017 and December 31, 2017.

Continuous enrollment: The measurement year with no more than a single one-month gap.

Denominator

Eligible population.

Numerator

Number of members who had at least one outpatient encounter for mental health or substance abuse services during the measurement year.

Notes – Additional Clarification

None.

1.45 LTSS Services Utilization (Measure eliminated effective 6/1/19)

1.46 Long Term Services and Supports (LTSS) Enrollees Using Consumer-Directed Services

Measure Steward: DMAS

Frequency: Annual (Based on Calendar Year)

Due Date: March 31st following the measurement year

Measure Description

Members who received consumer-directed services while enrolled in the CCC Plus waiver.

Eligible population

Members enrolled in the CCC Plus waiver for at least 90 consecutive days during the measurement year.

Denominator

Eligible population.

Numerator

Members who received consumer-directed services during a period of enrollment in the CCC Plus waiver of at least 90 consecutive days.

Notes – Additional Clarification

Use the reporting template supplied by DMAS for submitting measure results. Instructions for submission are included within the template.

1.47 Nursing Facility Residents Hospitalization Rate

Measure Steward: DMAS

Frequency: Quarterly (Based on State Fiscal Year)

Due Date: End of third month following reporting period.
State Fiscal Quarters:
Q1 = July – September (Due December 31st)
Q2 = October – December (Due March 31st)
Q3 = January – March (Due June 30th)
Q4 = April – June (Due September 30th)

Measure Description

Members residing in a nursing facility who were admitted to a hospital during the reporting period.

Intake Period

The 90 days immediately preceding the reporting period through the earliest of the following two dates:

- Last day of the reporting period
- First date of admission to a hospital during the reporting period

Eligible population

Members who resided in a nursing facility throughout the intake period.

Continuous enrollment: The intake period. A hospital stay during that part of the intake period that preceded the reporting quarter does not impact continuous enrollment.

Denominator

Eligible population.

Numerator

Members with a hospital admission during the reporting period.

Notes – Additional Clarification

Use the reporting template supplied by DMAS for submitting measure results. Instructions for submission are included within the template.

This measure is a key performance indicator.

1.48 Nursing Facility Diversion

Measure Steward: DMAS

Frequency: Quarterly (Based on Calendar Year)

Due Date: N/A

Note: DMAS will calculate this measure. No submission is required.

Measure Description

Number of members who are newly eligible for nursing facility level of care who opt for Home and Community-based Services (HCBS) over institutional placement.

Eligible population

Members who were newly determined to be eligible for nursing facility level of care during the previous reporting period including members newly enrolled during the previous reporting period who were residing in a nursing facility at the time of enrollment.

Continuous Enrollment: From the date on which the member was determined to be eligible for nursing facility level of care (the date of enrollment for members residing in a nursing facility at the time of enrollment) through the end of the reporting period.

Denominator

Eligible population.

Numerator

Members who opted for HCBS by the end of the reporting period.

1.49 Continuity of Pharmacotherapy for Opioid Use Disorder

Measure Steward: Rand Corporation

Frequency: Semi-annual (Based on Calendar Year)

Due Date: End of third month following reporting period (e.g., January 1 – June 30 reporting period results will be due September 30).

Measure Description

Percentage of adults 18-64 years of age with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment.

Notes – Additional Clarification

Follow specifications on the National Quality Forum website for measure #3175 with the following modifications:

1) Intake Period: The interval beginning 179 days prior to the start of the reporting period and ending 179 days prior to the last day of the reporting period. For example, for the January 1 – June 30 reporting period, the intake period would begin on July 6 of the previous year and end on January 2 (note that the end date would be January 3 during a leap year).

   Note: For the January 1 – June 30 reporting period for 2018 only, the intake period begins August 1, 2017.

2) Continuous Enrollment:

   a. For inclusion in the denominator: 179 days following the earliest dispensing date during the intake period for a medication prescribed for OUD.

   b. For inclusion in the numerator: The entire qualifying period of 180 days of continuous pharmacotherapy with no gap in coverage.

3) Numerator: The numerator statement has been changed to read as follows:

   Individuals in the denominator who had 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days such that day 180 occurred during the reporting period.

4) Denominator: The denominator statement has been changed to read as follows:

   Individuals 18-64 years of age who had a diagnosis of OUD and at least one claim for an OUD medication with a date of service that occurred during the intake period.

To qualify for the denominator, a member must have been 18 to 64 years of age at the start of the intake period.

This measure will only apply to non-dual eligible members and dual eligible members whose CCC Plus health plan also serves as their Medicare managed care health plan.

Use the reporting template supplied by DMAS for submitting measure results. Instructions for submission are included within the template.

The following additional details were adapted from the *Behavioral Health 2016-2017 Technical Report*, published by the National Quality Forum on August 28, 2017.

Numerator Details

Continuous pharmacotherapy for OUD is identified on the basis of the days covered by the days' supply of all prescription claims for any OUD medication (see list below) or number of days for which the drug was dispensed in a physician office or treatment center with the exceptions noted in this paragraph.

If two or more prescription claims occur on the same day or overlap, the surplus based on the days' supplies accumulates over all prescriptions. However, if another claim is submitted after a claim for an injectable OUD medication or an oral OUD medication that is dispensed in an office or treatment center, the surplus from the day's supply for the injectable or office-dispensed medication is not retained.

Surplus supplies will factor into the calculation of continuous days of pharmacotherapy as follows:

1. Oral drug, pharmacy-dispensed: The days' supply of a refill obtained before the current days' supply runs out will be added to the total current days' supply (i.e., the days' supply of the most recent previously filled prescription), as people commonly obtain refills before their current supplies run out.

2. Injectable drug: Injectables are good for 30 days. Patients sometimes get re-injected before day 30 (e.g., if day 30 is on a weekend). When a patient is re-injected, any days that remain of the 30 days of therapeutic effect normally provided by a previous injection will not be counted toward the total days of continuous pharmacotherapy since the previous injection does not extend the effect of the subsequent injection. In other words, when injectable treatments overlap, surplus days from the previous injection are not retained.

3. Oral drug dispensed in an office or treatment center: Patients are sometimes provided additional pills when receiving an oral drug in an office or treatment center. Any part of the days' supply of such pills that remain on the day a

pharmacy-dispensed prescription is filled will not be counted toward the total days of continuous pharmacotherapy. In other words, any surplus of an oral drug dispensed in an office or treatment center is not retained.

4. Overlap of days' supply of oral drug and therapeutic period of injectable drug: Such an overlap indicates the switching of therapy regimens. Neither any part of the 30-day period following an injection nor any part of the days' supply of an oral drug that remains at the time of the switch will be counted toward the total days of continuous pharmacotherapy. In other words, no surplus from the previous regimen will be retained.

