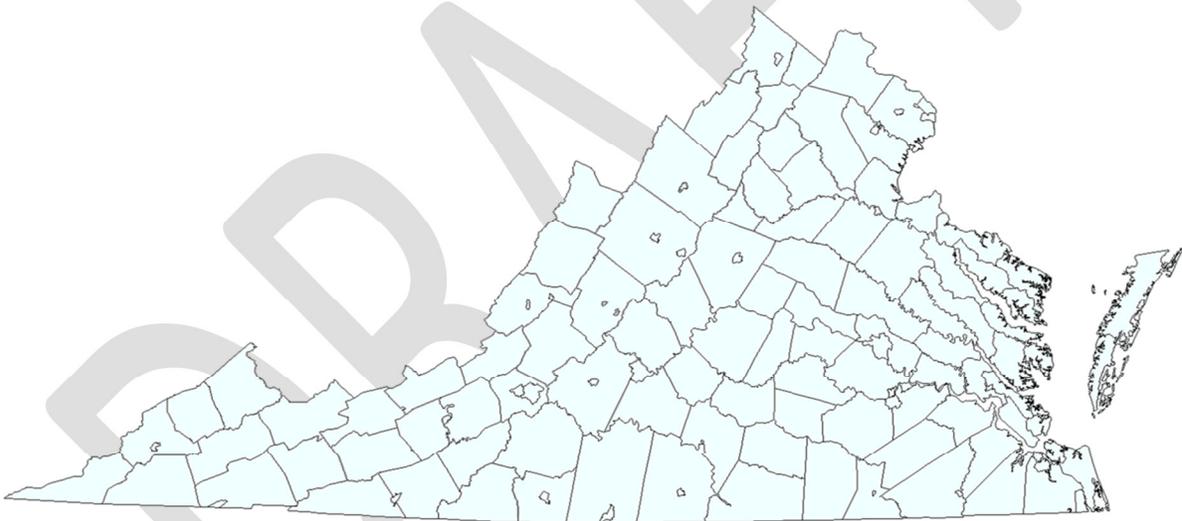


MLTSS

Draft Reporting

Manual 1.0



NOTE: This manual is subject to change and will be finalized with the MLTSS contract. This manual is a work in progress and not all reports are included at this time.

Virginia Department of Medical Assistance
MLTSS Version 1.0 In Draft

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1 Enrollment Roster & Payment Files

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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 834 electronic data interchange (EDI) transaction set to the Contractor. Unless otherwise notified by the Department, these files will be available on the 20th (mid-month) and 2nd (end of month) of each calendar month. The 834 Enrollment Roster shall provide the Contractor with ongoing information about its active and disenrolled members.

The 834 Mid-Month and End of the Month rosters will list all of the Contractor's members for the prospective enrollment month as of the report generation date. The Mid-Month 834 will be provided to the Contractor on the twentieth (20th) day of the month prior to member enrollment. The End of the Month Enrollment Report will be provided to the Contractor on the second (2nd) day of the current member enrollment month.

(Sample shown below):

ELIGIBILITY CUT-OFF	MID-MONTH 834 RUN	MID-MONTH 834 AVAILABILITY	END OF MONTH 834 RUN	END OF MONTH 834 AVAILABILITY
02/16/2016 Tue	02/18/2016 Thu	02/20/2016 Sat	02/29/2016 Mon	03/02/2016 Wed
03/16/2016 Wed	03/18/2016 Fri	03/20/2016 Sun	03/31/2016 Thu	04/02/2016 Sat
04/16/2016 Sat	04/18/2016 Mon	04/20/2016 Wed	04/30/2016 Sat	05/02/2016 Mon
05/16/2016 Mon	05/18/2016 Wed	05/20/2016 Fri	05/31/2016 Tue	06/02/2016 Thu
06/16/2016 Thu	06/18/2016 Sat	06/20/2016 Mon	06/30/2016 Thu	07/02/2016 Sat

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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

(Sample shown below):

CAPITATION 820 RUN	CAPITATION 820 AVAILABILITY	CAPITATION CHECK DATE
02/26/2016 Fri	02/29/2016 Mon	03/04/2016 Fri
03/25/2016 Fri	03/28/2016 Mon	04/01/2016 Fri
04/29/2016 Fri	05/02/2016 Mon	05/06/2016 Fri
05/27/2016 Fri	05/30/2016 Mon	06/03/2016 Fri
06/24/2016 Fri	06/27/2016 Mon	07/01/2016 Fri

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1.2.1 Capitation Payment Remittance (820) – “Best Practices” in Reconciliation

- If the MCO receives payment on the 820 file for a member that was not listed on the previous 834 enrollment file, the member is retroactively enrolled to the MCO for the dates listed.
- If the MCO 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 MCO must research the member on the DMAS eligibility website. If the member is no longer eligible on the website, the MCO will terminate the member. However, if the member still is shown as active on the website, the member will not be terminated.

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2 MCO Contract Deliverables

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2.1 Reporting Standards

DMAS **strongly recommends** that the MCOs develop automated reporting processes for each deliverable in order to maintain the consistency and accuracy of ongoing deliverable submissions. It has been DMAS' experience that manual reporting processes are prone to errors and inconsistencies. DMAS also recommends that each MCO develop and implement standardized processing for each deliverable submission, including comprehensive quality control procedures to ensure data integrity and accuracy. Please note there are additional quality MLTSS performance measures that will be added to this manual.

All deliverable submissions must conform to the specifications documented in the current version of this Technical Manual, including all documented formatting requirements. It is the MCO'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 MCO will be required to correct and re-submit deliverables as necessary to comply with the reporting requirements set forth in this document.

DMAS will post the current version of the MLTSS Technical Manual on the Virginia Medicaid MLTSS web site, and also in the report directory of the DMAS secure MLTSS FTP server. The version number of the MLTSS Technical Manual will be incremented whenever any change is made within the document. Every change will be documented in the 'Version Change Summary' section at the front of the document.

The MLTSS Technical Manual will be updated no more frequently than monthly. The revised MLTSS Technical Manual will be posted to the MLTSS web site and to the FTP server no later than the last calendar day of each month. The MCOs must check the web site or server at the beginning of each month to ensure that they are using the most current version of the program specs for their next submission to DMAS.

This reporting manual is released in draft. It may not contain the entire reporting requirement in the to be final MLTSS contract. This manual will be finalized with MLTSS contract. DMAS reserves the right to request ad hoc reports. These reports may include those described in the MLTSS Technical Manual outside the regular submission schedule as well as others not covered in the manual. Upon such request, MLTSS Health Plans will be given a reasonable amount of time for ad hoc report submission.

Encounter submission and reporting will be outlined in separate document outside of this reporting manual. To support health plan readiness, additional reporting requirements will be required, such as provider network file submission, which are all outside the scope of this reporting manual.

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2.1.1 DMAS secure MLTSS FTP server

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

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

When the files are moved to the DMAS' local intranet server, the system assigns a prefix to the MCO file that allows DMAS to identify which MCO sent the file. The system also assigns a date and time stamp within the filename prefix that identifies when the file was originally posted to the server by the MCO.

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2.1.2 Deliverable Scoring

DMAS will evaluate each deliverable submission and assign a numeric score based on the whether the submission meets all of the reporting parameters specified for that deliverable in this document. Scoring will be on a 100 point scale. The grading scale is as follows:

- A: ≥ 91
- B: ≥ 81 and < 91
- C: ≥ 71 and < 81
- D: ≥ 61 and < 71
- F: < 61
- 0: = 0

2.1.2.1 Transmittal Requirements

Any deliverable submission that does not meet the basic transmittal requirements set forth for the deliverable will be scored as a zero. In particular, each of the following requirements must be met in order for a submission to be accepted by DMAS for processing:

- Submission must be transmitted via the method specified for the deliverable (e.g., DMAS secure FTP).
- File must be formatted as specified for the deliverable (e.g., comma separated values, Excel 2007, 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, and no additional columns/ fields are included. Do not include a header row in .csv files. If there is no data to report for a specific report, submit the report but leave it blank without headers or any other text.
- Except as otherwise specified, only one consolidated deliverable per report cycle is submitted. The MCO cannot submit separate deliverables for their subcontractor(s).

2.1.2.2 Timeliness

Points will be deducted if the deliverable is submitted after the specified due date. For each business day late, the overall score will be reduced by ten (10) points. Note that the cut-off for delivery via the DMAS secure FTP is 6:00 PM EST each day.

2.1.2.3 Field-Level Editing

All deliverables that meet the Transmittal Requirements will be edited for compliance with the specific field-level format and content criteria specified for the particular report. Additional scoring deductions will be applied based on the criteria specified for the report.

2.1.2.4 Report Card Generation Schedule

The standard schedule for generation of the report cards is as follows:

- Preliminary report cards are generated on the morning of the 15th and returned to the MCOs via FTP in the mid-day batch transfer. This allows several hours for the MCO to make corrections if necessary and re-submit prior to the cut-off at close of business on the 15th.

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- Report cards are generated again on the morning of the 16th using the most recent MCO submissions received via the batch transfer process. These report cards are returned to the MCOs via FTP in the mid-day batch transfer. If the MCO did not resubmit any deliverables, their scores will be the same as the report generated previously on the 15th. This is the first 'official' report card.
- On the 16th, the MCO can submit correction (replacement) file(s) if desired. However, note that when a deliverable is submitted or re-submitted after the cut-off on the 15th, the grade for that deliverable on the report card will be adjusted according to the editing and timeliness criteria specified above. It is DMAS' intent for all reports to be submitted according to the specified standards prior to the deadline on the 15th as specified in the MLTSS contract.
- DMAS will run the report card generation process up to a total of 5 business days in order to collect all corrections submitted by the MCOs. The report grades are not final until the end of this period or until all MCOs have completed all submissions (whichever is earlier).
- Report cards are not generated on weekends or state holidays. The delivery schedule is adjusted accordingly for these events. For example, if the 15th falls on a Sunday, deliverables are not due until close of business on the 16th.

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2.1.3 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'.

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2.1.4 Quality Performance Measure Reporting

As part of the MLTSS reporting requirements, quality performance measures reporting will be required to cover the following 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

Among the above four domains, DMAS further identify five priority areas. DMAS then selected measures that align with federal, state and MLTSS quality improvement aims and priorities under each of the five priority areas. These measures are listed below within the MLTSS Core Measures List. Final core measure specifications including detail measure definitions, reporting beginning date, frequency, due date, data elements, and additional notes will be released as part of the final MLTSS Reporting Manual or separate quality reporting requirement document included in MLTSS contract. Please note DMAS reserves the right to add or delete measures listed in the attached MLTSS Core Measures List.

MLTSS Core Measures List

Measure Name (NQF # if any)	Description	Measure Steward	Data Source
Priority One: Access, Disease Management and Service Utilization			
Adults' Access to Preventive/ Ambulatory Health Services	The percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year.	NCQA	Health Plans
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004)	The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following. Initiation of ADO, engagement of AOD.	NCQA	Health Plans

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<p>SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge (NQF #1664)</p>	<p>The measure is reported as an overall rate which includes all hospitalized patients 18 years of age and older to whom alcohol or drug use disorder treatment was provided, or offered and refused, at the time of hospital discharge, and a second rate, a subset of the first, which includes only those patients who received alcohol or drug use disorder treatment at discharge. The Provided or Offered rate (SUB-3) describes patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment. The Alcohol and Other Drug Disorder Treatment at Discharge (SUB-3a) rate describes only those who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment. Those who refused are not included.</p>	<p>The Joint Commission</p>	<p>Health Plans</p>
<p>Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (NQF #2605)</p>	<p>The percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge.</p>	<p>NCQA</p>	<p>Health Plans</p>
<p>Asthma Medication Ratio (NQF #1800)</p>	<p>The percentage of members 5–64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.</p>	<p>NCQA</p>	<p>Health Plans</p>
<p>Medication Management for People With Asthma (Medication Compliance 75% Rate only) (NQF #1799)</p>	<p>The percentage of members 5–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported: 1. The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period. 2. The percentage of members who remained on an asthma controller medication for at least 75% of</p>	<p>NCQA</p>	<p>Health Plans</p>

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	their treatment period.		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (NQF #0058)	The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.	NCQA	Health Plans
Comprehensive Diabetes Care (Rate—BP Control <140/90, Rate—HbA1c Control (<8.0%), HbA1c Poorly Controlled (>9.0%), Eye Examination, Medical Attention for Nephropathy) (NQF #0731)	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:	NCQA	Health Plans
Controlling High Blood Pressure (NQF #0018)	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90) during the measurement year. Use the Hybrid Method for this measure.	NCQA	Health Plans
Pharmacotherapy Management of COPD Exacerbation (Both Rates) (NQF #0549)	The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1–November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported:	NCQA	Health Plans
Use of Imaging Studies for Low Back Pain (NQF #0052)	The percentage of members 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 the diagnosis.	NCQA	Health Plans
Medication Reconciliation After Discharge from Inpatient Facility (All	The percentage of discharges for patients for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record by a prescribing	NCQA/ DMAS	Health Plans

