COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

CINDI B. JONES
DIRECTOR

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MASTER INTERAGENCY / BUSINESS ASSOCIATE AGREEMENT;
PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION

GENERAL CONDITIONS

THIS BUSINESS ASSOCIATE AGREEMENT is made as of the date below, by the Department of Medical Assistance Services (herein referred to as "Covered Entity"), with an office at East Broad Street, Suite 1300, Richmond, Virginia 23219 and the Virginia Department of Health (here in referred to as "Business Associate"), a Virginia State Agency with an office at P.O. Box 2448, Richmond, Virginia 23218-2448, 109 Governor Street, Richmond, Virginia 23219. This covered Entity and the Business Associate are jointly herein referred to as "Parties".

The Covered Entity and Business Associate, as defined in 45 CFR 160.103, have entered into this Business Associate Agreement to comply with all applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), P.L. 104-191, as amended, the current and future Privacy and Security requirements for such an Agreement, the Health Information Technology for Economic and Clinical Health (HITECH) Act, (P.L. 111-5) Section 13402, requirements for business associates regarding breach notification, as well as our duty to protect the confidentiality and integrity of Protected Health Information (PHI) required by law, Department policy, professional ethics, and accreditation requirements.

DMAS and Business Associate ("parties") shall fully comply with all current and future provisions of the Privacy and Security Rules and regulations implementing HIPAA and HITECH, as well as Medicaid requirements regarding Safeguarding Information on Applicants and Recipients of 42 CFR 431, Subpart F, and Virginia Code § 32.1-325.3. The parties desire to facilitate the provision of or transfer of electronic PHI in agreed formats and to assure that such transactions comply with relevant laws and regulations. The parties intending to be legally bound agree as follows:

I. Definitions. As used in this agreement, the terms below will have the following meanings:
   a. Business Associate has the meaning given such term as defined in 45 CFR 160.103.
   b. Covered Entity has the meaning given such term as defined in 45 CFR 160.103.
   c. Provider: Any entity eligible to be enrolled and receive reimbursement through Covered Entity for any Medicaid-covered services.
   d. MMIS: The Medicaid Management Information System, the computer system that is used to maintain recipient (*member*), provider, and claims data for administration of the Medicaid program.
   e. Protected Health Information (PHI) has the meaning of individually identifiable health information as those terms are defined in 45 CFR 160.103.
   f. Breach has the meaning as that term is defined at 45 CFR 164.402.
   g. Required by law shall have the meaning as that term is defined at 45 CFR 160.103.
   h. Unsecured Protected Health Information has the meaning as that term is defined at 45 CFR 164.40.

i. Transport Layer Security (TLS): A protocol (standard) that ensures privacy between communicating applications and their users on the Internet. When a server and client communicate, TLS ensures that no third party may eavesdrop or tamper with any message. TLS is the successor to the Secure Sockets Layer (SSL).

Terms used, but not otherwise defined, in this Agreement shall have the same meaning given those terms under HIPAA, the HITECH Act, and other applicable federal law.

II. Notices

1. Written notices regarding impermissible use or disclosure of unsecured protected health information by the Business Associate shall be sent via email or general mail to the DMAS Privacy Officer (with a copy to the DMAS contract administration) at:

DMAS Privacy Officer, Office of Compliance and Security
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219
hipaaprivacy@dmas.virginia.gov

2. Other written notices to the Covered Entity should be sent via email or general mail to DMAS contract administrator at:

Contact: Brian McCormick, DMAS Policy Division
Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219

III. Special Provisions to General Conditions

1. Uses and Disclosure of PHI by Business Associate. The Business Associate
   a. May use or disclose PHI received from the Covered Entity, if necessary, to carry out its legal responsibilities and for the proper management and administration of its business.
   b. Shall not use PHI otherwise than as expressly permitted by this Agreement, or as required by law.
   c. Shall have a signed confidentiality agreement with all individuals of its workforce who have access to PHI.
   d. Shall not disclose PHI to any member of its workforce except to those persons who have authorized access to the information, and who have signed a confidentiality agreement.
   e. Shall ensure that any agents and subcontractors to whom it provides PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, agree in writing to all the same restrictions, terms, special provisions and general conditions in this BAA that apply to Business Associate. In addition, Business Associate shall ensure that any such subcontractor or agent agrees to implement reasonable and appropriate safeguards to protect Covered Entity's PHI. In instances where one DMAS Business Associate is required to access DMAS PHI from another DMAS Business Associate, the first DMAS Business Associate shall enter into a business associate agreement with the second DMAS Business Associate.
   f. Shall provide Covered Entity access to its facilities used for the maintenance and processing of PHI, for inspection of its internal practices, books, records, and policies and procedures relating to the use and disclosure of PHI, for purpose of determining Business Associate's compliance with this BAA.
   g. Shall make its internal practices, books, records, and policies and procedures relating to the use and disclosure of PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, available to the Secretary of Department of Health and Human Services (DHHS) or its designee and provide Covered Entity with copies of any information it has made available to DHHS under this section of this BAA.
   h. Shall not directly or indirectly receive remuneration in exchange for the provision of any of Covered Entity's PHI, except with the Covered Entity's consent and in accordance with 45 CFR 164.502.
   i. Shall make reasonable efforts in the performance of its duties on behalf of Covered Entity to use, disclose, and request only the minimum necessary PHI reasonably necessary to accomplish the intended purpose with the terms of this Agreement.

j. Shall comply with 45 CFR 164.520 regarding Notice of privacy practices for protected health information.

2. Safeguards - Business Associate shall
   a. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of Covered Entity as required by the HIPAA Security Rule, 45 CFR Parts 160, 162, and 164 and the HITECH Act.
   b. Include a description of such safeguards in the form of a Business Associate Data Security Plan.
   c. In accordance with the HIPAA Privacy Rule, the Security Rule, and the guidelines issued by the National Institute for Standards and Technology (NIST), Business Associate shall use commercially reasonable efforts to secure Covered Entity's PHI through technology safeguards that render PHI unusable, unreadable and indecipherable to individuals unauthorized to access such PHI.
   d. Business Associate shall not transmit PHI over the Internet or any other insecure or open communication channel, unless such information is encrypted or otherwise safeguarded using procedures no less stringent than described in 45 CFR 164.312(e).
   e. Business Associate shall cooperate and work with Covered Entity's contract administrator to establish TLS-connectivity to ensure an automated method of the secure exchange of email.

3. Accounting of Disclosures - Business Associate shall
   a. Maintain an ongoing log of the details relating to any disclosures of PHI outside the scope of this Agreement that it makes. The information logged shall include, but is not limited to;
      i. the date made,
      ii. the name of the person or organization receiving the PHI,
      iii. the recipient's (member) address, if known,
      iv. a description of the PHI disclosed, and the reason for the disclosure.
   b. Provide this information to the Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528.

4. Sanctions - Business Associate shall
   a. Implement and maintain sanctions for any employee, subcontractor, or agent who violates the requirements in this Agreement or the HIPAA privacy regulations.
   b. As requested by Covered Entity, take steps to mitigate any harmful effect of any such violation of this agreement.

5. Business Associate also agrees to all of the following:
   a. In the event of any impermissible use or disclosure of PHI or breach of unsecured PHI made in violation of this Agreement or any other applicable law, the Business Associate shall notify the DMAS Privacy Officer
      i. On the first day on which such breach is known or reasonably should be known by Business Associate or an employee, officer or agent of Business Associate other than the person committing the breach, and

      ii. Written notification to DMAS Privacy Officer shall include the identification of each individual whose unsecured PHI has been, or is reasonably believed by the Contractor to have been, accessed, acquired, used or disclosed during the breach. Business Associate shall confer with DMAS prior to providing any notifications to the public or to the Secretary of HHS.

   b. Breach Notification requirements.
      i. In addition to requirements in 5.a above, in the event of a breach or other impermissible use or disclosure by Business Associate of PHI or unsecured PHI, the Business Associate shall be required to notify in writing all affected individuals to include,
         a) a brief description of what happened, including the date of the breach and the date the Business Associate discovered the breach;
         b) a description of the types of unsecured PHI that were involved in the breach;
         c) any steps the individuals should take to protect themselves from potential harm resulting from the breach;

d) a brief description of what Business Associate is doing to investigate the breach, mitigate harm to individuals, and protect against any future breaches, and, if necessary,
e) Establishing and staffing a toll-free telephone line to respond to questions.

ii. Business Associate shall be responsible for all costs associated with breach notifications requirements in 5b, above.

iii. Written notices to all individuals and entities shall comply with 45 CFR 164.404(c)(2), 164.404(d)(1), 164.406, 164.408 and 164.412.

6. Amendment and Access to PHI - Business Associate shall

a. Make an individual's PHI available to Covered Entity within ten (10) days of an individual's request for such information as notified by Covered Entity.
b. Make PHI available for amendment and correction and shall incorporate any amendments or corrections to PHI within ten (10) days of notification by Covered Entity per 45 CFR 164.526.
c. Provide access to PHI contained in a designated record set to the Covered Entity, in the time and manner designated by the Covered Entity, or at the request of the Covered Entity, to an individual in order to meet the requirements of 45 CFR 164.524.

7. Termination

a. Covered Entity may immediately terminate this agreement if Covered Entity determines that Business Associate has violated a material term of the Agreement.
b. This Agreement shall remain in effect unless terminated for cause by Covered Entity with immediate effect, or until terminated by either party with not less than thirty (30) days prior written notice to the other party, which notice shall specify the effective date of the termination; provided, however, that any termination shall not affect the respective obligations or rights of the parties arising under any Documents or otherwise under this Agreement before the effective date of termination.
c. Within thirty (30) days of expiration or earlier termination of this agreement, Business Associate shall return or destroy all PHI received from Covered Entity (or created or received by Business Associate on behalf of Covered Entity) that Business Associate still maintains in any form and retain no copies of such PHI.
d. Business Associate shall provide a written certification that all such PHI has been returned or destroyed, whichever is deemed appropriate by the Covered Entity. If such return or destruction is infeasible, Business Associate shall use such PHI only for purposes that make such return or destruction infeasible and the provisions of this agreement shall survive with respect to such PHI.

8. Amendment

a. Upon the enactment of any law or regulation affecting the use or disclosure of PHI, or the publication of any decision of a court of the United States or of this state relating to any such law, or the publication of any interpretive policy or opinion of any governmental agency charged with the enforcement of any such law or regulation, Covered Entity may, by written notice to the Business Associate, amend this Agreement in such manner as Covered Entity determines necessary to comply with such law or regulation.
b. If Business Associate disagrees with any such amendment, it shall so notify Covered Entity in writing within thirty (30) days of Covered Entity's notice. If the parties are unable to agree on an amendment within thirty (30) days thereafter, either of them may terminate this Agreement by written notice to the other.

9. This Agreement shall have a document ("Scope of Work"), attached hereto and made a part hereof, containing the following:

a. The names and contact information for at least one primary contact individual from each party to this Agreement.

b. A complete list of all individuals, whether employees or direct contractors of Business Associate, who shall be authorized to access Covered Entity's PHI

c. A list of the specific data elements required by Business Associate in order to carry out the purposes of this Agreement.

d. The purposes for which such data is required.

e. A description of how Business Associate intends to use, access or disclose such data in order to carry out the purposes of this Agreement.

Business Associate agrees to update the above noted information as needed in order to keep the information current. Covered Entity may request to review the above-referenced information at any time, including for audit purposes, during the term of this Agreement.

EACH PARTY has caused this Agreement to be properly executed on its behalf as of the date first above written.

For: Department of Medical Assistance Services

BY: _____

Cindi B. Jones
Director, Department of Medical Assistance Services

DATE: _____

For: Virginia Department of Health

BY: _____

Marissa J. Levine, M.D., M.P.H., F.A.A.F.P.
Commissioner, Virginia Department of Health

DATE: _____

SCOPE-OF-WORK

The **Scope-of Work** provisions are identified and organized into the following sections:

Section I: Methods of Payment (Contract Administrator and Contract Monitors – DMAS: Reporting Manager, Fiscal and Purchases Division)

Section II: Long-Term Care Agreements (Contract Monitor – DMAS: Supervisor, Long Term Care Division)

A. Nursing Facility Licensure and Certification
B. Pre-Admission Screenings
C. Developmental Disabilities (DD) Waiver Screening Assessments

Section III: Program Collaborations (Contract Monitor – DMAS: Policy and Services Manager, Maternal and Child Health Division)

A. Baby Care
B. Children with Special Health Care Needs
C. Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT)
D. Maternal Outreach (Resource Mothers) Program
E. Special Supplemental Food Program for Women, Infants, and Children (WIC))
F. Plan First
G. Maternal and Child Health Collaboration

Section IV: MDS Automation Project (Contract Monitor – DMAS Office of Data Analytics)

Section V: Eligibility Information (Contract Monitor – DMAS Office of Data Analytics)

Section VI: Decedent Information (Contract Monitor – Program Operations Division Manager)

Section VII: Virginia Vaccines for Children (Contract Monitors – Maternal and Child Health Division Manager and Office of Epidemiology)

Section IX: HIV AIDS Data Transfer (Contract Monitors – DMAS Office of Data Analytics and VDH Office of Epidemiology)

Section X: STD and Hepatitis Data Transfer (Contract Monitors – DMAS Office of Data Analytics and VDH Office of Epidemiology)

Section XI: Dental Data Exchange Project (Contract Monitors – DMAS Health Care Services, Program Administration and VDH Office of Family Health Services)

Section XII: Payment for Virginia Birth Records (Contract Monitors – DMAS Fiscal Division and Director VDH Division of Vital Records)

Section XIII: Pandemic Relief/Anti-Viral Medication Tracking System (Contract Monitors – DMAS Information Technology Division and VDH Office of Emergency Preparedness)

Section XIV: Fatality Review and Surveillance (Contract Monitors – DMAS Maternal and Child Health Division Manager and VDH Office of the Chief Medical Examiner)
Section XV: Virginia Medicaid Expedited Eligibility and Enrollment Reimbursement (Contract Monitors - VDH Office of Family Health Services)

Section XVI: All Payers Claims Database (Contract Monitors – DMAS Policy Division Director and VDH Office of Information Management)

Section XVII: State Office of Primary Care Designations Data Exchange (Contract Monitors – DMAS Office of Data Analytics VDH Office of Minority Health and Health Equity)

Definitions

As used in this attachment, the terms below will have the following meanings:

a. ALF – Assisted Living Facility
b. APA – Audit of Public Accounts
c. BabyCare – Virginia Health program for education/counseling services for high risk pregnant women
d. CCC - Care Connection for Children
e. CDC - Centers for Disease Control and Prevention
f. CFR – Code of Federal Regulations
g. CMS – Centers for Medicare and Medicaid Services (formerly HCFA)
h. COBRA - Consolidated Omnibus Budget Reconciliation Act
i. CSHCN - Children with Special Health Care Needs
j. DD – Developmental Disabilities
k. DD Waiver - Individual and Family Developmental Disabilities Support Waiver,
l. DHHS – Department of Health and Human Services (Federal)
m. DMAS – Department of Medical Assistance Services
n. DOE – Department of Education
o. DSS – Department of Social Services
p. EBL - Elevated Blood Lead
q. EPSDT – Early and Periodic Screenings, Diagnosis and Treatment Services
r. FAMIS – Family Access to Medical Insurance Security
s. FFP – Federal Financial Participation
t. FIPS – Federal Information Processing Standards (codes)
u. FQHC-Federally Qualified Health Center
v. HIPAA – Health Insurance Portability and Accountability Act
w. HMO – Health Maintenance Organization
x. IAT – Interagency Transfer
y. ICF/MR – Intermediate Care Facility for the Mentally Retarded
z. IS-Information System
aa. MDS – Minimum Data Set
bb. MMIS – Medicaid Management Information System
cc. Title V – Maternal and Child Health Services Block Grant of the Social Security Act
dd. Title XIX – Medicaid provisions of the Social Security Act
ee. Title XVIII – Medicare provisions of the Social Security Act
ff. RAI - Resident Assessment Instrument
gg. RAL - Regular Assisted Living
hh. RHC-Rural Health Clinic
ii. SCHIP – State Children's Health Information Program
jj. SME-Subject Matter Expert
kk. SSA – Social Security Act
ll. UAI – Uniform Assessment Instrument
mm. VMAP – Virginia Medical Assistance Services Program / Medicaid
nn. VAC – Virginia Administrative Code
oo. VaMMIS – Virginia Medicaid Management Information Systems
pp. Va. Code – Code of Virginia
qq. VCHS – Virginia Center for Health Statistics
rr. VDH – Virginia Department of Health
ss. VHLS - Department of Health/Lead Safe Virginia
tt. WIC – Special Supplemental Nutrition Program for Women, Infants and Children

Section I: Methods of Payment

DMAS Contact: – Reporting Manager, Fiscal and Purchases Division

VDH Contact: Deputy Commissioner for Administration

If monetary reimbursement is to be made for the performance of services described herein, DMAS will reimburse VDH by one of four methods identified below and defined in the Virginia Department of Accounts' memorandum of May 20, 1998, entitled "Procedures for Identifying and Accounting for Transactions between State Agencies and Institutions." The method of payment, if any, for each service covered by the Agreement is set forth in the relevant section.

VDH agrees to collect, record and maintain documentation and an audit trail that supports expenses related to carrying out the provisions of this Agreement. VDH shall bill DMAS via Interagency Transfer (IAT) for its monthly costs within forty-five (45) days of the close of each month. The IAT shall reflect the total expenditures incurred (i.e., both the General and Non-general funds), the project number assigned to each service, and the services performed. Sufficient documentation in the form of accounting or ledger reports shall be submitted with the IAT to support the draw of federal monies. Any indirect costs included in the billings shall be supported by a federally approved cost allocation plan and shall be separately identified on the billing. If sufficient documentation is not presented with the IAT, DMAS shall return the IAT to VDH. Once sufficient documentation has been presented, DMAS will use its best efforts to process the IAT. If the APA or other auditing agents question costs associated with billings by VDH, VDH shall be responsible for providing additional backup documentation and verification. VDH shall reimburse DMAS for any unsupported or disallowed costs. All requests for reimbursement shall be sent to:

Medicaid Grant Supervisor
Fiscal Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Method 1 – Pass Through Subrecipient Transaction:
Under this method, DMAS, acting in its capacity as the single state agency, will transfer only federal matching funds to VDH to reimburse VDH for the costs of rendering services to the Medicaid and SCHIP programs in accordance with the VDH Cost Allocation Plan. VDH, rather than DMAS, holds the state appropriations from the General Assembly for both the General and Non-General Funds. Under this method, VDH is DMAS' subrecipient.

DMAS shall:

- Record the transactions using Fund 1000, Transaction Code 497, GLA 989, CFDA number 93.778 (93.767 for FAMIS) and a project number as defined in the applicable section of this Agreement;
- Report the pass through on the Schedule of Subrecipient under VDH; and
- Transfer funds from the Medicaid or SCHIP programs to VDH within 30 days of receipt of the IAT.

VDH shall:

- Record expenditures using the appropriate subobject codes using Fund 1000.
- Funds from DMAS should be coded with Transaction Code 116 using GLA 988and Fund 1000.
- Report the expenditures on the Schedule of Pass Through Funds Received from Other Agencies; and Report to the DMAS Grant Supervisor prior to July 15 each fiscal year the total amount of funds transferred through subrecipient activity during the preceding fiscal year. If there are any unresolved discrepancies between DMAS and VDH calculations, the DMAS calculation shall be used for final filing of the Schedule of Federal Assistance.

Method 2 – Vendor Transaction:
Under this method, DMAS, acting in its capacity as the single state agency, will reimburse VDH for both the federal and state portions of qualifying expenditures related to services VDH has rendered to the Medicaid or SCHIP programs. DMAS holds the appropriation from the General Assembly.

DMAS shall:

- Record the transactions using Funds 0100 and 1000, Transaction Code 380, CFDA number 93.778, the appropriate subobject codes and a project number as defined in the applicable section of this Agreement;
- Process the IAT within 30 days from the date of receipt of the IAT and supporting documentation; and

- Report the vendor expenditure on the Schedule of Federal Assistance under the Medicaid Grant.

VDH shall:

- Record the amount received as revenue under Revenue Source Code 03007, Sale of Good, or Services to State Entities.

Method 3 – Licensure and Certification:
As the designated State Survey Agency for Medicare/Medicaid by DHHS, VDH receives reimbursement directly from CMS for 75% of the total costs (FFP) of Medicaid survey and certification activities. The remaining 25%, (Medicaid State Match) is the responsibility of VDH.

Method 4 – Federal Match Claims Processing:
Under this method, DMAS acting in its capacity as the single state agency, will reimburse VDH, the State Survey Agency, for the federal match portion of qualifying expenditures related to completion of pre-admission screening services which VDH has rendered to DMAS. DMAS holds the General Fund appropriation for the Medicaid State Match from the General Assembly.

DMAS shall:

- Execute claims processing of federal and general funds to reimburse VDH for the Medicaid pre-admission screenings submitted by each locality for processing.

VDH shall:

- Have localities submit completed pre-admission screening documentation for processing and adjudication by VaMMIS.
- Record DMAS' transfer of the Medicaid State Match amount special fund revenue.

VDH shall submit annual budget estimates to the DMAS Budget Office, no later than September 1, for the Medicaid State Match for reimbursable activities included in this Agreement, so that DMAS may include the estimates in requests for General Fund Appropriations from the General Assembly.

VDH and DMAS shall undertake an annual review of the intent and provisions of the responsibilities described herein. Each agency shall designate a senior staff individual to serve as its principal contact on questions that arise on these subjects and/or for initiating amendments to this agreement when they are required.

Method 5 – DMAS Claims Processing:
Under this method, Payment will be made to VDH health districts with provider billing agreements with DMAS and are authorized to render services at reimbursement rates established by DMAS. Reimbursement shall be made via the routine DMAS claims submission and payment process.

Section II: Long-Term Care Agreements

A. Nursing Facility Licensure and Certification

DMAS Contact: Contract Monitor, Long Term Care Division Supervisor

VDH Contact: Deputy Commissioner for Chief Deputy for Public Health and Preparedness

State and Federal Code Reference:
Title 32.1, Chapter 10, of the Va. Code, 1950, as amended, and through agreement with the U.S. Secretary of the DHHS, to administer the Virginia State Plan for Medical Assistance Services and the provisions of Title XIX (Medicaid) of the SSA.

The VDH is the official State Survey Agency designated by agreement with the Secretary of DHHS, under statute 1864(a) of the Title XVIII of the SSA and § 32.1-137 of the Code of Virginia, 1950, amended.

State Code and Plan Reference:
VDH is the designated licensing agency responsible for carrying out provisions of Title 32.1, Chapter 5, Article 1 (Hospital and Nursing Home Licensure and Inspection), Article 2 (Rights and Responsibilities of Patients in Nursing Homes), Article 7 (Hospice Program Licensing) of the Va. Code, 1950, as amended, Article 7.1 (Home Care Organization Licensing) of the Va. Code, 1950, as amended, and the rules and regulations of the State Board of Health adopted from these statutes.

Purpose:
The purpose of this interagency agreement is to define the contractual responsibilities of the DMAS and the VDH, with respect to the execution of the federal survey and certification requirements, as well as clarify areas of collaboration related to state licensing requirements.

Description:
DMAS has contracted with VDH to execute the requirements relating to the on-site survey and certification of providers/suppliers participating in, or requesting participation in the Medicaid program. The scope of services covered under the VMAP may impact VDH's program plans and budgets. Similarly, actions of VDH may affect Medicaid provider service requirements and the cost of services. Therefore, each agency hereby states its intention to coordinate plans to alter current levels of health related services that could affect the plans or operations of the other agency and to consider responses concerning potential impacts before changes are adopted.