An individual is considered to have continuous pharmacotherapy with OUD medication if there is no treatment gap of more than seven days. A gap is defined as a period during which the individual does not have oral OUD medication available based on the days' supply, or is more than 7 days overdue for having an injection of an extended-release OUD medication.

OUD medications are identified using National Drug Codes (NDCs) for the following:
- Buprenorphine
- Naltrexone (oral)
- Buprenorphine and Naloxone

and HCPCS codes for the following:
- Buprenorphine or Buprenorphine/naloxone, oral
- Methadone administration
- Naltrexone (extended-release injectable)

The National Drug Codes (NDCs) for the oral medications and the HCPCS codes for the injectable medications and office-dispensed oral medications (methadone and buprenorphine/naloxone) are contained in the tables that follow. Note that the NDC code list DOES NOT include NDC codes for methadone, as it can legally only be dispensed as OUD pharmacotherapy in licensed treatment centers. Buprenorphine can be dispensed through a pharmacy or in an office and is therefore identified based on either NDC or HCPCS codes.

Denominator Details

The denominator includes individuals 18-64 years of age during their treatment period who had a diagnosis code of OUD during an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or emergency department encounter at any time during the intake period.

The diagnosis codes used to identify individuals with OUD include:
- ICD-9: 304.0x, 305.5x

- ICD-10: F11.xxx

These codes and descriptions are contained in the table that follows.

OUD medications are identified using National Drug Codes (NDCs) for the following:

- Buprenorphine
- Naltrexone (oral)
- Buprenorphine and Naloxone

and HCPCS codes for the following:

- Buprenorphine or Buprenorphine/naloxone, oral
- Methadone administration
- Naltrexone (extended-release injectable)

The National Drug Codes (NDCs) for the oral medications and the HCPCS codes for the injectable medications and office-dispensed oral medications (methadone and buprenorphine/naloxone) are contained in the tables that follow. Note that the NDC code list DOES NOT include NDC codes for methadone, as it can legally only be dispensed as OUD pharmacotherapy in licensed treatment centers. Buprenorphine can be dispensed through a pharmacy or in an office and is therefore identified based on either NDC or HCPCS codes.

National drug codes (NDCs) for oral OUD medications

Proprietary Name	11 digit NDC
Buprenorphine HCl	00054-0176-13
Buprenorphine HCl	00054-0177-13
buprenorphine hydrochloride and naloxone hydrochloride dihydrate	00054-0188-13
buprenorphine hydrochloride and naloxone hydrochloride dihydrate	00054-0189-13
Buprenorphine	00093-5378-56
Buprenorphine	00093-5379-56
Buprenorphine and Naloxone	00093-5720-56
Buprenorphine and Naloxone	00093-5721-56
Buprenorphine	00228-3153-73
Buprenorphine and Naloxone	00228-3154-73
Buprenorphine and Naloxone	00228-3155-73
Buprenorphine	00228-3156-73
Buprenorphine Hydrochloride Sublingual	00378-0923-93
Buprenorphine Hydrochloride Sublingual	00378-0924-93
Buprenorphine HCl and Naloxone HCl	00406-1923-09
Buprenorphine HCl and Naloxone HCl	00406-1924-09
Buprenorphine Hydrochloride	00409-2012-32

Proprietary Name	11 digit NDC
Buprenorphine Hydrochloride	00517-0725-05
Sublocade	12496-0300-01
Buprenex	12496-0757-05
Suboxone	12496-1202-03
Suboxone	12496-1204-03
Suboxone	12496-1208-03
Suboxone	12496-1212-03
Buprenorphine Hydrochloride	21695-0515-10
Suboxone	35356-0004-30
Buprenorphine Hydrochloride	42023-0179-10
Buprenorphine HCl and Naloxone HCl	42291-0174-30
Buprenorphine HCl and Naloxone HCl	42291-0175-30
Suboxone	43063-0184-30
buprenorphine hydrochloride	43063-0667-06
BUPRENORPHINE HYDROCHLORIDE	49349-0554-02
buprenorphine hydrochloride	50090-1571-00
Buprenorphine and Naloxone	50383-0287-93
Buprenorphine and Naloxone	50383-0294-93
buprenorphine hydrochloride	50383-0924-93
buprenorphine hydrochloride	50383-0930-93
buprenorphine hydrochloride	52125-0678-02
Zubsolv	54123-0114-30
Zubsolv	54123-0914-30
Zubsolv	54123-0929-30
Zubsolv	54123-0957-30
Zubsolv	54123-0986-30
Suboxone	54569-6399-00
Buprenorphine HCl and Naloxone HCl	54569-6408-00
buprenorphine hydrochloride	54569-6578-00
Suboxone	54868-5707-04
Suboxone	54868-5750-00
Buprenorphine HCl	55154-4962-04
Suboxone	55700-0147-30
Buprenorphine HCl	55700-0302-30
Buprenorphine HCl	55700-0303-30
Probuphine[1]	58284-0100-14
BUNAVAIL	59385-0012-30

[1] Use the dispensing date as the start date for the six-month treatment period.

Proprietary Name	11 digit NDC
BUNAVAIL	59385-0014-30
BUNAVAIL	59385-0016-30
Buprenorphine and Naloxone	60429-0586-30
Buprenorphine and Naloxone	60429-0587-30
Buprenorphine Hydrochloride Sublingual	61786-0678-02
Buprenorphine	61786-0911-02
Buprenorphine	61786-0912-02
Buprenorphine and Naloxone	62175-0452-32
Buprenorphine and Naloxone	62175-0458-32
Buprenorphine	62756-0459-83
Buprenorphine	62756-0460-83
Suboxone	63629-4028-02
suboxone	63629-4034-04
Buprenorphine hydrochloride	63629-4092-02
Buprenorphine HCl and Naloxone HCl	63629-5074-01
buprenorphine hydrochloride	64725-0930-04
buprenorphine hydrochloride	64725-1924-04
Buprenorphine HCl and Naloxone HCl	65162-0415-09
Buprenorphine HCl and Naloxone HCl	65162-0416-09
NALTREXONE HYDROCHLORIDE	00406-1170-03
Naltrexone Hydrochloride	00555-0902-02
Naltrexone Hydrochloride	16729-0081-10
Naltrexone Hydrochloride	42291-0632-30
Naltrexone Hydrochloride	43063-0469-15
NALTREXONE HYDROCHLORIDE	43063-0591-15
NALTREXONE HYDROCHLORIDE	47335-0326-88
Naltrexone Hydrochloride	50436-0105-01
Naltrexone Hydrochloride	51224-0206-50
Naltrexone Hydrochloride	52125-0727-02
Naltrexone Hydrochloride	54868-5574-00
Naltrexone Hydrochloride	63629-5304-02
NALTREXONE HYDROCHLORIDE	68084-0291-21
Naltrexone Hydrochloride	68094-0853-62