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Age Groups) (Modified from NQF #0097)	practitioner, clinical pharmacist or registered nurse.		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (NQF #1933)	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.	NCQA	Health Plans
Care for older adults: Medication Review and Advance Care Plan (NQF #0553 and #0326)	The percentage of adults 66 years and older who had each of the following during the measurement year: Advance care planning. Medication review.	NCQA	Health Plans
Inpatient Utilization—General Hospital/ Acute Care	This measure summarizes utilization of acute inpatient care and services in the following categories: Total, Maternity, Surgery, Medicine	NCQA	Health Plans
Ambulatory Care - Emergency Department (ED) Visits	This measure summarizes utilization of ambulatory care in the following categories: Outpatient visits, ED visits	NCQA	Health Plans
Mental Health Utilization	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, and other Medicaid Behavioral Health Services.	NCQA	Health Plans
Plan All-Cause Readmissions (NQF #1768)	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.	NCQA	Health Plans
Antidepressant Medication Management (Both Rates) (NQF #0105) ¹	The percentage of members 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	NCQA	Health Plans

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Follow-Up After Hospitalization for Mental Illness (7-Day Rate only) (NQF #0576)	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA	Health Plans
Use of High-Risk Medications in the Elderly	The percentage of patients 65 years of age and older who received at least one high-risk medication. The percentage of patients 65 years of age and older who received at least two different high-risk medications.	NCQA	Health Plans
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (NQF #1879)	The percentage of members 19–64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	NCQA	Health Plans
Children and Adolescents' Access to Primary Care Practitioners	The percentage of members 12 months–19 years of age who had a visit with a PCP. The organization reports four separate percentages for each product line.	NCQA	Health Plans
Adolescent's well-care visits	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.	NCQA	Health Plans
Well-Child Visits in the First 15 Months of Life (NQF #1392)	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.	NCQA	Health Plans
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (NQF #1516)	The percentage of children 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.	NCQA	Health Plans
Use of First-Line Psychosocial Care for Children and Adolescents	Use of First-Line Psychosocial Care for Children and Adolescents	NCQA	Health Plans
Metabolic Monitoring for Children and Adolescents on Antipsychotics	Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA	Health Plans

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Use of Multiple Concurrent Antipsychotics in Children and Adolescents	Use of Multiple Concurrent Antipsychotics in Children and Adolescents	NCQA	Health Plans
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (NQF #1365)	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	AMA	Health Plans
PQI 01: Diabetes Short-Term Complication Admission Rate (NQF #0272)	Admissions for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 population, ages 18 years and older. Excludes obstetric admissions and transfers from other institutions.	AHRQ	Health Plans
PQI 08: Heart Failure Admission Rate (NQF #0277) ¹	Admissions with a principal diagnosis of heart failure per 100,000 population, ages 18 years and older. Excludes cardiac procedure admissions, obstetric admissions, and transfers from other institutions.	AHRQ	Health Plans
PQI 05: COPD and Asthma in Older Adults Admission Rate (NQF #0275)	Admissions with a principal diagnosis of chronic obstructive pulmonary disease (COPD) or asthma per 100,000 population, ages 40 years and older. Excludes obstetric admissions and transfers from other institutions.	AHRQ	Health Plans
Annual Monitoring for Patients on Persistent Medications (NQF #2371)	This measure assesses the percentage of patients 18 years of age and older who received a least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year.	NCQA	Health Plans
PQA: Use of Opioids at High Dosage in Persons Without Cancer	The proportion (XX out of 1,000) of individuals without cancer receiving a daily dosage of opioids greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer.	PQA	Health Plans
PQA: Use of Opioids from Multiple Providers in Persons Without Cancer	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids from four (4) or more prescribers AND four (4) or more pharmacies.	PQA	Health Plans

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PQA: Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer, AND who received opioid prescriptions from four (4) or more prescribers AND four (4) or more pharmacies.	PQA	Health Plans
Outpatient behavioral health encounter in the last 12 months for Medicaid population with behavioral health condition	Outpatient behavioral health encounters, including both Mental Health and Substance Abuse services in the last 12 months for Medicaid population with behavioral health condition	DMAS	Health Plans
LTSS Services Utilization	Unduplicated number of members received LTSS services by major LTSS service type.	DMAS	DMAS
Recovery Oriented Measure for Severe Mental Illness	Employment, housing and intensity of care management for person with SMI and Severe Substance Abuse Dependence	DMAS	Health Plans
Percentage of LTSS Enrollees using Consumer-Directed Services	LTSS members who used consumer-directed services by LTSS benefit types.	DMAS	DMAS
Personal Care and Respite Care Services with Increase and Decrease Authorization Hours	EDCD LTSS members who experienced an increase or decrease in authorized personal care hours or respite care hours.	DMAS	DMAS
Increase or decrease in other tech LTSS services	Tech LTSS members who experienced an increase or decrease in authorized key LTSS service hours.	DMAS	DMAS
Nursing Facility Residents Hospitalization and Readmission Rate	Example: Percent of long-stay nursing facility residents with a hospital admission within 6 months of baseline assessment	DMAS	Health Plans
Nursing Facility Diversion	Number and percent of new members meeting nursing facility level of care criteria who opt for HCBS over institutional placement	DMAS	DMAS
Priority Two: Care Management and Transition Coordination			
Care Manager to Member Ratio	Members to care management ration reported by member classifications	DMAS	Health Plans

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Care Manager Encounters	Intensity of member Care Manger encounters	DMAS	Health Plans
Assessments and Reassessments	Completion of assessment and reassessments based on the requirements in MLTSS model of care	DMAS	Health Plans
Plan of Care and POC Revisions	Completion of plan of care (POC) and POC revisions based on the requirements in MLTSS model of care	DMAS	Health Plans
Documentation of Care Goals	Plan of care documentation of member care goals based on the requirements in MLTSS model of care	DMAS	Health Plans
Transition of members between Community Well, LTSS and NF Services and successful retention in lower care settings	Number of members moving from different capitation rate cells including institutional care, LTSS services, and community well. Percentage of community-living MLTSS beneficiaries admitted to an institutional facility, for varying lengths of time. Percentage of MLTSS beneficiaries admitted to an institutional facility and discharged to the community after a short-term stay. Percent of MLTSS members transitioned from NF to community who returned to NF within 90 days. Percent of MLTSS members who transitioned from the LTSS to the NF for greater than 180 days Number and Proportion of Benes transitioned to LTSS from an institution and did not return within a year. Percentage of long-term facility residents discharged back to the community successfully.	DMAS	DMAS
Advance Planning Directives Counseling	Percentage of members who have received Advance Planning Directives counseling	DMAS	Health Plans
Nursing Facility Option Counseling	Members newly admitted to nursing facilities w/out a discharge plan in place were first afforded supports and services in the community	DMAS	Health Plans

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Transition of Members between SUD Levels of Care (including Inpatient Hospital, Residential Treatment, Partial Hospitalization, Intensive Outpatient, and Outpatient SUD Treatment) and hospitals and NF and the community (Modified from NQF #0648)	Total number of transitions where the member's PCP was notified of the transition within 1 business day of the transition. Total number of discharges with documented participation in the discharge plan by the care coordinator and the member, or the member's representative. Members, regardless of age, discharged from an inpatient facility or residential treatment facility to home or any other site of care for whom a transition record was transmitted within 24 hours of discharge to the facility or primary care provider or other health care professional designated for follow-up care.	AMA/D MAS	Health Plans
Discharge Follow-up	Members with first follow-up visit within 30 days of discharge.	DMAS	Health Plans
Priority Three: Prevention, Healthy Living and Aging Well			
Adult BMI Assessment ¹	The percentage of members 18–74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.	NCQA	Health Plans
Breast Cancer Screening (NQF #2372)	The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	NCQA	Health Plans
Cervical Cancer Screening (NQF #0032)	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.	NCQA	Health Plans
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (NQF #1932)	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.	NCQA	Health Plans
Colorectal Cancer Screening (NQF #0034)	The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer.	NCQA	Health Plans

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Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (the total of all ages for each of the 3 rates) (NQF #0024)	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.	NCQA	Health Plans
Medical Assistance With Smoking and Tobacco Use Cessation (Advising Smokers and Tobacco Users to Quit Rate only) (NQF #0027)	· <i>Advising Smokers and Tobacco Users to Quit.</i> A rolling average represents the percentage of members 18 years of age and older who are current smokers or tobacco users and who received cessation advice during the measurement year.	NCQA	Health Plans
Flu Vaccinations for Adults Ages 18 and Older (NQF #0039)	The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period. This measure collected via the CAHPS 5.0H adults survey for Medicare, Medicaid, commercial populations. It is reported as two separate rates stratified by age: 18-64 and 65 years of age and older.	NCQA	Health Plans
Pneumococcal Vaccination Status for Older Adults (NQF #0043)	Percentage of patients 65 years of age and older who ever received a pneumococcal vaccination	NCQA	Health Plans
Diabetes: Foot Exam (NQF #0056)	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection and sensory exam with mono filament and a pulse exam) during the measurement year.	NCQA	Health Plans
Childhood Immunization Status (NQF #0038)	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 H 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.	NCQA	Health Plans

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Immunizations for Adolescents (NQF #1407)	The percentage of adolescents 13 years of age who had the recommended immunizations (meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td)) by their 13th birthday.	NCQA	Health Plans
Human Papillomavirus Vaccine for Female Adolescents (NQF #1959)	Percentage of female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.	NCQA	Health Plans
Screening for Clinical Depression and Follow-up Plan (NQF #0418)	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented	CMS	Health Plans
Priority Four: Member Safety, Satisfaction and Quality of Life			
Fall Prevention ¹	Percentage of MLTSS beneficiaries 18 years and older at risk of future falls who had each of the following: (1) Risk Assessment for Falls – Beneficiaries with a history of falls or one or more activity of daily living limitation who had a risk assessment for falls completed within 12 months, and (2) Plan of Care for Falls – Beneficiaries with a history of falls or one or more activity of daily living limitation who had a plan of care for falls documented within 12 months. Percentage of members who did not have any falls requiring medical intervention during the measurement period	DMAS	Health Plans
Injury Prevention	Percentage of members who did not experience any injuries, including hip fracture, other fracture, 2nd and 3rd degree burns, or unexplained injuries during the measurement period	DMAS	Health Plans
Critical Incident and Abuse	Number of critical incident and abuse reports for all members	DMAS	Health Plans
Prevalence of pressure ulcers among LTSS members	High risk long stay nursing facility residents with pressure ulcers Short stay nursing home residents with pressure ulcers that are new or worsened LTSS members with pressure ulcers	CMS and DMAS	Health Plans
HCBS experience	HCBS experience survey	DMAS	Health

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survey			Plans
Quality of life and member satisfaction survey CMS Specific	Quality of life and member satisfaction survey CMS Specific	DMAS	Health Plans
CAHPS for Children including Medicaid and Children with Chronic Conditions Supplemental Items	Medicaid CAHPS	NCQA	Health Plans
Medicaid CAHPS for Adults (NQF #0006)	Medicaid CAHPS	AHRQ	Health Plans
Priority Five: Value-Based Payment			
Key performance indicators selected from this list are potential measures for value-based payment program(s).			
Foot Notes: 1. Measures in orange color will only apply to ABD members, non-dual MLTSS members and dual members in a MLTSS health plan that also manages their Medicare services as their Medicare Managed Care Health Plan. All measures in black will apply to all members. 2. Measures in black will apply to all members. 3. Measures designated as key performance indicators are listed in a separate document. 4. HEDIS® refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA). 5. NCQA Health Plan (HP) Accreditation refers to National Committee for Quality Assurances NCQA Medicaid Health Plan Accreditation			

Under CMS Medicaid Home and Community-Based Services HCBS waiver requirements, DMAS is required by CMS to meet a set of requirements known as the HCBS waiver assurances. There are six assurance domains, which are as follows: 1) Level of Care; 2) Service Plan; 3) Qualified Providers; 4) Health and Welfare; 5) Financial Accountability; and 6) Administrative Authority. These waiver assurance measures are listed below in MLTSS HCBS Waiver Assurance Measures List .

Currently, DMAS' Division of Long Term Care conducts quality management reviews for all waiver individuals to ensure all CMS waiver assurances were met. Following the MLTSS implementation, DMAS authorized the MLTSS health plans to conduct waiver quality management reviews under the supervision and monitoring of DMAS as part of the DMAS CMS waiver quality assurances. MLTSS health plans are required by DMAS to follow all DMAS waiver quality assurances procedures and protocols. By directly conducting these waiver quality assurances, the MLTSS health plans will incorporate these assurances into their own Quality Management Program.