Responsibilities:
The Department of Medical Assistance Services shall:

- Promptly provide copies to the VDH (the State Survey Agency) of all changes, revisions, and interpretations in the State Plan or federal regulations that affect the certification of providers/suppliers in the Title XIX , prior to the effective date of implementation;
- Promptly perform the functions required by federal statutes and regulations related to medical review, utilization review, and evaluation of the care of individual recipients for reimbursement purposes;
- Promptly forward to VDH correspondence relating to approval of Medicaid agreements for each certified provider; correspondence and reports relating to the evaluation of appropriateness of care, medical review, and utilization review visits; and all materials for investigations of complaints on actions by Medicare/Medicaid providers/suppliers that affect the healthcare or life safety of Medicare/Medicaid patients;
- Participate in meetings, training sessions and joint on-site visits that are of mutual benefit to both agencies;
- Designate the Director, Long-Term Care and Quality Assurance Division, as the DMAS' liaison with VDH for all matters relating to patient care; and
- Designate the Director, Program Operations Division, as the DMAS primary contact with VDH for all matters relating to provider agreements and enrollment status of Medicaid providers/suppliers of services.

VDH shall:

- Promptly forward to DMAS required survey documents for each provider/supplier in the Title XIX (Medicaid) program, surveyed or re-surveyed;
- Promptly forward to DMAS appropriate licensure and complaint information for Medicaid certified facilities;
- Participate in meetings, training sessions, and on-site visits that the VDH determines are of mutual benefit to both agencies; and
- Designate the Director, Office of Licensure and Certification as liaison with DMAS for coordination of licensure and certification issues which affect both agencies.

Areas of Collaboration:
The Department of Medical Assistance Services and the Department of Health agree to:

- Confer regarding the status of nursing facilities and ICF/MR facilities that are out of compliance with Medicare/Medicaid certification requirements as often as necessary to assure timely communication;
- Furnish copies of nursing facility letters with attached survey reports, regarding the status of nursing facilities and ICF/MR facilities that are out of compliance with Medicare/Medicaid certification requirements;

- Work collaboratively to provide information to recipients and their families if a nursing facility or ICF/MR loses its Medicare and/or Medicaid certification. VDH will be available to explain the survey results as needed to recipients and their families.
- Collaborate on any issues or problems that may arise concerning the effectiveness of this process;

Reimbursement:
As the designated State Survey Agency for Medicare/Medicaid by DHHS, VDH receives reimbursement directly from CMS for 75% of the total costs (FFP) of Medicaid survey and certification activities. The remaining 25%, (Medicaid State Match) is the responsibility of VDH.

B. Pre-Admission Screenings

DMAS Contact: (Contract Monitor - Long Term Care Division Supervisor)

VDH Contact: Director, Public Health Nursing, Community Health Services

Federal Code Reference:
42 CFR § 441.302(c)(1) requires a screening of all individuals who, at the time request admission to community-based care or an ICF/MR are eligible for medical assistance.

State Code and Plan Reference:
§ 32.1-330 of the Va. Code and the Virginia State Plan of Medical Assistance Services require DMAS to evaluate all individuals who will be eligible for institutional or community-based care services to determine their need for nursing facility services as defined in the State Plan.

Purpose:
The assignments of responsibilities as stated herein are intended to result in improved use of state government resources and more effective service delivery by assuring that the provision of authorized Medicaid services are consistent with the statutory functions and the missions of the participating State departments.

Description:
The pre-admission screening evaluation is done in order to determine if the beneficiary does in fact require long-term care services and, if so, whether the provision of institutional services or community-based services represents the most appropriate response to current medical needs. The individual who is seeking nursing facility placement services, a family member, a physician, a community health services or social services professional or any other concerned individual in a community may initiate requests for pre-admission screening.

Planning and Coordination:
The scope of services covered under the VMAP may impact VDH's program plans and budgets. Similarly, actions of VDH to offer health care services to individuals living in poverty may affect Medicaid provider service requirements and the cost of services. Therefore, each agency hereby states its intention to coordinate plans to alter current levels of health related services that could affect the plans or operations of the other agency and to consider responses concerning potential impacts before changes are adopted.

Responsibilities:
<u>DMAS shall:</u>

- Require pursuant to the Va. Code, 1950, as amended, §32.1-330, a pre-admission screening of all individuals who, at the time request for admission to community-based care or a certified nursing facility as defined in Va. Code §32.1-123, are eligible for medical assistance or will become eligible within 180 days following admission;
- Require local or district pre-admission screening committees to be available to render decisions on applications to DMAS for admission to nursing facilities;
- Prepare, distribute and maintain a Medicaid Pre-Admission Screening Manual that describes current program procedures and criteria for conducting pre-admission screenings; and
- Provide training as required to ensure that all members of pre-admission screening committees are qualified to conduct the evaluations annually, and provide a roster of health department personnel trained.

- Authorize Medicaid reimbursement for institutional care or when more appropriate, alternate services that are available under one of the Medicaid home or community-based care waivers.

VDH shall:

- Follow requirements as defined in the Medicaid Pre-Admission Screening Manual;
- Ensure that as a condition of payment for pre-admission screenings all local health department personnel who are assigned as members of pre-admission screening teams have been properly trained in the procedure for conducting such screenings;
- Determine the necessity for institutional care or when more appropriate, alternate services which are available under one of the Medicaid community-based care waivers in accordance with procedures and criteria specified by DMAS in the Medicaid Pre-Admission Screening Manual;
- Authorize Medicaid reimbursement for institutional care or when more appropriate, alternate services which are available under one of the Medicaid community-based care waivers in accordance with procedures and criteria specified by DMAS in the Medicaid Pre-Admission Screening Manual;
- Submit required forms, include but not limited to, (UAI, DMAS-96, DMAS-97, MI/MR, and DMAS-101A/B) to:

Current Fiscal Intermediary

- Inform the applicant, recipient or family member in writing of the decision rendered for authorization of Medicaid services and of the appeal process that is available. DMAS and VDH agree to:
- Collaborate on any issues or problems that may arise concerning the effectiveness of this process;
- Collaborate on various initiatives involving the implementation of Olmstead Recommendations and any other grants and initiatives concerning institutional or home and community-based services; and
- Collaborate to facilitate training as needed regarding new programs/services and existing programs available through the pre-admission screening process.

Reimbursement:
With the implementation of the VaMMIS, pre-admission screening packages are now treated as completed claims once all edits for eligibility and service provision have been satisfied.

Pre-admission screenings (which may result in a beneficiary being eligible for placement in a nursing facility, or a community-based care waiver program, or placement in an assisted living facility) shall be handled as claims transactions in accordance with procedures set forth in the basic agreement. DMAS will pay the federal share (75%) of the interim rate for all pre-admission screenings in accordance with Method 4 Federal Match Claims Payment Method as set forth in Section I of the Scope of Work Attachment. A cost settlement will be conducted annually based on the VDH Cost Allocation Plan. The Cost Allocation Plan explains that annually VDH will determine the cost of pre-admission screenings and final payments will be reconciled to the federal share of the cost. Any additional payment (or recovery) of the federal share will be made using a pass through transaction in accordance with procedures set forth in Section I of the Scope of Work Attachment

C. Developmental Disabilities (DD) Waiver Screening

DMAS Contact: Contract Monitor - Long Term Care Division Supervisor

VDH Contact: CSHCN Program Supervisor, Division of Child and Family Health, Office of Family Health Services

Federal Code Reference:
42 CFR § 441.302(c)(1) requires a screening of all individuals who, at the time of application for admission to community-based care or an ICF/ID are eligible for medical assistance.

State Code and Plan Reference:
12 VAC-30-120-700. Individual and Family Developmental Disabilities Support Waiver

Purpose:
The assignments of responsibilities as stated herein are intended to result in improved use of state government resources and more effective service delivery by assuring that the provision of authorized Medicaid services is consistent with the statutory functions and the missions of the participating State departments.

Description:
The Individual and Family Developmental Disabilities Support Waiver, known as the "DD Waiver," is a Medicaid waiver that will provide home and community-based care services to Medicaid eligible individuals who would otherwise be eligible for placement in an Intermediate Care Facility for the Intellectually Disabled (ICF/ID) This waiver is effective July 1, 2000. Individuals 6 years of age and older with a condition related to intellectual disability, but who do not have a diagnosis of intellectual disability, and who have been determined to require the level of care provided in an ICF/ID are eligible to receive services. Prior to becoming eligible, (DMAS requires that a screening be conducted to determine if the individual meets the diagnostic and functional requirements for admission to the waiver.

Planning and Coordination
Virginia Medicaid may impact VDH's program plans and budgets. Similarly, actions of VDH to offer health care services to individuals living in poverty may affect Medicaid provider service requirements and the cost of services. Therefore, each agency hereby states its intention to coordinate plans to alter current levels of health related services that could affect the plans or operations of the other agency and to consider responses concerning potential impacts before changes are adopted.

Responsibilities:
DMAS shall:

- Require a screening of all individuals who, at the time of application for admission to community-based care or an IDF/ID are eligible for medical assistance.
- Prepare, distribute, and maintain instructions and forms for waiver screenings.
- Provide training as required to ensure that individuals who conduct the screenings are qualified to conduct the evaluation.
- Provide an updated list of support coordinators.
- On a monthly basis, submit the names of individuals requesting to be screened for the DD Waiver to each clinic.
- Provide technical assistance to screening teams as issues arise.
- Inform the applicant, recipient or family member in writing of the decision rendered for authorization of Medicaid Services and of the appeal process that is available.

VDH shall:

- Ensure that as a condition of payment for all screenings conducted at a local health department or contracted available clinic, personnel who are assigned as members of the screening team have been properly trained in the procedure for conducting such screenings;
- Determine the necessity for institutional care or when more appropriate, alternate services which are available under the DD Waiver in accordance with procedures and criteria specified by DMAS in the Individual and Family Developmental Disabilities Support Waiver Screening Team Resource Guide;
- Refer the individual to DMAS when institutional care is determined to be the appropriate service and the individual chooses institutional care in lieu of home and community-based services through the DD Waiver;
- If the applicant meets the criteria for institutional care and chooses DD Waiver services, provide the applicant with a list of available support coordinators and allow the applicant to choose the coordinator of his/her choice. Once the applicant chooses the coordinator, forward screening materials to the support coordinator; and
- Participate in the appeals process as needed if the applicant requesting the screening decides to appeal the screening decision.

Areas of Collaboration:
DMAS and VDH agree to:

- Resolve any problems or issues that may arise concerning the effectiveness of this process; and
- Provide training as needed regarding screening process and the DD Waiver.

Reimbursement:
VDH, Local Health Districts that conduct DD wavier screenings shall bill DMAS in accordance with Method 2 Vendor Transactions as set forth by Section I of the Scope of Work Attachment. A Xerox Summary Report outlining the screenings performed that month shall support the billing. VDH contractors shall directly submit bills to and be reimbursed by DMAS at the stipulated rate of $300 ($350 in northern Virginia) for each screening performed.

Section III: Maternal and Child Health Collaborations

A. Baby Care

DMAS Contact: Contract Monitor, Maternal and Child Health Supervisor

VDH Contact: Contract Monitor, Division of Child and Family Services, Office of Family Health Services

Federal Code Reference:
Title XIX of the SSA, Section 1902 (42 U.S.C. 1396a) requires that the state plan for medical assistance provide for entering into cooperative agreements with the State Health and Title V agencies. 42 CFR 431.615 sets forth requirements for agreements between these agencies. Title V of the SSA, Section 501 (42 USC 701) requires that the state agency administering the state's program under Title V will participate in arrangement and carrying out of coordination agreements relating to coordination of care and services available under Title V and Title XIX and provide, directly and through providers and institutional contractors, of services to identify pregnant women and infants who are eligible for medical assistance and once identified, to assist them in applying for such assistance.

State Code and Plan Reference:
12 VAC30-50-410. Case management services for high-risk pregnant women and children.

Purpose:
The assignments of responsibilities as stated herein are intended to result in improved use of state government resources and more effective service delivery by assuring that the provision of authorized Medicaid services is consistent with the statutory functions and the missions of the participating State departments.

Description:

BabyCare provides pregnant women with the support and services they need through targeted case management services as well as expanded prenatal care services. The program aims to improve birth outcomes by ensuring pregnant women and infants receive all the services they need. BabyCare services can include case management, nutritional counseling, substance abuse treatment, prenatal education, child development education, or home maker services. Such management is provided by a registered nurse or a social worker/family support worker with experience in health care and working with pregnant women and their families.

BabyCare targeted case management services encompass:

- Outreach or case finding and risk screening, which initiates the referral for services and identifies a woman and infant as needing care coordination. Outreach is conducted through medical clinics, physicians' offices, and hospitals. Plans are developed locally in conjunction with community partners.
- Assessments and Service Planning, which is a process that outlines services and resources needed to meet the needs of the client and provides assistance in accessing resources.
- Education and counseling including referral to expanded prenatal services which include classes on smoking cessation, preparation for parenting and childbirth, nutritional counseling, and homemaker services.
- Follow-up and monitoring to assess the ongoing progress and ensure that services are delivered through accurate record keeping.

Planning and Coordination:
The scope of services covered under the VMAP impacts other program plans and budgets. Similarly, actions of VDH to offer health care services to individuals living in poverty can affect Medicaid provider service requirements and the cost

of services. Therefore, each agency hereby states its intention to coordinate plans to alter current levels of health related services that could affect the plans or operations of the other agency and to consider responses concerning potential impacts before changes are adopted.

DMAS and VDH shall collaborate on an as needed basis to:

- Resolve any problems or issues that may arise concerning the effectiveness of this process; and
- Provide training as needed regarding new programs or services and existing programs.

Responsibilities:
The responsibility for the administration of the BabyCare program is a collaborative effort between the DMAS and VDH.

DMAS shall:

- Provide overall administration of the BabyCare Program.
- Collect data and evaluate the effectiveness of the BabyCare Program for pregnant women and children; maintain data for program evaluation and improvement.
- Monitor BabyCare providers in local health departments, private provider practices, Federally Qualified Health Centers and Rural Health Clinics.
- Work in conjunction with VDH to develop presentations to providers and other stakeholder groups on BabyCare as well as other maternal and child health issues that promote improved access to care.
- Maintain the BabyCare case management data tracking system.
- Maintain the BabyCare Provider Manual and other policies, procedures, forms and instructional materials developed in conjunction with the Virginia Department of Health in response to federal and state statutory or regulatory requirements.
- Maintain the VaMMIS subsystem files so that they remain sufficient to accomplish BabyCare claims processing, provider enrollment, and recipient enrollment.
- Authorize the VDH to apply to the federal Department of Health and Human Services for special grants or waivers or to any source of special funding as may be made available in the future for further development expansion of the Medicaid BabyCare program.
- Act as liaison between DMAS, VDH and the Medicaid Managed Care Organization.
- Participate in the VDH Home Visiting Consortium.

VDH shall:

- Provide BabyCare services in each health district where programs exist. This includes the identification of high-risk pregnant women, infants and children eligible to participate and to refer potential pregnant women and children to DSS for eligibility determination.
- Ensure that all Medicaid eligible high-risk pregnant women and children who are identified to health departments and are receptive to receive BabyCare services, receive prenatal care including support services such as appointment scheduling, transportation assistance, assessment of health needs, Behavioral Health Risk Screens, expanded prenatal services and tracking and care coordination to ensure initiation and continuation of treatment for identified problems.
- Provide maternal and child health expertise in the development of outreach and educational materials such as brochures and public relation campaigns.
- Work in conjunction with DMAS to develop presentations to professional and community groups on maternal and child health issues that promote improved access to care.
- Establish and maintain working relationships with local Medicaid participating providers of pediatric and obstetric services to BabyCare Program eligible recipients.
- Develop standards and procedures for quality assurance for maternal and child health providers in cooperation with DMAS.
- Assure that all local health department staff working with pregnant women and children are aware of participating Medicaid providers for maternal and child health services.
- Encourage local health departments to develop partnerships with private maternal and child health providers to facilitate access to care for pregnant women and children and to assist in identifying high-risk clients.

- Provide clinical consultation and technical assistance to local health department professional staff in the development of health care standards, guidelines, and administrative procedures for providers in the delivery of prenatal and postpartum services.
- Support the DMAS' efforts to obtain sufficient state appropriations to maintain provider reimbursement at a level that can assure that BabyCare services are as accessible to Medicaid recipients as they are to the general population.
- Designate a VDH BabyCare Program Manager who will provide program support and ascertain local health department BabyCare training needs as well as participate in any planning and implementation of training indicated.
- Communicate with DMAS and the Medicaid Managed Care Organizations issues that impact pregnant women and infants.

Areas of Collaboration:
DMAS and VDH shall:

- Develop materials to be included in the BabyCare Manual and other provider notices as may be required.
- Share data and participate in planning efforts to develop joint training to improve the delivery of services to high-risk pregnant women and children.
- Develop training and education programs for Medicaid providers, local professional staff, and recipients of BabyCare services.
- Keep each other appraised at all times of those services available to eligible individuals pursuant to federal law and state regulations and guidelines.
- Collaborate in the development of program objectives and outcome criteria including data needs in order to evaluate program effectiveness.
- Designate a liaison from their staff whose responsibilities shall include regular and periodic communication about programs and operations described in this agreement.

Reimbursement:
There shall be no reimbursement to VDH for services rendered in support of the administration of the BabyCare Program. Reimbursement for targeted case management services as well as expanded prenatal care services shall be made in accordance with Method 5 DMAS Claims Processing as set forth by Section I of the Scope of Work Attachment to local health districts who have provider agreements with DMAS and are authorized to render this service at reimbursement rates established by DMAS. Reimbursement shall be made via the DMAS claims submission and payment process.

VDH agrees to collect, record and maintain services and claims billing documentation that supports expenses related to carrying out the provisions of this Agreement.

VDH and DMAS shall take all appropriate steps and implement all appropriate safeguards to ensure the confidential treatment of information provided by providers or by VDH to DMAS or by DMAS to VDH, and to follow the requirements and procedures governing the confidentiality of patient data as mandated by federal and state statutes and regulations.

B. Children with Special Health Care Needs Program

DMAS Contact: (Contract Monitor – Maternal and Child Health Supervisor

VDH Contact: Director, Children with Special Health Care Needs Program, Division of Child and Family Health, Office of Family Health Services

Federal Code Reference:
Title XIX of the SSA, Section 1902 (42 U.S.C. 1396a) requires that the state plan for medical assistance provide for entering into cooperative agreements with the State health and Title V agencies. 42 CFR 431.615 sets forth requirements for agreements between these agencies. Title V of the SSA, Section 501 (42 USC 701) requires that the state agency administering the state's program under Title V will participate in arrangement and carrying out of coordination agreements relating to coordination of care and services available under Title V and Title XIX and provide, directly and

through providers and institutional contractors, of at services to identify pregnant women and infants who are eligible for medical assistance and once identified, to assist them in applying for such assistance.

State Code and Plan Reference:
Va. Code § 32.1-77 authorizes the Board of Health to prepare, amend, and submit to the appropriate federal authority, a state plan for maternal and child health services and children's specialty services pursuant to Title V of the SSA and any amendments thereto. The State Health Commissioner is authorized to administer such plans and to receive and expend federal funds.

Va. Code § 32.1-89 authorizes the Board of Health to establish a program for the care and treatment of persons suffering from hemophilia and other related bleeding diseases.

Va. Code § 32.1-90 authorizes the Board of Health to provide health services for persons suffering from epilepsy and cystic fibrosis.

Purpose:
The assignments of responsibilities as stated herein are intended to result in improved use of state government resources and more effective service delivery by assuring that the provision of authorized Medicaid services is consistent with the statutory functions and the missions of the participating State departments.

Description:
Special needs populations require more diverse and intense services than do individuals without special health care needs. This population includes children with special health care needs (CSHCN) who receive services through the health department's CSHCN Program funded by Title V of the SSA and state funds. CSHCN have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition(s) and who need health and related services of a type or amount over and above the usual for the child's age. The CSHCN Program administers the Care Connection for Children Program, Child Development Services Program, and the Virginia Bleeding Disorders Program that serve these children.

Planning and Coordination:
The scope of services covered under the VMAP impacts other program plans and budgets. Similarly, actions of the VDH to offer health care services to individuals living in poverty can affect Medicaid provider service requirements and the cost of services. Therefore, each agency hereby states its intention to coordinate plans to alter current levels of health related services that could affect the plans or operations of the other agency and to consider responses concerning potential impacts before changes are adopted.

DMAS and VDH shall collaborate on an as needed basis to:

- Resolve any problems or issues that may arise concerning the effectiveness of this process; and
- Provide training as needed regarding new programs or services and existing programs.

Responsibilities:
<u>DMAS shall</u>:

- Collaborate and coordinate on an ongoing basis with VDH on CSHCN issues, share resources, and disseminate information of mutual interest.
- Provide an upper management liaison between DMAS and the Care Connection for Children (CCC) Inter-Center Work Group to:
    - Serve as a point of contact for regular communication between DMAS and CCC
    - Facilitate education so that CCC staff learns about Medicaid and FAMIS and DMAS staff learns about CCC
    - Participate in problem solving with CCC about CSHCN issues
    - Seek CCC input on DMAS policies related to CSHCN
    - Attend the CCC Inter-Center Work Group meeting a minimum of once per year
- Communicate with the Medicaid Managed Care Organizations issues that impact CSHCNs.

VDH shall:

- Provide feedback to DMAS on the impact of managed care on CSHCN, managed care contracts, identification of CSHCN, quality assurance and other issues that impact CSHCN.
- Collaborate and coordinate on an ongoing basis with DMAS on CSHCN issues, share resources, and disseminate information of mutual interest.

Reimbursement:
Reimbursement for services shall be made to the CSHCN Program in accordance with Method 5 DMAS Claims Processing as set forth by Section I of the Scope of Work Attachment to local health districts who have provider agreements with DMAS and are authorized to render this service at reimbursement rates established by DMAS. Reimbursement shall be made via the DMAS claims submission and payment process. For children who are enrolled in a Medicaid MCO, the CSHCN Program and local health departments must be a provider for the particular MCO the member is enrolled to be reimbursed for covered services.

VDH agrees to collect, record and maintain services and billing documentation that supports expenses related to carrying out the provisions of this Agreement.

VDH and DMAS shall take all appropriate steps and implement all appropriate safeguards to ensure the confidential treatment of information provided by providers or by VDH to DMAS or by DMAS to VDH, and to follow the requirements and procedures governing the confidentiality of patient data as mandated by federal and state statutes and regulations.

C. Early and Periodic Screenings, Diagnosis and Treatment Services (EPSDT)

DMAS Contact: (Contract Monitor – Maternal and Child Health Supervisor)

VDH Contact: Policy Analyst, Division of Child and Family Health, Office of Family Health Services

Federal Code Reference:
Title XIX of the SSA, Section 1902 (42 U.S.C. 1396a) requires that the state plan for medical assistance provide for entering into cooperative agreements with the State health and Title V agencies. 42 CFR 431.615 sets forth requirements for agreements between these agencies. Title V of the SSA, Section 501 (42 USC 701) requires that the state agency administering the state's program under Title V will participate in arrangement and carrying out of coordination agreements relating to coordination of care and services available under Title V and Title XIX and provide, directly and through providers and institutional contractors, of at services to identify pregnant women and infants who are eligible for medical assistance and once identified, to assist them in applying for such assistance.

State Code and Plan Reference: None

Purpose:
The assignments of responsibilities as stated herein are intended to result in improved use of state government resources and more effective service delivery by assuring that the provision of authorized Medicaid services is consistent with the statutory functions and the missions of the participating State departments.

Description:
The Virginia EPSDT Program is a Medicaid Program that provides services for children as defined in 42 CFR§§ 44O.4O (b) and 441, Subpart B. These preventive health services encompass:

- Screening and diagnostic services to determine physical or mental defects in recipients under age 21, and
- Health care, treatment, and other necessary measures to correct or ameliorate any defects and chronic conditions discovered.

The administration of the EPSDT program is a collaborative effort among three state agencies: DMAS, VDH, and DSS.

Planning and Coordination:
The scope of services covered under the VMAP may impact VDH's program plans and budgets. Similarly, actions of VDH to offer health care services to individuals living in poverty may affect Medicaid provider service requirements and the cost of services. Therefore, each agency hereby states its intention to coordinate plans to alter current levels of health related services that could affect the plans or operations of the other agency and to consider responses concerning potential impacts before changes are adopted.