HCPCS codes for injectable medications and office-dispensed oral medications (methadone and buprenorphine/naloxone)

HCPCS Code	HCPCS Code Description
H0020	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)
J0571-J0575	Buprenorphine/naloxone, oral (code range)
J2315	Injection, naltrexone, depot form, 1 mg

ICD-10-CM diagnosis codes for OUD

ICD-10-CM Code	ICD-10 Code Description
F11	Opioid related disorders
F11.1	Opioid abuse
F11.10	…… uncomplicated
F11.12	Opioid abuse with intoxication
F11.120	…… uncomplicated
F11.121	…… delirium
F11.122	…… with perceptual disturbance
F11.129	…… unspecified
F11.14	…… with opioid-induced mood disorder
F11.15	Opioid abuse with opioid-induced psychotic disorder
F11.150	…… with delusions
F11.151	…… with hallucinations
F11.159	…… unspecified
F11.18	Opioid abuse with other opioid-induced disorder
F11.181	Opioid abuse with opioid-induced sexual dysfunction
F11.182	Opioid abuse with opioid-induced sleep disorder
F11.188	Opioid abuse with other opioid-induced disorder
F11.19	…… with unspecified opioid-induced disorder
F11.2	Opioid dependence
F11.20	…… uncomplicated
F11.21	…… in remission
F11.22	Opioid dependence with intoxication
F11.220	…… uncomplicated
F11.221	…… delirium
F11.222	…… with perceptual disturbance
F11.229	…… unspecified
F11.23	…… with withdrawal
F11.24	…… with opioid-induced mood disorder
F11.25	Opioid dependence with opioid-induced psychotic disorder
F11.250	…… with delusions

ICD-10-CM Code	ICD-10 Code Description
F11.251	…… with hallucinations
F11.259	…… unspecified
F11.28	Opioid dependence with other opioid-induced disorder
F11.281	Opioid dependence with opioid-induced sexual dysfunction
F11.282	Opioid dependence with opioid-induced sleep disorder
F11.288	Opioid dependence with other opioid-induced disorder
F11.29	…… with unspecified opioid-induced disorder
F11.9	Opioid use, unspecified
F11.90	…… uncomplicated
F11.92	Opioid use,unspecified with intoxication
F11.920	…… uncomplicated
F11.921	…… delirium
F11.922	…… with perceptual disturbance
F11.929	…… unspecified
F11.93	…… with withdrawal
F11.94	…… with opioid-induced mood disorder
F11.95	Opioid use, unspecified with opioid-induced psychotic disorder
F11.950	…… with delusions
F11.951	…… with hallucinations
F11.959	…… unspecified
F11.98	Opioid use, unspecified with other specified opioid-induced disorder
F11.981	Opioid use, unspecified with opioid-induced sexual dysfunction
F11.982	Opioid use, unspecified with opioid-induced sleep disorder
F11.988	Opioid use, unspecified with other opioid-induced disorder
F11.99	…… with unspecified opioid-induced disorder

1.50 Residential Treatment for Substance Use Disorder (SUD) 180-Day Readmission Rate (Measure eliminated effective 7/15/19)

1.51 Inpatient Treatment for Substance Use Disorder (SUD) 14-Day Readmission Rate (Measure eliminated effective 7/15/19)

1.52 Follow-up after Emergency Department Visit for Mental Illness

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year.

Measure Description

The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness. Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit.
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit.

Notes – Additional Clarification

Follow HEDIS specifications for measure FUM. Plans must use a HEDIS certified vendor/auditor to complete this measure.

This measure is both a key performance indicator and a Performance Withhold Program measure.

2.1 Reassessments

Measure Steward: DMAS

Frequency: Quarterly (Based on State Fiscal Year)

Due Date: End of second month following reporting period:

State Fiscal Quarters:

Q1 = July – September (Due November 30th)
Q2 = October – December (Due February 28th)
Q3 = January – March (Due May 31st)
Q4 = April – June (Due August 31st)

Measure Description

The rate at which members who were due a routine health risk reassessment during the reporting period had a reassessment 1) completed during the reporting period and 2) completed by the due date.

Eligible population

Members for whom a routine reassessment was due to be completed during the reporting period based on the member's subpopulation classification and most recent health risk assessment completion date as of the start of the reporting period.

Also include those members who met the above condition during the preceding reporting period for whom a reassessment was not completed during that reporting period (i.e., members whose routine reassessment was overdue as of the start of the current reporting period).

Exclusions:

- Members who experienced a triggering event for reassessment on or before the due date of an otherwise required routine reassessment that had been due during the reporting period but which was not completed.

- Members who were disenrolled on or before the due date of an otherwise required routine reassessment that had been due during the reporting period but which was not completed.

Denominator

Eligible population.

Numerators

Numerator 1:

Members of the eligible population who had a routine reassessment completed during the reporting period.

Numerator 2:

Members of the eligible population who had a routine reassessment completed during the reporting period by the due date of the reassessment.

Notes – Additional Clarification

Use the reporting template supplied by DMAS for submitting measure results. Instructions for submission are included within the template.

This measure is a key performance indicator.

2.2 Documentation of Care Goals

Measure Steward: DMAS

Frequency: Quarterly (Based on State Fiscal Year)

Due Date: End of second month following reporting period:
State Fiscal Quarters:
Q1 = July – September (Due November 30th)
Q2 = October – December (Due February 28th)
Q3 = January – March (Due May 31st)
Q4 = April – June (Due August 31st)

Measure Description

Members for whom CCC Plus model of care member care goals have been documented as part of their individualized care plan (ICP).

Eligible population

Members for whom an ICP was completed during the reporting period.

Exclusions:

Members who are incapable of participating in their care plans and have no authorized representatives to participate on their behalf.

Denominator

Eligible population.

Numerator

Members for whom care goals based on the requirements of the CCC Plus model of care were documented in the course of ICP completion.

Notes – Additional Clarification

Results for this measure such as "not applicable" or "no care goals at this time" will not count as documented care goals for the numerator.

Use the reporting template supplied by DMAS for submitting measure results. Instructions for submission are included within the template.

This measure is a key performance indicator.

2.3 Advance Planning Directives Counseling

Measure Steward: DMAS

Frequency: Annual (Based on Calendar Year)

Due Date: March 31st following the measurement year

Measure Description

Members who have received advance planning directives counseling.