MLTSS HCBS Waiver Assurance Measures List

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Waiver Assurance Domain	Measure Description	Numerator and Denominator
I. LOC Determination	Number and percent of all new enrollees who have a level of care indicating a need for institutional/waiver services.	N: # of new enrollees who have level of care indicating institutional/waiver eligibility D: # of new enrollees
I. LOC Determination	Number and percent of waiver participants who received an annual LOC evaluation of eligibility within 365 days of their initial LOC evaluation or within 365 days of their last annual LOC evaluation using the states approved form(s).	N: # of participants who received a LOC review within required timeframe. D: Total # LOC reviews completed.
I. LOC Determination	Number and percent of completed LOC forms entered into LOCERI system for standardized LOC review.	N: # of completed LOC forms entered into LOCERI system for standardized LOC review. D: Total # LOC reviews forms completed.
I. LOC Determination	Number and percent of LOC reviews that LOCERI indicate do not meet LOC criteria sent for higher level review (HLR).	N: # of LOC reviews that LOCERI indicate do not meet LOC criteria sent for higher level review (HLR). D: Total # of LOC reviews that LOCERI indicate do not meet LOC criteria.
I. LOC Determination	Number and percent of waiver individuals who did not meet LOC criteria after HLR who were terminated from the waiver after completion of appeal process (if any).	N: # of waiver individuals who did not meet LOC criteria after HLR who were terminated from the waiver after completion of appeal process (if any). D: Total # of waiver individuals who did not meet LOC criteria after HLR.
II. Service Plans	Number and percent of waiver individuals who have a service plan in the record.	N: # of waiver individual's records whom have a service plans D: total # of waiver individual's records reviewed.
II. Service Plans	Number and percent of waiver individuals who have service plans that are adequate and appropriate to their needs and personal goals, as indicated in the assessment.	N: # of waiver individual's records who have service plans that are adequate and appropriate to their needs and personal goals, as indicated in the assessment D: total # of waiver individual's records reviewed which include a service plan
II. Service Plans	Number and percent of service plans developed in accordance with the State's regulations and policies.	N: # service plans developed in accordance with State's regulations and policies. D: total # service plans reviewed.

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II. Service Plans (EDCD Waiver Only)	Number and percent of waiver individuals whose service plan was updated / revised at least annually.	N: # of individuals whose service plan was updated/revised at least annually. D: Total # records reviewed which include a service plan
II. Service Plans (Tech Waiver Only)	Number and percent of individuals whose service plan was updated / revised at least every 60 days, as specified in the Waiver application.	N: # of individuals whose service plan was updated /revised at least every 60 days. D: Total # records reviewed which include a service plan
II. Service Plans	Number and percent of waiver individuals whose service plan was revised as needed, to address changing needs.	N: # individuals whose service plan was revised as needed, to address changing needs D: total # individual service plans reviewed where the record indicated a change in needs.
II. Service Plans	Number and percent of waiver individuals who received services of the type specified in the service plan.	N: # individuals who received services of the type specified in the service plan D: total # records reviewed which include a service plan.
II. Service Plans	Number and percent of waiver individuals who received services in the scope specified in the service plan.	N: # individuals who received services in the scope specified in the service plan D: total # records reviewed which include a service plan
II. Service Plans	Number and percent of waiver individuals who received services in the amount specified in the service plan.	N: # individuals who received amount specified in the service plan D: total number records reviewed which include a service plan
II. Service Plans	Number and percent of waiver individuals who received services for the duration specified in the service plan.	N: # individuals who received services for the duration, specified in the service plan D: total # records reviewed which include a service plan
II. Service Plans	Number and percent of waiver individuals who received services in the frequency specified in the service plan.	N: Number individuals who received services in the frequency specified in the service plan D: total # records reviewed which include a service plan
II. Service Plans	Number and percent of waiver individuals whose records contain an appropriately completed and signed form that specifies choice was offered between institutional care and waiver services.	N: total # of records that contain documentation of choice between institutional care and waiver services D: total # of records reviewed.
II. Service Plans	Number and percent of waiver individuals whose records contain an appropriately completed and	N: total # of records that contain documentation of choice among waiver services D: total # of records reviewed

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	signed form that specifies choice was offered among waiver services.	
II. Service Plans	Number and percent of waiver individuals whose records documented that choice of waiver providers was provided to the individual.	N: total # of records that contain documentation that choice of the waiver providers was offered to the individual D: total # of case management records reviewed.
III. Qualified Providers	Number and percent of licensed/certified waiver agency provider enrollments, for which appropriate licensure/certification were obtained in accordance with law & waiver requirements prior to service provision.	N: # new waiver agency provider enrollments with licensure/certification in accordance with requirements before service provision D: total # new enrolled waiver providers with licensure/certification requirement
III. Qualified Providers	Number and percent of licensed/certified waiver provider agencies continuing to meet applicable licensure/certification following initial enrollment.	N: # licensed/certified providers continuing to meet applicable licensure/certification following initial enrollment D: total # licensed/certified provider agencies reviewed.
III. Qualified Providers	Number and percent of licensed/certified waiver provider agency direct support staff who have criminal background checks as specified in policy/regulation with satisfactory results following initial enrollment.	N: # licensed/certified provider direct support staff who have criminal background check as specified in policy/regulation with satisfactory results following initial enrollment D: total # licensed/certified provider agency direct support staff records reviewed.
III. Qualified Providers	Number and percent of new non-licensed/non-certified waiver individual provider enrollments, who initially met waiver provider qualifications.	N: # new non-licensed/non-certified individual provider enrollments, who initially met waiver provider qualifications. D: total # new non-licensed/non-certified individual provider enrollments.
III. Qualified Providers	Number and percent of new non-licensed/non-certified consumer-directed employees who meet requirements.	N: # of new consumer-directed attendants who meet requirements D: total # of new consumer-directed employees.
III. Qualified Providers (EDCD Waiver Only)	Number and percent of new consumer-directed employees who have a criminal background check at initial enrollment.	N: # of new consumer-directed employees who have a criminal background check at initial enrollment D: total # new consumer-directed employees enrolled.

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III. Qualified Providers (EDCD Waiver Only)	Number and percent of consumer-directed employees with a failed criminal background check that are barred from employment.	N: # of consumer-directed employees who have a failed criminal background who are barred from employment D: total # consumer-directed employees who have a failed criminal background check.
III. Qualified Providers	Number and percent of waiver provider staff meeting provider staff training requirements.	N: # provider staff meeting provider staff training requirements D: total # provider staff records reviewed
III. Qualified Providers (EDCD Waiver Only)	Number and percent of consumer-directed employers trained, as required, regarding employee management and training.	N: # of consumer-directed employers for new enrollees during the review period trained trained, as required, regarding employee management and training D: total # of consumer-directed employer training records for new enrollees during the review period trained reviewed.
IV. Health and Welfare	Number and percent of waiver individual's records with indications of abuse, neglect or exploitation documenting appropriate actions taken.	N: # of individual's records with indications of abuse, neglect or exploitation documenting appropriate actions taken ; D: Total # of individual's records with indications of abuse, neglect or exploitation.
IV. Health and Welfare	Number and percent of waiver individual's records with indications of safety concerns documenting appropriate actions taken.	N: # of individual's records with indications of safety concerns documenting appropriate actions taken ; D: Total # of individual's records with indications of safety concerns.
IV. Health and Welfare	Number and percent of waiver individual's records with indications of risk in the physical environment documenting appropriate actions taken.	N: # of individual's records with indications of risk in the physical environment documenting appropriate actions taken ; D: Total # of individual's records with indications of risk in the physical environment.
IV. Health and Welfare	Data-bridge captures types of incidents, location of incidents and services offered/accepted. Non-disability waivers take less time to respond.	N: # of individuals that were offered services as a result of substantiated report; D: Total # of reports made that were substantiated.
IV. Health and Welfare		Licensing entities monitor the prohibition of restraints or seclusion for agency-directed providers during scheduled licensing reviews.

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V. Administrative Authority	Number and percent of satisfactory IAA/MOU/contract evaluations.	N: # of satisfactory IAA/MOU/contract evaluations; D: Total # of IAA/ MOU/ contracts with entities performing functions related to the waiver.
VI. Financial Accountability	Number and percent of adjudicated waiver claims submitted to Participating Plans that were paid within the timely filing requirements.	N: # of adjudicated claims submitted using the correct rate. D: Total # of adjudicated claims

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2.1.5 Quality Performance Measure Reporting

To enable DMAS to conduct frequency and intensive contract monitoring and compliance on MLTSS health plans, MLTSS health plans will be required to report current contract status, progress and deliverables via dashboard. Dashboard data elements will include, but not limited to Enrollment, care management status, grievances and appeals, claim processing, authorization processing, utilization data, call center statistics, provider training activities and member outreaching activities, etc. The frequency of the dashboard may start with weekly. MLTSS health plans will be supplied the dashboard reporting template and instructions in a separate document. MLTSS health plans are expected to report data accurately, completely and timely for ongoing frequent dashboard reporting submissions.

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2.2 Monthly Deliverables

Unless otherwise noted, the reporting period for all monthly reports is the previous calendar month. For example, the deliverables submitted on February 15th should include activity occurring during the reporting period from January 1st through the 31st. Certain reports reflect different reporting periods, and these exceptions are defined in the detailed reporting specifications for that deliverable.

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2.2.1 Enrollment Broker Provider File

Contract Reference: TBD

2.2.1.1 File Specifications

Field	Specifications	Type	Beg	End
MCO Code	Required	NUM(10)	1	10
Action Ind	Required. Valid values are A (active) and D (delete)	CHAR(01)	11	11
Clinic/PCP Ind	Required. Valid values are P (PCP) and C (Clinic)	CHAR(01)	12	12
Provider Number	Value <u>must be unique</u> per provider and office location	CHAR(15)	13	27
Program Code	Required-Default value is MLTSS	CHAR(02)	28	29
Provider Last Name	Required	CHAR(30)	30	59
Provider First Name	Required	CHAR(30)	60	89
Address Line 1	Required	CHAR(30)	90	119
Address Line 2		CHAR(30)	120	149
City	Required	CHAR(30)	150	179
Zip Code	Required	NUM(09)	180	188
Phone Area Code		NUM(03)	189	191
Phone Number		NUM(07)	192	198
Phone Extension		NUM(04)	199	202
Office Hours		CHAR(25)	203	227
Specialty Code	C=Clinic F=Family G=General I=Internist O=OB/GYN P=Pediatrics X=Other	CHAR(01)	228	228
Language 1	SP=Spanish	CHAR(02)	229	230
Language 2	GR=German	CHAR(02)	231	232
Language 3	FR=French	CHAR(02)	233	234
Language 4	IT=Italian	CHAR(02)	235	236
Language 5	RS=Russian	CHAR(02)	237	238

Method: As specified by DMAS' MLTSS Enrollment Broker
 Format: As specified by DMAS' MLTSS Enrollment Broker
 File Name: As specified by DMAS' MLTSS Enrollment Broker
 Trigger: Monthly
 Due Date: As specified by DMAS' MLTSS Enrollment Broker
 DMAS: MLTSS Enrollment Broker

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2.2.1.2 Requirements

As specified in the contract section referenced above. Must conform to requirements provided by DMAS current enrollment broker.

2.2.1.3 Examples

N/A

2.2.1.4 Scoring Criteria

N/A

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2.2.2 Patient Utilization Management and Safety Program (PUMS) Members

Contract Reference: TBD

2.2.2.1 File Specifications

Field Description	Specifications
Member Last Name	Must be 20 characters or less
Member First Name	Must be 13 characters or less
Member Medicaid	Must be a valid Medicaid ID Format: xx bytes with leading zeros
PUMS Start Date	Must be a valid date Format: mm/dd/yyyy
PUMS End Date	Must be a valid date Format: mm/dd/yyyy
PUMS Pharmacy/Provider Name	Must be 40 characters or less
PUMS Pharmacy/Provider ID Number	Must be 10 characters or less Must be a valid Provider ID
PUMS Pharmacy/Provider Address	Must be 40 characters or less
PUMS Pharmacy/Provider City	Must be 17 characters or less
PUMS Pharmacy/Provider State	Must be 2 characters or less Must be valid state code (USPS standards)
PUMS Pharmacy/Provider Zip	Must be 9 characters or less
PUMS Type	Must be 1 character Valid Values: 1, 2
PUMS Reason	Must be 1 character Valid Values: 1,2,3,4,5,6,7,8

Method: DMAS secure MLTSS 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 should be included. Do not include a header row in .csv files.

File Name: MLTSS_PUMS.csv

Trigger: Monthly

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

DMAS: Program Integrity Division

2.2.2.2 Requirements

Include members who were in the PUMS program for at least one day during the reporting period. Use the following codes for PUMS Type:

1 = Physician

2 = Pharmacy

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A member may have more than one PUMS Type – submit a separate line for each PUMS Type. Use the following codes for PUMS reason(s):

- 1 = Buprenorphine Containing Product: Therapy in the past 30 days – **AUTOMATIC LOCK-IN**,
- 2 = High Average Daily Dose: > 120 morphine milligram equivalents per day over the past 90 days,
- 3 = Overutilization: Filling of > 7 claims for all controlled substances in the past 60 days,
- 4 = Doctor Shopping: > 3 prescribers OR > 3 pharmacies writing/filling claims for any controlled substance in the past 60 days,
- 5 = Use with a History of Dependence: Any use of a controlled substance in the past 60 days with at least 2 occurrences of a medical claim for controlled Substance Abuse or Dependence in the past 365 days,
- 6 = Use with a History of Poisoning/Overdose: Any use of a controlled substance in the past 60 days with at least 1 occurrence of a medication for controlled substance overdose in the past 365 days,
- 7 = “Frequent Flyer”: > 3 Emergency department visits in the last 60 days,
- 8 = Poly-Pharmacy: > 9 unique prescriptions in a 34 day period written by >3 physician’s OR filled by > 3 pharmacies.

A member may have more than one PUMS reason. Submit a separate line for each PUMS reason.

