Table 2: Pre-screening and Post-payment Audit MDAAP Eligibility Criteria

Requirements	Measures/Procedures	Data Source	Data Elements	Audit Plan Details	State's Audit Time frame	Notes
1. Pre-screening. MDAAP provider must be one of the following permissible Medicaid provider type and provider specialty combinations: • Home Health Agency (10)/non-profit (S20) • PT-OT-SLP (17)/Physical therapy (65) • PT-OT-SLP (17)/occupational therapy (67) • PT-OT-SLP (17)/speech pathologist (S30) • MSTR LVL PSYCH,LCMHC,LICSW,LPC,LMFT (19)/independent billing psychologist (62) • MSTR LVL PSYCH,LCMHC,LICSW,LPC,LMFT (19)/addiction medicine (79) • MSTR LVL PSYCH,LCMHC,LICSW,LPC,LMFT (19)/licensed psychologist/social worker (80) • MSTR LVL PSYCH,LCMHC,LICSW,LPC,LMFT (19)/licensed clinical mental health counselor (S70) • MSTR LVL PSYCH,LCMHC,LICSW,LPC,LMFT (19)/marriage family therapist (S71) • Psychologist-Doctorate (30)/independent billing psychologist (62) • Psychologist-Doctorate (30)/clinical psychologist/PHD (S72) • Audiologist (35)/independent-billing audiologist (64) • State Designated MH Clinic (37)/community behavioral health (S12)	The pre-screening reviewer will review the Medicaid provider type and provider specialty on the signed attestation submitted via email and compare it to the provider type and specialty reported in the MMIS for the Medicaid ID, and verify the provider type/specialty combination is one eligible for MDAAP.	• Reference list of eligible MDAAP provider type and specialty combinations • MMIS database/ provider management module • Signed attestation submitted via email	• Provider Type • Provider Specialty • Provider Medicaid ID • Provider type and specialty codes per MMIS/provider management module • MDAAP provider type and specialty combination per reference list • Medicaid provider type and specialty per attestation	The pre-screening reviewer will review the provider type and provider specialty on the signed attestation submitted via email, and compare it to the provider type and specialty combinations listed in MMIS for the attested Medicaid ID. The Provider Type/Specialty (PRTS) MMIS screen/provider management module, can be used to view the provider type and specialties associated with the attested Medicaid ID in MMIS. The pre-screening reviewer will verify the provider type/specialty combination is one eligible for MDAAP. The provider must be one of the following Medicaid provider type and provider specialty combinations to be eligible for MDAAP: • Home Health Agency (10)/non-profit (S20) • PT-OT-SLP (17)/Physical therapy (65) • PT-OT-SLP (17)/occupational therapy (67) • PT-OT-SLP (17)/speech pathologist (S30) • MSTR LVL PSYCH,LCMHC,LICSW,LPC,LMFT (19)/independent billing psychologist (62) • MSTR LVL PSYCH,LCMHC,LICSW,LPC,LMFT (19)/addiction medicine (79) • MSTR LVL PSYCH,LCMHC,LICSW,LPC,LMFT (19)/licensed psychologist/social worker (80) • MSTR LVL PSYCH,LCMHC,LICSW,LPC,LMFT (19)/licensed clinical mental health counselor (S70) • MSTR LVL PSYCH,LCMHC,LICSW,LPC,LMFT (19)/marriage family therapist (S71) • Psychologist-Doctorate (30)/independent billing psychologist (62) • Psychologist-Doctorate (30)/clinical psychologist/PHD (S72) • Audiologist (35)/independent-billing audiologist (64) • State Designated MH Clinic (37)/community behavioral health (S12) • State Designated Intellectual Disability Clinic (38)/state defined intellectual disability services (S13)	Pre-screening	VT GCH Demonstration approved 7/1/22 (11-W-00194/1); 8.3(a) MDAAP Eligibility

Requirements	Measures/Procedures	Data Source	Data Elements	Audit Plan Details	State's Audit Time frame	Notes