Eligible population

Active members as of the end of the measurement year.

Continuous enrollment: The last 6 months of the measurement year.

Denominator

Eligible population.

Numerator

Members who have received advance planning directives counseling.

Notes – Additional Clarification

Use the reporting template supplied by DMAS for submitting measure results. Instructions for submission are included within the template.

2.4 Notification of Transition between SUD Levels of Care (Measure eliminated effective 7/15/19)

2.5 Discharge Planning (Measure eliminated effective 7/15/19)

2.6 Timely Transmission of Transition Record (Measure eliminated effective 7/15/19)

2.7 Notification of Transition between Nursing Facility and Community (Measure eliminated effective 6/1/19)

2.8 Nursing Facility Options Counseling (Measure eliminated effective 7/15/19)

2.9 CCC Plus Waiver Members Who Re-entered the Community after a Short-Term Nursing Facility Stay

Measure Steward: DMAS

Frequency: Quarterly (Based on State Fiscal Year)

Due Date: N/A

Note: DMAS will calculate this measure. No submission is required.

Measure Description

CCC Plus waiver members who were admitted to a nursing facility and returned to the community following a stay of less than 90 days.

Eligible population

CCC Plus waiver members who entered a nursing facility during the reporting period.

Continuous enrollment: At least 89 days following admission to a nursing facility.

Denominator

Eligible population.

Numerator

Members who re-entered the community following a nursing facility stay of less than 90 days.

Notes – Additional Clarification

This measure is a key performance indicator.

2.10 Members Who Transitioned from a Nursing Facility to the Community Who Returned to the Nursing Facility within 90 Days

Measure Steward: DMAS

Frequency: Quarterly (Based on State Fiscal Year)

Due Date: N/A

Note: DMAS will calculate this measure. No submission is required.

Measure Description

Members who transitioned from a nursing facility to the CCC Plus waiver and then returned to a nursing facility less than 90 days after the transition.

Eligible population

Members who transitioned from a nursing facility to the CCC Plus waiver during the reporting period.

Continuous enrollment: At least 89 days following the transition from a nursing facility to the CCC Plus waiver.

Denominator

Eligible population.

Numerator

Members who returned to a nursing facility after less than 90 days in the CCC Plus waiver.

Notes – Additional Clarification

This measure is a key performance indicator.

2.11 Members Who Transitioned from a Nursing Facility to the CCC Plus Waiver and Remained in the Waiver for at Least One Year

Measure Steward: DMAS

Frequency: Quarterly (Based on State Fiscal Year)

Due Date: N/A

Note: DMAS will calculate this measure. No submission is required.

Measure Description

Members who transitioned from a nursing facility to the CCC Plus waiver and remained in the waiver for at least one year.

Eligible population

Members who transitioned from a nursing facility to the CCC Plus Waiver between 12 and 15 months prior to the end of the reporting period (see notes below).

Continuous enrollment: From 30 days prior to the transition from a nursing facility to the CCC Plus waiver and for 12 months following the transition.

Denominator

Eligible population.

Numerator

Members who remained in the CCC Plus waiver continuously for at least one year following transition from a nursing facility.

Notes – Additional Clarification

This measure will require a look-back period of 15 months prior to the end of the reporting period.

Example:

| Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | . . . | Jan | Feb | Mar | Measure due April 30

|----------| Member transitioned to CCC Plus waiver

|----------| Evaluate for retention in waiver

| Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | . . . | Apr | May | Jun | Measure due July 31

|----------| Member transitioned to CCC Plus waiver

|----------| Evaluate for retention in waiver

This measure is a key performance indicator.

2.12 CCC Plus Waiver Members Who Transitioned to a Nursing Facility and Remained in a Nursing Facility for at Least 180 Days

Measure Steward: DMAS

Frequency: Quarterly (Based on State Fiscal Year)

Due Date: N/A

Note: DMAS will calculate this measure. No submission is required.

Measure Description

CCC Plus waiver members who transitioned to a nursing facility and remained in a nursing facility for at least 180 days following that transition.

Eligible population

Members who transitioned from the CCC Plus waiver to a nursing facility between 6 and 9 months prior to the end of the reporting period (see notes below).

Continuous enrollment: 180 days following transition to a nursing facility.

Denominator

Eligible population.

Numerator

Members who remained in a nursing facility continuously for at least 180 days following a transition from the CCC Plus waiver.

Notes – Additional Clarification

This measure will require a look-back period of 9 months prior to the end of the reporting period. Example:

| Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Measure due October 31

|----------| Member transitioned to nursing facility

|----------| Evaluate for retention in nursing facility

| Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Measure due January 31

|----------| Member transitioned to nursing facility

|----------| Evaluate for retention in nursing facility

This measure is a key performance indicator.

2.13 Follow-up after Discharge

Measure Steward: DMAS

Frequency: Quarterly (Based on State Fiscal Year)

Due Date: End of third month following reporting period:
State Fiscal Quarters:
Q1 = July – September (Due December 31st)
Q2 = October – December (Due March 31st)
Q3 = January – March (Due June 30th)
Q4 = April – June (Due September 30th)

Measure Description

The number of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge.

Eligible population

Members discharged from a hospital during the reporting period who were either non-dual eligible members or dual eligible members whose CCC Plus health plan also served as their Medicare managed care health plan.

Continuous enrollment: From discharge date through 30 days following discharge date.

Denominator

Number of discharges from a hospital during the reporting period. Exclude discharges followed by readmission within 30 days and discharges due to death.

Numerator

Of the discharges reported in the denominator, the number of discharges where the member had an ambulatory follow-up visit within 30 days of discharge to assess the member's health.

Notes – Additional Clarification

Plans may have to look beyond the reporting period for follow-up visits if the discharge occurred less than 30 days prior to the end of the reporting period.

Identify hospital stays using the following UB Revenue codes:

0100	0117	0126	0134	0142	0151	0160	0193	0206	0213
0101	0118	0127	0136	0144	0152	0164	0194	0207	0214
0110	0119	0128	0137	0146	0154	0167	0199	0208	0219
0111	0120	0129	0138	0147	0156	0169	0200	0209	1000

0112	0121	0130	0139	0148	0157	0190	0201	0210	1001
0114	0122	0131	0140	0149	0158	0191	0202	0211	1002
0116	0124	0132	0141	0150	0159	0192	0204	0212	

Identify ambulatory visits using the following CPT or HCPCS codes:

CPT Codes		
99201	99309	99348
99202	99310	99349
99203	99315	99350
99204	99316	99385
99205	99318	99386
99211	99324	99387
99212	99325	99395
99213	99326	99396
99214	99327	99397
99215	99328	99401
99241	99334	99402
99242	99335	99403
99243	99336	99404
99244	99337	99411
99245	99341	99412
99304	99342	99429
99305	99343	99495
99306	99344	99496
99307	99345	
99308	99347	

HCPCS Codes	
G0402	G0463

Use the reporting template supplied by DMAS for submitting measure results. Instructions for submission are included within the template.