2.2.2.3 Examples

None

2.2.2.4 Scoring Criteria

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

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2.2.3 Appeals & Grievances Summary

Contract Reference: TBD

2.2.3.1 File Specifications

Field Description	Provider Specifications	Member Specifications
Transportation (Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
MCO Administrative Issue (Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Benefit or Denial or Limitation (Appeal)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Resolved This Month (Resolution)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Carried Forward (Resolution)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Total Resolved Prior Month (Resolution)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
MCO Customer Service (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Access to Services/Providers (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Provider Care & Treatment (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Transportation (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Administrative Issues (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces
Reimbursement Related (Grievance)	Value must be ≥ 0 Cannot be blank/spaces	Value must be ≥ 0 Cannot be blank/spaces

Method: DMAS secure MLTSS FTP server

Format: Comma separated value (.csv) file (a template of this report format, named APP_GRIEV_FMT is available in the forms section on the DMAS MLTSS Web Site). All columns/fields for this deliverable must be included in the order specified, and no additional columns should be included. Numeric fields should not include commas, dollar signs, or other extraneous characters. Do not include a header row in .csv files. When populating this report please do not replace the information that is currently populated in the first column of the template. Begin dropping your data in column B.

File Name: MLTSS_APP_GRIEV.csv

Trigger: Monthly

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

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DMAS: TBD
CMS

2.2.3.2 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 type.

- Transportation - Any transportation related appeal.
- MCO Administrative Issues - MCO's failure to provide services in a timely manner or to act within timeframes set forth in the Contract and 42CFR438.408 (b).
- Benefit Denial or Limitation - The reduction, suspension or termination of a previously authorized service; denial in whole/part of payment for services; and denial/limited (reduced) authorization for a service authorization request.

Resolution:

- Total End of Month Unresolved should be carried forward in the 'Total Carried Forward' field on the Appeals Report next month.

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.

Type of Grievance:

Categorize grievances in the most appropriate column.

- MCO 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 MCO, etc.

2.2.3.3 Examples

N/A

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2.2.3.4 Scoring Criteria

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

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2.2.4 Monies Recovered by Third Parties

Contract Reference: TBD

2.2.4.1 File Specifications

Field Description	Specifications
Member First Name	Must be 13 characters or less
Member Last Name	Must be 20 characters or less
Medicaid ID	Must be a valid Medicaid ID Format: 12 bytes with leading zeros
Third Party	Must be 50 characters or less
Amount Recovered	Must be 10 characters or less

Method: DMAS secure MLTSS 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 should be included. Do not include a header row in .csv files.

File Name: MLTSS_MNY_RECOV.csv

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

2.2.4.2 Requirements

As specified in the contract section referenced above.

Program: Include members enrolled in MLTSS.

Amount Recovered: Include only actual recoveries received (e.g., checks) in this field. Do not include Cost Avoidance or coordination of benefits amounts.

2.2.4.3 Examples

NONE

2.2.4.4 Scoring Criteria

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

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2.2.5 Comprehensive Health Coverage

Contract Reference: TBD

2.2.5.1 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 MLTSS 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 should be included. Do not include a header row in .csv files.

File Name: MLTSS_COMP_CVG.csv

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

2.2.5.2 Requirements

As specified in the contract section referenced above.

Include members enrolled in MLTSS.

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.

2.2.5.3 Examples

None

2.2.5.4 Scoring Criteria

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

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2.2.6 Workers' Compensation

Contract Reference: TBD

2.2.6.1 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 \leq 15 characters or blank
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 MLTSS 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 should be included. Do not include a header row in .csv files.

File Name: MLTSS_WKR_COMP.csv

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

2.2.6.2 Requirements

As specified in the contract section referenced above.

Include members enrolled in MLTSS.

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

2.2.6.3 Examples

NONE

2.2.6.4 Scoring Criteria

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

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2.2.7 Estate Recoveries

Contract Reference: TBD

2.2.7.1 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 MLTSS 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 should be included. Do not include a header row in .csv files.

File Name: MLTSS_EST_RECOV.csv

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

2.2.7.2 Requirements

As specified in the contract section referenced above.

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

2.2.7.3 Examples

None

2.2.7.4 Scoring Criteria

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

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2.2.8 Other Coverage

Contract Reference: TBD

2.2.8.1 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 MLTSS 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 should be included. Do not include a header row in .csv files.

File Name: MLTSS_OTH_COVG.csv

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

2.2.8.2 Requirements

As specified in the contract section referenced above.

Include members enrolled in MLTSS.

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.

2.2.8.3 Examples

NONE

2.2.8.4 Scoring Criteria

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

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2.2.9 Behavioral Health Home (BHH) Enrollment Roster

Contract Reference: TBD

2.2.9.1 File Specifications

Field Description	Specifications/Validation Rules
Medicaid ID	Must be a valid Medicaid ID Format: 12 bytes with leading zeros
BHH Enrollment Begin Date	Format = mm/dd/yyyy. Must be a valid date. Must be greater than 07/01/2015.
BHH Enrollment End Date	Format = mm/dd/yyyy. Must be a valid date. Must be greater than 07/01/2015. For active / ongoing member enrollment, use value = 12/31/9999.

Method: DMAS secure MLTSS 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 should be included.

File Name: MLTSS_BHH_ENROLL.csv

Frequency: Monthly

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

DMAS: HCS Systems & Reporting

2.2.9.2 Requirements

- As specified in the contract section referenced above.
- Do not include a header row in this file.
- Only include members who are actually enrolled in the Behavioral Health Home pilot program. Do not include members who are eligible but not enrolled.
- Only Medicaid members are eligible for this pilot program.
- Each monthly file submission must be a full replacement file, i.e., Include all members who were previously enrolled or who will be enrolled in the BHH.
- Members must be enrolled with the MCO for their entire BHH enrollment period.
- A member may have more than one record on the file, but each member record must have a different Begin and End Date. Date spans on different records for the same member within the file must not overlap.
- Members should not be enrolled in a BHH for a partial month. Enrollment Begin Date and End Date should start on the first / last day of a calendar month. The only exception would be when the member's MCO enrollment ends on a date other than the end of month.

2.2.9.3 Examples

None

2.2.9.4 Scoring Criteria

None

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2.3 Quarterly Deliverables

All quarterly reporting deliverables are due to DMAS by the last calendar day of the month following the end of the reporting quarter, or as noted by specific report. If the last calendar day falls on a Saturday, Sunday, or state holiday, then the quarterly report deliverables are due by close of business of the next full business day.

Unless otherwise stated, the reporting periods and submission dates for quarterly reporting are as follows:

Report Period	Submission Due
January – March,	April 30 th
April – June,	July 31 st
July – September	October 31 st
October – December	January 31 st

Certain reports reflect different reporting periods, and these differences are defined in the detailed reporting specifications within this document.

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2.3.1 Provider Network File

Contract Reference: TBD

Delivery Method: DMAS secure MLTSS FTP server

Format: Please refer to the MLTSS provide file (PS-F_106) document for detailed instructions.

Trigger: Weekly

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2.3.2 Providers Failing Accreditation/Credentialing and Terminations

Contract Reference: TBD

2.3.2.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Excel (.xlsx file)
File Name: MLTSS_PRV_CRED.xlsx
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

2.3.2.2 Requirements

Include providers participating in MLTSS. Include all MCO-terminated providers in this report. The template is located on the DMAS web site, titled "Providers Failing Accreditation/Credentialing and Terminations."

2.3.2.3 Examples

None

2.3.2.4 Scoring Criteria

None

2.3.3 Program Integrity Activities

Contract Reference: TBD

2.3.3.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: PDF file
File Name: MLTSS_PI_ACTIV.pdf
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

2.3.3.2 Requirements

As specified in the contract section referenced above.

Include all components as specified by the contract. The template is located on the DMAS web site, titled "Quarterly PI Abuse Overpayment-Recovery Report".

2.3.3.3 Examples

None

2.3.3.4 Scoring Criteria

None

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2.3.4 BOI Filing - Quarterly

Contract Reference: TBD

2.3.4.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_BOI_QTRLY.pdf
Trigger: Quarterly
Due Date: On the same day on which it is submitted to the Bureau of Insurance
DMAS: Provider Reimbursement Division

2.3.4.2 Requirements

As specified in the contract section referenced above.

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

2.3.4.3 Examples

None

2.3.4.4 Scoring Criteria

None

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2.3.5 Financial Report

Contract Reference: TBD – REVIEW WITH PROVIDER REIMBURSEMENT

2.3.5.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Excel (.xlsx) file
File Name: MLTSS_FIN_QTRLY.xlsx
Trigger: Quarterly
Due Date: First, second and third quarter reports are due by the close of business 45 days following the end of the reporting quarter. Fourth quarter, CY and the Annual Statement to BOI are due by the close of business 60 days following the end of the reporting quarter.
DMAS: Provider Reimbursement Division

2.3.5.2 Requirements

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

The template for submission of this report is provided on the MLTSS web site.

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

2.3.5.3 Examples

None

2.3.5.4 Scoring Criteria

None

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2.3.6 Reinsurance

Contract Reference: TBD

2.3.6.1 File Specifications

Field	Specifications
CLAIM_ID	Format: CHAR(20) Unique MCO or MMIS claim identification number (ICN/CCN) Required
FROM_DATE	Format: MM/DD/YYYY(10) First date on which service provided Required
FILL_DATE	Format: DATE(10) - MM/DD/YYYY Date prescription was filled Optional
PAID_DATE	Format: DATE(10) - MM/DD/YYYY Date claim paid; important for calculating IBNR/trend estimates Required
RECIP_ID	Format: CHAR(12) Member's Medicaid ID number Required
SSN	Format: CHAR(9) No dashes. Fill with spaces if SSN is not available. Optional
BIRTH	Format: DATE(10) - MM/DD/YYYY Member's birth date Optional
SEX	Format: CHAR(1) Valid Values: 'F' = female; 'M' = male; 'U' = unknown Optional
CTY_CNTY	Format: CHAR(3) FIPS code of member's residence – Must be valid Virginia city/county code Optional
ELIG_CAT	Format: CHAR(10) Member's aid category code If provided, must be a valid Virginia Medicaid aid category Optional
PROV_NPI	Format: CHAR(10) Provider NPI or API number Required
PROV_TAXID	Format: CHAR(9) Provider tax ID Optional
BILLED_AMT	Format: Numeric with 2 decimal places, no leading zeroes, no commas, and no dollar sign. Must be greater than zero. Billed/charged amount Required

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Field	Specifications
PAID_AMT	Format: Numeric with 2 decimal places, no leading zeroes, no commas, and no dollar sign. Must be greater than zero. Paid amount- INGREDIENT COST + DISPENSING FEE Required
COPAY_AMT	Format: Numeric with 2 decimal places, no leading zeroes, no commas, and no dollar sign. Must be greater than zero. Co-pay collected Required
DISPENSE_FEE	Format: Numeric with 2 decimal places, no leading zeroes, and no dollar sign. Dispensing fee Required
BRAND_GEN	Format: CHAR(1) Brand/Generic indicator. Valid values are: 'B'=brand, 'G'=generic Optional
DRUG	Format: CHAR(50) Drug name Optional
DAW	Format: CHAR(1) Dispensed as written indicator. 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. Optional
NDC	Format: CHAR(11) Must be a valid NDC National drug code (NDC) Situational based on claim type (pharmacy / medical).
THER_CLS	Format: CHAR(2) Standard therapeutic class code Optional
REFILL	Format: CHAR(1) Refill indicator: Valid Values: 'Y' = refill; 'N' = not refill Optional
STATUS	Format: CHAR(1) Claim status; please submit final adjudicated paid claims only. Identifies whether this claim record represents an original payment or an adjustment / void to a prior quarter payment Valid Values: O = Original; A = Adjustment (full replacement); V = Void. 'A' and 'V' values are used for corrections to prior period claims Required
SUB_CAP	Format: CHAR(1) Indicates whether claim is paid FFS or is a capitated service; Valid Values: 'F' =FFS, 'C' = Capitated Required

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Field	Specifications
PROC_CD	Format: Char(5) HCPCS / CPT/ J-code used for medical claims. Situational based on claim type (pharmacy / medical).

Method: DMAS secure MLTSS FTP server
 Format: Comma Separated Values
 File Name: MLTSS_REINSURE.csv
 Trigger: Quarterly
 Due Date: Q3 – Due by DMAS close of business on October 31st
 Q4 – Due by DMAS close of business on January 31st
 Q1 – Due by DMAS close of business on April 30th
 Q2 – Due by DMAS close of business July 31st
 DMAS: Provider Reimbursement Division

2.3.6.2 Requirements

As specified in the contract section referenced above.

Include members enrolled in MLTSS

Only include non-dual eligible members whose total MCO payment amount for all drug costs for the current contract year is over the \$150,000 threshold. Includes pharmacy, physician, and outpatient hospital costs.

Data submitted each quarter must be cumulative year to date. For example, if a member exceeds the threshold in the first quarter, then report all prescription drug costs associated with that member in each successive quarter along with any new prescription drug costs.

In order to be processed for reimbursement by DMAS, MCO 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.

2.3.6.3 Examples

None

2.3.6.4 Scoring Criteria

None

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2.3.7 Patient Utilization Management and Safety Outcome Report

Contract Reference: TBD

2.3.7.1 File Specifications

Field Description	Specifications
Total number of members referred to PUMS program	Value must be ≥ 0
Number of members under PUMS referral reason #1	Value must be ≥ 0
Number of members under PUMS referral reason #2	Value must be ≥ 0
Number of members under PUMS referral reason #3	Value must be ≥ 0
Number of members restricted to a pharmacy	Value must be ≥ 0
Number of members restricted to a provider	Value must be ≥ 0
Number of members with a substance abuse treatment referral	Value must be ≥ 0
Number of members with Contractor action #1	Value must be ≥ 0

Method: DMAS secure MLTSS 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 should be included. Numeric fields should not include commas, dollar signs, or other extraneous characters. Do not include a header row in .csv files.