Responsibilities:
DMAS shall:

- Disseminate the EPSDT Supplement and other policies, procedures, forms, and instructional materials developed in conjunction with VDH in response to federal and state statutory or regulatory requirements;
- Maintain the VaMMIS EPSDT subsystem files so that they remain sufficient to accomplish EPSDT claims processing and report statistics required by the CMS and by other federal and state agencies.
- Authorize VDH to apply to the federal DHHS for special grants or waivers or to any other source of special funding as may be made available in the future for further development and expansion of the Medicaid EPSDT program.

VDH shall:

- Offer input to DMAS, regarding the current EPSDT program information brochures and other materials that are needed to communicate information about and promote EPSDT to the target population;
- Support DMAS' efforts to obtain sufficient State appropriations to maintain physician reimbursement at a level that can assure that services are available to Medicaid recipients at least to the extent that those services are available to the general population.
- Collaborate with DMAS and DSS in the development of screening standards and procedure guidelines for EPSDT providers.
- Assist with developing materials to be included in the EPSDT Supplemental Medicaid Manual and other provider notices as may be required.

Areas of Collaboration:
DMAS and VDH agree to:

- Collaborate in the development of screening standards and procedure guidelines for EPSDT providers.
- Collaborate with DSS, Head Start, Early Intervention, Department of Education (DOE), and other appropriate organizations to increase the annual number of screenings statewide.
- Provide or facilitate training and technical assistance on EPSDT policies/procedures to local public health department personnel on an as needed basis.
- Share data pursuant to a properly executed Scope of Work specified under this Agreement.

Reimbursement:
There shall be no reimbursement to VDH for services rendered in support of the administration of the EPSDT Program. Payment for medical services provided under the Medicaid and FAMIS Programs shall be made in accordance with Method 5 DMAS Claims Processing as set forth by Section I of the Scope of Work Attachment to local health districts that have provider agreements with DMAS and at rates established by DMAS. Reimbursement for these services shall be made via the DMAS claims submission and payment process.

VDH agrees to collect record and maintain services and billing documentation that supports expenses related to carrying out the provisions of this Agreement. For children who are enrolled in a Medicaid MCO, local health departments must be a provider for the particular MCO the member is enrolled to be reimbursed for covered services.

D. Resource Mothers

DMAS Contact: Contract Monitor – Maternal and Child Health Supervisor

VDH Contact: Contract Monitor, Division of Child and Family Health, Office of Family Health Services

Federal Code Reference:
Title XIX of the SSA, Section 1902 (42 U.S.C. 1396a) requires that the state plan for medical assistance provide for entering into cooperative agreements with the State health and Title V agencies. 42 CFR 431.615 sets forth requirements for agreements between these agencies. Title V of the SSA, Section 501 (42 USC 701) requires that the state agency administering the state's program under Title V will participate in arrangement and carrying out of coordination agreements relating to coordination of care and services available under Title V and Title XIX and provide, directly and through providers and institutional contractors, of at services to identify pregnant women and infants who are eligible for medical assistance and once identified, to assist them in applying for such assistance.

State Code and Plan Reference: None

Purpose:
The assignments of responsibilities as stated herein are intended to result in improved use of state government resources and more effective service delivery by assuring that the provision of authorized Medicaid services is consistent with the statutory functions and the missions of the participating State departments.

Description:
Resource Mothers Medicaid Outreach and Eligibility Services provide Medicaid outreach and eligibility targeting pregnant and parenting teens and their infants. Services provided are to reduce the mortality and morbidity associated with teen pregnancy by assisting the pregnant or parent teen with necessary information on the Medicaid and child's Health Insurance Programs (i.e., FAMIS) available in the Commonwealth. Also includes assisting teens with the identification of and enrollment in Medicaid and FAMIS.

The Resource Mother Program recruits community health workers from the community and provides them with intensive training to serve as a "resource mother" for pregnant and parenting teens and carries out the following duties:

- Identifying pregnant teenagers and getting them into prenatal care early, and
- Assisting teenagers in obtaining Medicaid.

DMAS and VDH agree that the Resource Mother Program serves as a vehicle for expanding maternal outreach efforts as a service under Medicaid.

Planning, Coordination, and Collaboration:
The scope of services covered under the VMAP may impact VDH's program plans and budgets. Similarly, actions of VDH offer health care services to individuals living in poverty may affect Medicaid provider service requirements and the cost of services. Therefore, each agency hereby states its intention to:

- Coordinate plans to alter current levels of health related services that could affect the plans or operations of the other agency.
- Consider responses concerning potential impacts before changes are adopted.
- Provide training as required to ensure that all members are qualified to conduct the evaluations.

DMAS and VDH shall collaborate on an as needed basis to:

- Resolve any problems or issues that may arise concerning pregnant teenagers obtaining Medicaid.
- Provide training as needed regarding new programs or services and existing programs.
- Take all appropriate steps and implement all appropriate safeguards to ensure the confidential treatment of information provided by providers or by VDH to DMAS or by DMAS to VDH, and to follow the requirements and procedures governing the confidentiality of patient data as mandated by federal and state statutes and regulations.

- Promote the implementation of the intent and provisions of the responsibilities, herein described, by the designation of a senior staff individual to serve as the principal contact for each department on questions that arise on these subjects and/or for initiating amendments to this agreement when required. Amendments shall be in writing and executed by signatures of both parties.
- Participate in meetings, training sessions, and joint on-site visits that are of mutual benefit to both agencies.

Program Responsibilities:

DMAS shall**:**

- Claim as an administrative expense in Federal reports the cost of the Resource Mothers Program from the Medicaid Grant in accordance with federal regulations and grant procedures.
- Keep abreast of federal regulations, policies, or directives that may affect the program.
- Designate a staff member to serve as DMAS' liaison for the Resource Mother Program.
- Up to the dollar limit set forth herein and subject to available appropriations, reimburse VDH for the Federal share of the cost of the Maternal Outreach Program via IAT invoice prepared by VDH within thirty (30) calendar days of receipt of the billing invoice.
- Track Maternal Outreach Program expenditures and prepare a report quarterly for the VDH of the expenditures against allotted funds to ensure that expenditures do not exceed appropriations.

VDH shall:

- Ensure that qualified community health workers are recruited as necessary to meet program needs.
- Ensure that newly hired community health workers receive appropriate training on Medicaid and FAMIS eligibility and covered services (i.e., attend Sign Up Now training). A major objective of the training program must be a thorough familiarization with Medicaid programs, with special emphasis on the application process and covered services.
- Provide program consultation and technical assistance to the program sites.
- Provide to DMAS not later than thirty (30) days after the end of each calendar quarter a report that specifies for the quarter:
    - The number of pregnant teenagers entering the program.
    - The number of infants entering the program.
- The number and percent of teenagers and infants enrolled in Medicaid should be provided to the DMAS not later than ninety (90) days after the end of each state fiscal year; a summary report to DMAS describing the population served and program outcomes during that fiscal year. Maintain personnel, expenditure, and other fiscal records necessary to document the use of funds and its performance of responsibilities under the agreement, and make such records available to federal officials or DMAS staff on request

Reimbursement:

Reimbursement for eligible Resource Mothers costs shall be reimbursed as a pass through transaction in accordance with the. DMAS approved VDH Cost Allocation Plan and in accordance with Method 1 Pass Through Subrecipient Transaction in Section I of the Scope of Work Attachment. Only eligible costs pursuant to this plan shall be submitted to DMAS for reimbursement. VDH agrees to maintain and provide to DMAS documentation supporting all costs submitted with reimbursement. VDH shall bill DMAS utilizing the IAT process monthly within 45 days from the close of the fiscal month. The IAT shall include total costs incurred and request reimbursement for the computable federal share of such costs. Any indirect costs billed shall be in accordance with the approved Cost Allocation Plan. Indirect costs calculations must be fully documented. Such documentation shall include any supporting CARS reports and work papers supporting the calculations. DMAS shall review all documentation and process the IAT to reimburse VDH for the federal share of all allowable costs within 30 days of receipt. DMAS shall be responsible for ensuring all costs are allowable and adequately documented before processing reimbursement to VDH.

Under this method, DMAS, acting in its capacity as the single state agency, will reimburse VDH for the Federal portion of qualifying expenditures related to services VDH has rendered to the Medicaid or FAMIS programs. VDH holds the appropriation from the General Assembly.

Budget Estimates:

The VDH Budget Office shall submit budget estimates to the DMAS Budget Office for reimbursable activities included in this agreement so that DMAS may include the estimates in the Quarterly CMS-37 Reports furnished to CMS. Estimates shall be submitted to the DMAS Budget Office no later than January 15, April 15, July 15, and October 15 of each year and shall cover the timeframes specified by CMS. A separate estimate shall be submitted for each service. By separate correspondence DMAS and VDH shall designate contacts within their respective Budget Offices to coordinate the preparation and transmittal of the estimates.

Reimbursement:
VDH will follow the budgetary procedures as specified Section I of this Agreement.

Reimbursement for eligible Resource Mothers costs shall be reimbursed as a pass through transaction. VDH agrees to maintain a DMAS approved Cost Allocation Plan. Only eligible costs pursuant to this plan shall be submitted to DMAS for reimbursement. VDH agrees to maintain and provide to DMAS documentation supporting all costs submitted for reimbursement. VDH shall bill DMAS utilizing the IAT process monthly within 45 days from the close of the fiscal month. The IAT shall include the total costs incurred and request reimbursement for the computable federal share of such costs. Any indirect costs billed shall be in accordance with the approved cast allocation plan. Indirect cost calculations must be fully documented. Such documentation shall include any supporting CARS reports and work papers supporting the calculations. DMAS shall review all documentation and process the IAT to reimburse VDH for the federal share of all allowable costs within 30 days of receipt. DMAS shall be responsible for ensuring all costs are allowable and adequately documented before processing reimbursement to VDH.

If the APA or other entity auditing has questions regarding the transaction, VDH shall support DMAS by timely providing any necessary additional documentation.

DMAS shall:

- Record the transactions using Fund 1000, Transaction Code 497. GLA 989, CFDA number #93.778 (93.767 for FAMIS) and a project number set forth in the applicable Appendix to this agreement (70072).
- Report the pass through on the Schedule of subrecipient under VDH.
- Transfer funds from the Medicaid or FAMIS programs to VDH within 30 days of receipt of the IAT.
- Process the IAT within 30 days from date of receipt of the IAT and supporting documentation.
- Report the vendor expenditure on the Schedule of Federal Assistance under the Medicaid Grant. (VDH will not have to report the expenditure on any year-end federal schedules.)

VDH shall:

- Record the amount received as revenue under Revenue Source Code 03007, Sale of Goods, or Services to State Entities.
- Record the expenditure using the appropriate subobject codes using Fund 1000, Transaction Code 116, and GLA 988;
- Report the expenditures on the Schedule of Pass-Through Funds Received from Other Agencies;
- Report to the DMAS Grant Supervisor prior to July 15 each fiscal year the total amount of funds transferred through subrecipient activity during the preceding fiscal year. If there are any discrepancies between DMAS and VDH calculations, the DMAS calculation shall be used for final filing of the Schedule of Federal Assistance.
- Record the transactions using Funds 0100 and 1000, Transaction Code 380, CFDA number #93.378, the appropriate subobject codes, and a project number set forth in the applicable Appendix to this agreement.

Under this method, DMAS, acting in its capacity as the single state agency, will reimburse VDH for the Federal portion of qualifying expenditures related to services VDH has rendered to the Medicaid or FAMIS programs. VDH holds the appropriation from the General Assembly.

E. Women, Infants and Children (WIC)

DMAS Contact: Contract Monitor – Maternal and Child Health Supervisor

VDH Contact: Contract Monitors: Director and Systems Manager/EDI Coordinator, Division of Community Nutrition, Office of Family Health Services

Federal Code Reference:
The federal grants administration procedures detailed in Title 43 CFR, Part 74 and the provisions of 42 CFR § 431.300

State Code Reference:
12 VAC 30-10-770. Required coordination between the Medicaid and WIC Programs.

State Plan Reference:
The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with §1902(a)(53) of the Act.

Purpose:
The assignments of responsibilities as stated herein are intended to result in improved use of state government resources, more effective service delivery, and improved and documented outcomes by assuring that the provision of authorized Medicaid services is consistent with the statutory functions and the missions of the participating State agencies.

Description:
The Omnibus Budget Reconciliation Act of 1989 mandated the coordination and referral of services with the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) Program and other maternal and child health programs. Through the EPSDT program administered by DMAS, children from birth through 20 years of age may receive medically necessary services identified through screening exams conducted by a medical professional. The WIC program provides low income pregnant, postpartum, and breastfeeding women, infants and children up to their fifth birthday with nutritious supplemental food, infant formula, and nutrition education.

Scope of Services:
The scope of services covered under the VMAP may impact VDH's program plans and budgets. Similarly, actions of VDH to offer health care services to low income individuals may affect Medicaid provider service requirements and the cost of services. Therefore, each agency hereby states its intention to coordinate plans to alter current levels of health related services that could affect the plans or operations of the other agency and to consider responses concerning potential impacts before changes are adopted.

Responsibilities:
DMAS shall:

- Keep abreast of federal regulations, policies, or directives that may affect the program
- Designate a staff member to serve as DMAS' liaison for the WIC program
- Work with VDH to review overall participation of Medicaid recipients in WIC to include unserved potentially eligible recipients. This will be done annually.
- Reimburse VDH for the **state share and federal match** of the cost of exempt infant formula and medical foods for infants and children enrolled in Virginia Medicaid via claims submitted electronically by VDH. Claims submitted correctly will be paid within thirty (30) calendar days of receipt of the claim.
- Update MMIS system as needed if new formula codes are available.
- Keep VDH/WIC informed of any claims or billing problems that would affect their process.
- Pay claims for exempt formula and medical foods for the WIC amount and any medically necessary amount over the WIC limit.
- Ensure the VDH is conducting appropriate monitoring of the providers of exempt formula and medical foods.

VDH shall:

- Keep abreast of federal regulations, policies, or directives that may affect the program.

- Designate a staff member to serve as VDH's liaison for the WIC program. Ensure that qualified staffs are recruited as necessary to meet program needs.
- Provide program consultation and technical assistance to the program sites.
- Monitor and evaluate the program through site visits, reports, and statistical reviews and provide a copy of the evaluation to DMAS. The evaluation should include comparative statistics that show the impact of the program.
- Maintain personnel, expenditure, and other fiscal records necessary to document the use of funds and its performance of responsibilities under the agreement, and make such records available to federal officials or DMAS staff on request.
- Provide quantities of exempt formula and medical foods in excess of that allowable for WIC and will submit a claim to DMAS for the full amount issued.
- Use the same policy, monitoring and review processes with Medicaid participants as with non-Medicaid WIC participants with the exception of providing ready to feed exempt formula when concentrate is not available to premature infants who receive Medicaid.
- Provide DMAS with information on reviews including the number of reviews conducted and any adverse actions that were taken as result of such reviews.

F. Plan First

DMAS Contact: Maternal and Child Health Supervisor

VDH Contact: Family Planning Program Supervisor, Division of Child and Family Health, Office of Family Health Services

Federal Code Reference:
Title V of the Social Security Act
Title XIX of the Social Security Act

State Code and Plan Reference:
Va. Code § 32.1-77 authorizes the Board of Health to prepare, amend, and submit to the appropriate federal authority, a state plan for maternal and child health services and children's specialty services pursuant to Title V of the SSA and any amendments thereto. The State Health Commissioner is authorized to administer such plans and to receive and expend federal funds.

Va. Code § 32.1-325 authorizes the Board of Medical Assistance Services to prepare, amend, and submit to the Secretary of the United States DHHS a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto.

Purpose:

The purpose of this data exchange is directly related to the administration of the State Plan for Medical Assistance. For this project DMAS will provide to VDH certain data in order to evaluate Plan First enrollment and services provided under the Plan First, the Medicaid State Plan option for family planning (hereinafter, "Plan First"). This data in this project will also be used to provide outreach for enrollment as well as provider training.

The assignment of responsibilities as stated herein is intended to result in improved use of State resources and provide more effective service delivery by assuring that the provision of authorized Medicaid services is consistent with the statutory functions and the missions of the participating State departments.

Type and Format of the Data to be Exchanged:

- VDH is authorized to use eligibility data provided by DMAS pursuant to Section V of this Agreement for the purposes of this subsection.

- DMAS shall provide a monthly file of Medicaid (fee-for-service and managed care) enrollment data of pregnant women getting ready to lose coverage postpartum to VDH for targeted enrollment to Plan First.

The file shall contain the following data elements:

- Member Medicaid ID
- Member first name
- Member middle initial
- Member last name
- Member FIPS
- Member address (street, city, state, zip)
- Member telephone number
- Member aid category
- Member Estimated Date of Delivery
- Member race

- DMAS shall provide a monthly file to VDH with contact information of practitioner based prenatal care providers of Medicaid (fee-for-service and managed care) pregnant women for targeted outreach of Plan First.

  The file shall contain the following data elements:

  - Service provider name (Agency name, first name, last name)
  - Provider type
  - Provider servicing address (street, city, state, zip and FIPS)
  - Provider telephone and fax numbers
  - Provider email addresses
  - National Provider Identifier

- DMAS shall provide to VDH a monthly data file of members with a claim paid or denied under Plan First at any point in time during the reporting period. The file shall contain the following data elements:

  - Medicaid Member ID
  - Member FIPS
  - Member address (street, city, state, zip)
  - Member race, age
  - Service provider name (Agency name, first name, last name)
  - Provider NPI
  - Provider type
  - Provider servicing address (street, city, state, zip)
  - Procedure code and description
  - Drug code and drug name
  - Amount billed
  - Claim status
  - Total paid
  - Denial reason

- DMAS shall provide to VDH a monthly data file of localities where there are high rates of no enrollment in Medicaid for women postpartum. The file shall contain the following data elements:
  - FIPS of Member when enrolled in pregnancy coverage

Security and Confidentiality:

VDH and DMAS shall take all appropriate steps and implement all appropriate safeguards to ensure the confidential treatment of information provided by providers or by VDH to DMAS or by DMAS to VDH, and to follow the requirements and procedures governing the confidentiality of patient data as mandated by federal and state statutes and regulations.

Responsibilities:

DMAS shall:

- Provide training and consultation about Plan First services to family planning providers and case managers.
- Develop and make available printed information about Plan First services for active and potential members, and make these resources available to VDH family planning clinics and other maternal and child health service providers.
- Track and analyze enrollment and claims data on monthly, quarterly and annual basis.
- Notify VDH of any changes to Plan First application or other marketing material.

VDH shall:

- Provide additional analysis of Plan First enrollment and claims data as mutually agreed upon by DMAS and VDH to evaluate system performance and to develop a systematic plan for additional public and/or provider outreach and education.

- Except for disclosures required by law, VDH shall consult with DMAS prior to use of any of the exchanged data in a manner that could result in the disclosure of individually identifiable health information, as defined by the Health Insurance Portability and Accountability Act (HIPAA). VDH understands and agrees to abide by the confidentiality provisions included in HIPAA and other relevant federal and state laws, including, but not limited to, the limitation on the publication and disclosure of data as described in 45 C.F.R. § 164.514.

Areas of Collaboration:

- DMAS and VDH agree to collaborate on needs assessment, planning, analysis of enrollment and claims data, and evaluation of Plan First to help increase enrollment and utilization in Plan First. DMAS and VDH agree to encourage local health departments to collaborate with their local departments of social services regarding Plan First applications and enrollment process. DMAS and VDH agree to provide training and consultation about Plan First services to family planning providers and case managers.

Reimbursement:

There shall be no reimbursement to the VDH for services rendered in support of the administration of Plan First. Reimbursement for family planning services shall be made in accordance with Method 5 DMAS Claims Processing as set forth by Section I of the Scope of Work Attachment to local health districts who have provider agreements with DMAS and are authorized to render this service at reimbursement rates established by DMAS. Reimbursement shall be made via the DMAS claims submission and payment process.

G. Maternal and Child Health Collaboration (Perinatal Health)

DMAS Contact: Maternal and Child Health Services Manager

VDH Contact: Policy Analyst (MCH Lead), Division of Policy and Evaluation, Office of Family Health Services

Federal Code Reference:
Title XIX of the SSA, Section 1902 (42 U.S.C. 1396a) requires that the state plan for medical assistance provide for entering into cooperative arrangements with State Health and Title V agencies. 42 CFR § 431.615 sets forth requirements for agreements between these agencies. Title V of the SSA, Section 501 (42 USC 701) requires that the state agency administering the state's program under Title V will participate in arrangement and carrying out of coordination agreements relating to coordination of care and services available under Title V and Title XIX and provide, directly and through providers and institutional contractors, of at services to identify pregnant women and infants who are eligible for medical assistance and once identified, to assist them in applying for such assistance.

State Code and Plan Reference:

Va. Code § 32.1-77 authorizes the Board of Health to prepare, amend, and submit to the appropriate federal authority, a state plan for maternal and child health services and children's specialty services pursuant to Title V of the SSA and any

amendments thereto. The State Health Commissioner is authorized to administer such plans and to receive and expend federal funds.

Va. Code § 32.1-325 authorizes the Board of Medical Assistance Services to prepare, amend, and submit to the Secretary of the United States DHHS a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto.

Va. Code § 32.1-351 authorizes the DMAS to develop and submit to the federal Secretary of Health and Human Services a Title XXI plan for the Family Access to Medical Insurance Security Plan (FAMIS) and revise such plan as may be necessary.

Purpose:

The purpose of this data exchange is directly related to the administration of the State Plan for Medical Assistance (Medicaid) and the Family Access to Medical Security Plan (FAMIS). For this project DMAS will provide VDH data in order to evaluate perinatal health outcomes for services provided under Medicaid and FAMIS, including FAMIS MOMS.

The assignments of responsibilities as stated herein are intended to result in improved use of State resources and provide more effective service delivery by assuring that the provision of authorized Medicaid services is consistent with the statutory functions and the missions of the participating State departments.

A subcomponent of the data exchange is a requirement from the Centers for Medicare and Medicaid Services (CMS) Strong Start Initiative grant to test the effectiveness of the Centering Pregnancy prenatal care model in reducing preterm birth. CMS aims to test and evaluate this prenatal care model for women enrolled in Medicaid or FAMIS who are at risk for having a preterm birth. The goal of the initiative is to determine if these approaches to care can reduce the rate of preterm births, improve the health outcomes of pregnant women and newborns, and decreases the anticipated total cost of medical care during pregnancy, delivery and over the first year of life for children born to mothers in Medicaid or FAMIS. Virginia Commonwealth University (VCU) is a recipient of the CMS Strong Start Initiative grant. VCU is tasked to monitor and evaluate the effectiveness of Centering Pregnancy prenatal care model in reducing poor birth outcomes. The grant requires the utilization of linked birth registry-claims data to evaluate the Initiative.

Type and Format of the Data to be Exchanged:

- VDH is authorized to use eligibility data provided by DMAS pursuant to Section V of this Agreement for the purposes of this subsection.

- DMAS shall provide to VDH an annual data file of females of reproductive age who were enrolled Medicaid or FAMIS at any point of time during the calendar year. The file shall contain the following data elements:

    - Recipient ID
    - Social Security Number
    - Recipient first name
    - Recipient middle initial
    - Recipient last name
    - Date of birth
    - All eligibility/aid categories for enrollment periods active during the reporting year and previous year, with begin and cancel dates.
    - All managed care enrollment spans active during the reporting year and previous year, with begin and end dates.

- DMAS shall provide Medicaid fee-for-service and encounter claims data for services provided to pregnant women and newborns as needed for special projects agreed to by VDH and DMAS to support the purpose of this section.

- VDH shall provide to DMAS or to a contractor of DMAS or VDH a data file with vital records data linked to DMAS data for projects that are mutually agreed to by DMAS and VDH to support the purpose of this section.