3.1 Adult BMI Assessment (Measure eliminated 2/16/2021).

3.2 Breast Cancer Screening

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year

The first submission of this measure will not be due until 2020 due to the continuous enrollment requirement.

Measure Description

The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.

Endorsed by NQF as measure #2372.

Notes – Additional Clarification

Follow HEDIS specifications for measure BCS. Plans must use a HEDIS certified vendor/auditor to complete this measure.

This measure is a key performance indicator.

3.3 Cervical Cancer Screening

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year

Measure Description

The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21–64 who had cervical cytology performed every 3 years.
- Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.

Endorsed by NQF as measure #0032.

Notes – Additional Clarification

Follow HEDIS specifications for measure CCS. Plans must use a HEDIS certified vendor/auditor to complete this measure.

This measure is a key performance indicator.

3.4 Colorectal Cancer Screening

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year.

The first submission of this measure will not be due until 2020 due to the continuous enrollment requirement.

Measure Description

The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.

Endorsed by NQF as measure #0034.

Notes – Additional Clarification

Follow HEDIS specifications for measure COL. Plans must use a HEDIS certified vendor/auditor to complete this measure.

Because this measure is not standard for Medicaid, it is not part of the IDSS submission. Report this measures using the report template located on SharePoint.

This measure is a key performance indicator.

3.5 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year

Measure Description

The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year.

- BMI percentile documentation*.
- Counseling for nutrition.
- Counseling for physical activity.

**Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.*

Endorsed by NQF as measure #0024.

Notes – Additional Clarification

Follow HEDIS specifications for measure WCC. Plans must use a HEDIS certified vendor/auditor to complete this measure.

This measure is a key performance indicator.

3.6 Medical Assistance with Smoking and Tobacco Use Cessation

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year

Measure Description

The following components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation:

Advising Smokers and Tobacco Users to Quit	A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year.
Discussing Cessation Medications	A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.
Discussing Cessation Strategies	A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.

Endorsed by NQF as measure #0027.

Notes – Additional Clarification

Follow HEDIS specifications for measure MSC. Plans must use a HEDIS certified vendor/auditor to complete this measure.

This measure is a key performance indicator.

3.7 Screening for Clinical Depression and Follow-up Plan – *measure suspended*

Measure Steward: CMS

Frequency: Annual (Based on Calendar Year)

Due Date: *This measure is under review and has been suspended until further notice. No submission is required at this time.*

Measure Description

Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if screening is positive, have had a follow-up plan documented on the date of the positive screen

See CMS specifications for measure CMS2v7. Endorsed by NQF as measure #0418.

Notes – Additional Clarification

Follow specifications on the National Quality Forum website for measure #0418 with the following modification:

> Denominator: The denominator statement has been changed to read as follows:
>
> Denominator includes all patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period.

This measure will only apply to non-dual eligible members and dual eligible members whose CCC Plus health plan also serves as their Medicare managed care health plan.

Use the reporting template supplied by DMAS for submitting measure results. Instructions for submission are included within the template.

Additional guidance from CMS (from ECQI Resource Center):

A depression screen is completed on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, either additional evaluation for depression, suicide risk assessment, referral to a practitioner who is qualified to diagnose and treat depression, pharmacological interventions, or other interventions or follow-up for the diagnosis or treatment of depression is documented on the date of the positive screen.

Screening Tools:

- The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record
- The depression screening must be reviewed and addressed in the office of the provider, filing the code, on the date of the encounter
- The screening should occur during a qualified encounter

- Standardized Depression Screening Tools should be normalized and validated for the age appropriate patient population in which they are used and must be documented in the medical record

Follow-Up Plan:

- The follow-up plan must be related to a positive depression screening, example: Patient referred for psychiatric evaluation due to positive depression screening.
- Pharmacologic treatment for depression is often indicated during pregnancy and/or lactation. Review and discussion of the risks of untreated versus treated depression is advised. Consideration of each patient's prior disease and treatment history, along with the risk profiles for individual pharmacologic agents, is important when selecting pharmacologic therapy with the greatest likelihood of treatment effect.

3.8 Childhood Immunization Status

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year

Measure Description

The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.

Endorsed by NQF as measure #0038.

Notes – Additional Clarification

Follow HEDIS specifications for measure CIS. Plans must use a HEDIS certified vendor/auditor to complete this measure.

3.9 Immunizations for Adolescents

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year

Measure Description

The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine and three doses of the human papillomavirus (HPV) vaccine by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.

Notes – Additional Clarification

Follow HEDIS specifications for measure IMA. Plans must use a HEDIS certified vendor/auditor to complete this measure.

3.10 Alcohol Screening and Follow-up for People with Serious Mental Illness (Measure eliminated effective 7/15/19)

3.11 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

Measure Steward: NCQA

Frequency: Annual (Based on Calendar Year)

Due Date: July 31 following the measurement year

Measure Description

The percentage of members 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Endorsed by NQF as measure #1932.

Notes – Additional Clarification

Follow HEDIS specifications for measure SSD. Plans must use a HEDIS certified vendor/auditor to complete this measure.

3.12 Comprehensive Diabetes Care: Foot Exam (Measure eliminated effective 6/1/19)

4.1 Prevalence of Pressure Ulcers among LTSS Members

Measure Steward: DMAS

Frequency: Quarterly (Based on State Fiscal Year)

Due Date: End of third month following reporting period:

State Fiscal Quarters:

Q1 = July – September (Due December 31st)
Q2 = October – December (Due March 31st)
Q3 = January – March (Due June 30th)
Q4 = April – June (Due September 30th)

Measure Description

Occurrence of pressure ulcers among members of the following subpopulations:

- Long stay nursing facility members
- Short stay nursing facility members
- CCC Plus waiver members

Eligible population

Members who were residing in a nursing facility or enrolled in the CCC Plus waiver during the reporting period.

Continuous enrollment:

Denominator 1: The last 90 days of the nursing facility stay.
Denominator 2: The entire nursing facility stay

Denominators

Denominator 1:

Members with a nursing facility stay that exceeded 89 days, at least part of which occurred during the reporting period.

Denominator 2:

Members with a nursing facility stay, at least part of which occurred during the reporting period, that did not exceed 89 days at any point during the reporting period. Count a member once for each such nursing facility stay.