File Name: MLTSS_PUMS_OUTCOME.csv

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

2.3.7.2 Requirements

As specified in the contract section referenced above.

Only include members referred to the PUMS program during the reporting quarter. The referral reasons and actions should only reflect those for members referred to the PUMS during the reporting quarter. A member may be counted in more than one referral action type and more than one type of action category.

2.3.7.3 Examples

None

2.3.7.4 Scoring Criteria

None

2.3.8 Sentinel Event and Serious Reportable Events

Contract Reference: TBD

2.3.8.1 File Specifications

Method	DMAS secure MLTSS FTP server
Format	Adobe .pdf file
File Name	MLTSS_SENTINEL.pdf.
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

2.3.8.2 Requirements

Summary of all events that occurred during the quarter.

2.3.8.1 Examples

N/A

2.3.8.2 Scoring Criteria

None

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2.3.9 Provider GeoAccess® GeoNetworks® File

Contract Reference: TBD

2.3.9.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: PROVIDER_ACCESS.pdf
Trigger: Quarterly, or on a more frequent basis as requested by the Department
Due Date: By close of business on the last calendar day of the month following the end of the reporting quarter
DMAS: TBD

2.3.9.2 Requirements

As specified in the contract section referenced above.

The Contractor shall submit to the Department a file using GeoAccess® GeoNetworks® or equivalent software on a quarterly basis. The file must provide information on travel time and/or distance access standards for certain provider types identified in the MLTSS contract. The standards must be provided for members at the county/FIPS level for all applicable urban and rural service areas. The file must indicate the date of the membership file used in the calculations.

MCOs may elect to provide either travel time or distance access standards.

The file must show the standards in a numeric format – maps are not acceptable.

Member to provider ratios may be included in the report but should be provided only in addition to the time and distance standards.

2.3.9.3 Examples

None

2.3.9.4 Scoring Criteria

None

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2.4 Annual Deliverables

All annual reporting deliverables are due to DMAS within 90 calendar days after the effective contract date, or as noted by specific report. If the last calendar day falls on a Saturday, Sunday, or state holiday, then the report deliverables are due by close of business of the next full business day. The reporting period for annual reporting is the twelve month period January - December. Certain reports reflect different reporting periods, and these differences are defined in the detailed reporting specifications within this document.

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2.4.1 List of Subcontractors

Contract Reference: TBD

2.4.1.1 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 MLTSS FTP server

Format: Comma-separated value (.csv) file

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

Trigger: Annually and prior to any changes

Due Date: Within 90 calendar days of the start of contract cycle each year and 30 calendar days prior to implementation of any changes

DMAS: TBD

2.4.1.2 Requirements

As specified in the contract section referenced above.

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Report should utilize form available from DMAS MLTSS 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.

2.4.1.3 Examples

N/A

2.4.1.4 Scoring Criteria

None

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2.4.2 Provider Satisfaction Survey Instrument

Contract Reference: TBD

2.4.2.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_PROV_SRVY.pdf
Trigger: Bi-Annual
Due Date: Submit copy of the survey instrument 30 days prior to distribution
DMAS: MLTSS Quality Analyst

2.4.2.2 Requirements

As specified in the contract section referenced above.

2.4.2.3 Examples

None

2.4.2.4 Scoring Criteria

None

2.4.3 Provider Satisfaction Survey Methodology

Contract Reference: TBD

2.4.3.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_PROV_SRVY_METH.pdf
Trigger: Bi-Annual
Due Date: Submit copy of methodology 30 days prior to distribution
DMAS: MLTSS Quality Analyst

2.4.3.2 Requirements

As specified in the contract section referenced above.

2.4.3.3 Examples

None

2.4.3.4 Scoring Criteria

None

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2.4.4 **Provider Satisfaction Survey Results**

Contract Reference: TBD

2.4.4.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_PROV_SRVY._RSLTS.pdf
Trigger: Bi-Annual
Due Date: Submit results within 120 days after conducting the survey
DMAS: MLTSS Quality Analyst

2.4.4.2 Requirements

As specified in the contract section referenced above.

2.4.4.3 Examples

None

2.4.4.4 Scoring Criteria

None

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2.4.5 Marketing Plan

Contract Reference: TBD

2.4.5.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Word document
File Name: MLTSS_MKTG_PLAN.docx
Trigger: Annually and prior to any changes
Due Date: Within 90 calendar days of the start of contract cycle each year and 30 calendar days prior to implementation of any changes
DMAS: TBD

2.4.5.2 Requirements

As specified in contract section referenced above.

2.4.5.3 Examples

None

2.4.5.4 Scoring Criteria

None

2.4.6 Provider Profiling Methodology

Contract Reference: TBD

2.4.6.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Word document
File Name: MLTSS_Provider Profiling Methodology.docx
Trigger: Annually and prior to any changes
Due Date: Within 90 calendar days of the start of contract cycle each year and 30 calendar days prior to implementation of any changes
DMAS: TBD

2.4.6.2 Requirements

As specified in contract section referenced above. (per meeting notes: add results requirement)

2.4.6.3 Examples

None

2.4.6.4 Scoring Criteria

None

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2.4.7 Member Handbook

Contract Reference: TBD

2.4.7.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_MBR_HNDBK.pdf
Trigger: Prior to Signing Original Contract
Annually and prior to any changes
Due Date: 60 calendar days prior to printing (new or revised).
Within 10 business days of receipt of DMAS request
DMAS: TBD

2.4.7.2 Requirements

As specified in the contract section referenced above.

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.

2.4.7.3 Examples

None

2.4.7.4 Scoring Criteria

None

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2.4.8 **Quality Assessment & Performance Improvement Plan**

Contract Reference: TBD

2.4.8.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_QAPI_PLAN.pdf
Trigger: Annual
Due Date: January 31st
DMAS: MLTSS Quality Analyst

2.4.8.2 Requirements

As specified in the contract section referenced above.

2.4.8.3 Examples

None

2.4.8.4 Scoring Criteria

None

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2.4.9 Quality Assessment & Performance Improvement Annual Evaluation

Contract Reference: TBD

2.4.9.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_QAPI_PLAN.pdf
Trigger: Annual
Due Date: June 30th
DMAS: MLTSS Quality Analyst

2.4.9.2 Requirements

As specified in the contract section referenced above.

2.4.9.3 Examples

None

2.4.9.4 Scoring Criteria

None

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2.4.10 HEDIS Results

Contract Reference: TBD

2.4.10.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Excel file
File Name: MLTSS_HEDIS.xlsx
Trigger: Annual
Due Date: January 31st
DMAS: MLTSS Quality Analyst

2.4.10.2 Requirements

As specified in the contract section referenced above.

2.4.10.3 Examples

None

2.4.10.4 Scoring Criteria

None

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2.4.11 CAHPS Survey Results

Contract Reference: TBD

2.4.11.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Excel or PDF file
File Name: MLTSS_CAHPs.pdf or CAHPs.xlsx
Trigger: Annual
Due Date: January 31st
DMAS: MLTSS Quality Analyst

2.4.11.2 Requirements

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

2.4.11.3 Examples

None

2.4.11.4 Scoring Criteria

None

2.4.12 Program Integrity Plan

Contract Reference: TBD

2.4.12.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_PI_PLAN.pdf
Trigger: Annual
Due Date: Within 90 calendar days of the effective contract date.
DMAS: Program Integrity Division

2.4.12.2 Requirements

As specified in the contract section referenced above.

2.4.12.3 Examples

None

2.4.12.4 Scoring Criteria

None

2.4.13 Program Integrity Activities Annual Summary

Contract Reference: TBD

2.4.13.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_PRI_OUTCM.pdf
Trigger: Annual
Due Date: March 31st
DMAS: Program Integrity Division

2.4.13.2 Requirements

As specified in the contract section referenced above.

2.4.13.3 Examples

None

2.4.13.4 Scoring Criteria

None

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2.4.14 Organizational Charts

Contract Reference: TBD

2.4.14.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_ORG_CHART.pdf
Trigger: Annual0
Due Date: Within 90 calendar days of the effective contract date.
DMAS: TBD

2.4.14.2 Requirements

As specified in the contract section referenced above. (need to define level of change that must be reported; also, should include changes to both personnel and structure)

2.4.14.3 Examples

None

2.4.14.4 Scoring Criteria

None

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2.4.15 Program Integrity Compliance Audit (PICA)

Contract Reference: TBD

2.4.15.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Excel (.xlsx) file
File Name: MLTSS_PICA.xlsx
Trigger: Annual
Due Date: June 30th
DMAS: Program Integrity Division

2.4.15.2 Requirements

As specified in the contract section referenced above. Contractor must utilize Program Integrity Compliance Audit (PICA) form that will be made available on the DMAS MLTSS web site. Contractors shall produce a standard audit report for each completed audit that includes, at a minimum:

- Purpose
- Methodology
- Findings
- Determination of Action and Final Resolution
- Claims Detail List

In developing the types of audits to include in the plan Contractors shall:

- Determine which risk areas will most likely affect their organization and prioritize the monitoring and audit strategy accordingly.
- Utilize statistical methods in:
 - Randomly selecting facilities, pharmacies, providers, claims, and other areas for review;
 - Determining appropriate sample size; and
 - Extrapolating audit findings to the full universe.
- Assess compliance with internal processes and procedures.
- Review areas previously found non-compliant to determine if the corrective actions taken have fully addressed the underlying problem.

2.4.15.3 Examples

None

2.4.15.4 Scoring Criteria

None

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2.4.16 BOI Filing - Annual

Contract Reference: TBD

2.4.16.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_BOI_ANNUAL.pdf
Trigger: Annual
Due Date: On the same day on which it is submitted to the Bureau of Insurance
DMAS: Provider Reimbursement Division

2.4.16.2 Requirements

As specified in the contract section referenced above.

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

2.4.16.3 Examples

None

2.4.16.4 Scoring Criteria

None

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2.4.17 Audit by Independent Auditor (Required by BOI)

Contract Reference: TBD

2.4.17.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_IND_AUDIT.pdf
Trigger: Annual
Due Date: At the time it is submitted to the Bureau of Insurance or within 30 days of completion of audit (whichever is sooner)
DMAS: Provider Reimbursement Division

2.4.17.2 Requirements

As specified in contract section referenced above.

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

2.4.17.3 Examples

None

2.4.17.4 Scoring Criteria

None

2.4.18 Company Background History

Contract Reference: TBD

2.4.18.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe.pdf file
File Name: MLTSS_BACK_HIST.pdf
Trigger: Annual
Due Date: Within 90 calendar days of the effective contract date.
DMAS: TBD

2.4.18.2 Requirements

As specified in the contract section referenced above.

The Contractor shall submit annually an updated company background history that includes any awards, major changes or sanctions imposed since the last annual report. The Contractor shall also submit the same information for all of its subcontractors.

2.4.18.3 Examples

None

2.4.18.4 Scoring Criteria

None

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2.4.19 Health Insurer Fee

Contract Reference: TBD

2.4.19.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe (.pdf) file
File Name: MLTSS_Health Insurer Fee (HIF) Certification.pdf
Trigger: Annual
Due Date: March 15th
DMAS: Provider Reimbursement Division

2.4.19.2 Requirements

As specified in the contract section referenced above.

Use the template posted on the 'HIF Certification' template posted on the DMAS MLTSS web site, 'Studies and Reports' tab, 'Reporting Documentation' section.

The MLTSS contract provides for the reimbursement of that portion of the ACA Health Insurer Fee allocated to the Virginia Medicaid line of business. Use the provided Microsoft Word template to certify the calculation of the Virginia Medicaid portion of the fee. Complete the certification and submit it via FTP along with the calculation of the Virginia Medicaid portion including gross up and the Final Fee calculation letter 5067C.

2.4.19.3 Examples

None

2.4.19.4 Scoring Criteria

None

2.4.20 Patient Utilization Management and Safety (PUMS) PA Requirements

Contract Reference: TBD

2.4.20.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_PUMS_PRIOR_AUTH.pdf
Trigger: Annual
Due Date: Within 90 calendar days of the effective contract date
DMAS: TBD

2.4.20.2 Requirements

As specified in the contract section referenced above.

2.4.20.3 Examples

N/A

2.4.20.4 Scoring Criteria

None

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2.4.21 **Medically Necessary Use of Out-of-network Providers**

Contract Reference: TBD

2.4.21.1 File Specifications (This will need to be modified further)

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_OON.PROV.pdf
Trigger: Annual
Due Date: Within 90 calendar days of the effective contract date
DMAS: TBD

2.4.21.2 Requirements

As specified in the contract section referenced above.

2.4.21.3 Examples

N/A

2.4.21.4 Scoring Criteria

None

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2.4.22 Member Incentive Awards

Contract Reference: TBD

2.4.22.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_INCENT_AWD.pdf
Trigger: Prior to signing original contract
Annual
Implementation of incentive award program
Due Date: Prior to signing original contract and annually thereafter
30 days prior to implementation
DMAS: TBD

2.4.22.2 Requirements

As specified in the contract section referenced above.