- VDH shall provide VCU linked vital records and DMAS data in an aggregate form to evaluate the effectiveness of the Strong Start Initiative in Virginia. This data shall be provided to VCU annually through the life of the project 2013-2016. De-identified aggregate data shall be reported to CMS.

Security and Confidentiality:

VDH and DMAS shall take all appropriate steps and implement all appropriate safeguards to ensure the confidential treatment of information provided by providers or by VDH to DMAS or by DMAS to VDH, and to follow the requirements and procedures governing the confidentiality of patient data as mandated by federal and state statutes and regulations.

Responsibilities:

DMAS shall:

- DMAS shall provide to VDH an annual data file as needed of females of reproductive age who were enrolled into Medicaid or FAMIS at any point of time during the calendar year. The file shall contain the following data elements:
    - Recipient ID
    - Social Security Number
    - Recipient first name
    - Recipient middle name
    - Recipient last name
    - Date of birth
    - All eligibility/ aid categories for enrollment periods active during the reporting year and previous year, with begin and cancel dates.
    - All managed care enrollment spans active during the reporting year and previous year, with begin and end dates.
- DMAS shall provide to VDH Medicaid fee-for-service and encounter claims data for services provided to pregnant women and newborns as needed for special projects agreed to by VDH and DMAS to support the purpose of this section.
- Provide training and consultation about Medicaid, FAMIS, and FAMIS MOMS eligibility and services to local health department providers and case managers.
- Develop printed information for active and potential recipients, and make these resources available to VDH clinics and other maternal and child health service providers.
- Permit VDH to review and approve the representation (in written and oral form) of the linked data before initial public disclosure of such information. This review and approval shall be limited to confidentiality concerns as related to the Health Insurance Portability and Accountability Act (HIPAA), laws governing vital records, and other pertinent federal and state laws.

VDH shall:

- VDH is authorized to use eligibility data provided by DMAS pursuant to Section V of this agreement for the purposes of this subsection.
- VDH shall provide to DMAS or to a contractor of DMAS or VDH a data file with vital records data linked to or including identifiers needed for linkage to DMAS data for projects that are mutually agreed to by DMAS and VDH to support the purpose of this section.
    - As the Strong Start grant recipient, VDH shall provide linked vital records and DMAS data or vital records data capable of linkage with DMAS data to evaluate the effectiveness of the Strong Start Initiative in Virginia. This data shall be provided to VCU annually through the life of the project 2013-2016. Only de-identified aggregate data shall be reported to CMS.
- Provide other analysis for the purposes of this subsection as mutually agreed upon by DMAS and VDH, such as;
    - Link DMAS data to birth record data, natural fetal death record data, and VDH program data based on identifying information of the mother.

- Provide to DMAS the number of births and natural fetal deaths to Medicaid and FAMIS enrollees by eligibility/aid category and coverage plan.
- Provide to DMAS the number of low weight and very low weight births to Medicaid and FAMIS enrollees.
- Provide to DMAS data on pregnancy risk factors for Medicaid and FAMIS enrollees.

- Permit DMAS to review and approve the representation (in written and oral form) of the exchanged data before initial public disclosure of such information. This review and approval shall be limited to confidentiality concerns as related to the Health Insurance Portability and Accountability Act (HIPAA) and other pertinent federal and state laws.

Provide de-identified linked vital registry and DMAS data to VCU. Data will flag Centering Pregnancy (Strong Start) recipients.

Areas of Collaboration:

DMAS and VDH agree to collaborate on outreach, needs assessment, planning, and evaluation of services for pregnant women and infants eligible for Medicaid, FAMIS, and FAMIS MOMS coverage.

Reimbursement:

There shall be no reimbursement to VDH for services rendered in support of the administration of the Medicaid, FAMIS, or FAMIS MOMS programs. Reimbursement for perinatal health services shall be made in accordance with Method 5 DMAS Claims Processing as set forth by Section I of the Scope of Work Attachment to local health districts who have provider agreements with DMAS and are authorized to render this service at reimbursement rates established by DMAS. Reimbursement shall be made via the DMAS claims submission and payment process.

Section IV. MDS Automation Project – Resident Assessment Instrument (RAI) Data System

DMAS Contact: Contract Monitor – Office of Data Analytics

VDH Contact: Director, Office of Licensure and Certification

Purpose:
The purpose is to improve utilization of Agency resources through targeting potential problem facilities and by focusing onsite survey activities on specific problem areas within a facility. Provide data for use in support of State Medicaid functions to include the Medicaid payment system, utilization review, service placement and improvement in the State's ability to monitor and evaluate the cost effectiveness and quality of care and services provided.

Description:
Operation and management of the RAI data system used for survey and certification of nursing home providers suppliers participating or requesting to participate in Medicaid programs. Certification includes on site visitation and evaluation. CMS requires the use of "Resident Assessment Instrument (RAI) in federally certified long-term care facilities to assess the clinical characteristics and care needs of long term care residents." Resident records of care and treatment provisions are reviewed. The RAI's purpose is to better utilize survey agency resources by targeting potential problem facilities and focusing on site survey activities on specific problem areas within a facility. An objective of RAI system use is to provide data to support the Medicaid payment system, utilization review, service placement and improving the process of monitoring and evaluating the cost effectiveness, services provided and quality of care under the Medicaid program.

Federal Code Reference:
§§ 1864 and 1874, Title XVIII, SSA; Health Standards and Quality

State Code & State Plan Reference:
Title 32.1 Chapter 10, Code of Virginia

Planning & Coordination:

VDH and DMAS will take appropriate steps and implement all appropriate safeguards to ensure the confidential treatment of information provided by nursing home providers and to follow requirements and procedures governing the confidentiality of patient data.

VDH and DMAS will develop options made available by CMS to state regarding the Minimum Data Set portion of the RAI including part S of the MDS data record.

Responsibilities:
VDH agrees to the following:

Installation of the RAI system provided by CMS or CMS contractors in VDH's premises.

VDH shall perform day to day operations of the system to include receipt and validation of RAI records. CMS must be provided access to the RAI data systems.

VDH shall provide DMAS with a fully exportable file / data set containing all MDS data collected from nursing facilities and processed through the CMS edits.

VDH shall designate the optional version of Resource Utilization Groups (RUG) III 1997 update as the quarterly assessment instrument to be completed by nursing facilities for support of the Medicaid payment system.

VDH shall process information from the MDS portion of the RAI for all residents in long term Medicare and / or Medicaid certified long term care facilities.

VDH shall absorb all costs associated with the daily operation of the RAI system to include staff, space, utilities, equipment, maintenance and facility submission support.

DMAS agrees to the following:
DMAS shall absorb all costs related to the development and operation of the DMAS case-mix based reimbursement system.

If DMAS requests any special work or work products from VDH, DMAS shall incur the cost. Prior to initiation of such work, DMAS and VDH shall agree upon the cost of the special request.

DMAS shall establish and operate computing hardware and software for the purpose of receiving and storing MDS data retrieved by DMAS from records maintained on the CMS supplied MDS portion of the RAI data systems.

Areas of Collaboration:
VDH is the Federal agent and designee of CMS, assigned the duty to receive, possess, maintain, implement, use and control the RAI data system on behalf of CMS.

Section V. Eligibility Information

DMAS Contact: Office of Data Analytics

VDH Contact: Director/CIO, Office of Information Management and Health IT

Purpose:
The assignments of responsibilities as stated herein are intended to result in improved use of state government resources by providing for the sharing of official enrollment and eligibility data between the VDH and DMAS.

Background:
Staff of the DMAS Division of Cost Settlement and Reimbursement provided VDH with an analysis of total denied claims from VDH operating units by specific reasons of denial for SFY 2000 and SFY 2001. This analysis was provided in order to furnish VDH with specific information that could lead to improvements in the billing processes thereby producing a cost savings to DMAS. The volume of VDH claims denied for payment from DMAS based on

reasons related to accurate eligibility, led to the initiation of a basic efficiency and productivity survey of VDH operating units. The results of this survey document that: 1) VDH operating units devote considerable staff time to the acquisition of eligibility information that can only be garnered through a telephonic queuing process; 2) Mistakes are made in the billing process due to the lack of or inaccurate eligibility information; and 3) The VDH WebVision system, used by VDH operating units for billing purposes, can be easily modified to provide electronic on-line DMAS eligibility information.

Federal Code Reference:
None

State Code & State Plan Reference:
Va. Code § 32.1-127.1:04 requires the agencies of the Secretary of Health and Human Resources to establish a secure system for sharing PHI that may be necessary for the coordination of prevention and control of disease, injury or disability.

Responsibilities:

DMAS shall:

- Provide a key contact within DMAS whose responsibility will be to ensure a secure data transfer process and proper data use safeguards.
- Provide VDH representative with selected Eligibility File data on a biweekly basis.
  The data provided will be in a mutually agreed upon format using a mutually agreed upon procedure that complies with all applicable HIPAA and VITA requirements.
- The data will include all active Medicaid enrollees and contain the following data fields:

  - Recipient ID number
  - Recipient name
  - Social Security Number
  - Sex
  - Date of birth
  - Medicaid program enrolled in
  - Beginning and end dates for current and previous two enrollment periods
  - Third party payor to include type of insurance and policy number
  - Policy effective begin and end dates
  - HMO provider ID
  - Lock-In program provider and effective dates

VDH shall:

- Provide a procedure and primary contact within VDH for the secure data transfer through a means compliant with Commonwealth Security Standards for the transfer of sensitive data. VDH will have a dedicated data owner whose responsibilities include the transfer, management, and storage of the data. Use the data only for the purpose of eligibility verification.

Section VI. Decedent Information

DMAS Contact: Contract Monitor: Program Operations Division
Working Job Title: Sr. Systems Analyst

VDH Contact: Director, Office of Vital Records and Health Statistics, Office of Information Management

Purpose:
The assignments as stated herein are intended to result in improved use of state government resources by providing for the sharing of official decedent data between VDH and DMAS, in order to assist DMAS from removing deceased individuals from its roles and preventing fraud and abuse against the Commonwealth.

Description:
In 1997 an audit test conducted by the DMAS Division of Internal Audit & Contract Evaluation determined that, because of untimely notice of recipient mortality, the Medicaid program was paying approximately $100,000.00 per annum in claims and capitation payment (primarily for pharmacy claims and to HMOs) for recipients who were deceased. Such payments require DMAS staff to attempt recoupment upon eventual DMAS receipt of official notice of death from the VDH. The recoupment of such monies can be difficult because recoupment sometimes starts many months after the original payment.

Federal Code Reference:

None

State Code & State Plan Reference:
Va. Code § 32.1-272 entitled "Certified copies of vital records; other copies" reads in part: D. Other federal, state and local, public or private agencies in the conduct of their official duties may, upon request and payment of a reasonable fee, be furnished copies or other data from the system of vital records for statistical or administrative purposes upon such terms or conditions as may be prescribed by the Board. Such copies or other data shall not be used for purposes other than those for which they were requested unless so authorized by the State Registrar.

Responsibilities:
DMAS shall:

- Provide a key contact within DMAS whose responsibility will be to ensure a secure data transfer process and establish proper data use safeguards.
- Use data only for the purpose of verification of a recipients' status on the Eligibility File and to check for payments made on behalf of deceased recipients either through error or as the result of fraudulent activities. Upon receipt of such data, DMAS will acknowledge the receipt of the information to VDH by e-mail.
- Retain this information in a secure environment with controlled access to its contents during the duration of its usefulness, and ensure that DMAS employee and those that work under contract, who have access to this data, strictly adhere to the applicable privacy and confidentiality requirements of state and federal law.
- Dispose of these files in a manner consistent with the applicable requirements of state and federal privacy and confidentiality laws.
- Coordinate any use of this data for publishing statistical reports with Virginia Center for Health Statistics (VCHS) analytical staff to insure consistency between the agencies' publications.
- DMAS will work with VCHS to identify areas where information contained in the MMIS and other appropriate systems may be extracted for population-based analyses of key indicators important in public health assessment.
- The results of such studies will be made available to both DMAS and VDH.
- Individually identifiable data will not be published or disclosed.

VDH shall:

- Provide a key contact within VDH, Office of Vital Records, whose responsibility will be to ensure a secure data transfer process and proper data use safeguards.

- Provide mortality data on a quarterly basis for all death reported during the prior six months.
- The data exchange will be initiated by VDH by sending a CD with data in Microsoft Excel format to DMAS by regular mail. The CD will be clearly labeled "Contains Confidential Protected Health Information".
- The data will include all decedents for a period of six months and include the following data fields:
    - Social Security Number
    - Name
    - Street Address of Decedent's residence (including city/county)
    - Date of birth
    - Sex
    - Date of death

These files will be provided on a quarterly basis in format to be agreed upon by the technical staffs of the two agencies. This transfer will commence with the most recent months available upon initiation of the Agreement. Historical files for two years prior to the initiation of the Agreement will initially be created and then quarterly files created thereafter.

Section VII. Virginia Vaccines for Children Program (VVFC)

DMAS Contact: Maternal and Child Health Division Manager

VDH/DOI Contact: Director, Division of Immunization (DOI), Office of Epidemiology

Federal Code Reference: Title XIX, Sections 1902 (42 USC 1396(a) and (42 USC 1396(s)) of the Social Security Act

State Code and Plan Reference: 12VAC30-10-50. Pediatric immunization program

Purpose:

The assignments of responsibilities as stated herein are intended to result in improved use of state government resources and more effective service delivery by assuring that the provision of authorized Medicaid services is consistent with the statutory functions and the missions of the participating State departments.

Description:

VDH, Division of Immunization (DOI) is responsible for promoting and protecting the health of Virginians by ensuring that an adequate and viable inventory of vaccines are available to district health departments and private physicians participating in the Vaccines for Children (VFC) program. The Division also conducts quality assurance site visits, oversees the investigation of suspected cases of vaccine preventable disease and assesses immunization coverage statewide.

Planning and Coordination:

The scope of services covered under the Virginia Medical Assistance Services Program (Medicaid) may impact VDH's program plans and budgets. Similarly, actions of VDH to offer health care services to the underserved may affect Medicaid provider service requirements and the cost of services. Therefore, each agency hereby states its intention to coordinate plans to alter current levels of health related services that could affect the plans or operations of the other agency and to consider responses concerning potential impacts before changes are adopted.

To be eligible for free vaccine from the VVFC program, children must be under 19 years of age and meet at least one of the following criteria:

Medicaid enrolled, including Medicaid MCOs

Uninsured (those without health insurance)

Native American or Native Alaskans (no proof required) and

Underinsured (those whose insurance does not cover immunizations) (only at FQHCs or RHCs).

Responsibilities:

DMAS shall:

- Provide VDH with the name, address and Medicaid provider number of new Medicaid providers quarterly.
- Provide link to VVFC website on DMAS website.
- Annually provide Medicaid enrollment data in a template provided by VVFC.
- Authorize VVFC to implement the "Opt Out Policy" and issue exemption letters on behalf of VVFC and DMAS.

VDH shall:

- Make available on the VDH website the VVFC policies, program guidelines and forms at: http://www.vdh.virginia.gov/epidemiology/immunization/vfc/index.htm
- Distribute VVFC enrollment information to new Medicaid providers.
- Provide a link to the DMAS website on the VVFC enrollment page website.
- Provide information on vaccine pricing and new vaccines as needed.
- Provide template for the annual reporting of Medicaid enrollment
- Write letters on behalf of VVFC and DMAS to VVFC providers who have been approved for exemption from VVFC within 30 days of identification and forward DMAS Program Integrity staff person a copy of the letter.

Areas of Collaboration:

DMAS and VDH agree to:

1. Provide training and technical assistance on policies, procedures, and services on an as needed basis.
2. Participate in workgroups to address programmatic challenges and issues as needed.
3. Resolve problems or issues as they arise.

Vaccines for Children's Program Opt Out Policy:

As part of the Medicaid provider agreement, Medicaid doctors that wish to enroll in Medicaid also must enroll and participate in the Commonwealth of Virginia's Vaccines for Children (VVFC) Program. The VVFC program is designed to keep the client at the medical home to receive immunizations.

There are providers enrolled in Medicaid who do not participate with VVFC. Providers enrolled in Medicaid must meet the following criteria to opt-out of VVFC participation:

Provider's Medicaid panel has less than 10 VVFC eligible children under the age of 3 years old; and

If the provider does meet the criteria, they may request exemption from the VVFC participation requirement. The request must contain the following:

- Where they are referring the patients,
- Justification for referring the patients, and
- How plans for retrieving the immunization record from the other facility, including clearance from the immunizing facility to agree to provide feedback.

This documentation will be kept on file by VVFC for reference purposes. If the provider does not meet the criteria, then they are required to enroll in VVFC. VVFC will contact them in one year to follow up on their membership.

Reimbursement:

There shall be no reimbursement to either agency for services rendered in support of the administration of the VVFC Program and the Medallion program. Payments for medical services provided under the Medicaid and FAMIS Programs shall be made in accordance with Method 5 DMAS Claims Processing as set forth by Section I of the Scope of Work

Attachment to local health districts who have provider agreements with DMAS at rates established by DMAS. Reimbursement for these services shall be made via the DMAS claims submission and payment process.

Section IX. HIV AIDS Data Transfer

DMAS Contact: Office of Data Analytics

VDH Contact: Director, HIV Surveillance, Division of Disease Prevention, Office of Epidemiology

Purpose:

The purpose of this data exchange is directly related to the administration of the State Plan for Medical Assistance For this project DMAS will work collaboratively with VDH to identify overlap and improve the delivery of medical services to the Medicaid population with HIV infection. DMAS will supply VDH with patient-related data that VDH will use for the purpose of meeting federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act grant requirements including identifying how many people in their service area know they are HIV-positive but are not receiving regular I-IIV-related primary medical care VDH has a responsibility to support this process by assessing service needs and barriers in order to improve access to care DMAS will use the findings of this VDH assessment and the assurance processes to improve the delivery of medical services to the Medicaid population.

Federal Code Reference:
The Ryan White CARE Act, Public Law 106-345, re-authorized the amendments of 2000, and contains multiple **provisions focused on enhancing access to primary care for persons living with HIV disease who are not in care** These provisions also include enhancements to needs assessment requirements, directing the development of epidemiologic measures "for establishing the number of individuals living with HIV disease who are not receiving HIV-related health services "

State Code Reference:

Va. Code § J2 .1-36 requires physicians and laboratories to report any patient in Commonwealth who tests positive for exposure to human immunodeficiency virus (HIV) to VDH Furthermore, § 32.1-36 allows for the voluntary reporting of additional information at the request of VDH for special surveillance or other epidemiological studies. The patients' and the providers' identities and disease state shall be confidential as provided in §§ 3.2. 1-36. l and 32.1-41 Any unauthorized disclosure of reports made pursuant to this section shall be subject to the penalties of § 32.1-27.

Type and Format of the Data to be Exchanged:

DMAS shall provide to VDH client-level information of Medicaid recipients with HIV infection in a format and type to be determined by VDH. DMAS shall provide this data to VDH in hardcopy or electronic form via removable media or secure data transfer.

DMAS shall provide on a quarterly basis to VDH data fields that include but are not limited to the following, as available:

Infections:
Acquired Immunodeficiency Syndrome (AIDS)
Human Immunodeficiency Virus (HIV)

Data Variables:
Last Name
First Name
Middle Name

Social Security Number
Street Address
City
State
ZIP Code
Race
Sex
Date of Birth
Date of Death or Cancellation Reason 001
Date of HIV Diagnosis
Date of AIDS Diagnosis
Date of Most Recent Viral Load
Results of Most Recent Viral Load
Date of Most Recent CD4 Count
Results of Most Recent CD4 Count
Date of the Most Recent Antiretroviral Therapy Rx
Date of the Most Recent Medical Visit
Provider Name
Healthcare Facility Name
Provider Phone
Provider Street Address
Provider City
Provider State
Provider Zip Code

VDH shall provide to DMAS the Diagnosis and Procedure Codes necessary to generate the requested data fields

Security and Confidentiality:

All data provided by DMAS to VDH is subject to all applicable security and confidentiality limitations described in the Business Associate Agreement signed by the parties on September 1, *2005*. In addition, VDH will abide by supplemental guidelines that describe data release protocols in place for appropriate administrative, technical, and physical safeguards to ensure the security and confidentiality of HIV records

Responsibilities:

DMAS and VDH agree to:

1. VDH shall primarily use the information from the exchanged data to fulfill annual grant application requirements. Aggregate data without client identifiers may also be included in applicable reports and publications prepared by VDH. VDH will provide a copy of aggregate data analyses used for these purposes to DMAS

2. DMAS shall be permitted to review and approve any additional representation (in written and oral form) of the exchanged data before initial public disclosure of such information. This review and approval shall be limited to confidentiality concerns as related to the Health Insurance Portability and Accountability Act (HIPAA) and other pertinent federal and state laws.

Reimbursement:
N/A

Section X. STD and Hepatitis C Data Transfer

DMAS Contact: Office of Data Analytics

VDH Contact: Director, STD Surveillance, Operations and Data Administration, Division of Disease Prevention, Office of Epidemiology

Purpose:

The purpose of this data exchange is directly related to the administration of the State Plan for Medical Assistance. For this project DMAS will work collaboratively with VDH to identify overlap and improve the delivery of medical services to the Medicaid population with STD and Hepatitis C infections. DMAS will supply VDH with patient-related data that VDH will use for the purpose of assessing state mandated reporting requirements, as well as federal "Improving Sexually Transmitted Disease Programs through Assessment, Assurance, Policy Development, and Prevention Strategies (AAPPS)" grant requirements, including identifying how many people in Virginia are 1) diagnosed with STDs and Hepatitis C; 2) known to have been linked to primary medical care (especially for HIV-co-infected persons); and 3) receiving appropriate treatment services to limit antimicrobial resistance. VDH has a responsibility to support this process by assessing service needs and barriers in order to improve STD and Hepatitis C prevention and access to care activities. DMAS will use the findings of VDH assessment and assurance processes to improve the delivery of medical services to the Medicaid population.

Federal Code Reference:

See Section IX.

State Code Reference:

Code of Virginia §32 .1-36 requires every physician practicing in the Commonwealth of Virginia who diagnoses or reasonably suspects any patient to have any disease required by the Board of Health to be reported and every director of any laboratory doing business in the Commonwealth of Virginia that performs any test whose results indicate the presence of any such disease shall make a report within such time and in such manner as may be prescribed by Board of Health Regulations (Regulations for Disease Reporting and Control, March 2011). Furthermore, § 32.1-36 allows for the voluntary reporting of additional information at the request of VDH for special surveillance or other epidemiological studies. The patient's and provider's identity and disease state shall be confidential as provided in § 32.1-36, § 32.1-36.1 and §32.1-41. Any unauthorized disclosure of reports made pursuant to this section shall be subject to the penalties of§ 32.1-27.

Type and Format of the Data to be Exchanged:

DMAS shall provide to VDH client-level information of Medicaid recipients with STD and hepatitis infections in a format and type to be determined by VDH. DMAS shall provide this data to VDH in hardcopy or electronic form via removable media or secure data transfer.

DMAS shall provide on a quarterly basis to VDH data fields that include but are not limited to the following, as available:

Infections:
Acquired Immunodeficiency Syndrome (AIDS)
Chancroid
Chlamydia trachomatis infection
Gonorrhea
Granuloma inguinale
Hepatitis C
Human immunodeficiency virus (HIV)\
Lymphogranuloma venereum
Syphilis (all stages)

Data Variables:
Last Name First Name Middle Name
Social Security Number
Street Address
City
State
ZIP Code
Race
Sex
Date of Birth
Date of Death or Cancellation Reason 001
Diagnosis
Diagnosis Date
Treatment Received
Treatment Date
Date of Most Recent Medical Visit
Provider Name
Healthcare Facility Name
Provider Phone
Provider Street Address
Provider City
Provider State
Provider Zip Code

VDH shall provide to DMAS the Diagnosis and Procedure Codes necessary to generate the requested data fields.