Denominator 3:

Members who were enrolled in the CCC Plus waiver at any time during the reporting period.

Numerators

Numerator 1:

Members with a pressure ulcer that was newly diagnosed during the reporting period after the member had resided more than 89 consecutive days in a nursing facility (subset of denominator 1).

Numerator 2:

Members with a pressure ulcer that was newly diagnosed or, if existing at the start of the reporting period, worsened, during the reporting period following admission to a nursing facility (whether in the current or preceding reporting period) for a stay that did not exceed 89 days at any point during the reporting period (subset of denominator 2). Count a member once for each nursing facility stay included in denominator 2 during which a pressure ulcer was either newly diagnosed or worsened.

Numerator 3:

Members with a pressure ulcer that was newly diagnosed during the reporting period while enrolled in the CCC Plus waiver (subset of denominator 3).

Notes – Additional Clarification

For each numerator, plans must report all pressure ulcers newly diagnosed in the designated setting during the reporting period regardless of any prior setting or reporting period in which a pressure ulcer may have originated.

If claims are used to identify members with newly diagnosed ulcers, the following code values for diagnosis or treatment are applicable:

- ICD-CM-10: in the range L89000 – L8995
- CPT: in the range 15920 - 1599

Plans may use health risk assessment (HRA) data to identify members with pressure ulcers that were newly developed or worsened during the reporting period while those members resided in a nursing facility. All members who resided in a nursing facility at any time during the reporting period should have had either an initial HRA or a reassessment completed during the following quarter or upon discharge from the nursing facility to another care setting during the reporting period (with the exception of members who were disenrolled prior to completion of either an initial HRA or reassessment).

It is not expected that plans will have completed all initial HRAs and reassessments noted above in time to be included in the calculation of this measure. Plans are expected to use any HRA data that is available to them at the time the measure is calculated.

Use the reporting template supplied by DMAS for submitting measure results. Instructions for submission are included within the template.

4.2 Critical Incidents and Abuse (Measure eliminated effective 7/15/19)

4.3 Injury Prevention

Measure Steward: DMAS

Frequency: Quarterly (Based on State Fiscal Year)

Due Date: End of third month following reporting period:
State Fiscal Quarters:
Q1 = July – September (Due December 31st)
Q2 = October – December (Due March 31st)
Q3 = January – March (Due June 30th)
Q4 = April – June (Due September 30th)

Measure Description

Members who did not experience any injuries requiring medical attention during the reporting period.

Eligible population

All members enrolled during the reporting period who were either non-dual eligible members or dual eligible members whose CCC Plus health plan also served as their Medicare managed care health plan.

Continuous enrollment: The reporting period.

Denominator

Eligible population.

Numerator

Members who had no injuries requiring medical attention during the reporting period.

Notes – Additional Clarification

An injury is defined as any physical damage caused to the body by violence or accident. Injuries may be identified by any ICD-10-CM code falling within, but not limited to, the range S00-Y99.

Use the reporting template supplied by DMAS for submitting measure results. Instructions for submission are included within the template.

Sampling Methodology

Step 1: Determine the *Eligible Population*. Create a list of eligible members, including full name, date of birth, and event (if applicable).

Step 2: Determine the *Final Sample Size*. The *Final Sample Size* will be 411 plus an adequate number of additional records to make substitutions. Oversample only enough to guarantee that the targeted sample size of 411 is met. The following oversampling rates are acceptable: 5 percent, 10 percent, 15 percent, or 20 percent. If oversampling, round up to the next whole number when determining the final sample size.

Step 3: If the *Eligible Population* exceeds the *Final Sample Size* as determined in Step 2, proceed to Step 5.

Step 4: If the *Eligible Population* is less than or equal to the *Final Sample Size* as determined in Step 2, the *Final Sample Size* can be reduced from 411 cases to a reduced *Final Sample Size* by using the following formula:

$$\text{Reduced } \textit{Final Sample Size} = \frac{\text{Original } \textit{Final Sample Size}}{1 + \left(\frac{\text{Original } \textit{Final Sample Size}}{\textit{Eligible Population}} \right)}$$

where the original *Final Sample Size* is the number derived from Step 2, and the *Eligible Population* is the number derived from Step 1.

Step 5: Sort the list of eligible members in alphabetical order by last name, first name, date of birth and event (if applicable). Sort this list by last name from A to Z during even reporting years and from Z to A in odd reporting years (i.e., name will be sorted from A to Z in 2018, 2020, and 2022 and from Z to A in 2019, 2021, and 2023.

Note: Sort order applies to all components. For example, for reporting period 2018, last name, first name, date of birth, and events will all be sorted in ascending order.

Step 6: Calculate *N*, which will determine which member will start your sample. Round down to the nearest whole number.

$$N = \frac{\textit{Eligible Population}}{\textit{Final Sample Size}}$$

where *Eligible Population* is the number derived from Step 1. The *Eligible Population* is either:

The number derived from Step 2, for instances in which the

Eligible Population exceeds the *Final Sample Size* as determined in Step 2.

OR

The number derived in Step 4, for instances in which the *Eligible Population* was less than or equal to the number derived from Step 2.

Step 7: Randomly select starting point *k* by choosing a number between one and *N* using a table of random numbers or a computer-generated random number.

Step 8: Select every *kth* record thereafter until the selection of the sample is completed

Revised CY 2019 and SFY 2021 CCC Plus Performance Withhold Program Methodology

Project Overview

The Virginia Department of Medical Assistance Services (DMAS) contracted with Health Services Advisory Group, Inc. (HSAG), as their External Quality Review Organization (EQRO), to establish, implement, and maintain a scoring mechanism, for the managed care Performance Withhold Program (PWP). For the PWP, Commonwealth Coordinated Care Plus (CCC Plus) managed care organizations' (MCOs') performance is evaluated on four National Committee for Quality Assurance's (NCQA's) Healthcare Effectiveness Data and Information Set (HEDIS®) measures[1] and two Centers for Medicare and Medicaid Services' (CMS') Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) measures. HSAG is responsible for collecting MCOs' audited HEDIS measure rates and the CMS Adult Core Set measure rates from DMAS. HSAG will validate the two CMS Adult Core Set measures in accordance with *External Quality Review (EQR) Protocol 2: Validation of Performance Measures: A Mandatory Protocol for External Quality Review (EQR)*, October 2019.[2] HSAG will derive PWP scores for each measure and calculate the portion of the 1 percent quality withhold earned back for each MCO.