2.4.22.3 Examples

N/A

2.4.22.4 Scoring Criteria

None

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2.4.23 Member Health Education & Prevention Plan

Contract Reference: TBD

2.4.23.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_EDUC_PGM.pdf
Trigger: Prior to Signing Original Contract
Annual
Upon Revision
Upon Request
Due Date: Prior to signing original contract and annually thereafter
10 business days prior to implementation of any revision
Within 10 business days of receiving request from DMAS
DMAS: TBD

2.4.23.2 Requirements

As specified in the contract section referenced above.

2.4.23.3 Examples

N/A

2.4.23.4 Scoring Criteria

None

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2.4.24 Services Not Covered Due to Moral or Religious Objections

Contract Reference: TBD

2.4.24.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_OBJ_SRVCS.pdf
Trigger: Prior to signing of original contract
Annual
Upon adoption of such policy
Upon Request
Due Date: Prior to signing original contract and annually thereafter
10 business days prior to implementation of any change(s)
Within 10 business days of receiving a request from DMAS
DMAS: TBD

2.4.24.2 Requirements

As specified in the contract section referenced above.

2.4.24.3 Examples

N/A

2.4.24.4 Scoring Criteria

None

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**2.4.25 Patient Utilization Management and Safety (PUMS) Program Policies
and Procedures**

Contract Reference: TBD

2.4.25.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_PUMS_OUTCM.pdf
Trigger: Prior to signing original contract
Annual
Upon Revision
Due Date: Prior to signing original contract and annually thereafter
10 business days prior to implementation of any revision
DMAS: TBD

2.4.25.2 Requirements

As specified in the contract section referenced above.

Plan must provide MCO's applicable policies and procedures, including clinical protocols used to determine appropriate intervention(s) and referral(s) to other services that may be needed (such as substance abuse treatment services, etc.).

2.4.25.3 Examples

N/A

2.4.25.4 Scoring Criteria

None

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2.4.26 Utilization Management Plan

Contract Reference: TBD

2.4.26.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_UM_PLAN.pdf
Trigger: Prior to Signing Original Contract
Annual
Upon Revision
Upon Request
Due Date: Prior to signing original contract and annually thereafter
10 business days prior to any published revision to the Provider Manual
Within 10 business days of receiving a request from DMAS
DMAS: TBD

2.4.26.2 Requirements

As specified in the contract section referenced above.

2.4.26.3 Examples

N/A

2.4.26.4 Scoring Criteria

None

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2.4.27 Fraud, Waste and Abuse Policies & Procedures

Contract Reference: TBD

2.4.27.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_FWA_POLICY.pdf
Trigger: Prior to Signing Original Contract
Annual
Upon Revision
Upon Request
Due Date: Prior to signing original contract and annually thereafter
10 business days prior to implementation of any revision
Within 10 business days of receiving a request from DMAS
DMAS: Program Integrity Division

2.4.27.2 Requirements

As specified in the contract section referenced above.

2.4.27.3 Examples

N/A

2.4.27.4 Scoring Criteria

None

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2.4.28 Provider Appeals Process

Contract Reference: TBD

2.4.28.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_PROV_APPEALS.pdf
Trigger: Prior to Signing Original Contract
Annual
Upon Revision
Due Date: Prior to signing original contract and annually thereafter
10 business days before any revision
DMAS: TBD

2.4.28.2 Requirements

As specified in the contract section referenced above.

2.4.28.3 Examples

N/A

2.4.28.4 Scoring Criteria

None

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2.4.29 Member Grievance Policies & Procedures

Contract Reference: TBD

2.4.29.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_MEMBER_GRIEVANCE.pdf
Trigger: Prior to Signing Original Contract
Annual
Upon Revision
Upon Request
Due Date: Prior to signing original contract and annually thereafter
10 business days prior to implementation of any revision
Within 10 business days of receiving a request from DMAS
DMAS: TBD

2.4.29.2 Requirements

As specified in the contract section referenced above.

2.4.29.3 Examples

N/A

2.4.29.4 Scoring Criteria

None

2.4.30 Member Appeal Policies & Procedures

Contract Reference: TBD

2.4.30.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_MEMBER_APPEAL.pdf
Trigger: Prior to Signing Original Contract
Annual
Upon Revision
Upon Request
Due Date: Prior to signing original contract and annually thereafter
10 business days prior to implementation of any revision
Within 10 business days of receiving a request from DMAS
DMAS: TBD

2.4.30.2 Requirements

As specified in the contract section referenced above.

2.4.30.3 Examples

N/A

2.4.30.4 Scoring Criteria

None

2.4.31 Encounter Data Plan for Completeness

Contract Reference: TBD

2.4.31.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_ENC_PLAN.pdf
Trigger: Prior to Signing Original Contract
Annual
Upon Revision
Upon Request
Due Date: Prior to signing original contract and annually thereafter
10 business days prior to implementation of any revision
Within 10 business days of receiving a request from DMAS
DMAS: TBD

2.4.31.2 Requirements

As specified in the contract section referenced above.

2.4.31.3 Examples

N/A

2.4.31.4 Scoring Criteria

None

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

Contract Reference: TBD

2.4.32.1 File Specifications

Method: Email: TBD
Format: Adobe .pdf file
File Name: MLTSS_CMS1513.pdf
Trigger: Annually at Contract signing
Upon Request
Due Date: Annually at Contract signing
Within 35 days of receiving a request from DMAS
DMAS: TBD

2.4.32.2 Requirements

As specified in the contract section referenced above.

2.4.32.3 Examples

N/A

2.4.32.4 Scoring Criteria

None

2.4.33 Data Security Plan for Department Data

Contract Reference: TBD

2.4.33.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_DATA_SECUR.pdf
Trigger: Prior to Signing Original Contract
Annual
Upon Revision
Upon Request
Due Date: Prior to signing original contract and annually thereafter
10 business days prior to implementation of any revision
Within 10 business days of receiving a request from DMAS
DMAS: TBD

2.4.33.2 Requirements

As specified in the contract section referenced above.

2.4.33.3 Examples

N/A

2.4.33.4 Scoring Criteria

None

2.4.34 Data Confidentiality Policies & Procedures

Contract Reference: TBD

2.4.34.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_DATA_CONFID.pdf
Trigger: Prior to Signing Original Contract
Annual
Upon Revision
Upon Request
Due Date: Prior to signing original contract and annually thereafter
10 business days prior to implementation of any revision
Within 10 business days of receiving a request from DMAS
DMAS: TBD

2.4.34.2 Requirements

As specified in the contract section referenced above.

2.4.34.3 Examples

N/A

2.4.34.4 Scoring Criteria

None

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2.4.35 Notification of Potential Conflict of Interest

Contract Reference: TBD

2.4.35.1 File Specifications

Method: Email: TBD
Format: N/A
File Name: N/A
Trigger: Prior to signing original contract
Annual
Prior to any changes
Due Date: Prior to signing original contract and annually thereafter
Within 10 business days of identification of conflict of interest
DMAS: TBD

2.4.35.2 Requirements

As specified in the contract section referenced above.

2.4.35.3 Examples

N/A

2.4.35.4 Scoring Criteria

None

2.4.36 Third Party Administrator (TPA) Firewall

Contract Reference: TBD

2.4.36.1 File Specifications

Method: Email: TBD
Format: N/A
File Name: N/A
Trigger: 10 days prior to execution, and then annually or upon amendment thereafter
Due Date: As defined in trigger
Trigger: Signing of contract
Due Date: Sixty days or more prior to contract signing
DMAS: TBD

2.4.36.2 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 additional services beyond those referenced in Section 14.7.A, or 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.

2.4.36.3 Examples

N/A

2.4.36.4 Scoring Criteria

None

2.4.37 Insurance Coverage Verification

Contract Reference: TBD

2.4.37.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_INS_COVG.pdf
Trigger: Prior to Signing Original Contract
Annual
Upon Revision
Upon Request
Due Date: Prior to signing original contract and annually thereafter
10 business days prior to implementation of any revision
Within 10 business days of receiving a request from DMAS
DMAS: TBD

2.4.37.2 Requirements

As specified in the contract section referenced above.

2.4.37.3 Examples

N/A

2.4.37.4 Scoring Criteria

None

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2.4.38 Practice Guidelines

Contract Reference: TBD

2.4.38.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_PRACT_GUIDE.pdf
Trigger: Prior to Signing Original Contract
Annual
Upon Revision
Upon Request
Due Date: Prior to signing original contract and annually thereafter
10 business days prior to implementation of any revision
Within 10 business days of receiving a request from DMAS
DMAS: TBD

2.4.38.2 Requirements

As specified in the contract section referenced above.

2.4.38.3 Examples

N/A

2.4.38.4 Scoring Criteria

None

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2.4.39 Enrollment – Excluding Members

Contract Reference: **TBD**

2.4.39.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: **MLTSS_ENROL_EXCLUSION.pdf**
Trigger: Upon learning that a member meets one or more of the exclusion criteria
Due Date: Within 48 hours of discovery
DMAS: **TBD**

2.4.39.2 Requirements

As specified in the contract section referenced above.

Contractor must utilize **Member Action Form that will be made available on the DMAS MLTSS web site.**

Submit each member enrollment exclusion request to DMAS in a separate file.

When there is more than one exclusion request per day, append a sequence number to the file name, e.g., ENROL_EXCLUSION1.pdf, ENROL_EXCLUSION2.pdf, etc.

2.4.39.3 Examples

N/A

2.4.39.4 Scoring Criteria

None

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2.5 Other Reporting Requirements

This section documents reporting deliverables that fall outside of the usual monthly, quarterly, and annual report cycles.

Each deliverable in this section is required by contract. Contract references are provided for each deliverable.

This section provides additional detail for each deliverable, including the specific trigger event(s) and the time frame (due date) in which the deliverable is required to be provided to DMAS.

Where applicable, this section also describes the specific content that is required for the particular deliverable.

DRAFT

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2.5.1 NCQA Deficiencies

Contract Reference: TBD

2.5.1.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_NCQA_DEF.pdf
Trigger: MCO receipt of notification from NCQA of deficiency(s)
Due Date: 30 calendar days after NCQA notification
DMAS: MLTSS Quality Analyst

2.5.1.2 Requirements

As specified in the contract section referenced above.

2.5.1.3 Examples

N/A

2.5.1.4 File Specifications

None

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2.5.2 NCQA Accreditation Status Changes

Contract Reference: TBD

2.5.2.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_NCQA_ACRED.pdf
Trigger: Notification by NCQA of Change in MCO's Accreditation Status
Due Date: 10 calendar days after NCQA notification
DMAS: MLTSS Quality Analyst and Contract Monitoring Team

2.5.2.2 Requirements

As specified in the contract section referenced above.

2.5.2.3 Examples

N/A

2.5.2.4 Scoring Criteria

None

2.5.3 MCO Staffing Changes

Contract Reference: TBD

2.5.3.1 File Specifications

Method: Email: ADDRESS TBD
Format: N/A
File Name: N/A
Trigger: Change in key staff position at MCO as specified in the MLTSS contract
Due Date: Must be reported to DMAS within 5 business days of each change
DMAS: TBD

2.5.3.2 Requirements

As specified in the contract section referenced above.
MCO must provide all of the relevant documentation for each staffing change.
Staffing changes include newly created vacancies.

2.5.3.3 Examples

N/A

2.5.3.4 Scoring Criteria

None

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2.5.4 Provider Network Change Affecting Member Access to Care

Contract Reference: TBD

2.5.4.1 File Specifications

Method: Email: TBD

Format: N/A

File Name: N/A

Trigger: Change to the provider network affecting member access to care

Due Date: Within 10 business days of notification

DMAS: TBD

2.5.4.2 Requirements

As specified in the contract section referenced above.

2.5.4.3 Examples

N/A

2.4.24.4 Scoring Criteria

None

2.5.5 Major Contract Changes

Contract Reference: TBD

2.5.5.1 File Specifications

Method: Email: TBD
Format: N/A
File Name: N/A
Trigger: Change to any major network provider contract
Due Date: Within 30 business days
DMAS: TBD

2.5.5.2 Requirements

As specified in the contract section referenced above.

2.5.5.3 Examples

N/A

2.5.5.4 Scoring Criteria

None

2.5.6 Changes to Claims Operations

Contract Reference: TBD

2.5.6.1 File Specifications

Method: Email: TBD
Format: N/A
File Name: N/A
Trigger: Any significant changes to the MCO's claims processing operations
Due Date: 45 calendar days in advance of any change
DMAS: TBD

2.5.6.2 Requirements

As specified in the contract section referenced above.

2.5.6.3 Examples

N/A

2.5.6.4 Scoring Criteria

None

2.5.7 Provider Disenrollment Policies & Procedures

Contract Reference: TBD

2.5.7.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_PROV_DISENROLL.pdf
Trigger: Initial MLTSS contract signing
Due Date: Prior to signing of original contract
10 business days prior to implementation of any revision
Within 10 business days of request from DMAS
DMAS: TBD

2.5.7.2 Requirements

As specified in the contract section referenced above.