In addition, DMAS will provide to VDH the chlamydia HEDIS measure, the percentage of women 16-24 years of age enrolled in Medicaid who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
The numerator for this measure is the number of sexually active females 16-24 years of age enrolled in Medicaid that were tested at least once for chlamydia during the measurement period. The denominator for this measure is the number of sexually active females 16-24 enrolled in Medicaid. This measure should be provided quarterly if possible, and annually at a minimum.

Security and Confidentiality:

All data provided by DMAS to VDH is subject to all applicable security and confidentiality limitations described in the Business Associate Agreement signed by the parties on September 1, 2005. In addition, VDH will abide by supplemental guidelines that describe data release protocols in place for appropriate administrative, technical, and physical safeguards to ensure the security and confidentiality of STD and Hepatitis records.

Responsibilities:

DMAS and VDH agree to the following:

1. VDH shall primarily use the information from the exchanged data to fulfill annual grant application requirements. Aggregate data without client identifiers may also be included in applicable reports and publications prepared by VDH. VDH will provide a copy of aggregate data analyses used for these purposes to DMAS.

2. DMAS shall be permitted to review and approve any additional representation (in written and oral form) of the exchanged data before initial public disclosure of such information. This review and approval shall be limited to confidentiality concerns as related to the Health Insurance Portability and Accountability Act (HIPAA) and other pertinent federal and state laws.

Section XI. Dental Data Exchange Project

DMAS Contact: DMAS Dental Contract Monitor, Health Care Services Division, Program Administration

VDH Contact: Maternal and Early Child Oral Health Coordinator and Dental Health Program Manager, Division of Child and Family Services, Office of Family Health Services

Purpose:

The purpose of this section is to provide for data exchanges DMAS and VDH. Both agencies require the electronic exchange of data for purposes directly related to the administration of the State Plan for Medical Assistance. This section provides for such data exchange regarding the provision of dental services to enrollees. VDH will use an IS application to plot the dental provider locations in Virginia (provider names will not be used). VDH will use the member and provider data to help identify provider shortage areas and to assist in the establishment of a dental home. In addition, the parties shall also exchange claims data submitted by non-dental providers for the treatment of fluoride varnish on Medicaid children under age 3. They use this information to help increase the number of non-dental providers who are trained to apply fluoride varnish.

Responsibilities:

DMAS shall provide to VDH *Medicaid dental reimbursement data*, to include the following:

(1) Medicaid Provider NPI Number
(2) Dentist License Number
(3) Medicaid Location ID
(4) Full Location Street Address [Street, City, Zip]
(5) Physician First Name
(6) Physician Middle Initial (if available)
(7) Physician Last Name
(8) Medicaid Member Count per Provider
(9) Member First Name
(10) Member Last Name
(11) Member Age
(12) Member Claim Count per Provider
(13) Total Medicaid Dental Payments per Provider
(14) All the locations where the Provider practices
(15) EIN
(16) Dental FTE per site
(17) Total Medicaid FTE for each Dentist's Practice Location

Reimbursement:

N/A

Section XII. Payment for Virginia Birth Records

DMAS Contact Analyst: Fiscal Division

VDH Contact: Director, Division of Vital Records, Office of Information Management

Federal Code Reference:
Title XIX, Sections 1902 (42 USC 1396a) and 1928 (42 USC 1396s) of the Social Security Act

State Code Reference:
12VAC30-40

Purpose:

The assignments of responsibilities as stated herein are intended to result in improved use of state government resources and more effective service delivery by assuring that current recipients and future applicants born in Virginia can be shown to have United States citizenship per §6036 of the Deficit Reduction Act of 2005 (DRA) through an allowed data match process.

Description:

To assist in the process of eligibility determination for Medicaid applicants/recipients, VDH, Division of Vital Records will perform searches for Virginia birth records upon a proper request from authorized Medicaid eligibility workers. Verification will be provided back to the requestor for those searches producing a valid Virginia birth record.

Planning and Coordination:

Each agency hereby states its intention to coordinate plans to alter current levels of health related services that could affect the plans or operations of the other agency and to consider responses concerning potential impacts before changes are adopted.

Responsibilities:

DMAS shall:

- Provide Medicaid reimbursement to the Business Associate for birth record verifications related to §6036 of the Deficit Reduction Act of 2005 (DRA). Reimbursement shall be monthly, or at an interval mutually agreed upon, and shall be determined on a fee schedule as follows:
    - For birth verifications where the authorized Medicaid eligibility worker provides the required information on the approved request form *with* a copy of a Virginia birth certificate or birth certificate number, DMAS will reimburse a fee of $3.00 per search by the VDH Division of Vital Records.
    - For birth verifications where the authorized Medicaid eligibility worker provides the required information on the approved request form *without* a copy of a Virginia birth certificate or birth certificate number, DMAS will reimburse a fee of $6.00 per search by the VDH Division of Vital Records.

VDH shall:

- Initiate the payment process through the electronic submission of reports to DMAS detailing the number of searched per month by type (described above).
- Maintain detailed records regarding requests for and execution of searches intended to provide birth verification for purposes of the determination of Medicaid eligibility.
- Allow DMAS or its agent access to detailed records (i.e. fax verification requests/responses) that verify and describe the birth verification searches performed by the Business Associate under this agreement.

Areas of Collaboration:

DMAS and VDH agree to:

1. Provide technical assistance on policies, procedures, and services and their coordination on an as-needed basis.
2. Participate in a workgroup to address challenges and issues faced in this area.
3. Resolve any problems or issues that may arise concerning the effectiveness of this process.

Reimbursement:

DMAS shall reimburse VDH for services rendered as described above under "Responsibilities," in accordance with Method 2 Vendor Transactions as set forth by Section I of the Scope of Work Attachment.

Section XIII. Pandemic Relief/ Anti-Viral Medication Tracking System

DMAS Contact: Information Technology Division Director

VDH Contact: Director, Office of Emergency Preparedness

Purpose:
The purpose of this section is to develop an anti-viral medication dispensing tracking system in the DMAS Medicaid Management Information System (MMIS) for use in the event of a pandemic flu outbreak and to provide technical support for this system to users via an Interactive Voice Recorded (IVR)/operator call support center.

Responsibilities:

DMAS shall create a program within the MMIS with the capacity to track the dispensing of anti-viral medications and reimburse VDH for the provision of said medications. VDH will reimburse DMAS for the cost of making the system modifications. In addition, if the system is put into effect, DMAS will send VDH monthly reports documenting medications dispensed, and VDH will reimburse DMAS for the cost of all claims processed. Additional duties between the parties are noted on the attached Information Services Request. DMAS, acting in a liaison role, facilitate the maintenance of an IVR/operator technical call support center for users of this application. VDH will bear the responsibility for determining the scope of services provided and for any compensation due to the vendor for services rendered in association with this technical call support center.

The original specifications of the modifications to the MMIS are described in Information Service Request 2009-152-001-M.

Reimbursement:

f the system is put into effect VDH will reimburse DMAS for the cost of all claims processed by DMAS for VDH at the per claim cost for pharmacy point of sale claims in effect at the time under DMAS' contract for MMIS fiscal agent services as well as the cost of the claim if paid by DMAS on behalf of VDH. VDH will compensate the contracted vendor for all cost associated with the operation of an IVR/operator technical call support center for the anti-viral dispensing tracking system.

Section XIV. Fatality Review and Surveillance

DMAS Contact: Maternal and Child Health Division Manager

VDH Contact: Program Manager, Fatality Review and Surveillance, Office of the Chief Medical Examiner

Purpose:
The purpose of this section is to assist in data collection and case review for fatality review and surveillance projects in the Office of the Chief Medical Examiner (OCME) of VDH:

- The State Child Fatality Review Team, established pursuant to § 32.1-283.1
- Family and Intimate Partner Homicide Surveillance, established pursuant to § 32.1-283.3
- The Maternal Death Surveillance and Maternal Mortality Review Team, conducted pursuant to § 32.1-40
- The Virginia Violent Death Reporting System
- The Adult Fatality Review Team, established pursuant to § 32.1-283.5

The purpose of these projects is to generate public health information about decedents' injuries, diseases, and contacts with social service agencies that is more detailed and timely than is currently available. In return the

OCME shall provide to DMAS results from maternal mortality surveillance reflecting the number of women who died who were recipients of services paid for by funds administered through.

Responsibilities:

The Virginia Department of Medical Assistance Services agrees to provide service and claims information including the names of agencies and providers of service for all persons receiving care on either a Fee For Service (FFS) or through a Medicaid Managed Care Organization (MCO). It is agreed that individual case information will be provided upon request, including Medicaid/FAMIS/FAMIS MOMS enrollment including dates of enrollment and FFS vs. MCO, claims information including DOS and provider contact leading up to date of death.

OCME will provide upon request from the results from maternal mortality surveillance reflecting the number of women who died who were recipients of services paid for by funds administered through DMAS.

Reimbursement:
N/A

Section XV. Virginia Medicaid Expedited Eligibility and Enrollment (E&E)

DMAS Contacts: Information Technology Division, eHHR Program Director
Budget and Contracts Manager

VDH Contacts: Director/CIO, Office of Information Management and Health IT

Purpose:

The purpose of this section is to set out the terms whereby DMAS can reimburse VDH for the costs incurred in successfully meeting the goals of the Virginia Medicaid Expedited Eligibility and Enrollment (E&E) version 2, Implementation - Advance Planning Document (I-APD) in:

- Establishing interfaces for eligibility and enrollment system workflow automation to the Enterprise environments such as Birth Reporting Interface (BRI), Death Reporting Interface (DRI), Immunization Registry Interface (IRI), and Rhapsody Connectivity (RC) Interfaces
- Upgrading the existing VDH services/interfaces as necessary to national standards/implementation guides approved by HITSAC
- Supporting a Publish/Subscribe model for automatic enrollment and disenrollment and electronic notifications of birth and date, respectively

Description:

The timeline and the technical requirements VDH shall meet to develop these interfaces are described in Section 8: MITA Care Management Business Area Services - MITA Interfaces and Legacy Interfaces/Meaningful Use of the Virginia Medicaid Expedited Implementation Advanced Planning Document (I-APD) for Eligibility and Enrollment, which is incorporated by reference into this Agreement and made a part hereof.

These projects are a joint effort between DMAS and VDH and will be staffed with members from both agencies. DMAS will provide SOA enterprise staff and VDH will provide staff knowledgeable of current VDH systems for birth, death, and immunization systems. The project teams will jointly produce the following Software Development Life-Cycle documents: requirements, design, test plans/scenarios, test results, and implementation guide(s).

The costs shall be reimbursed in accordance with the Centers for Medicare and Medicaid Services (CMS)-approved Implementation Advanced Planning Document (I-APD) for Eligibility and Enrollment.

Under this Agreement, VDH will function in a vendor relationship. VDH will provide time and effort, and materials and information to DMAS and report any staff/contract time and materials charged. Travel costs are non-reimbursable; all other costs including staff and contractor costs, equipment, supplies, materials, and training will be reimbursed from Section 8 - MITA Care Management Business Area Services of DMAS' CMS approved

I-APD for Eligibility and Enrollment for a total amount not to exceed $1,696,960 as broken down in the table below:

VDH Budget - Care Management Business Area Services (Oct 1, 2012 - Mar 31, 2016)			
#	E&E I-APD Funded Projects	Fund Source	Program Cost
			TOTAL
1	Section 8. MITA Care Management Business Area Services - MITA Interfaces - Death Reporting Interface (DRI)	E&E/CHIP	$286,520
2	Section 8. MITA Care Management Business Area Services - MITA Interfaces - Birth Reporting Interface (BRI)	E&E/CHIP	$286,520
3	Section 8. MITA Care Management Business Area Services - Legacy Interfaces/Meaningful use - Immunization Registry Interface (IRI)	E&E/CHIP	$499,920
4	Section 8. MITA Care Management Business Area Services - Legacy Interfaces/Meaningful use - Rhapsody Connectivity (RC)	E&E/CHIP	$624,000
Total Program Costs			**$1,696,960**

DMAS will hire or utilize existing full-time, classified as well as non-classified positions in order to meet the goals described above within the budget approved by CMS. Some of these personnel include an Agency Project Technical Lead and an Agency Project Business SME. The salaries of these personnel will be allocated based on the percentage of time spent on the Care Management business area services described above.

Responsibilities:

DMAS agrees to the following:

- DMAS will assume responsibility for creating all full-time, classified and non-classified positions for the Enterprise Development and Implementation.
- DMAS will assume responsibility for the supervising, monitoring and evaluating of these personnel.

VDH agrees to the following:

- VDH shall assume responsibility for creating all full-time, classified and non-classified, positions for any changes in existing VDH systems.
- VDH shall provide DMAS with monthly and annual updates on financial expenditures as it relates to position funding.

Reimbursement:

1. Payments shall be made in accordance with Method 2 Vendor Transactions as set forth by Section I of the Scope of Work Attachment and to the following:

2. VDH shall submit invoices monthly to DMAS via Interagency Transfer (IAT) Form directed to:

Dave Mix
eHHR Program Manager
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

3. DMAS agrees to reimburse VDH for the costs incurred in establishing the Death Reporting Interface (DRI), Birth Reporting Interface (BRI), Immunization Registry Interface (IRI), and the Rhapsody Connectivity Interface (RC) to the enterprise environments, from Section 8 of DMAS' CMS-approved I-APD for Eligibility and Enrollment, for the period from October 1, 2012 to March 31, 2016.

DMAS has authority under this Agreement to withhold payment of any invoice for work which DMAS determines fails to comply with the requirements of Section 8 of the I-APD.

4. All invoices submitted by VDH should be broken down by the projects worked upon in the description field of the Miscellaneous Services Invoice Detail Report such as:

   E&E VDH Death Reporting Interface (DRI)
   E&E VDH Birth Reporting Interface (BRI)
   E&E VDH Immunization Registry Interface (IRI)
   E&E VDH Rhapsody Connectivity Interface (RC)

5. All invoices submitted by VDH shall include adequate supporting documentation to support confirmation of goods purchased or services provided.

6. Payment date will be 30 days after receipt of a DMAS-approved invoice. DMAS will process an expenditure IAT comprised of total expenditures, including both general funds and federal funds, in accordance with the Department of Accounts' Commonwealth Accounting Policies and Procedures (CAPP) Topic No. 20405 using the CFDA Number of #93.778 for Medicaid and #93.767 for CHIP. DMAS will seek federal reimbursement from the Centers for Medicare and Medicaid Services (CMS) based on Section 8 of DMAS' CMS-approved I-APD for Eligibility and Enrollment.

7. VDH shall collect, record, and maintain documentation, and an audit trail that supports expenses related to carrying out the provision of the amendment. VDH shall maintain cost documentation for three years. If auditing agents (e.g. Auditor of Public Accounts or Centers for Medicare and Medicaid) question costs associated with this activity, then they will need to contact VDH directly for additional backup and verification. VDH must provide supporting documentation and verification upon request.

Section XVI. All Payers Claims Database

DMAS Contact: Director, Policy Division

VDH Contact: Director / CIO, Office of Information Mgmt and Health IT

Purpose:

The purpose of this section is to set out the terms under which DMAS shall participate in the All Payer Claims Database (APCD), administered through VDH through its subcontractor, Virginia Health Information (VHI). The terms of DMAS' participation in the APCD are fully set out in the following documents, which are attached hereto and incorporated herein by reference:

Attachment 1 Virginia All Payer Claims Database Data Submission and Use Agreement – This document sets forth the terms that govern DMAS' submission of certain data to VHI. Article 8.2 (Indemnification) of the Data Submission and Use Agreement shall not apply between the parties. VHI may update this document. VHI shall provide copies of each update to DMAS. Any update not objected to by DMAS within 45 days of receipt by DMAS shall become part of Modification No. 12 without any further action by VHI.

Exhibit 1 Data Submission Manual – This document addresses the technical requirements for DMAS' data submission to VHI. It sets forth in detail the elements and file types of data to be submitted, in addition to system requirements and data transfer.

Reimbursement:

Reimbursement shall be as set as described in Exhibit 1 Data Submission Manual or as otherwise agreed to by the parties.

ATTACHMENT 1

VIRGINIA ALL-PAYER CLAIMS DATABASE
DATA SUBMISSION AND USE AGREEMENT

This Virginia All-Payer Claims Database Data Submission and Use Agreement ("Agreement"), effective as of [DATE] (the "Effective Date") is entered into by and between Virginia Health Information, Inc. ("VHI") and _____ ("Data Supplier"). VHI and Data Supplier may be referred to herein each as a "Party" and collectively as the "Parties."

RECITALS

1. The Virginia All-Payer Claims Database (the "APCD") was created on April 9, 2012, by the passage of House Bill 343 (the "Act"), enacting and revising certain Sections of the Code of Virginia.

2. Pursuant to Section 32.1-276.4 of the Code of Virginia as amended by the Act, the State Health Commissioner (the "Commissioner") has entered into a contract with VHI, a Virginia nonprofit, tax-exempt 501(c)(3) corporation, for the operation of the APCD.

3. Section 32.1-276.7:1(C) of the Code of Virginia obligates the Commissioner to ensure that VHI executes a standard data submission and use agreement with each entity electing to participate in the APCD as a Data Supplying Entity and specifies certain provisions, terms, and conditions which must be included in such agreements, including but not limited to data specifications for submitted data as is set forth below and in applicable Exhibits hereto.
In consideration of the mutual covenants and conditions herein, the Parties agree to the following:

AGREEMENT

ARTICLE 1 – DEFINITIONS

1.1. Actual Reimbursement Amounts –Reimbursement information included in the Claims Data submitted by Data Supplying Entities, whether referred to as "paid amounts," "allowed amounts," "negotiated charges," or another term having the same or similar meaning, and whether in reference to the payer who paid the Actual Reimbursement Amount or the provider who received the Actual Reimbursement Amount.

1.2. Advisory Committee - The committee appointed by the Commissioner pursuant to Code Section 32.1-276.7:1(D).

1.3. All-Payer Claim Database or APCD – The repository of Claims Data created by Code Section 32.1-276.7:1(A) to facilitate data-driven, evidence-based improvements in access, quality and cost of health care and to promote and improve the public health through the understanding of health care expenditure patterns and operation and performance of the health care system.

1.4. Claims Data – Data elements associated with the paid health care claims of Virginia residents that will be collected by VHI for the APCD, which may include eligibility data, medical claims data, pharmacy claims data, provider data, Actual Reimbursement Amount(s), member payment responsibility, and such other data elements as are described in Code Section 32.1-276.7:1(C)(2).2

1.5. Code – The Code of Virginia.

1.6. Commissioner – The Virginia Commissioner of Health.

1.7. Covered Entity Reports – Information meeting the standard of Code Section 32.1- 276.7:1(C)(6) to the extent that state-law standard does not conflict with HIPAA, and supplied to any Covered Entity that is a Data Supplying Entity after VHI's collection, aggregation, and analysis of PHI supplied by more than one Data Supplying Entity. To receive a Covered Entity Report, a recipient must be a Covered Entity (or such Covered Entity's Business Associate) and such Reports shall be available only for the Health Care Operations of the recipient.

1.8. Data Specifications – The specific elements of Claims Data that will be collected by VHI for the APCD, along with the detailed field definitions, submission guidelines and instructions set forth in Exhibit 1 (Data Submission Manual), which is attached hereto and incorporated herein by reference.

1.9. Data Supplying Entity – Data Supplier or another entity which has elected to provide Claims Data to the APCD pursuant to Code Section 32.1-276.7:1(B)

1.10. De-Identified Data – Data meeting the HIPAA Privacy Rule's de-identification standard as set forth in 45 CFR 164.514(b) and which VHI is permitted to generate from the Claims Data pursuant to its Business Associate Agreement with each Data Supplying Entity who is a Covered Entity. De-Identified Data shall contain only Pre-processed Claims Data, which includes Standardized Proxy Reimbursement Amounts as further defined herein.

1.11. De-Identified Data Set – The data set comprised of De-Identified Data derived from the Pre-processed Claims Data, to be used by VHI to create the De-Identified Reports. The De- Identified Data Set shall not include any Actual Reimbursement Amounts.

1.12. De-Identified Reports – A Report containing only De-Identified Data which may be made available to third parties or Data Supplying Entities pursuant to the terms of this Agreement. A De-Identified Report shall meet the standard of Code Section 32.1-276.7:1(C)(6). 1.13. Health Care Operations – For purposes of this Agreement, activities satisfying the definition at 45 CFR 164.501, "*health care operations"* types (1) and (2) and consisting of:

a. Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting health care providers and patients with information about treatment alternatives; and related functions that do not include treatment; and/or

b. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities.

1.14. HIPAA – The Health Insurance Portability and Accountability Act of 1996, as amended, and its implementing regulations (45 C.F.R. Parts 160-164), as well as the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (the "HITECH Act") and any regulations adopted or to be adopted pursuant thereto. All capitalized terms in this Agreement not otherwise defined, if defined in HIPAA, have the meaning defined in HIPAA.

1.15. Payer – An entity that, with respect to Virginia residents, is: (i) an issuer of individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; (ii) a corporation providing individual or group accident and sickness subscription contracts; (iii) a health maintenance organization providing a health care plan for health care services; or (iv) a third-party administrator or other entity that receives or collects charges, contributions, or premiums for, or adjusts or settles health care claims; (v) Department of Medical Assistance Services; or (vi) federal health insurance plans including but not limited to Medicare, TRICARE, and the Federal Employees Health Benefits Plan.

1.16. Pre-processed Claims Data – Claims Data from which all Actual Reimbursement Amounts have been removed and replaced with Standardized Proxy Reimbursement Amounts.

1.17. Provider – A hospital or physician as defined in Chapter 32.1 of the Code or any other health care practitioner licensed, certified, or authorized under the Code to provide covered services represented in the Claims Data.

1.18. Public Health Oversight Reports – Those Reports generated for the Virginia Department of Health by VHI which are generated using the Claims Data supplied pursuant to this Agreement. Public Health Oversight Reports shall be only those Reports: (i) identified in writing in a manner consistent with 45 CFR 164.512(b) and 45 CFR 164.514(d)(3)(iii)(A) by the Department of Health as necessary for the Department to carry out its public health oversight functions as specified by state law; and (ii) meeting the standard of Code Section 32.1-276.7:1(C)(6), to the extent that that state-law standard does not conflict with HIPAA.

1.19. Report – A Covered Entity Report, a De-Identified Report, or a Public Health Oversight Report only.

1.20. Standardized Proxy Reimbursement Amounts-- The single schedule of substitute reimbursement amounts which shall be: (1) obtained by VHI from the external source identified in Exhibit 1 (Data Submission Manual) and: (2) used by VHI in lieu of the Actual Reimbursement Amounts in performing all APCD analyses and producing all APCD Reports, except as expressly provided in Exhibit 4 (Permitted Uses of Actual Reimbursement Amounts).

1.21. Virginia Health Information or VHI – The Virginia nonprofit, tax-exempt 501(c)(3) corporation with which the Commissioner has entered into a contract for the operation of the APCD pursuant to Code Section 32.1-276.4.4

ARTICLE 2 – OBLIGATIONS OF VHI

2.1. General Obligations.

a. Pursuant to Section 32.1-276.4(A) and to the terms of the agreement between the Commissioner and VHI for the operation of the APCD, VHI shall collect, aggregate, process, and analyze the Claims Data in accordance with the terms of this Agreement, or shall arrange for the same and manage the oversight of subcontractors in order to develop and disseminate Reports as set forth in Article 5 of this Agreement.

b. Subcontractors. VHI shall be permitted to disclose the Claims Data to subcontractors acting on its behalf in performing VHI's obligations under this Agreement; provided, however, that VHI shall ensure that such subcontractors comply with all the requirements imposed upon VHI under this Agreement.

2.2. Obligation to Enter into Data Submission and Use Agreements. Pursuant to Code Section 32.1-276.7:1(C), VHI shall enter into a Data Submission and Use Agreement with each current and future Data Supplying Entity with terms in all material respects the same as the terms of this Agreement.