• State Designated Intellectual Disability Clinic (38)/state defined intellectual disability services (S13) • State Defined Children and Family Waiver Clinic (39)/state defined community behavioral health services (S25) • State Defined Independent Aging and Living Waiver (42)/state defined community behavioral health services (S25) • Personal Care services (T04)/personal care services (S21) • Licensed Nurse (T07)/RN (S22) • Licensed Nurse (T07)/state defined dme nursing-high tech (S28) • State Defined Residential Care Waiver (T14)/state defined community behavioral health services (S25) • Waiver Case Manager-Aging and Adult (T15)/state defined community behavioral health services (S25) • State Defined Targeted Case Management (T16)/case management (S26) • State Defined Individual Case Manager (T17)/case management (S26) • State Defined Vocational Rehab Agency (T19)/state defined community behavioral health services (S25) • DCF State Defined Designated Case Management (T20)/public health agency (60) • DCF State Defined Designated Case Management (T20)/case management (S26) • State Designated Childrens Medical Services (T21)/public health agency (60) • State Defined non-Medical Residential Facility (T23)/residential treatment services (61)				• State Defined Children and Family Waiver Clinic (39)/state defined community behavioral health services (S25) • State Defined Independent Aging and Living Waiver (42)/state defined community behavioral health services (S25) • Personal Care services (T04)/personal care services (S21) • Licensed Nurse (T07)/RN (S22) • Licensed Nurse (T07)/state defined dme nursing-high tech (S28) • State Defined Residential Care Waiver (T14)/state defined community behavioral health services (S25) • Waiver Case Manager-Aging and Adult (T15)/state defined community behavioral health services (S25) • State Defined Targeted Case Management (T16)/case management (S26) • State Defined Individual Case Manager (T17)/case management (S26) • State Defined Vocational Rehab Agency (T19)/state defined community behavioral health services (S25) • DCF State Defined Designated Case Management (T20)/public health agency (60) • DCF State Defined Designated Case Management (T20)/case management (S26) • State Designated Childrens Medical Services (T21)/public health agency (60) • State Defined non-Medical Residential Facility (T23)/residential treatment services (61) • State Defined non-Medical Residential Facility (T23)/rehabilitation (S04) • State Defined non-Medical Residential Facility (T23)/case management (S26) • State Defined ADAP Facility (T26)/rehabilitation (S04) • State Defined Department of Education (T27)/public health agency (60) • State Defined Case Rate Agency (T34)/state defined case rate services (S31) • Independent Billing High Tech Nurses (T36)/RN (S22) • Independent Billing High Tech Nurses (T36)/LPN (S23) • Licensed Alcohol Drug Counselor (T38)/addiction medicine (79)		

Requirements	Measures/Procedures	Data Source	Data Elements	Audit Plan Details	State's Audit Time frame	Notes
• State Defined non-Medical Residential Facility (T23)/rehabilitation (S04) • State Defined non-Medical Residential Facility (T23)/case management (S26) • State Defined ADAP Facility (T26)/rehabilitation (S04) • State Defined Department of Education (T27)/public health agency (60) • State Defined Case Rate Agency (T34)/state defined case rate services (S31) • Independent Billing High Tech Nurses (T36)/RN (S22) • Independent Billing High Tech Nurses (T36)/LPN (S23) • Licensed Alcohol Drug Counselor (T38)/addiction medicine (79) • Licensed Physical Therapy Assistant (T41)/physical therapy (65) • Nutritional Educators (T44)/Diabetic Counselors (98) • Nutritional Educators (T44)/registered dieticians (S38) • Behavioral Analyst (T46)/board certified behavioral analyst (S50) • Behavioral Analyst (T46)/board certified assistant behavioral analyst (S51) • Family Supportive Housing (T47)/family supportive housing (S53)				• Licensed Physical Therapy Assistant (T41)/physical therapy (65) • Nutritional Educators (T44)/Diabetic Counselors (98) • Nutritional Educators (T44)/registered dieticians (S38) • Behavioral Analyst (T46)/board certified behavioral analyst (S50) • Behavioral Analyst (T46)/board certified assistant behavioral analyst (S51) • Family Supportive Housing (T47)/family supportive housing (S53) If the provider type and provider specialty cannot be verified as one of the permissible MDAAP professional types, the provider is not eligible for a MDAAP incentive.		