2.5.7.3 Examples

N/A

2.5.7.4 Scoring Criteria

None

2.5.8 Provider Education & Outreach

Contract Reference: TBD

2.5.8.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_PROV_OUTREACH.pdf
Trigger: Networking or outreach program event
Due Date: 2 calendar weeks prior to event
DMAS: TBD

2.5.8.2 Requirements

N/A

2.5.8.3 Examples

N/A

2.5.8.4 Scoring Criteria

None

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2.5.9 Member Education & Outreach

Contract Reference: TBD

2.5.9.1 File Specifications

Method: DMAS secure MLTSS 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 should be included. Do not include a header row in .csv files.
File Name: MLTSS_MBR_OUTREACH.csv
Trigger: Community education, networking or outreach program event
Due Date: 2 calendar weeks prior to event
DMAS: TBD

2.5.9.2 Requirements

N/A

2.5.9.3 Examples

N/A

2.5.9.4 Scoring Criteria

None

2.5.10 Program Changes

Contract Reference: TBD

2.5.10.1 File Specifications

Method: Email: TBD
Format: N/A
File Name: N/A
Trigger: When they occur
Due Date: 30 calendar days prior to implementation
DMAS: TBD

2.5.10.2 Requirements

As specified in the contract section referenced above.

2.5.10.3 Examples

N/A

2.5.10.4 Scoring Criteria

None

2.5.11 EPSDT Second Review Process

Contract Reference: TBD

2.5.11.1 File Specifications

Method: Email: TBD
Format: N/A
File Name: N/A
Trigger: Prior to signing original contract
Upon Revision
Due Date: Prior to signing contract original contract
10 business days prior to implementation of any revision
DMAS: TBD

2.5.11.2 Requirements

As specified in the contract section referenced above.

2.5.11.3 Examples

N/A

2.5.11.4 Scoring Criteria

None

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2.5.12 Compliance for Sterilizations & Hysterectomies

Contract Reference: TBD

2.5.12.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_STERL_HYST.pdf
Trigger: Prior to Signing Original Contract
Upon Revision
Upon Request
Due Date: Prior to signing original contract
10 business days prior to implementation of any revision
Within 10 business days of receiving a request from DMAS
DMAS: TBD

2.5.12.2 Requirements

As specified in the contract section referenced above.

2.5.12.3 Examples

N/A

2.5.12.4 Scoring Criteria

None

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2.5.13 **Substance Abuse Services for Pregnant Women**

Contract Reference: TBD

2.5.13.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_SUBS_ABS_PREG.pdf
Trigger: Prior to Signing Original Contract
Upon Revision
Upon Request
Due Date: Prior to signing original contract
10 business days prior to any published revision to the Provider Manual
Within 10 business days of receiving a request from DMAS
DMAS: TBD

2.5.13.2 Requirements

As specified in the contract section referenced above.

2.5.13.3 Examples

N/A

2.5.13.4 Scoring Criteria

None

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2.5.14 **Access to Services for Disabled Children & Children with Special Health Care Needs**

Contract Reference: TBD

2.5.14.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_CSHCN_ACCESS.pdf
Trigger: Prior to Signing Original Contract
Upon Revision
Upon Request
Due Date: Prior to signing original contract
10 business days prior to implementation of any revision
Within 10 business days of receiving a request from DMAS
DMAS: TBD

2.5.14.2 Requirements

As specified in the contract section referenced above.

2.5.14.3 Examples

N/A

2.5.14.4 Scoring Criteria

None

2.5.15 Atypical Drug Utilization Reporting

Contract Reference: TBD

2.5.15.1 File Specifications

Method: Email: TBD
Format: N/A
File Name: N/A
Trigger: DMAS request
Due Date: Within 10 business days of request (or sooner if request is expedited by DMAS)
DMAS: TBD

2.5.15.2 Requirements

As specified in the contract section referenced above.

2.5.15.3 Examples

N/A

2.5.15.4 Scoring Criteria

None

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2.5.16 Incarcerated Members

Contract Reference: TBD

2.5.16.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_INCAR_999999999999.pdf (where 9s are the member ID)
Trigger: Identification of incarcerated member
Due Date: Within 48 hours of knowledge
DMAS: TBD

2.5.16.2 Requirements

As specified in the contract section referenced above.

Contractor must utilize the Member Event reporting template provided on MLTSS website.

Submit each incarcerated member report to DMAS in a separate file.

2.5.16.3 Examples

N/A

2.5.16.4 Scoring Criteria

None

2.5.17 Enhanced Services

Contract Reference: TBD

2.5.17.1 File Specifications

Method: Email: TBD
Format: N/A
File Name: N/A
Trigger: Upon Revision
Due Date: 30 calendar days prior to implementing any new enhanced services
DMAS: TBD

2.5.17.2 Requirements

As specified in the contract section referenced above.

2.5.17.3 Examples

N/A

2.5.17.4 Scoring Criteria

None

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2.5.18 NCQA Accreditation Renewal

Contract Reference: TBD

2.5.18.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_NCQA_RENEW.pdf
Trigger: NCQA Accreditation Assessment or Renewal
Due Date: Within 30 calendar days after NCQA notification to the MCO
DMAS: TBD

2.5.18.2 Requirements

As specified in the contract section referenced above. Must include all components.

2.5.18.3 Examples

N/A

2.5.18.4 Scoring Criteria

None

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2.5.19 Fraud and/or Abuse Incident

Contract Reference: TBD

2.5.19.1 File Specifications

Method: Email: TBD

Format: Adobe .pdf file

File Name: N/A

Trigger: Discovery of an incident of potential or actual fraud and/or abuse on the part of the Contractor, its network providers or members. To include marketing services fraud, waste and/or abuse.

Initiation of any investigative action by the Contractor or notification to the Contractor that another entity is conducting such an investigation of the Contractor, its network providers or members. To include marketing services fraud, waste and/or abuse.

Due Date: Within 48 hours of discovery of incident

DMAS: Program Integrity Division

2.5.19.2 Requirements

As specified in the contract section referenced above.

Report must use one of the following templates available from the MLTSS web site:

Notice of Suspected Recipient Fraud or Misconduct

Notification of Provider Investigation

Referral of Suspected Provider Fraud

2.5.19.3 Examples

N/A

2.5.19.4 Scoring Criteria

None

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2.5.20 Enrollment Verification for Providers Policies & Procedures

Contract Reference: TBD

2.5.20.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_ENROL_VER.pdf
Trigger: Prior to signing original contract
Upon Revision
Upon Request
Due Date: Prior to signing original contract
10 business days prior to implementation of any revision
Within 10 business days of receiving a request from DMAS
DMAS: TBD

2.5.20.2 Requirements

As specified in the contract section referenced above.

2.5.20.3 Examples

N/A

2.5.20.4 Scoring Criteria

None

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2.5.21 Encounter Data Deficiencies

Contract Reference: TBD

2.5.21.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_ENC_DEFIC.pdf
Trigger: Identification of deficiency(s) in encounter data processes
Due Date: Within 30 calendar days of identification
DMAS: TBD

2.5.21.2 Requirements

As specified in the contract section referenced above.

2.5.21.3 Examples

N/A

2.5.21.4 Scoring Criteria

None

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2.5.22 BOI Filing - Revisions

Contract Reference: TBD

2.5.22.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_BOI_REVISION.pdf
Trigger: Upon Revision
Due Date: On the same day on which it is submitted to the Bureau of Insurance
DMAS: Provider Reimbursement Division

2.5.22.2 Requirements

As specified in the contract section referenced above.

2.5.22.3 Examples

None

2.5.22.4 Scoring Criteria

None

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2.5.23 Financial Report - Revisions

Contract Reference: TBD

2.5.23.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_FIN_REVISION.pdf
Trigger: Upon Revision
Due Date: On the same day on which it is submitted to the Bureau of Insurance
DMAS: Provider Reimbursement Division

2.5.23.2 Requirements

As specified in the contract section referenced above and additional guidance provided by DMAS Provider Reimbursement Division.

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

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

2.5.23.3 Examples

None

2.5.23.4 Scoring Criteria

None

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2.5.24 Basis of Accounting Changes

Contract Reference: TBD

2.5.24.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_BOA_CHANGE.pdf
Trigger: Implementation of any change(s) to the MCO's basis of accounting
Due Date: Must be submitted to DMAS 30 calendar days prior to implementation of change(s)
DMAS: Provider Reimbursement Division

2.5.24.2 Requirements

As specified in the contract section referenced above.

2.5.24.3 Examples

N/A

2.5.24.4 Scoring Criteria

None

2.5.25 Reserve Requirements Changes

Contract Reference: TBD

2.5.25.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_RESERVE.pdf
Trigger: Written notification received by the MCO from BOI or any other entity requiring sanctions or/or changes to the MCO's reserve requirements
Due Date: Must be submitted to DMAS within 2 business days
DMAS: Provider Reimbursement Division

2.5.25.2 Requirements

As specified in the contract section referenced above.

2.5.25.3 Examples

N/A

2.5.25.4 Scoring Criteria

None

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2.5.26 FQHC/RHC Arrangements

Contract Reference: TBD

2.5.26.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_FQHC_ARRANGE.pdf
Trigger: Original contract signature
Establishment of a financial arrangement with an FQHC or RHC, or changes to an existing arrangement
Due Date: 60 calendar days prior to contract signature
Within 10 business days of establishing or changing arrangement
DMAS: Provider Reimbursement Division

2.5.26.2 Requirements

As specified in the contract section referenced above.

2.5.26.3 Examples

N/A

2.5.26.4 Scoring Criteria

None

2.5.27 FQHC/RHC Reimbursement Methodology

Contract Reference: TBD

2.5.27.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_FQHC_REIMBS.pdf
Trigger: DMAS request
Due Date: Within 30 calendar days of the request
DMAS: Provider Reimbursement Division

2.5.27.2 Requirements

As specified in the contract section referenced above.

2.5.27.3 Examples

N/A

2.5.27.4 Scoring Criteria

None

2.5.28 Transaction with Other Party of Interest

Contract Reference: TBD

2.5.28.1 File Specifications

Method: Email: TBD
Format: Adobe .pdf file
File Name: MLTSS_OTH_INTEREST.pdf
Trigger: Occurrence of material transaction between the Contractor (MCO) and other party of Interest
Due Date: Must be submitted to DMAS within 5 business days after transaction occurs
DMAS: TBD

2.5.28.2 Requirements

As specified in the contract section referenced above.

2.5.28.3 Examples

N/A

2.5.28.4 Scoring Criteria

None

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2.5.29 Acquisition/Merger/Sale

Contract Reference: TBD

2.5.29.1 File Specifications

Method: Email: TBD
Format: Adobe .pdf file
File Name: MLTSS_MERGER.pdf
Trigger: Public announcement of agreement as identified in the MLTSS contract.
Due Date: Within 5 calendar days of any such agreement
DMAS: TBD

2.5.29.2 Requirements

As specified in the contract section referenced above.

2.5.29.3 Examples

N/A

2.5.29.4 Scoring Criteria

None

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2.5.30 Ownership Change

Contract Reference: TBD

2.5.30.1 File Specifications

Method: Email: TBD
Format: Adobe .pdf file
File Name: MLTSS_OWNERSHIP.pdf
Trigger: Change to MCO's ownership as identified in the MLTSS contract
Due Date: 5 calendar days prior to change
DMAS: TBD

2.5.30.2 Requirements

As specified in the contract section referenced above.

2.5.30.3 Examples

N/A

2.5.30.4 Scoring Criteria

None

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2.5.31 MCO Principal Conviction or Criminal Offense

Contract Reference: TBD

2.5.31.1 File Specifications

Method: Email: TBD

Format: PDF

File Name: MLTSS_OFFENSE.pdf

Trigger: Identification any person, principal, agent, managing employee, or key provider of health care services who (1) has been convicted of a criminal offense related to that individual's or entity's involvement in any program under Medicaid or Medicare since the inception of those programs (1965) or (2) has been excluded from the Medicare and Medicaid programs for any reason.

Due Date: Within 48 hours of identification

DMAS: Program Integrity Division

2.5.31.2 Requirements

As specified in the contract section referenced above.

2.5.31.3 Examples

N/A

2.5.31.4 Scoring Criteria

None

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2.5.32 Contractor or Subcontractor on LEIE

Contract Reference: TBD

2.5.32.1 File Specifications

Method: Email: TBD
Format: PDF
File Name: MLTSS_SUB_LEIE.pdf
Trigger: Identification of any Contractor or subcontractor owners or managing employees on the Federal List of Excluded Individuals/Entities (LEIE) database.
Due Date: Within 5 business days of identification
DMAS: Program Integrity Division

2.5.32.2 Requirements

As specified in the contract section referenced above.

2.5.32.3 Examples

N/A

2.5.32.4 Scoring Criteria

None

2.5.33 Other Categorically Prohibited Affiliations

Contract Reference: TBD

2.5.33.1 File Specifications

Method: Email: TBD
Format: PDF
File Name: MLTSS_OTH_EXCL.pdf
Trigger: Action taken by contractor to exclude entity(s) based on the provisions in MLTSS contract
Due Date: Within 48 hours of action
DMAS: Program Integrity Division

2.5.33.2 Requirements

As specified in the contract section referenced above.