2.3. Privacy and Security Obligations.

a. General. In performing its obligations hereunder, VHI shall comply with all applicable state and federal privacy and information security laws, including but not limited to HIPAA; Titles XIX and XXI of the Social Security Act; Virginia Code Section 32.1- 127.01:3; and Chapter 6 of Title 38.2 (Sections 38.2-600 *et seq.*) of the Code, and Title I of the Sherman Anti-Trust Act.

b. HIPAA Protections. VHI acknowledges that it is a Business Associate of Data Supplier with respect to the Claims Data submitted hereunder, as the term Business Associate is defined in HIPAA, and that VHI and its subcontractors and agents are therefore subject to HIPAA's Privacy and Security Rules (45 CFR Part 164 Subparts C and E), as amended, including amended Rules issued after the effective date of this Agreement, as well as expanded requirements for business associates of HIPAA-covered entities included in the HITECH Act of 2009. Data Supplier's participation in the APCD and its obligations under this Agreement shall be conditional upon the execution by VHI of a Business Associate Agreement ("BAA") with Data Supplier, a copy of which executed BAA shall be attached hereto as Exhibit 2. The Security Standards that shall apply to the custody of data by VHI or its subcontractors are attached to the BAA as Exhibit A. VHI agrees that it and its agents and subcontractors shall be bound by the terms of such BAA and the Security Standards and shall enter into written agreements with its subcontractors and agents to assure their compliance with such terms.

a. FOIA Exemption. Pursuant to Code Section 32.1-276.7:1(H), information provided to the APCD by Data Supplier shall be confidential and shall be exempt from disclosure by the Virginia Freedom of Information Act (Code Sections 2.2-3700 *et seq.*).

d. Security. VHI, as a Business Associate of Data Supplier, shall meet all appropriate security standards and implementation specifications pursuant to HIPAA regulations 45 CFR Part 164 Subparts A and C and ensure the data is received, maintained, accessed, used, and disclosed in a secure manner.

e. Maintenance and Final Disposition of Data. VHI shall implement record retention policies and procedures to appropriately and securely maintain the data being collected from Data Supplying Entities and, as necessary, dispose of data that is no longer valid or has met the record retention period subject to the specific HIPAA rules on retention or destruction of PHI by Business Associates and Article 7 below.

2.4. Obligation to Pre-Process and Verify the Accuracy of the Data Submitted by Data Supplying Entities. Pursuant to Code Section 32.1-276.7:1(F), VHI shall not commence reporting until the Claims Data has been pre-processed and verified at levels of accuracy consistent with the standards set forth in Exhibit 1. Such pre-processing shall include substituting the Standardized Proxy Reimbursement Amounts for the Actual Reimbursement Amounts.

2.5. Obligation to Analyze the Data. Pursuant to Code Sections 32.1-276.7:1(A) and (C), VHI shall internally analyze the Pre-processed Claims Data for purposes of finding opportunities to effect data-driven, evidence-based improvements in health care and the public health in Virginia, and use those analyses to produce the Reports specified in Article 5. Such analyses may include, but are not limited to:

a. Geographic, demographic, economic and peer-group comparisons; and

b. Comparisons of Providers and health plans with regard to their provision of safe, cost effective, and high-quality health care services for use by public and private health care purchasers, employers, consumers, health plans, insurers, data analysts, and Providers.

2.6. Obligation to Produce Aggregate Reports and Verify Accuracy of Content of Reports.

a. General Requirement. Subject to the requirements of Sections 2.3, 2.4, and 2.7, VHI shall produce aggregate Reports based on the Pre-processed Claims Data.

b. Types of Reports. Pursuant to Code Section 32.1-276.7:1(E), VHI shall produce and make available the Reports described in Article 5.

2.7. Obligation Not to Disclose Reimbursement Information. Pursuant to Code Section 32.1- 276.7:1(C)(6) and notwithstanding any other provision of this Agreement, VHI shall not disclose or report in any manner whatsoever: (i) any Provider-specific or Payer-specific Actual Reimbursement Amount(s); (ii) information capable of being reverse-engineered, combined, or otherwise used to calculate or derive such reimbursement information; or (iii) comparative reimbursement statistics that would allow a Provider or Payer to determine their relative rate of reimbursement compared to a peer. However, VHI may use the Standardized Proxy Reimbursement Amounts and the Pre-processed Claims Data containing such Standardized Proxy Reimbursement Amounts in producing Reports, and may use the Actual Reimbursement Amounts and the Claims Data containing such Actual Reimbursement Amounts to the minimum extent necessary to perform the activities enumerated in Exhibit 4 (Permitted Uses of Actual Reimbursement Amounts).

2.8. Obligation for Responsible Use of the Data. Pursuant to Code Section 32.1-276.7:1(C)(7), VHI shall use the Pre-processed Claims Data and the Claims Data, as set forth in Exhibit 4, to improve health care value and, in such a manner as to preserve the integrity and utility of the APCD, VHI shall, when performing services for the Department, use and disclose the Claims Data, as set forth in Exhibit 4, and the Pre-processed Claims Data only to the extent specified by the Department as being the minimum necessary for VHI 6 to perform the services for which the Department has engaged VHI. When performing services or creating Reports for a Data Supplying Entity in its capacity as such Data Supplying Entity's Business Associate, VHI shall only use and disclose the Claims Data in a manner consistent with the terms of the applicable Business Associate Agreements (Exhibit 2).

2.9. Obligation to Maintain Liability Insurance. During the term of this Agreement, VHI shall:

a. Maintain Commercial General Liability insurance in an amount not less than one million dollars ($1,000,000.00) per occurrence and two million dollars ($2,000,000) annual aggregate covering any and all damage to property or injury to persons arising from or out of installation and/or operation of Equipment and/or performance of the work. Coverage shall include premises and operations, independent contractors, products and completed operations, contractual liability, personal injury and advertising injury, and broad form property damage coverage.

b. Maintain excess or umbrella liability insurance extending over the required commercial general liability, and employer's liability in an amount not less than five million dollars ($5,000,000) per occurrence and five million dollars ($5,000,000) annual aggregate.

c. Maintain professional liability (errors and omissions) insurance in the amount of two million dollars ($2,000,000) per occurrence and four million dollars ($4,000,000) annual aggregate. Any excess or umbrella liability insurance used for this requirement must make reference to professional liability.

d. Maintain cyber risk/privacy liability insurance coverage in the amount of five million dollars ($5,000,000).

e. Maintain worker's compensation insurance and employer's liability insurance of at least:

i. Worker's Compensation Insurance – the statutory coverage

ii. Employer's Liability Insurance

- Each employee – $500,000 bodily injury by accident
- Each employee – $500,000 bodily injury by disease
- Policy limit – $500,000 bodily injury by disease

Further, Data Supplier's Claims Data shall not be disclosed to any person or entity, including but not limited to, disclosure via release of any Reports incorporating such Claims Data, until and unless the errors and omissions liability insurance required of VHI by this Section 2.9 has been procured and is in effect, and documentation thereof has been provided to Data Supplier by VHI.

ARTICLE 3 – DATA SPECIFICATIONS

3.1. Data Specifications. Subject to the terms of this Article 3, the Data Specifications shall be as set forth in Exhibit 1.

3.2. Purpose. Pursuant to Code Sections 32.1-276.4 and 32.1-276.7:1(E), the Data Specifications shall be designed to enable VHI to develop and disseminate Reports as set forth in Article 5 of this Agreement.

3.3. Use of Data from Existing Claims Systems. Notwithstanding any data specification described in Section 3.5, pursuant to Section 32.1-276.7:1(C)(2), the Data Specifications shall not require the submission of data elements other than those available from Data Supplier's existing claims systems as the result of Data Supplier's normal business activities. Data Supplier shall not be required to (i) modify, alter, enlarge, or reprogram its claims systems, or (ii) collect additional or enhanced data elements in conducting its normal business activities, in order to comply with the Data Specifications.

3.4. Exemptions. Pursuant to 32.1-276.7.1(c) (5), Data Supplier shall be granted the following exemptions from supplying the information specified in Article 4:

a. An exemption with respect to each data element appearing in the Data Specifications that Data Supplier does not collect and maintain in its claims systems in the normal course of its business activities;

b. An exemption as to reimbursements not made on a per-claim basis in the ordinary course of Data Supplier's business activities; and

c. Any other exemption granted by the Advisory Committee.

3.5. Use of Existing Standards. Pursuant to Code Section 32.1-276.7:1(C)(5), to the extent practicable and consistent with the permissible uses of the Claims Data under the Act, the APCD shall make use of existing data collection standards and methods which are compatible with Data Suppliers' existing systems, including but not limited to the applicable electronic reporting standard adopted by The Accredited Standards Committee X12 ("ASC X12") and the APCD Council.

ARTICLE 4 – DATA SUBMISSION

4.1. Obligation to Provide Data. Subject to the terms of Article 3 of this Agreement and of this Article 4, Data Supplier shall submit complete and accurate Claims Data files to the APCD in accordance with the Data Specifications set forth in Exhibit 1. Data Supplier shall submit such Claims Data on a quarterly basis, commencing

on a date to be determined by VHI and continuing thereafter by the 45th day after the end of each successive quarter. VHI shall provide Data Supplier with sixty (60) days' prior notice of the date in which Data Supplier shall first submit Claims Data.

4.2. Privacy and Security. Data Supplier shall produce and submit its Claims Data files in compliance with the requirements of applicable state and federal privacy and information security laws, including HIPAA and the regulations promulgated thereunder; Titles XIX and XXI of the Social Security Act; Code Section 32.1-127.01:3; and Chapter 6 of Title 38.2 (Sections 38.2-600 *et seq.*) of the Code.
4.3. Scope. Data Supplier shall submit such Claims Data files with respect to claims of Virginia residents associated with (i) its entire book of Virginia insured business (excluding Medicare Advantage, FEHBP (unless authorized by the United States Office of Personnel Management to provide the Claims Data), and TRICARE); and (ii) its Virginia self-funded business products for which Data Supplier volunteered to supply data as reflected in the Health Plan Adoption Form it executed to signify its agreement to participate in the APCD pursuant to the Participation Agreement (as defined in Section 6.1 hereof).8

4.4. Ownership of Data. By providing the Claims Data files, Data Supplier does not convey any ownership rights in its Claims Data, nor does VHI, any other Data Supplying Entity, any subscriber to the APCD, or any other third party acquire such rights.

ARTICLE 5 –USES AND DISCLOSURES OF DATA AND REPORTS

5.1. Uses and Disclosures of Data by VHI

a. Permitted Uses and Disclosures. Subject to the terms and conditions of this Agreement, Data Supplier hereby grants to VHI the right to use and disclose the Claims Data or Pre-processed Claims Data, solely and to the minimum extent necessary for VHI to perform its obligations as set forth herein and in the Act (collectively, the "Purpose"); provided, however, that such uses and disclosures of the Claims Data and Pre-processed Claims Data shall be subject to the following limitations:

i. Except as permitted under Section 2.1(b) of this Agreement, all disclosures of the Claims Data and Pre-processed Claims Data shall be in the form of Reports and shall be subject to Section 2.7 of this Agreement;

ii. Only the Pre-processed Claims Data in which the Standardized Proxy Reimbursement Amounts have been substituted for the Actual Reimbursement Amounts shall be used, except as specified in Exhibit 4 (Permitted Uses of the Actual Reimbursement Amounts) and to allow VHI the ability to verify the accuracy and quality of the Claims Data submitted by an individual Data Supplying Entity; and

iii. Recipients of the Claims Data disclosed by VHI shall be restricted from re-disclosing such Claims Data, except as expressly permitted under the terms of this Agreement, the Business Associate Agreement, attached hereto as Exhibit 2, and the Data Subscriber Agreement, attached hereto as Exhibit 3. Notwithstanding the general prohibition regarding the re-disclosure of Claims Data as set forth in this Section 5.1(a), a Data Supplying Entity may re-disclose Claims Data to its employees, subcontractors and agents for the Health Care Operations of the Data Supplying Entity.

b. Fees for Reports. Except as prohibited by the Act or other applicable law, VHI may charge such fees for De-Identified Reports as it determines to be appropriate.

c. Non-Permitted Uses and Disclosures. For purposes of this provision, "APCD Data" shall mean the Claims Data, in whole or in part, or any reports, summaries, or analyses hereof. VHI shall use the APCD Data only to accomplish the Purpose, and, except as permitted under this Section 5.1, shall not use or disclose it for any other reason, including but not limited to: (i) selling or disclosing the APCD Data to any third party; or(ii) conducting research or analytics for any third party using the APCD Data.

d. Format and Content of Reports. VHI may produce, subject to Section 5.1(a), the types of Reports as set forth in Sections 5.1(d)(i), (ii), (iii), and (iv) below. In preparing such Reports VHI shall, pursuant to Code Section 32.1-276.7:1(E), follow the recommendations of the Advisory Committee with respect to the

appropriate level of specificity of the reported data contained within the Report that is necessary (1) to protect patient privacy and (2) to accurately attribute services and resource utilization rates to providers. When appropriate, VHI shall further consult with the Advisory Committee to ensure that the creation or disclosure of a Report complies with HIPAA.9

i. Reports for the Department of Health. Pursuant to Code Section 32.1- 276.7:1(E)(1), VHI may produce De Identified Reports and Public Health Oversight Reports for the Department of Health. Such Reports shall include, but not be limited to, Reports on (i) injuries; (ii) chronic diseases; (iii) health conditions of pregnant women, infants, and children; and (iv) geographic and demographic information for use in community health assessment, prevention education, and public health improvement, formatted to allow comparison with reports produced by other nationwide data programs. Such Reports shall also include Reports that permit the design and evaluation of alternative delivery and payment models. Reports produced for the Department of Health shall be in such format and shall include such content as the Department of Health requests so long as the content is permissible under the Act and other applicable law and is consistent with the terms of this Agreement.

ii. Reports for Health Care Purchasers. Pursuant to Code Section 32.1-276.7:1(E)(1) and (2), VHI may produce De-Identified Reports for use by health care purchasers including employers and consumers ("Health Care Purchasers"), in such format and including such content as VHI, after consultation with the Advisory Committee, shall determine. Such De-Identified Reports for Health Care Purchasers, or access to data sets or databases prepared by VHI, shall be made available pursuant to the terms of the Data Subscriber Agreement as shown in Exhibit 3 and as VHI may amend from time to time.

iii. Other De-Identified Reports. VHI may produce De-Identified Reports, which may include searchable subsets of the De-Identified Data Set or access to data sets or databases prepared by VHI and containing information derived solely from the De- Identified Data Set for use by the Department, Providers, third parties, Health Care Purchasers, and the general public, in such format and including such content as VHI, after consultation with the Advisory Committee, shall determine. Such De- Identified Reports, or access to data sets or databases prepared by VHI, shall be made available pursuant to the terms of the Data Subscriber Agreement as shown in Exhibit 3 and as VHI may amend from time to time.

iv. Covered Entity Reports. VHI may prepare Covered Entity Reports for use by Data Supplier or another Data Supplying Entity that is a Covered Entity in carrying out its Health Care Operations, in such format and including such content as is the minimum necessary to carry out the specific intended Health Care Operation the report is intended to support, subject to the unanimous approval of the affected Data Supplying Entities. Once the format and content of a Covered Entity Report is finalized, VHI shall not alter it without further consultation with the Advisory Committee and approval by the affected Data Supplying Entities.

e. Review Period and Corrections. Pursuant to Code Section 32.1-276.7:1(F), prior to releasing any Report specifically naming any Data Supplying Entity or Provider (each an "Affected Entity"), VHI shall provide such Affected Entity with notice of the pending Report and shall allow for a period of review of at least 60 days' duration. During this period, the Affected Entity may seek explanations of results and the correction of data that such Affected Entity proves to be inaccurate. VHI shall make these corrections prior to releasing the Report.

f. Use of the De-Identified Data Set. Data Supplier agrees that, subject to Section 5.1(c) and the provisions of the Act, VHI may prepare any De-Identified Report, including but10 not limited to an analysis, data set or database containing only information from the De- Identified Data Set, and make such De-Identified Reports available to third parties in exchange for such fees as VHI shall determine is appropriate.

g. Transparency. All publicly available Reports created by VHI using any Pre-processed Claims Data or De-Identified Data obtained from the APCD shall fully disclose the methodology used to create the Report, either by (1) outlining the methodology within the text of the Report or (2) including a link within the Report to a web site that sets forth the Report's methodology. VHI shall ensure that all third parties who either (1) create Reports on behalf of VHI or (2) access the De-Identified Data Set to create Reports are subject to the

requirements of this Section 5.1(g). A Report's detailed methodology may include, as appropriate, the following components:

i. Providers and/or geography included within the Report;
ii. Specifications used to calculate included measures;
iii. Method used to attribute patients to Providers for each measure;
iv. Minimum number of observations used for assessment of the performance of Providers for each measure;
v. Confidence interval and/or reliability, as applicable, of each measure;
vi. Risk adjustment methodology used for each measure;
vii. Method of identifying and handling outlier cases for each measure;
viii. Any known limitations inherent in the data set for each measure; and
ix. A statement explaining an Affected Entity's right to review any Report and request the correction of data that such Affected Entity proves to be inaccurate prior to the release of a Report.

5.2. Uses and Disclosures of Reports By Data Supplier

a. Permitted Uses and Disclosures. Data Supplier may use the Covered Entity Reports and De-Identified Reports prepared by VHI independently and unilaterally, without consultation with the other Data Supplying Entities, for an unlimited duration:

i. For Covered Entity Reports in support of the Data Supplier's Health Care Operations;

ii. To develop products for sale to Data Supplier's Customers (including those of its affiliates and subsidiaries); provided that, to the extent such products include any Claims Data contained in a Covered Entity Report, the data will consist only of De-Identified Data. For purposes of this Section, "Customers" may include, but shall not be limited to, Health Care Purchasers, other Payers, and self-insured programs providing health care benefits provided or administered by Data Supplier; and

iii. To provide, whether directly or indirectly through a third party, quality, decision support, and consumer information to Data Supplier's current and potential members, subscribers, clients, and employers.

b. Non-Permitted Uses and Disclosures. Except as expressly permitted in this Section 5.2, Data Supplier shall not: (i) sell, lease or otherwise exchange for monetary compensation the Reports of another Data Supplying Entity to any third party for the purpose of such third party's commercial exploitation of any of the information contained therein; or (ii) provide any third party access to or use of the Covered Entity Reports, except that Data Supplier may provide access on a confidential basis 11 to subcontractors performing services on Data Supplier's behalf in connection with any of Data Supplier's activities permitted under this Section 5.2.

5.3. Uses and Disclosures of Data and Reports by Third Parties. Any Pre-processed Claims Data, and any Report produced for any Provider or other third party who is not a Data Supplying Entity shall be subject to the terms of a Data Subscriber Agreement between VHI and the Provider or other third party that is the same or substantially similar to the Data Subscriber Agreement attached hereto as Exhibit 3.

ARTICLE 6 – FUNDING

6.1 Data Supplier's Obligation to Fund APCD. Pursuant to the terms of that certain Participation Agreement dated as of November 28, 2012 (the "Participation Agreement") by and among VHI, the Virginia Association of Health Plans (the "VAHP") and certain members thereof, the Virginia Hospital and Healthcare Association and certain members thereof, VAHP agreed to fund, through its members, forty percent (40%) of the APCD's initial budget of Three Million Two Hundred Eighty One Thousand Five Hundred Dollars ($3,281,500.00) (the "Initial Budget"). As a member of VAHP, Data Supplier is responsible for contributing _____ Dollars ($_____) towards the Initial Budget. Data Supplier shall pay five percent (5%) of such amount to VHI no later than thirty (30) days after a sufficient number of Data Supplying Entities have executed Data Submission and Use Agreements to submit

Claims Data representing at least seventy-five percent (75%) of privately insured individuals and individuals covered under self-funded group health plans in the Commonwealth of Virginia that have directed a Data Supplying Entity to submit their Claims Data. Subsequent installments shall be paid on a quarterly basis upon invoice from VHI.

ARTICLE 7 – TERM AND TERMINATION

7.1. Term. Unless otherwise terminated as set forth in this Article 7, this Agreement shall be effective upon the Effective Date and shall remain in effect for thirty (30) months (the "Expiration Date"). The term will be automatically extended for a one (1) year period unless Data Supplier provides written notice to VHI at least 60 days prior to the Expiration Date that Data Supplier wishes for the Agreement to be allowed to expire without such extension of its term.

7.2. Termination for Cause. In the event that Data Supplier or VHI defaults in the observance or performance of any material obligation in this Agreement and such default is not cured or corrected within thirty (30) days after written notice thereof from the non-breaching Party, the non-breaching Party may, at its option, terminate this Agreement in whole or in part by providing written notice to the breaching Party. An unauthorized access, use, or disclosure of PHI shall be deemed a default in a material obligation by VHI and may, at Data Supplier's election, support a unilateral termination of this Agreement not subject to the 30 day cure period.

7.3 Effect of Termination. Pursuant to HIPAA, the parties agree that termination of this Agreement shall have the effects specified herein.

a. Upon the expiration or termination of this Agreement as to all Data Supplying Entities, VHI shall securely return or destroy all Claims Data for which it has custody or control. If such Claims Data cannot be securely returned or destroyed, VHI shall certify in writing signed by an officer that the Claims Data remains safe-kept and that neither it, nor any of its employees, agents,12 subcontractors, successors or assigns, shall use or disclose the Claims Data. Upon expiration or termination of this Agreement under the conditions stated in this subsection, neither Data Supplier nor any other Data Supplying Entity shall be obliged to supply additional data.

b. Upon expiration or termination of this Agreement as to Data Supplier, VHI shall cease to perform any Health Care Operations for Data Supplier and, as a result, VHI shall securely return or destroy all Claims Data for which it has custody or control. If such Claims Data cannot be securely returned or destroyed, VHI shall certify in writing signed by an officer that the Claims Data remains safe-kept and that neither it, nor any of its employees, agents, subcontractors, successors or assigns, shall use or disclose the Claims Data in the custody and control of VHI. Data Supplier's obligation to submit additional Claims Data shall end. In addition, each Party's rights and obligations accruing or arising prior to such termination or expiration, together with Sections 2 and 5 shall survive the expiration or termination of this Agreement and shall continue in perpetuity.

c. The termination or expiration of VHI's agreement with the Department shall have no automatic impact on the provisions of this Agreement except that Sections 2.1(a) and 2.5 shall no longer have effect.

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ARTICLE 8 – GENERAL PROVISIONS

8.1. Relationship of the Parties. With respect to all performance of this Agreement, each party, including its employees, officers and agents, shall be considered an independent contractor, and not an employee, agent, partner, or joint venturer of the other party. Except as expressly provided in this Agreement, neither party shall have any right to act for, obligate or make commitments, express or implied, on behalf of the other.

8.2. Indemnification. Each Party ("Indemnifying Party") shall indemnify, defend and hold harmless the other Party and officers, directors, agents, and employees as well as each other Data Supplying Entity (collectively, "Indemnified Party(ies)") from any and all actions, causes of actions, claims, demands, cost, liabilities, expenses, and damages (including reasonable attorneys' fees) (collectively, "Claims") incurred by Indemnified Party(ies) and arising out of or in connection with any of the following actions by Indemnifying Party, its agents, employees, representatives or subcontractors: (i) a breach of this Agreement; (ii) the breach of an agreement with a third party; (iii) the violation of any applicable law or regulation; and (iv) any misuse of the Claims Data submitted to the APCD or of the Reports.

8.3. Notices. All notices, requests, claims, demands, and other communications specifically required pursuant to this Agreement.(each a "Notice") shall be in writing, signed by an authorized representative of the Party providing the Notice, and shall be given or made by delivery in person, by a nationally recognized courier service (with proof of delivery), by certified mail (postage prepaid, return receipt requested) or by electronic mail containing a signed copy of the Notice in a separate attachment (with proof of delivery) to the respective
Party at the following address set forth below or at such other address as such Party may hereafter notify the other party in accordance with this Section 8.3:

For Data Supplier: _____
_____
_____
_____

For VHI: Virginia Health Information
Attn: Michael Lundberg
102 North 5th Street
Richmond, Virginia 23219

With copy to: Wyatt S. Beazley IV, Esquire
Williams Mullen
Post Office Box 1320
Richmond, Virginia 23218

8.4. Waiver. No failure or delay by either Party to exercise any right or to enforce any obligation herein, and, no course of dealing between the Parties, shall operate as a waiver of such right or obligation or be construed as or constitute a waiver of the right to enforce or insist upon compliance with such right or obligation in the future. Waiver of any provision herein must be in writing.