The following sections provide the PWP calculation methodology for calendar year (CY) 2019 and State Fiscal Year (SFY) 2021. **Due to the impacts of the Coronavirus Disease 2019 (COVID-19) pandemic on MCOs' abilities to collect and report data, as well as DMAS' ability to appropriately evaluate performance levels and improvement, DMAS has determined that both CY 2019 and SFY 2021 will be pay-for-reporting years for the PWP**; therefore, the MCOs are eligible to earn back all or a portion of their quality withhold based solely on their ability to sufficiently report the required measure rates. DMAS and HSAG will assess the methodology for SFY 2022 once additional information becomes available.

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

[2] Department of Health and Human Services, Centers for Medicare and Medicaid Services. *EQR Protocol 2: Validation of Performance Measures: A Mandatory Protocol for External Quality Review (EQR)* 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jun 1, 2020.

Performance Measures

DMAS selected the following HEDIS measures and CMS Adult Core Set measures for the CY 2019 PWP, as indicated in Table 1.

Table 1—CY 2019 PWP Measures

Indicator	Measure Specification	Required Reporting Method
Behavioral Health		
Follow-Up After Emergency Department (ED) Visit for Alcohol and Other Drug (AOD) Abuse or Dependence—7-Day Follow-Up—Total	HEDIS	Administrative
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total	HEDIS	Administrative
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total	HEDIS	Administrative
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total	HEDIS	Administrative
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Total	HEDIS	Administrative
Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Total	HEDIS	Administrative
Chronic Conditions		
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing	HEDIS	Hybrid
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	HEDIS	Hybrid
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	HEDIS	Hybrid
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	HEDIS	Hybrid
Comprehensive Diabetes Care—Medical Attention for Nephropathy	HEDIS	Hybrid
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	HEDIS	Hybrid
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)—Total	CMS Adult Core Set	Administrative
Heart Failure Admission Rate (Per 100,000 Member Months)—Total	CMS Adult Core Set	Administrative

DMAS selected the following HEDIS measures and CMS Adult Core Set measures for the SFY 2021 PWP, as indicated in Table 2, on the next page. Due to measure specification changes made by NCQA after the start of the SFY 2021 measurement period, DMAS must make conforming changes to both the SFY 2021 PWP measures (Table 2) and corresponding measure weights (Table 5). These adjustments address NCQA's decision to retire the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* indicator.

Table 2—SFY 2021 PWP Measures

Indicator	Measure Specification	Required Reporting Method
Behavioral Health		
Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total	HEDIS	Administrative
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total	HEDIS	Administrative
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total	HEDIS	Administrative
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total	HEDIS	Administrative
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Total	HEDIS	Administrative
Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Total	HEDIS	Administrative
Chronic Conditions		
Comprehensive Diabetes Care—HbA1c Testing	HEDIS	Hybrid
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	HEDIS	Hybrid
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	HEDIS	Hybrid
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	HEDIS	Hybrid
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	HEDIS	Hybrid
COPD or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)—Total	CMS Adult Core Set	Administrative
Heart Failure Admission Rate (Per 100,000 Member Months)—Total	CMS Adult Core Set	Administrative

Performance Period

The CY 2019 PWP assesses CY 2019 performance measure data (i.e., the performance measures will be calculated following HEDIS 2020 and CMS federal fiscal year [FFY] 2020 Adult Core Set specifications that use a CY 2019 measurement period) to determine what portion, if any, the MCOs will earn back from the funds withheld in CY 2019 (i.e., the 1 percent of capitation payments withheld from January 1, 2019 through December 31, 2019). The SFY 2021 PWP assesses CY 2020 performance measure data (i.e., the performance measures will be calculated following the HEDIS measurement year [MY] 2020 and CMS FFY 2021 Adult Core Set specifications that use a CY 2020 measurement period) to determine what portion, if any, the MCOs will earn back from the funds withheld from an 18-month period from January 1, 2020 through June 30, 2021. This one-time withhold window spanning 18 months is necessary to align the PWP program with the movement of the CCC Plus contract from a CY to SFY schedule. Subsequent withholding periods will cover the 12 months of the SFY.

Data Collection

The HEDIS Interactive Data Submission System (IDSS) files for the PWP calculation will be audited as required by NCQA. The auditor-locked IDSS files containing the HEDIS measure rates will be provided to HSAG by the MCOs. Starting with the CY 2019 PWP, DMAS will contract with HSAG, as their EQRO, to validate the two CMS Adult Core Set measures (two measure indicators) in accordance with *EQR Protocol 2: Validation of Performance Measures: A Mandatory Protocol for External Quality Review (EQR)*, October 2019. Following the performance measure validation, HSAG will provide the true, audited rates for the two CMS Adult Core Set measures (two measure indicators) to DMAS.

PWP Calculation

The following sections provide a detailed description of the PWP scoring and quality withhold funds model for the CY 2019 PWP and SFY 2021 PWP. With receipt of audited HEDIS measure rates and validated CMS Adult Core Set measure rates (i.e., non-HEDIS measure rates), each measure will be scored prior to calculating the amount of the quality withhold, if any, each MCO will earn back. Table 3 provides the HEDIS and non-HEDIS audit designations that will be eligible or ineligible to receive points in the PWP.

Table 3—HEDIS and Non-HEDIS Audit Designations

HEDIS Audit Designation	Non-HEDIS Audit Designation
Eligible for Points in CCC Plus PWP Analysis	
Reportable (R)	Reportable (R)
Small Denominator (NA)	
Ineligible for Points CCC Plus PWP Analysis	
Biased Rate (BR)	Do Not Report (DNR)
Not Required (NQ)	Not Applicable (NA)
No Benefit (NB)	No Benefit (NR)
Not Reported (NR)	
Unaudited (UN)	

As indicated in Table 3, only measure rates with a "*Reportable* (*R*)" (HEDIS and non-HEDIS rates) audit result (i.e., the plan produced a reportable rate for the measure in alignment with the technical specifications) or "*Small Denominator (NA)*" (HEDIS rates only) audit result (i.e., the plan followed the specifications but the denominator was too small to report a valid rate) will be included in the PWP calculation. Measure rates with the following audit results will receive a score of zero (i.e., the MCO will not be eligible to earn a portion of the quality withhold back for that measure):

- "*Biased Rate (BR)*" audit result for HEDIS measures or "*Do Not Report (DNR)*" audit result for non-HEDIS measures (i.e., the calculated rate was materially biased)
- "*Not Required (NQ)*" audit result for HEDIS measures or "*Not Applicable (NA)*" audit result for non-HEDIS measures (i.e., the plan was not required to report the measure)
- "*No Benefit (NB)*" audit result for HEDIS measures or "*No Benefit (NR)*" for non-HEDIS measures (i.e., the measure was not reported because the plan did not offer the required benefit)