2.5.33.3 Examples

N/A

2.5.33.4 Scoring Criteria

None

2.5.34 Ownership/Control of Other Entity

Contract Reference: TBD

2.5.34.1 File Specifications

Method: Email: TBD
Format: N/A
File Name: N/A
Trigger: Prior to signing original contract
Change in MCO's ownership and/or control of another entity
Due Date: 5 calendar days prior to change in ownership
DMAS: TBD

2.5.34.2 Requirements

N/A

2.5.34.3 Examples

N/A

2.5.34.4 Scoring Criteria

None

2.5.35 MCO Medicaid MLTSS Business Changes

Contract Reference: TBD

2.5.35.1 File Specifications

Method: Email: TBD
Format: N/A
File Name: N/A
Trigger: Change to MCO's Medicaid MLTSS business as identified in the MLTSS contract
Due Date: Within 5 business days
DMAS: TBD

2.5.35.2 Requirements

As specified in the contract section referenced above.

2.5.35.3 Examples

N/A

2.5.35.4 Scoring Criteria

None

2.5.36 PHI Breach/Disclosure Notification to DMAS

Contract Reference: TBD

2.5.36.1 File Specifications

Method: Email: TBD
Format: N/A
File Name: N/A
Trigger: Refer to contract language
Due Date: Refer to contract language
DMAS: TBD

2.5.36.2 Requirements

As specified in the contract section referenced above.

2.5.36.3 Examples

N/A

2.5.36.4 Scoring Criteria

None

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2.5.37 Third Party Administrator (TPA) Contracts

Contract Reference: TBD

2.5.37.1 File Specifications

Method: Email: TBD
Format: N/A
File Name: N/A
Trigger: 10 business days prior to execution, and then annually or upon amendment thereafter
Due Date: As defined in trigger
DMAS: TBD

2.5.37.2 Requirements

As specified in the contract section referenced above.

2.5.37.3 Examples

N/A

2.5.37.4 Scoring Criteria

None

2.5.38 Notification of Potential MCO Liability

Contract Reference: TBD

2.5.38.1 File Specifications

Method: Email: TBD
Format: N/A
File Name: N/A
Trigger: Involvement in a situation in which the contractor or one of its subcontractors may be held liable for damages or claims against the contractor or subcontractor
Due Date: Within 24 hours of involvement
DMAS: TBD

2.5.38.2 Requirements

As specified in the contract section referenced above.

2.5.38.3 Examples

N/A

2.5.38.4 Scoring Criteria

None

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2.5.39 Request for Publication or Presentation of DMAS-Related Subjects

Contract Reference: TBD

2.5.39.1 File Specifications

Method: Email: TBD
Format: N/A
File Name: N/A
Trigger: Presentation or publication of any DMAS data to any third party entity
Due Date: 30 calendar days prior to the publication / presentation / release of data
DMAS: TBD

2.5.39.2 Requirements

As specified in the contract section referenced above.

2.5.39.3 Examples

N/A

2.5.39.4 Scoring Criteria

None

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2.5.40 **Bankruptcy Petition**

Contract Reference: *TBD*

2.5.40.1 File Specifications

Method: Email: TBD
Format: N/A
File Name: N/A
Trigger: Filing a petition in bankruptcy by a principle network provider or subcontractor
Due Date: Within 24 hours of notification
DMAS: TBD

2.5.40.2 Requirements

As specified in the contract section referenced above.

2.5.40.3 Examples

N/A

2.5.40.4 Scoring Criteria

None

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2.5.41 Notification of Changes to Subcontractor Method of Payment or any Alternative Payment Methodology

Contract Reference: TBD

2.5.41.1 File Specifications

Method: Email: TBD
Format: N/A
File Name: N/A
Trigger: Change in MCO's method of payment to subcontractor
Due Date: 45 calendar days prior to change
DMAS: TBD

2.5.41.2 Requirements

As specified in the contract section referenced above.

2.5.41.3 Examples

N/A

2.5.41.4 Scoring Criteria

None

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2.5.42 New Agreements and Changes in Approved Agreements

Contract Reference: TBD

2.5.42.1 File Specifications

Method: DMAS secure MLTSS FTP server
Format: Adobe .pdf file
File Name: MLTSS_PHI_AGREE.pdf
Trigger: Prior to Signing Original Contract
Upon Revision
Upon Request
Due Date: Prior to signing original contract
10 business days prior to implementation of any revision
Within 10 business days of receiving a request from DMAS
DMAS: TBD

2.5.42.2 Requirements

As specified in the contract section referenced above.

2.5.42.3 Examples

N/A

2.5.42.4 Scoring Criteria

None

3 DMAS Reports

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3.1 Reports Generated by DMAS

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

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

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

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3.1.1 Provider File

Contract Reference: TBD

3.1.1.1 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

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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.

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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 secure MLTSS FTP server
Format Text .txt file
File Name MLTSS_Provider_yyyyymm.txt
Trigger Monthly
Schedule Generated around the 6th of the month, but may vary based on data availability
DMAS N/A

3.1.1.2 Description

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

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3.1.2 Plan Change Report

Contract Reference: TBD

3.1.2.1 File Specifications

Change Report - MM CCYY

Transferred From MCO	Transfer To MCO	Reason for MCO Change	Reason Description	Total number of Members

Transfer To MCO	Transferred From MCO	Reason for MCO Change	Reason Description	Total number of Members

Method DMAS secure MLTSS FTP server
 Format Excel
 File Name MLTSS_Plan_Chg_yyyymm.xlsx
 Trigger Monthly
 Schedule After 18th of the month
 DMAS N/A

3.1.2.2 Description

This report is generated monthly by DMAS' enrollment broker and forwarded to the MCOs around the 18th of the month. The report identifies the total number of recipients in each plan who have contacted the MLTSS Helpline to change MCOs and the reasons for the changes. This report does not contain recipient-specific information but rather is to provide the MCOs with information about why recipients are moving from their health plan. This report may be helpful in identifying potential access issues, barriers, etc.

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3.1.3 TPL

Contract Reference: TBD

3.1.3.1 File Specifications

Variable	Description
RECIP	Member Id
R_L_NAME	Member Last Name
R_F_NAME	Member First Name
R_M_NAME	Member Middle Initial
PROV	Provider NPI (MCO)
ENR_BEG	Benefit Enrollment Begin
ENR_END	Benefit Enrollment End
TPL_INS	TPL Carrier Code
CARRIER_NAME	TPL Carrier Name
TPL_POL	TPL Policy Number
COV	TPL Coverage Code
COV_DESC	TPL Coverage Description
COVBEG	TPL Coverage Begin
COVEND	TPL Coverage End

Method DMAS secure MLTSS FTP server
Format Excel 2007
File Name MLTSS_TPL_yyyymm
Trigger Monthly
Schedule After the 18th of the month
DMAS N/A

3.1.3.2 Description

This file provides TPL information (except for limited type coverage such as dental) for recipients who have been enrolled in the health plan during the last 12 month period, and who may have also had TPL during that 12 month period. Information contained in the TPL file includes the carrier name, policy, coverage begin and end dates, and coverage type. This information provides health plans with another source of information to coordinate past payments to providers, if needed.

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3.1.4 Medical Transition

Contract Reference: TBD

3.1.4.1 File Specifications

Variable	Description
RUN_DATE	Date that the MedTrans file was created.
PLAN_PROV	VAMMIS MCO provider identifier.
RECORD_TYPE	The MedTrans file contains data for claims and prior auths. This field indicates whether this record is for a claim 'C' or prior auth 'P'.
RECIP	VAMMIS recipient identifier.
AID_CAT	VAMMIS eligibility aid category.
R_L_NAME	Recipient last name.
R_F_NAME	Recipient first name.
R_M_NAME	Recipient middle initial.
BIRTH	Recipient birth date.
SEX	Recipient gender.
FIPS	Recipient FIPS (locality) code.
SERVICE_TYPE	General descriptive category indicating type of claim (invoice type) or service (service category).
SRV_PROV	Servicing (or authorizing) provider ID. This is the internal DMAS provider ID.
S_P_NAME	Servicing (or authorizing) provider name.
PROV_CLS	Servicing provider class type.
PRV_SPEC	Servicing provider specialty.
FROM_DTE	Service from date.
THRU_DTE	Service thru date.
DIAGNOSIS_CODE	Primary diagnosis code from claim or prior auth.
PROCCD	On a 1500 claim, this is the servicing procedure code. On a UB claim, this is the principle procedure code. On a pharmacy claim, this is the NDC. On a prior auth, this is the authorized procedure or NDC.
VUS	From claim, units billed or pharmacy quantity dispensed.
REFILL	Code indicating whether a prescription is an original or a refill.
PA_NUM	Prior authorization identifier number.
AUNIT	From the prior auth, this is number of units initially authorized.
AAMNT	From the prior auth, this is number of units initially authorized.
UUNIT	From the prior auth, this is number of units used to date.
SRVC_PROV_NPI	Servicing (or authorizing) provider ID. May be NPI or Medicaid administrative ID (API).
PRESC	Claim Pharmacy Prescription Number
DAYS_SUP	Claim Pharmacy Days Supply
C_NDC	NDC on the Practitioner claim
WAIVER	Waiver
E_I	Early Intervention
FC	Foster Care
ICN	Reference Number
BILLTYPE	Bill Type
COV_CHG	Billed Amount

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Variable	Description
PLACE	Location
PRSC_PRV	Prescriber ID

Method DMAS secure MLTSS FTP server
Format Text .txt files
File Name MLTSS_Med_Trans_yyymm.txt
Trigger Monthly
Schedule After the 18th of the month
DMAS N/A

3.1.4.2 Description

This report provides the prior 24 months of claim activity and the prior 12 months of prior authorizations that is on file for newly-eligible MCO recipients. “Newly eligible” status is determined by looking at the last 3 months of 834 files to see if the recipient was in the same MCO (three or more months prior). If not found, the recipient is considered “new” for the purposes of this report.

The following table identifies the source of the values provided in the ‘Service Code’ field in this report:

Service Type	EDI	Service Code Source
Hospital IP	837I	Principle Procedure Code (ICD9)
Nrsg Hm/ SNF	837I	Principle Procedure Code (ICD9)
OutPat/Hm Hlth	837I	Principle Procedure Code (ICD9)
Personal Care	837P	Procedure Code (CPT/HCPCS)
Practitioner	837P	Procedure Code (CPT/HCPCS)
Pharmacy	NCPDP	NDC
Laboratory	837P	Procedure Code (CPT/HCPCS)
Medicare Xover A	837I	Principle Procedure Code (ICD9)
Medicare Xover B	837P	Procedure Code (CPT/HCPCS)
ICF	837I	Principle Procedure Code (ICD9)
Dental	837D	Dental Procedure Codes
Transportation	837P	Procedure Code (CPT/HCPCS)

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3.1.5 EOM 834 Summary

Contract Reference: TBD

3.1.5.1 File Specifications

Variable	Description
PROVIDER	MCO NPI
MAIN_CD	Record Type 21 - Add, 24 - Term, 30 - Audit
RECORD_COUNT	Member Count

Method DMAS secure MLTSS FTP server
Format Excel 2007
File Name MLTSS_EOM834_Cnts_yyyymm.xlsx
Trigger Monthly
Schedule After the 1st of the month (EOM834)
DMAS N/A

3.1.5.2 Description

This report provides a count of members on the EOM 834.

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3.1.6 MID 834 Summary

Contract Reference: TBD

3.1.6.1 File Specifications

Variable	Description
PROVIDER	MCO NPI
MAIN_CD	Record Type 21 - Add, 24 - Term, 30 - Audit
RECORD_COUNT	Member Count

Method DMAS secure MLTSS FTP server
Format Excel 2007
File Name MLTSS_MID834_Cnts_yyyymm.xlsx
Trigger Creation of the mid-month 834 file
Schedule 5 business days after mid-month 834 creation
DMAS N/A

3.1.6.2 Description

This report provides a count of members on the MID 834 and sent to the MCO after the mid-month run.

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3.1.7 Patient Utilization Management and Safety (PUMS)

Contract Reference: TBD

3.1.7.1 File Specifications

Variable	Description
MEMBER_ID	Member ID
MEMBER_LAST_NAME	Member Last Name
MEMBER_FIRST_NAME	Member First Name
MEMBER_DOB	Member Date of Birth
PROGRAM_TYPE_CODE	Type of PUMS (Pharmacy or Provider)
PROVIDER_NPI	Provider NPI
PROVIDER_NAME	Provider Name
PROVIDER_STREET	Provider Street Address
PROVIDER_CITY	Provider City
PROVIDER_STATE	Provider State
PROVIDER_ZIP	Provider Zip Code
PROVIDER_PHONE	Provider Phone Number
RESTRICTION_BEGIN_DT	Restriction Begin Date
RESTRICTION_END_DT	Restriction End Date
SRV_CTR	Service Center - MCO identifier

Method DMAS secure MLTSS FTP server
Format Excel 2007
File Name MLTSS_PUMS_yyyymm.xlsx
Trigger Creation of the mid-month 834
Schedule 5 business days after mid-month 834 creation
DMAS N/A

3.1.7.2 Description

Identifies members were previously assigned to Client Medical Management (CMM) in Medicaid fee for service prior to being assigned to the MCO. Report includes the provider and/or pharmacy that the members were assigned to. Report is sent to the MCO after the mid-month 834 cycle is executed.

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3.1.12 Patient Pay Report

Contract Reference: TBD

3.1.12.1 File Specifications

Method

Format

File Name

Trigger

Schedule

DMAS

DRAFT

3.1.13 Capitation Patient Pay Discrepancy Report

Contract Reference: TBD

3.1.13.1 File Specifications

Method

Format

File Name

Trigger

Schedule

DMAS

DRAFT