2. Pre-screening. MDAAP provider must complete a Medicaid patient volume spreadsheet. Note that Designated Agency and Specialized Service Agency providers will use the Vermont Agency of Human Services Department of Mental Health Fiscal Year 2022 Statistical Report for their Medicaid patient volume and will not	• The pre-screening reviewer will review the Medicaid patient volume spreadsheet submitted via email and ensure that: • All required fields are completed • There are no duplicate entries	• Medicaid patient volume spreadsheet • Signed attestation submitted via email • VT Agency of Human Services	• Provider Medicaid ID • Billing provider NPI • Patient Unique ID • Medicaid Recipient unique ID	The pre-screening reviewer will review the information contained within the summary of the patient volume data to ensure that it matches the information on the application and that the Medicaid patient volume reaches at least 19.5% after the state proxy calculation. The pre-screening reviewer will look at the information contained within the spreadsheet to ensure that all required fields are filled out for each encounter, that there are no duplicate entries, that all encounters occurred during the 90 day timeframe listed in the summary, and a random check of a few Patient	Pre-Screening	VT GCH Demonstration approved 7/1/22 (11-W-00194/1); 8.3(a) MDAAP Eligibility

Requirements	Measures/Procedures	Data Source	Data Elements	Audit Plan Details	State's Audit Time frame	Notes
supply a patient volume spreadsheet.	• All encounter dates are within the selected 90 day timeframe • A random screening of identical Patient Medicaid IDs to ensure that identical Patient Medicaid IDs share one Patient Unique ID • The Medicaid patient volume reaches at least 19.5% after the state proxy calculation • For providers that are a State of Vermont Designated Agency or Specialized Service Agency, review the VT Agency of Human Services Department of Mental Health Fiscal Year 2022 Statistical Report, specifically, Table 2-4 Responsibility For Fee of Clients Served, to identify the percentage of clients served that are covered by Medicaid.	Department of Mental Health Fiscal Year 2022 Statistical Report (https://mentalhealth.vermont.gov/reports-forms-and-manuals/reports/statistical-reports-and-data)	• Patient Medicaid State • Encounter date • Group (when applicant is a group) • VT AHS Dept Mental Health FY2022 Statistical Report Table 2-4 Percent clients served covered by Medicaid	Medicaid IDs shows that identical Patient Medicaid IDs share one Patient Unique ID. For providers that are a State of Vermont Designated Agency or Specialized Service Agency, review the Vermont Agency of Human Services Department of Mental Health Fiscal Year 2022 Statistical Report, prepared May 2023. Specifically, review Table 2-4, Responsibility for Fee of Clients Served, to identify the percentage of clients served that are covered by Medicaid. Identify the percent of clients that are covered by Medicaid for the provider and verify that it is greater than or equal to 20%.		