8.5. Amendment. This Agreement is expressly limited to its terms and may be modified or amended only by a writing signed by an authorized representative of the Party against whom enforcement is sought.

8.6. Assignment. Neither Party will assign or otherwise transfer any rights, duties, obligations or interest in this Agreement or arising hereunder to any persons or entities whatsoever without the prior written consent of the other Party, except that a Data Supplier may assign this Agreement to any parent, subsidiary, or wholly owned affiliated company without the consent of VHI. Any attempt to assign or transfer without such prior written consent shall be null and void.

8.7. Successors and Assigns. This Agreement and all of the terms and conditions hereof shall be binding upon and inure to the benefit of the Parties and their respective successors, transferees, permitted assignees or legal representatives.

8.8. Counterparts. This Agreement may be executed and delivered in separate counterparts, each of which will constitute an original, but all of which together will constitute one and the same instrument. Any counterpart may comprise one or more duplicates, any of which may be executed by less than all of the Parties provided that each Party whose execution is required executes at least one such duplicate. A copy of this Agreement, executed on behalf of a Party and transmitted to the other Party by facsimile or in graphical-image form by email or other electronic transmission, is to be deemed for all purposes to have been executed and delivered by that Party to the other Party.

8.9. Force Majeure. Neither Party shall be liable for its failure to perform any of its obligations hereunder during any period in which such performance is delayed by acts of God, fire, war, terrorism, earthquake, embargo, riots, strikes, governmental acts, interruption in telecommunications service, or any other cause outside the reasonable control of such Party.

8.10. Severability. If any provision of this Agreement is deemed invalid or unenforceable, such provision shall be ineffective only to the extent of such prohibition or invalidity without invalidating the remainder of such provision or the remaining provisions of this Agreement. Headings are for reference purposes only and have no substantive effect.

8.11. Governing Law. This Agreement shall be governed by Virginia law, without reference to or use of any conflicts of law provisions. The Parties agree that with respect to any disputes, actions, suits or proceedings arising in connection with this Agreement, venue will be in the
Commonwealth of Virginia and in such event, the Parties hereby consent to the exclusive jurisdiction of the federal and state courts located in Richmond, Virginia.

8.12. Entire Agreement. The terms and conditions of this Agreement constitute the full and complete agreement between the Parties. No other verbal or written agreement shall, in anyway, vary or alter any provision of this Agreement unless both Parties consent to vary or alter any provision of this Agreement in a signed writing. This Agreement is an integrated writing. Any prior oral or written agreements between the Parties are merged into this Agreement and extinguished. No action of the VHI Board of Directors may override the terms of this Agreement. VHI may not adopt any recommendations of the Advisory Committee that would conflict with the terms of this Agreement.

Each of the undersigned represents, warrants, and covenants that he or she has the authority and the right to enter into this Agreement binding the Party on whose behalf the Agreement is hereby executed:

Virginia Health Information:	**Data Supplier**:
_____	_____
Signature	Signature
_____	_____
Printed Name	Printed Name
_____	_____
Title	Title
_____	_____
Date	Date

Index of Exhibits:

1. Exhibit 1 – Data Submission Manual

Exhibit 1

Virginia All-Payer Claims Database
Data Submission Manual

August 2013, v 1.2

REVISION HISTORY

Date	Version	Description	Author
11/8/12	1.0	Initial Draft	VHI
8/5/13	1.1	Proposed changes accepted by Data Submitters	VHI
8/28/13	1.2	Language added to clarify data submission requirements.	VHI

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Data Submission Requirements – General

To facilitate data communications, data submissions and processing, data submitters will provide to the VHI APCD data subcontractor registration information with the following information:

- o Company contacts
- o Control totals for reconciliation
- o Data files submitted and sources/platforms
- o Special data considerations
- o Member linkage information

The registration form should be completed within thirty days after the Data Submission Manual is finalized, whenever the data submitter's information is modified, and by June 30th of 2014 and every year thereafter.

Although data submitters may provide files on a quarterly basis, it is preferable that files be submitted on a monthly schedule due to the large volume of data contained in the files.

Pursuant to § 32.1-276.7:1.C.5, the APCD Advisory Committee has an exemption process for submitting entities that do not collect the specified data or pay on a per-claim basis.

It is expected that the data files, where applicable, be populated using the most current nationally adopted code sets. For those submitting entities that do not capture data in the manner set out below, best efforts must be used to complete all fields. A data key should be provided with the data submissions.

Data received from multiple data systems may be rolled up by member SSN# to report one line per member in the file or separate submitter codes can be provided, whichever is preferable for the submitting entity.

All medical or pharmacy claims processed by data submitters acting as Third Party Administrators (TPAs) or Pharmacy Benefits Managers (PBMs) under contract to a data submitter for carved-out services are to be submitted by the data submitter with unified member IDs in all files. If this is not possible due to contractual requirements, two fields are required for completion in both the Medical Claims (MC) and Pharmacy Claims (PC) files to link the individual claims to the specific carriers and to associate the members in the separate eligibility files. The fields, which are Carrier Associated with Claim (MC207/PC201) and Carrier Plan Specific Contract Number or Subscriber/Member Social Security Number (MC208/PC202), are to be filled by the TPA or PBM submitting the files. If the data submitter does provide unified member IDs in all files, MC207/PC203 and MC208/PC204 are optional.

Data submissions detailed below will include eligibility, medical claims, pharmacy claims, provider data, and product data files (Health Care Data). Field definitions and other relevant data associated with these submissions are specified in Exhibit A. These datasets have been developed by the **APCD Council** in collaboration with stakeholders across the nation.

Some updates are presented below:

Member Eligibility File (ME)

ME010 – Member Sequence Number is the unique identifier of the member within the plan. For plans that do not have a unique identifier within their dataset, please concatenate the subscriber contract number and the prefix number to create a unique ID. The member sequence number must be the same unique identifier across the member eligibility, medical claims and pharmacy claims file. A further explanation can be found on page 8 of the Data Submission Guide. Below is a table clarifying the referential integrity across the membership file and the claims files.

File	
ME009	MC008
ME009	PC008
ME010	MC009
ME010	PC009

ME011 – Member Identification Code is to be the *member's* social security number (SSN). If the member's SSN is not available, please leave null. This will enhance the integrity of the APCD master patient index (MPI).

Medical Claim File (MC)

MC004 – Payer Claim Control Number (PCCN) is to be consistent across claim versions and therefore should not be a transaction number. A combination of the PCCN and version number (MC005A) will be used to determine which rows will carry forward into the final claim. It is also imperative a reversal (claim status – MC038 – set to '22') uses the same PCCN as the original paid claim.

MC005A – Version Number is to be coded as a '0' for the original claim. It is expected that every additional claim submitted corresponding to the original claim will have a version number incremented by '1' for the service line affected. Version number is required when reporting adjustments and reversals.

MC024 – Service Provider Number must match the Provider ID (MP001) found in the medical provider file.
MC032 – Service Provider Specialty Code in the medical claims file is preferred to be the CMS specialty code. This will provide consistency across all payers in the APCD. A crosswalk of Taxonomy and CMS Specialty codes can be found on the CMS website. If the CMS specialty code is not available a dictionary is required.

MC036 – Type of Bill – Institutional is to be populated for *institutional claims only*. It is expected that facility type (MC037) will be left null for institutional claims.

MC037 – Place of Service – Professional is to be populated for *professional claims only*. It is expected that type of bill (MC036) will be left null for professional claims.

MC041 – MC053 – Principal and Other Diagnosis Codes - It is expected that ICD-9-CM or ICD-10-CM codes be used to populate these fields. However, if individual, non-bundled "home grown" codes are still in use, a table is required which lists the codes and definitions.

MC054 – Revenue Code is to be filled for *all institutional claims*.

MC055 – Procedure Code – It is expected that Health Care Common Procedure Coding System (HCPCS)/Common Procedural Terminology (CPT) codes be used to populate this field. However, if individual, non-bundled "home grown" codes are still in use, a table is required which lists the codes and definitions.

MC058 – An ICD-9-CM or ICD-10-CM Procedure Code is required for *all inpatient claims*. If multiple codes are submitted, line one will be considered the primary code.

MC059 – Date of Service - From is to be filled for all claim types.

MC060 – Date of Service - Thru is to be filled for all claim types. If the length of stay is 0, then code with the Date of Service – From (MC059).

Claim Selection Logic for Historical Files – paid claims with service dates 2 calendar years prior to the initial reporting year.

Claim Selection Logic for Incremental Files – any claim paid, adjusted or voided within the period with services dates beginning January 1 of the year 2 years prior to the initial reporting year.

Pharmacy Claim File (PC)

PC017 – Date Service Approved (AP Date) is only optional on the original claim. When reporting reversals, it must be submitted.

PC025 – Claim status is only optional for original claim. When reporting reversals, the code '22 must be submitted.

Medical Provider File (MP)

MP001 – Provider ID is the unique identifier for *one* provider. The Provider ID should only occur *once* in the table. Provider ID is based on the billing and/or servicing provider.

MP003 – Provider Entity Type Code: below are clearer definitions of the codes defined in the DSG. While reviewing the test submissions, we have seen this code applied incorrectly.

Code Definition

F Facility
G Group Practice
I IPA (Independent Practice Association)
P Physicians (individuals filing a professional claim).

An additional utilization test will be implemented to verify the combination of NPI (MP014) and the Provider Entity Type Code (MP003) match NPPES NPI and NPPES entity type code. Example – field will be populated with F. G, I, or P.

MP014 – Provider NPI is currently a threshold column, but is anticipated to increase its requirement over time. It is important to work toward filling this column as the National Provider ID will assist healthcare plans in reporting accurate provider information including license

numbers, taxonomy code and specialty codes. It will also enhance the integrity of the APCD by increasing match rates for the Master Provider Index (eMPI). The NPPES database is available on CMS website.

1.1 DATA TO BE SUBMITTED

1.2.1 MEDICAL CLAIMS DATA

a) Payers shall report health care service paid claims and encounters for all resident members. Payers may be required to identify encounters corresponding to a capitation payment (Exhibit A-2).

b) Payers must provide information to identify the type of service and setting in which the service was provided. Each submitted data file shall have control totals and transmission control data (see Exhibits for specifics)

Claim data is required for submission for each month during which some action has been taken on that claim (ie payment, adjustment or other modification). Any claims that have been "soft" denied (denied for incompleteness, incorrect or other administrative reasons) which the data supplier expects to be resubmitted upon correction, do not have to be submitted until corrections have been completed and the claim paid. It is desirable that payers provide a reference that links the original claim to all subsequent actions associated with that claim (see Exhibit A-2 for specifics).

c) ICD-9/ICD-10 Diagnosis and Procedure Codes are required to accurately report risk factors related to the Episode of Care. CPT/HCPCS codes are also required.

d) For historical data submitted during the on boarding process, payers shall provide as a separate report monthly totals of covered members for the periods associated with the Historical Data.

1.2.2 PHARMACY CLAIMS

a) Health Care Payers must provide data for all pharmacy paid claims for prescriptions that were actually dispensed to members and paid (Exhibit A-3).

b) If your health plan allows for medical coverage without pharmacy (or vice versa), ME018 – ME020 in Exhibit A-1 provides data elements in which such options must be identified in order to effectively and accurately aggregate claims based on Episodes of Care.

1.2.3 MEMBER ELIGIBILITY DATA

a) Health Care Payers must provide a data set that contains information on every covered plan member whether or not the member utilized services during the reporting period. The file must include member identifiers, subscriber name and identifier, member relationship to subscriber, residence, age, race, ethnicity and language, and other required fields to allow retrieval of related information from pharmacy and medical claims data sets (Exhibit A).

b) If dual coverage exists, send coverage of eligible members where payer insurance is primary, secondary, or tertiary. ME028 is a flag to indicate whether this insurance is primary, secondary, or tertiary coverage.

c) Membership data received from multiple data systems may be rolled up by SSN# to report one line per member in the file or separate submitter codes can be provided, whichever is preferable for the submitting entity.

1.2.4 PROVIDER DATA

a) Health Care Payers must provide a data set that contains information on every provider for whom claims were adjudicated during the targeted reporting period.

b) In the event the same provider delivered and was reimbursed for services rendered from two different physical locations, then the provider data file shall contain two separate records for that same provider reflecting each of those physical locations. One record shall be provided for each unique physical location for a provider.

1.2.5 FILE HEADER AND TRAILER DATA

Separate Header and Trailer Record files must be submitted with each Eligibility File, Medical Claims File, and Pharmacy Claims File.

2.0 **FILE SUBMISSION METHODS**

2.1. SFTP – Secure File Transport Protocol involves logging on to the appropriate FTP site and sending or receiving files using the SFTP client.

2.2 Web Upload – This method allows the sending and receiving of files and messages without the installation of additional software. This method requires internet access, a username and password.

2.3 Plan will have the option to choose one of the above file submission methods.

3.0 **DATA QUALITY REQUIREMENTS**

3.1 The data elements in Exhibit A provide, in addition to field definitions, an indicator regarding data elements that are required. A data element that is required must contain a value unless a waiver is put in place with a specific payer who is unable to provide that data element due to system limitations. A data element marked as "TH" means that a % of all records must have a value in this field based on the expected frequency that this data element is available. Data files that don't achieve this threshold percentage for that data element may be rejected or require follow up prior to load into the APCD. A data element marked as "O" is an optional data element that should be provided when available, but otherwise may contain a null value. In some cases, a data element may be marked as optional for professional claims, but it is noted in parenthesis to be required for inpatient claims. An overall record accuracy rate of 95% for fields completed is the goal in order to be considered processed and verified consistent with the Act. For example, for every 100 records submitted 95 must be free of error.

3.2 Data validation and quality edits will be developed in collaboration with each payer and refined as test data and production data is brought into the APCD. Data files missing required fields, or when claim line/record line totals don't match, may be rejected on submission. Other data elements will be validated against established ranges as the database is populated and may require manual intervention in order to ensure the data is correct.

The objective is to populate the APCD with quality data and each payer will need to work interactively with the state to develop data extracts that achieve validation and quality specifications. This is the purpose of test data submissions early in the implementation process. Waivers may be granted, at the discretion of the state, for

data variances that cannot be corrected due to systematic issues that require substantial effort to correct.

4.0 FILE FORMAT

4.1 All files submitted to the APCD will be formatted as standard text file.
Text files all comply with the following standards:

a) Always one line item per row; No single line item of data may contain carriage return or line feed characters.

b) All rows delimited by the carriage return + line feed character combination.

c) All fields are variable field length, delimited using the pipe character (ASCII=124). It is imperative that no pipes ('|') appear in the data itself. If your data contains pipes, either remove them or discuss using an alternate delimiter character.

d) Text fields are *never* demarcated or enclosed in single or double quotes. Any quotes detected are regarded as a part of the actual data.

e) The first row of the medical and pharmacy claims files *always* contains the data element names of data columns.

f) Unless otherwise stipulated, numbers (ID numbers, account numbers, etc) do not contain spaces, hyphens or other punctuation marks.

g) Text fields are never padded with leading or trailing spaces or tabs.

h) Numeric fields are never padded with leading or trailing zeros.

i) If a field is not available, or is not applicable, leave it blank. 'Blank' means do not supply any value at all between commas (including quotes or other characters).

5.0 DATA ELEMENT TYPES

date – date data type for dates from 1/1/0001 through 12/31/9999

int – integer (whole number)

tinyint – integer data from 0 through 255

decimal/numeric – fixed precision and scale numeric data

char – fixed length non-unicode data with a max of 8,000 characters

varchar – variable length non-unicode data with a maximum of 8,000 characters

text – variable length non-unicode data with a maximum of 2^31 -1 characters

EXHIBIT A - DATA ELEMENTS

A-1 ELIGIBILITY DATA

Frequency: Monthly or Quarterly Upload via FTP or Web Portal (due within 45 days of the end of the reporting period)

It is extremely important that the member ID (Member Suffix or Sequence Number) is unique to an individual and that this unique identifier in the eligibility file is consistent with the unique identifier in the medical claims/pharmacy file. This provides linkage between medical and pharmacy claims during established coverage periods and is critical for the implementation of Episode of Care reporting.

For Historic Data collected, eligibility data are to be reported for all Virginia residents who were covered members during that reporting month. In the event historical address data is not available, eligibility data for historical months shall be reported based on member's last known or current address. It is acknowledged that for some payers there may not be an eligibility record for each member identified in the medical claims file for that same period. In order to reconcile the total number of resident covered members for this 3 year period, each payer is to submit a summary report that totals the number of resident covered members for each month for Historic Data.

Additional formatting requirements:

- Eligibility files are formatted to provide one record per member per month. Member is either the Subscriber or the Subscriber's dependents.
- Data for administration fees, premiums, and capitation fees that is contained on the eligibility file is pre-allocated (i.e. broken out by employee by month) to match the eligibility data
- Payers submit data in a single, consistent format for each data type.

MEMBER ELIGIBILITY FILE HEADER RECORD **Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/valid values**
HD001	Record Type	char	2	ME
HD002	Payer Code	varchar	8	NAIC code (example: 12345); leave blank if not applicable
HD003	Payer Name	varchar	75	
HD004	Beginning Month	date	6	CCYYMM
HD005	Ending Month	date	6	CCYYMM

HD006	Record count	int	10	Total number of records submitted in the medical eligibility file, excluding header and trailer records

MEMBER ELIGIBILITY FILE TRAILER RECORD

Data Element #	Date Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	ME
TR002	Payer Code	varchar	8	NAIC code (example: 12345); leave blank if not applicable
TR003	Payer Name	varchar	75	
TR004	Beginning Month	date	6	CCYYMM
TR005	Ending Month	date	6	CCYYMM
TR006	Extraction Date	date	8	CCYYMMD

A-1.1 MEMBER ELIGIBILITY FILE

Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME001	N/A	Payer Name/Code	varchar	8	Payer submitting payments-assigned by VHI (may be multiple to support different platforms, or as required)	R
ME002	271/2100A/NM1/XV/09	National Plan ID	varchar	30	CMS National Plan ID or NAIC	O
ME003	271/2110C/EB/ /04, 271/2110D/EB/ /04	Insurance Type Code/Product	char	2	See Lookup Table B-1.A for codes.	R
ME004	N/A	Year	int	4	4 digit Year for which eligibility is reported in this submission	R
ME005	N/A	Month	char	2	Month for which eligibility is reported in this submission expressed numerical from 01 to 12.	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME006	271/2100C/REF/1L/02, 271/2100C/REF/IG/02, 271/2100C/REF/6P/02, 271/2100D/REF/1L/02, 271/2100D/REF/IG/02, 271/2100D/REF/6P/02	Insured Group or Policy Number	varchar	30	Group or policy number - not the number that uniquely identifies the subscriber	R
ME007	271/2110C/EB//02, 271/2110D/EB/ /02	Coverage Level Code	char	3	Benefit coverage level	R
					CHD Children Only	
					DEP Dependents Only	
					ECH Employee and Children	
					EPN Employee plus N where N equals the number of other covered dependents	
					ELF Employee and Life Partner	
					EMP Employee Only	
					ESP Employee and Spouse	
					FAM Family	
					IND Individual	
					SPC Spouse and Children	
					SPO Spouse Only	

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME008	271/2100C/NM1/MI/09	Subscriber Social Security Number	varchar	9	Subscriber's social security number; Set as null if unavailable	TH
ME009	271/2100C/NM1/MI/09	Plan Specific Contract Number	varchar	128	Plan assigned subscriber's contract number; Set as null if contract number = subscriber's social security number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the subscriber.	R
ME010	N/A	Member Suffix or Sequence Number	varchar	128	Unique number of the member within the contract. Must be an identifier that is unique to the member.	R
ME011	271/2100C/NM1/MI/09, 271/2100D/NM1/MI/09	Member Identification Code	varchar	9	Member's social security number; Set as null if contract number = subscriber's social security number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the member.	TH
ME012	271/2100C/INS/Y/02, 271/2100D/INS/N/02	Individual Relationship Code	char	2	Member's relationship to insured – see Lookup Table B-1.B for codes.	R
ME013	271/2100C/DMG//03, 271/2100D/DMG//03	Member Gender	char	1	M – Male F – Female U - UNKNOWN	R
ME014	271/2100C/DMG/D8/02, 271/2100D/DMG/D8/02	Member Date of Birth	char	8	CCYYMMDD	R
ME015	271/2100C/N4/ /01, 271/2100D/N4/ /01	Member City Name	varchar	30	City location of member	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME016	271/2100C/N4//02, 271/2100D/N4//02	Member State or Province	char	2	As defined by the US Postal Service	R
ME017	271/2100C/N4//03, 271/2100D/N4//03	Member ZIP Code	varchar	11	ZIP Code of member - may include non-US codes. Do not include dash. Plus 4 optional but desired.	R
ME018	N/A	Medical Coverage	char	1	Y – YES N - NO	R
ME019	N/A	Prescription Drug Coverage	char	1	Y – YES N - NO	R
ME020	N/A	Dental Coverage	char	1	Y – YES N – NO 3 - UNKNOWN	R
ME021	N/A	Race 1	varchar	6	See Lookup Table B-1.C for codes.	O
					Y = Patient is Hispanic/Latino/Spanish	
					N = Patient is not Hispanic/Latino/Spanish	
					U = Unknown	
ME022	N/A	Race 2	varchar	6	See code set for ME021.	O
ME023	N/A	Other Race	varchar	15	List race if MC021or MC022 are coded as R9.	O
ME024	N/A	Hispanic Indicator	char	1		O
ME025	N/A	Ethnicity 1	varchar	6	See Lookup Table B-1.D for codes.	O
ME026	N/A	Ethnicity 2	varchar	6	See code set for ME025.	O
ME027	N/A	Other Ethnicity	varchar	20	List ethnicity if MC025 or MC026 are coded as OTHER.	O

Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME028	N/A	Primary Insurance Indicator	char	1	Y – Yes, primary insurance N – No, secondary or tertiary insurance	R
ME029	N/A	Coverage Type	char	3	STN – short-term, non-renewable health insurance (ie COBRA) UND – plans underwritten by the insurer OTH – any other plan. Insurers using this code shall obtain prior approval.	R
ME030	N/A	Market Category Code	varchar	4		O
					IND – policies sold and issued directly to individuals (non-group)	
					FCH – policies sold and issued directly to individuals on a franchise basis	
					GS3 – policies sold and issued directly to employers having 50 or more employees (100 or more employees after 1/1/2016)	
					GS4 – policies sold and issued directly to employers having fewer than 50 employees (fewer than 100 employees after 1/1/2016)	
					GSA – policies sold and issued directly to employers having fewer than 50 employees (fewer than 100 employees after 1/1/2016) through a qualified association trust	
					OTH – policies sold to other types of entities. Insurers using this market code shall obtain prior approval.	
ME031	N/A	Special Coverage	varchar	3	0 - not applicable 1 - XXX – reserved for VA special statewide health care coverage program(s)	O
ME032	N/A	Group Name	varchar	128	Group name or IND for individual policies	O

ME101	271/2100C/NM1/ /03	Subscriber Last Name	varchar	128	The subscriber last name	R
Data Element #	**Reference**	**Data Element Name**	**Type**	**Length**	**Description/Codes/Sources**	**Required**
ME102	271/2100C/NM1/ /04	Subscriber First Name	varchar	128	The subscriber first name	R
ME103	271/2100C/NM1/ /05	Subscriber Middle Initial	char	1	The subscriber middle initial	O
ME104	271/2100D/NM1/ /03	Member Last Name	varchar	128	The member last name	R
ME105	271/2100D/NM1/ /04	Member First Name	varchar	128	The member first name	R
ME201	N/A	Member Street Address	varchar	50	Street address of member	R
ME202	N/A	Employer Name	varchar	50	Name of the Employer, or if same as Group Name, null	O
ME897	N/A	Plan Effective Date	char	8	CCYYMMDD Date eligibility started for this member under this plan type. The purpose of this data element is to maintain eligibility span for each member.	R
ME899	N/A	Record Type	char	2	Value = ME	R

A-2 MEDICAL CLAIMS DATA

Frequency: Monthly or Quarterly Upload via FTP or Web Portal (due within 45 days of the end of the reporting period)

Additional formatting requirements:

- Claims are paid claims. Non-covered or denied claims (e.g. duplicate or patient ineligible claims) are not included.
- Payers submit data in a single, consistent format for each data type.