- "*Not Reported (NR)*" audit result for HEDIS measures (i.e., the plan chose not to report the measure)
- "*Unaudited (UN)"* audit result for HEDIS measures (i.e., the measure was not audited)

CY 2019 PWP

As indicated above, scoring for the CY 2019 PWP will be based on whether the MCO reported valid HEDIS 2020 measure rates to NCQA in the required reporting method as indicated in Table 1 (i.e., hybrid for *Comprehensive Diabetes Care* and administrative for the remaining measures) and whether the MCO received an allowable audit designation as indicated in Table 3. For example, if the MCO receives a "*Reportable* (*R*)" audit designation for the applicable HEDIS measures and CMS Adult Core Set measures, then the MCO will earn back their entire quality withhold. However, if the MCO received any of the ineligible audit designations outlined in Table 3 then the MCO will not earn back the portion of their quality withhold attributed to that measure (e.g., if the MCO receives a "*Biased Rate* (*BR*)" audit designation for the *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Total* HEDIS measure, then the MCO would not receive the 7.5 percent of withheld funds associated with that measure). Table 4 shows the percentage of withhold associated with each performance measure indicator.

Table 4—CY 2019 PWP Measure Weights

Indicator	Measure Weight
Behavioral Health	
Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total	7.5%
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total	7.5%
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total	10%
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total	10%
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Total	7.5%
Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Total	7.5%
Chronic Conditions	
Comprehensive Diabetes Care—HbA1c Testing	3.33%*
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	3.33%*
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	3.33%*
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	3.33%*
Comprehensive Diabetes Care—Medical Attention for Nephropathy	3.33%*
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	3.33%*
COPD or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)—Total	15%
Heart Failure Admission Rate (Per 100,000 Member Months)—Total	15%

**The Comprehensive Diabetes Care (CDC) measure has a total weight of 20 percent; therefore, each indicator has a weight of 3.33 percent (i.e., 20 percent divided by 6). Please note, the 3.33 percent listed in the table is a rounded value.*

SFY 2021 PWP

The SFY 2021 PWP will be based on the same pay-for-reporting methodology described above for the CY 2019 PWP and will use the MCO's audited HEDIS MY 2020 and validated CMS FFY 2021 Adult Core Set performance measure data. Table 5 shows the percentage of withhold associated with each performance measure indicator.

Table 5—SFY 2021 PWP Measure Weights

Indicator	Measure Weight
Behavioral Health	
Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total	7.5%
Follow-Up After ED Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total	7.5%
Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total	10%
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total	10%
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total—Total	7.5%
Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total—Total	7.5%
Chronic Conditions	
Comprehensive Diabetes Care—HbA1c Testing	4%*
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)	4%*
Comprehensive Diabetes Care—HbA1c Control (<8.0 Percent)	4%*
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	4%*
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	4%*
COPD or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)—Total	15%
Heart Failure Admission Rate (Per 100,000 Member Months)—Total	15%

**The Comprehensive Diabetes Care (CDC) measure has a total weight of 20 percent; therefore, each indicator has a weight of 4 percent (i.e., 20 percent divided by 5).*

Managed Care Aid Categories			
AID_CAT	**DESCRIPTION**	**CCC+**	**MED4**
005	FAMIS MOMS-INC>133% FPL & INC<=166%		Yes
006	FAMIS Child under age 6, income >150% poverty AND <=200% poverty		Yes
007	FAMIS Child 6-19 years OLD, income >150% poverty AND <=200% poverty		Yes
008	FAMIS Child under age 6, income>133% poverty AND <=150% poverty		Yes
009	FAMIS Child 6-19 years OLD, income>133% poverty AND <=150% poverty		Yes
010	FAMIS DEEMED NEWBORN AT OR BELOW 150%FPL		Yes
011	C/N-SSI/QMB AGED	Yes	
012	C/N-AG/QMB AGED	Yes	
014	FAMIS DEEMED NEWBORN ABOVE 150% FPL		Yes
018	M/N-AGED NOT QMB	Yes	
020	C/NNMP-INST/AGED	Yes	
021	C/NNMP-QMB/AGED	Yes	
022	C/NNMP-INST/AQMB	Yes	
024	M/N-AGED SLMB PLUS	Yes	
025	300% SSI AGED SLMB PLUS	Yes	
028	M/N-AGED/DUAL ELIG	Yes	
029	AGED POVERTY-RELATED GROUP	Yes	
031	C/N-SSI/QMB BLIND	Yes	
032	C/N-AG/QMB BLIND	Yes	
038	M/N-BLIND NOT QMB	Yes	
039	BLIND POVERTY-RELATED GROUP	Yes	
040	C/NNMP-INST/BLIND	Yes	
041	C/NNMP-QMB/BLIND	Yes	
042	C/NNMP-INST/QMB	Yes	
044	M/N-BLIND/DISABLED SLMB PLUS	Yes	
045	300% SSI BLIND/DISABLED SLMB PLUS	Yes	
048	M/N-BLIND/DUAL-ELG	Yes	
049	DISABLED POVERTY-RELATED GROUP	Yes	
051	C/N-SSI/QMB-DISAB	Yes	
052	C/N-AG/QMB-DISAB	Yes	
054	HOSPICE PATIENTS	Yes	
058	M/N-DISAB/NOT-QMB	Yes	
059	MEDICAID WORKS	Yes	
060	C/NNMP-INST/DISAB	Yes	
061	C/NNMP-QMB DISAB	Yes	
062	C/NNMP-INST/DQMB	Yes	
066	BCCPTA INDIVIDUAL	Yes	
068	M/N-DISAB/DUAL-ELG	Yes	
070	FORMER FOSTER CARE	Yes	Yes
072	C/NNMP-NON4E CHLD	Yes	Yes
076	C/N/NMP NON4E	Yes	Yes
081	C/NNMP-LIFC QMB	Yes	Yes
082	C/NNMP-INST/CHILD	Yes	
083	C/NNMP LIFC-UP	Yes	Yes

088	M/N-ADC	Yes	
090	C/N-AFDC (TANF)	Yes	Yes
091	M/I-PREG.WOMN/CHLD	Yes	Yes
092	C/NNMP CHILD 6-19	Yes	Yes
093	C/NNMP-LT-1	Yes	Yes
094	CN/NMP CHILD 6-19 INC 100-133% FPL	Yes	Yes
100	CARETAKER ADULT, LE 100% FPL GT LIFC	Yes	Yes
101	CARETAKER ADULT, GT 100% FPL	Yes	Yes
102	CHILDLESS ADULTS, LE 100% FPL	Yes	Yes
103	CHILDLESS ADULTS, GT 100% FPL	Yes	Yes

As of 01/01/2022