MEDICAL CLAIMS FILE HEADER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	2	MC
HD002	Payer Code	varchar	8	NAIC code (example: 12345); leave blank if not applicable
HD003	Payer Name	varchar	75	Example:
HD004	Beginning Month	date	6	CCYYMM
HD005	Ending Month	date	6	CCYYMM
HD006	Record count	int	10	Total number of records submitted in the medical claims file, excluding header and trailer records

MEDICAL CLAIMS FILE TRAILER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	MC
TR002	Payer Code	varchar	8	NAIC code (example: 12345); leave blank if not applicable
TR003	Payer Name	varchar	75	
TR004	Beginning Month	date	6	CCYYMM
TR005	Ending Month	date	6	CCYYMM
TR006	Extraction Date	date	8	CCYYMMDD

A-2.1 **MEDICAL CLAIMS FILE**

Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC001	N/A	2330B NM109 where 2320 SR06 = 6	Payer	varchar	8	Payer submitting payments	R
MC002	837/2010BB /NM1/XV/09	2330B NM109 where NM108 = XV and 2320 SR06 = 6	National Plan ID	varchar	30	CMS National Plan ID	R
MC003	837/2000B/ SBR/ /09	2320 SBR09 where SBR06 = 6	Insurance Type/Product Code	char	2	See Lookup Table B-1.A	R
MC004	835/2100/CLP/ /07	2330B REF02 where REF01 = F8	Payer Claim Control Number	varchar	35	Must apply to the entire claim and be unique within the payer's system.	R
MC005	837/2400/LX/ /01	2400 LX01	Line Counter	tinyint	4	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim.	R
MC005A	N/A	N/A	Version Number	tinyint	4	The version number of this claim service line. The original claim will have a version number of 0, with the next version being assigned a 1, and each subsequent version being incremented by 1 for that service line.	R

Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC006	837/2000B/SBR/ /03	2000B SBR03 (I); 2320 SBR03 where SBR06 = 6 (P)	Insured Group or Policy Number	varchar	30	Group or policy number - not the number that uniquely identifies the subscriber.	R
MC007	835/2100/NM1/34/09	2010BA REF02 where 2010BA REF01 = SY	Subscriber Social Security Number	varchar	9	Subscriber's social security number; Set as null if unavailable	TH
MC008	835/2100/NM1/HN/09	2010BA NM109	Plan Specific Contract Number	varchar	128	Plan assigned subscriber's contract number; Set as null if contract number = subscriber's social security number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the subscriber.	R
MC009	N/A	N/A	Member Suffix or Sequence Number	varchar	20	Unique number of the member within the contract. Must be an identifier that is unique to the member.	R
MC010	835/2100/NM1/MI/089	2010CA NM109 or 2010BA NM109	Member Identification Code (patient)	varchar	9	Member's social security number; Set as null if contract number = subscriber's social security number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the member.	TH

Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC011	837/2000B/SBR//02, 837/2000C/PAT//01, 837/2320/SBR//02	2000C PAT01 or 2000B SBR02	Individual Relationship Code	char	2	Member's relationship to insured – payers will map their available codes to those listed in Lookup Table B-1.B	R
MC012	837/2010CA/DMG/ /03	2010C DMG03 or 2010B DMG03	Member Gender	char	1	M - Male F – Female U - Unknown	R
MC013	837/2010CA/DMG/D8/02	2010C DMG02 or 2010B DMG02	Member Date of Birth	char	8	CCYYMMDD	R
MC014	837/2010CA/N4//01	2010CA N401 or 2010BA N401	Member City Name	varchar	30	City name of member	R
MC015	837/2010CA/N4//02	2010CA N402 or 2010BA N402	Member State or Province	char	2	As defined by the US Postal Service	R
MC016	837/2010CA/N4//03	2010CA N403 or 2010BA N403	Member ZIP Code	varchar	11	ZIP Code of member - may include non-US codes. Plus 4 optional but desired.	R
MC017	N/A	2330B DTP03 where 2320 SBR06 = 6 and DTP01 = 573	Date Service Approved/Accounts Payable Date/Actual Paid Date	char	8	CCYYMMDD	R

Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC018	837/2300/DTP/435/03	2300 DTP03 (I); 2300 DTP 03 where DTP02 = 435 (P)	Admission Date	char	8	Required for all inpatient claims. CCYYMMDD	O (inpatient claims only)
MC019	837/2300/DTP/435/03	2300 DTP03 N435	Admission Hour	char	4	Required for all inpatient claims. Time is expressed in military time - HHMM	O (inpatient claims only)
MC020	837/2300/CL1//01	2300 CL101 N413	Admission Type	tinyint	1	Required for all inpatient claims (SOURCE: National Uniform Billing Data Element Specifications)	O (inpatient claims only)
						1 Emergency	
						2 Urgent	
						3 Elective	
						4 Newborn	
						5 Trauma Center	
						9 Information not available	
MC021	837/2300/CL1//02	2300 CL102 N414	Admission Source	char	1	Required for all inpatient claims (SOURCE: National Uniform Billing Data Element Specifications)	O (inpatient claims only)
MC022	837/2300/DTP/096/03	2300 CL103 N392	Discharge Hour	tinyint	4	Time expressed in military time – HHMM	O (inpatient claims only)

Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC023	837/2300/CL1 / /03	2300 CL103 N415	Discharge Status	char	2	Required for all inpatient claims. See Lookup Table B-1.E for codes.	O (inpatient claims only)
MC024	835/2100/NM 1/BD/09, 835/2100/NM 1/BS/09, 835/2100/NM 1/MC/09, 835/2100/NM 1/PC/09	2310D REF02 where REF01 = 0B, G2, or LU (I) or 2310A REF02 where REF01 = 0B, G2, or LU (I); 2420A REF02 where REF01 = 0B, G2, or LU (P) or 2310B REF02 where REF01 = 0B, G2, or LU (P) or 2010AA REF02 where REF01 = 0B, G2, or LU (P)	Service Provider Number	varchar	30	Payer assigned service provider number, preferably for the individual provider but alternately for the clinic where the service occurred.	R
MC025	835/2100/NM 1/FI/09	N/A	Service Provider Tax ID Number	varchar	10	Federal taxpayer's identification number	TH

Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC026	professional: 837/2420A/NM1/XX/09; 837/2310B/NM1/XX/09; institutional: 837/2420A/NM1/XX/09; 837/2420C/NM1/XX/09; 837/2310A/NM1/XX/09	2310D NM109 (I) or 2310A NM109 (I); 2320A NM109 (P) or 2310B NM109 (P) or 2010AA NM109 (P)	Service National Provider ID	varchar	20	National Provider ID. This data element pertains to the entity or individual directly providing the service.	TH
MC027	professional: 837/2420A/NM1/82/02; 837/2310B/NM1/82/02; institutional: 837/2420A/NM1/72/02; 837/2420C/NM1/82/02; 837/2310A/NM1/71/02	2310D NM102 (I) or 2310A NM102 (I); 2420A NM102 (P) or 2310B NM102 (P) or 2010AA NM102 (P)	Service Provider Entity Type Qualifier	char	1	HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as a "person", and these shall be coded as a person. Health care claims processors shall code according to:	TH
						1 Person	
						2 Non-Person	

Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC028	professional: 837/2420A/NM1/82/04; 837/2310B/NM1/82/04; institutional: 837/2420A/NM1/72/04; 837/2420C/NM1/82/04; 837/2310A/NM1/71/04	2310D NM104 (I) or 2310A NM104 (I); 2420A NM104 (P) or 2310B NM104 (P) or 2010AA NM104 (P)	Service Provider First Name	varchar	25	Individual first name. Set to null if provider is a facility or organization.	O
MC029	professional: 837/2420A/NM1/82/05; 837/2310B/NM1/82/05; institutional: 837/2420A/NM1/72/05; 837/2420C/NM1/82/05; 837/2310A/NM1/71/05	2310D NM105 (I) or 2310A NM105 (I); 2420A NM105 (P) or 2310B NM105 (P) or 2010AA NM105 (P)	Service Provider Middle Name	varchar	25	Individual middle name or initial. Set to null if provider is a facility or organization.	O

Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC030	professional: 837/2420A/NM1/82/03; 837/2310B/NM1/82/03; institutional: 837/2420A/NM1/72/03; 837/2420C/NM1/82/03; 837/2310A/NM1/71/03	2310D NM103 (I) or 2310A NM103 (I); 2420A NM103 (P) or 2310B NM103 (P) or 2010AA NM103 (P)	Service Provider Last Name or Organization Name	varchar	60	Full name of provider organization or last name of individual provider	R
MC031	professional: 837/2420A/NM1/82/07; 837/2310B/NM1/82/07; institutional: 837/2420A/NM1/72/07; 837/2420C/NM1/82/07; 837/2310A/NM1/71/07	2310D NM107 (I) or 2310A NM107 (I); 2420A NM107 (P) or 2310B NM107 (P) or 2010AA NM107 (P)	Service Provider Suffix	varchar	10	Suffix to individual name. Set to null if provider is a facility or organization. The service provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III), if applicable, rather than the clinician's degree (e.g., MD, LCSW).	O

Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC032	professional: 837/2420A/PRV/PE/03; 837/2310B/PRV/PE/03; institutional: 837/2310A/PRV/AT/03	2310A PRV03 (I); 2420A PRV03 (P) or 2310B PRV03 (P) or 2000AA PRV03 (P)	Service Provider Specialty	varchar	10	As defined by payer. Dictionary for specialty code values must be supplied during testing.	R
MC033	professional: 837/2420C/N4//01; 837/2310C/N4//01; institutional: 837/2310E/N4//01	2310E N401 (I); 2420C N401 (P) or 2310C N401 (P)	Service Provider City Name	varchar	30	City name of provider - preferably practice location	R
MC034	professional: 837/2420C/N4//02; 837/2310C/N4//02; institutional: 837/2310E/N4//02	2310E N402 (I); 2420C N402 (P) or 2310C N402 (P)	Service Provider State or Province	char	2	As defined by the US Postal Service	R

Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC035	professional: 837/2420C/N4/ /03; 837/2310C/N4/ /03; institutional: 837/2310E/N4/ /03	2310E N403 (I); 2420C N403 (P) or 2310C N403 (P)	Service Provider ZIP Code	varchar	11	ZIP Code of provider - may include non-US codes; do not include dash. Plus 4 optional but desired.	R
MC036	837/2300/CLM/ /05-1	CLM 05-1 & CLM05-3	Type of Bill – Institutional	char	3	Required for institutional claims; Not to be used for professional claims. See Lookup Table B-1.F for codes.	O (institutional claims only)
MC037	837/2300/CLM/ /05-1	2300 CLM05-1	Place of Service - Professional	char	2	Required for professional claims. Not to be used for institutional claims. Map where you can and default to "99" for all others. See Lookup Table B-1.G for codes.	O (professional claims only)
MC038	835/2100/CLP/ /02	2300 CLM17	Claim Status	char	2	See Lookup Table B-1.C	R
MC039	837/2300/HI/BJ/021-2	2300 DTP03	Admitting Diagnosis	varchar	7	Required on all inpatient admission claims and encounters. ICD-9-CM or ICD-10-CM. Do not code decimal point.	O (inpatient claims and encounters only)
MC040	837/2300/HI/BN/031-2	2300 HI01-2 where HI01-1 = BN (ICD-9) or = ABN (ICD-10)	E-Code	varchar	7	Describes an injury, poisoning or adverse effect. ICD-9-CM or ICD-10-CM. Do not code decimal point.	O

Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC041	837/2300/HI/BK/01-2	2300 HI01-2 where HI01-1 = BK (ICD-9) or = ABK (ICD-10)	Principal Diagnosis	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	R
MC042	837/2300/HI/BF/01-2	2300 HI01-2 where HI01-1 = BF (ICD-9) or = ABF (ICD-10)	Other Diagnosis – 1	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC043	837/2300/HI/BF/02-2	2300 HI02-2 where HI02-1 = BF (ICD-9) or = ABF (ICD-10)	Other Diagnosis – 2	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC044	837/2300/HI/BF/03-2	2300 HI03-2 where HI03-1 = BF (ICD-9) or = ABF (ICD-10)	Other Diagnosis – 3	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC045	837/2300/HI/BF/04-2	2300 HI04-2 where HI04-1 = BF (ICD-9) or = ABF (ICD-10)	Other Diagnosis – 4	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC041	837/2300/HI/BK/01-2	2300 HI01-2 where HI01-1 = BK (ICD-9) or = ABK (ICD-10)	Principal Diagnosis	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	R

Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC046	837/2300/HI/BF/05-2	2300 HI05-2 where HI05-1 = BF (ICD-9) or = ABF (ICD-10)	Other Diagnosis – 5	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC047	837/2300/HI/BF/06-2	2300 HI06-2 where HI06-1 = BF (ICD-9) or = ABF (ICD-10)	Other Diagnosis – 6	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC048	837/2300/HI/BF/07-2	2300 HI07-2 where HI07-1 = BF (ICD-9) or = ABF (ICD-10)	Other Diagnosis – 7	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC049	837/2300/HI/BF/08-2	2300 HI08-2 where HI08-1 = BF (ICD-9) or = ABF (ICD-10)	Other Diagnosis – 8	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC050	837/2300/HI/BF/09-2	2300 HI09-2 where HI09-1 = BF (ICD-9) or = ABF (ICD-10)	Other Diagnosis – 9	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC051	837/2300/HI/BF/10-2	2300 HI010-2 where HI010-1 = BF (ICD-9) or = ABF (ICD-10)	Other Diagnosis – 10	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O

Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC052	837/2300/HI/BF/11-2	2300 HI011-2 where HI011-1 = BF (ICD-9) or = ABF (ICD-10)	Other Diagnosis – 11	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC053	837/2300/HI/BF/12-2	2300 HI012-2 where HI012-1 = BF (ICD-9) or = ABF (ICD-10)	Other Diagnosis – 12	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC054	835/2110/SVC/NU/01-2	2430 SVD04	Revenue Code	char	10	National Uniform Billing Committee Codes. Code using leading zeroes, left justified, and four digits.	R
MC055	835/2110/SVC/HC/01-2	2430 SVD03-2	Procedure Code	varchar	10	Health Care Common Procedural Coding System (HCPCS); This includes the CPT codes of the American Medical Association.	R
MC056	835/2110/SVC/HC/01-3	2430 SVD03-3	Procedure Modifier – 1	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.	O
MC057	835/2110/SVC/HC/01-4	2430 SVD03-4	Procedure Modifier – 2	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.	O
MC058	835/2110/SVC/ID/01-2	2300 HI	ICD-9/10-CM Principal Procedure Code	char	7	Primary procedure code for this line of service. Do not code decimal point.	R

Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC059	835/2110/DTM/150/02	2400 DTP03 where DTP01 = 472 or 2300 DTP03 where DTP01 = 434	Date of Service – From	date	8	First date of service for this service line. CCYYMMDD	R
MC060	835/2110/DTM/151/02	2400 DTP03 where DTP01 = 472 or 2300 DTP03 where DTP01 = 434	Date of Service – Thru	date	8	Last date of service for this service line. CCYYMMDD	R
MC061	835/2110/SVC//05	2400 SV205 (I); 2400 SV104 (P)	Quantity	int	3	Count of services performed, which shall be set equal to one on all observation bed service lines and should be set equal to zero on all other room and board service lines, regardless of the length of stay.	R
MC062	835/2110/SVC//02	2400 SV203 (I); 2400 SV102 (P)	Charge Amount	int	10	Do not code decimal point or provide any punctuation where $1,000.00 converted to 100000 Same for all financial data that follows.	R
MC063	835/2110/SVC//03	2430 SVD02	Paid Amount	int	10	Includes any withhold amounts. Do not code decimal point. For capitated claims set to zero.	R

Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC064	N/A	2320 and/or 2430 CASxx where the CARC code is 104.	Prepaid Amount	int	10	For capitated services, the fee for service equivalent amount. Do not code decimal point.	R
MC065	N/A	2320 and/or 2430 CASxx where the CARC code is 3.	Co-pay Amount	int	10	The preset, fixed dollar amount for which the individual is responsible. Do not code decimal point.	R
MC066	N/A	2320 and/or 2430 CASxx where the CARC code is 2	Coinsurance Amount	int	10	The dollar amount an individual is responsible for – not the percentage. Do not code decimal point.	R
MC067	N/A	2320 and/or 2430 CASxx where the CARC code is 1.	Deductible Amount	int	10	Do not code decimal point.	R
MC068	837/2300/CLM/ /01	2300 CLM01	Patient Account/Control Number	varchar	20	Number assigned by hospital	O
MC069	N/A	2300 DTP02	Discharge Date	date	8	Date patient discharged. Required for all inpatient claims. CCYYMMDD	O (inpatient claims only)

Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC070	N/A	2310 NA04	Service Provider Country Name	varchar	30	Code US for United States.	R
MC071	837/2300/HI/DR/01-2	2300 HI01-2 or 2330B REF-2 where 2320 SBR06 = 6 and REF01 = 1N	DRG	varchar	10	Insurers and health care claims processors shall code using the CMS methodology when available. Precedence shall be given to DRGs transmitted from the hospital provider. When the CMS methodology for DRGs is not available, but the DRG system is used, the insurer shall format the DRG and the complexity level within the same field with an "A" prefix, and with a hyphen separating the DRG and the complexity level (e.g. AXXX-XX).	O
MC072	N/A	2330 B REF042	DRG Version	char	2	Version number of the grouper used	O
MC073	835/2110/REF/APC/02	N/A	APC	char	4	Insurers and health care claims processors shall code using the CMS methodology when available. Precedence shall be given to APCs transmitted from the health care provider.	O
MC074	N/A	N/A	APC Version	char	2	Version number of the grouper used	O

Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC075	837/2410/LIN/N4/03	2410 HL04 (I); 2410 LIN03 (P)	Drug Code	varchar	11	An NDC code used only when a medication is paid for as part of a medical claim.	O
MC076	837/2010AA/NM1/ID/09	2010AA REF02 where REF01 = G2 and/or LU	Billing Provider Number	varchar	30	Payer assigned billing provider number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change.	TH
MC077	837/2010AA/NM1/X X/09	2010AA NM109	National Billing Provider ID	varchar	20	National Provider ID	TH
MC078	837/2010AA/NM1//03	2010AA NM103	Billing Provider LastName or Organization Name	varchar	60	Full name of provider billing organization or last name of individual billing provider.	TH
MC101	837/2010BA/NM1//03	2010BA/NM1//03	Subscriber Last Name	varchar	128	Subscriber last name	R
MC102	837/2010BA/NM1/	2010BA/NM1//04	Subscriber First Name	varchar	128	Subscriber first name	R
MC103	837/2010BA/NM1/ /05	2010BA/NM1//05	Subscriber Middle Initial	char	1	Subscriber middle initial	O

Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC104	837/2010CA/NM1 / /03	2010CA NM103 or 2010BA NM103	Member Last Name	varchar	128	Member last name	R
MC105	837/2010CA/NM1 / /04	2010CA NM104 or 2010BA NM104	Member First Name	varchar	128	Member first name	R
MC106	837/2010CA/NM1 / /05	2010CA NM105 or 2010BA NM105	Member Middle Initial	char	1	Member middle intial	O
MC107	2010CA N301 & N302 or 2010BA N301 & N302	2010CA N301 & N302 or 2010BA N301 & N302	Member Street Address	varchar	50	Physical street address of the covered member	R
MC108	2310E N301 & N302 (I); 2420C N301 & N302 (P) or 2310C N301 & N302 (P)	Service Provider Street Address	Service Provider Street Address	varchar	50	Physical practice location street address of the provider administering the services	R
MC200	N/A	N/A	ICD-9 / ICD-10 Flag	char	1	0 - This claim contains ICD-9-CM codes 1 - This claim contains ICD-10-CM codes The purpose of this field is to identify which code set is being utilized.	R

Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC201		2300 HI01-2 where HI01-1 = BQ (ICD-9) or = BBQ (ICD-10)	ICD-9/10-CM Other Procedure Code - 1	varchar	7	Secondary procedure code for this line of service. Do not code decimal point.	O
MC2012		2300 HI02-2 where HI02-1 = BQ (ICD-9) or = BBQ (ICD-10)	ICD-9/10-CM Other Procedure Code – 2	varchar	7	Secondary procedure code for this line of service. Do not code decimal point.	O
MC203		2300 HI03-2 where HI03-1 = BQ (ICD-9) or = BBQ (ICD-10)	ICD-9/10-CM Other Procedure Code – 3	varchar	7	Secondary procedure code for this line of service. Do not code decimal point.	O
MC204		2300 HI04-2 where HI04-1 = BQ (ICD-9) or = BBQ (ICD-10)	ICD-9/10-CM Other Procedure Code – 4	varchar	7	Secondary procedure code for this line of service. Do not code decimal point.	O
MC205		2300 HI05-2 where HI05-1 = BQ (ICD-9) or = BBQ (ICD-10)	ICD-9/10-CM Other Procedure Code – 5	varchar	7	Secondary procedure code for this line of service. Do not code decimal point.	O

Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC206		2300 HI06-2 where HI06-1 = BQ (ICD-9) or = BBQ (ICD-10)	ICD-9/10-CM Other Procedure Code - 6	varchar	7	Secondary procedure code for this line of service. Do not code decimal point.	O
MC207		N/A	Carrier Associated with Claim	varchar	8	For each claim, the NAIC code of the carrier when a TPA processes claims on behalf of the carrier. Optional if all medical claims processed by data submitters acting as Third Party Administrators (TPAs) under contract to a data submitter for carved-out services are submitted by the data submitter with unified member IDs in all files.	R
MC208		N/A	Carrier Plan Specific Contract Number or Subscriber/Member Social Security Number	varchar	128	For each claim, the carrier specific contract number or subscriber/member social security number when a TPA processes claims on behalf of the carrier. Optional if all medical claims processed by data submitters acting as Third Party Administrators (TPAs) under contract to a data submitter for carved-out services are submitted by the data submitter with unified member IDs in all files.	R/O

Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC209		N/A	Practitioner Group Practice	varchar	60	Name of group practice to which a practitioner is affiliated if different from MC078	O
MC899	N/A	N/A	Record Type	char	2	Value = MC	R

A-3 PHARMACY CLAIMS DATA

Frequency: Monthly or Quarterly Upload via FTP or Web Portal (due within 45 days of the end of the reporting period)

Additional formatting requirements:

- Payers submit data in a single, consistent format for each data type.

PHARMACY CLAIMS FILE HEADER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	2	PC
HD002	Payer Code	char	8	NAIC code (example: 12345); leave blank if not applicable
HD003	Payer Name	char	75	Example:
HD004	Beginning Month	Date	6	CCYYMM
HD005	Ending Month	Date	6	CCYYMM
HD006	Record count	int	10	Total number of records submitted in the medical claims file, excluding header and trailer records

PHARMACY CLAIMS FILE TRAILER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	PC
TR002	Payer Code	varchar	8	NAIC code (example: 12345); leave blank if not applicable
TR003	Payer Name	varchar	75	
TR004	Beginning Month	Date	6	CCYYMM
TR005	Ending Month	Date	6	CCYYMM
TR006	Extraction Date	Date	8	CCYYMMDD