3. Post-payment Audit. MDAAP provider must be one of the following permissible Medicaid provider type and provider specialty combinations: • Home Health Agency (10)/non-profit (S20) • PT-OT-SLP (17)/Physical therapy (65) • PT-OT-SLP (17)/occupational therapy (67) • PT-OT-SLP (17)/speech pathologist (S30) • MSTR LVL PSYCH,LCMHC,LICSW,LPC,LMFT (19)/independent billing psychologist (62)	The post-payment auditor will review the provider type and provider specialty on the signed attestation submitted via email and compare it to the provider type and specialty reported in the MMIS for the Medicaid ID and verify the provider type/specialty combination is one eligible for MDAAP.	Signed attestation submitted via email or software system • MMIS database/provider management module	• Medicaid provider type and specialty per attestation submitted via email or software system • Provider Medicaid ID • Provider Type & Specialty per MMIS/provider management module	If needed, use MMIS Provider NPI-Medicaid ID Cross Reference (PRNX) to look up Medicaid ID number of provider. Use the Provider Type/Specialty (PRTS) MMIS screen/provider management module to see the provider type and specialty associated with the Medicaid ID in the MMIS. The provider must be one of the following Medicaid provider type and provider specialty combinations to be eligible for MDAAP: • Home Health Agency (10)/non-profit (S20) • PT-OT-SLP (17)/Physical therapy (65) • PT-OT-SLP (17)/occupational therapy (67) • PT-OT-SLP (17)/speech pathologist (S30) • MSTR LVL PSYCH,LCMHC,LICSW,LPC,LMFT (19)/independent billing psychologist (62)	Post-payment audit	VT GCH Demonstration approved 7/1/22 (11-W-00194/1); 8.3(a) MDAAP Eligibility

Requirements	Measures/Procedures	Data Source	Data Elements	Audit Plan Details	State's Audit Time frame	Notes
• MSTR LVL PSYCH,LCMHC,LICSW,LPC,LMFT (19)/addiction medicine (79) • MSTR LVL PSYCH,LCMHC,LICSW,LPC,LMFT (19)/licensed psychologist/social worker (80) • MSTR LVL PSYCH,LCMHC,LICSW,LPC,LMFT (19)/licensed clinical mental health counselor (S70) • MSTR LVL PSYCH,LCMHC,LICSW,LPC,LMFT (19)/marriage family therapist (S71) • Psychologist-Doctorate (30)/independent billing psychologist (62) • Psychologist-Doctorate (30)/clinical psychologist/PHD (S72) • Audiologist (35)/independent-billing audiologist (64) • State Designated MH Clinic (37)/community behavioral health (S12) • State Designated Intellectual Disability Clinic (38)/state defined intellectual disability services (S13) • State Defined Children and Family Waiver Clinic (39)/state defined community behavioral health services (S25) • State Defined Independent Aging and Living Waiver (42)/state defined community behavioral health services (S25) • Personal Care services (T04)/personal care services (S21) • Licensed Nurse (T07)/RN (S22) • Licensed Nurse (T07)/state defined dme nursing-high tech (S28) • State Defined Residential Care Waiver (T14)/state defined community behavioral health services (S25)				• MSTR LVL PSYCH,LCMHC,LICSW,LPC,LMFT (19)/addiction medicine (79) • MSTR LVL PSYCH,LCMHC,LICSW,LPC,LMFT (19)/licensed psychologist/social worker (80) • MSTR LVL PSYCH,LCMHC,LICSW,LPC,LMFT (19)/licensed clinical mental health counselor (S70) • MSTR LVL PSYCH,LCMHC,LICSW,LPC,LMFT (19)/marriage family therapist (S71) • Psychologist-Doctorate (30)/independent billing psychologist (62) • Psychologist-Doctorate (30)/clinical psychologist/PHD (S72) • Audiologist (35)/independent-billing audiologist (64) • State Designated MH Clinic (37)/community behavioral health (S12) • State Designated Intellectual Disability Clinic (38)/state defined intellectual disability services (S13) • State Defined Children and Family Waiver Clinic (39)/state defined community behavioral health services (S25) • State Defined Independent Aging and Living Waiver (42)/state defined community behavioral health services (S25) • Personal Care services (T04)/personal care services (S21) • Licensed Nurse (T07)/RN (S22) • Licensed Nurse (T07)/state defined dme nursing-high tech (S28) • State Defined Residential Care Waiver (T14)/state defined community behavioral health services (S25) • State Defined Targeted Case Management (T16)/case management (S26) • State Defined Individual Case Manager (T17)/case management (S26) • State Defined Vocational Rehab Agency (T19)/state defined community behavioral health services (S25) • DCF State Defined Designated Case Management (T20)/public health agency (60) • DCF State Defined Designated Case Management (T20)/case management (S26)		

Requirements	Measures/Procedures	Data Source	Data Elements	Audit Plan Details	State's Audit Time frame	Notes
• Waiver Case Manager-Aging and Adult (T15)/state defined community behavioral health services (S25) • State Defined Targeted Case Management (T16)/case management (S26) • State Defined Individual Case Manager (T17)/case management (S26) • State Defined Vocational Rehab Agency (T19)/state defined community behavioral health services (S25) • DCF State Defined Designated Case Management (T20)/public health agency (60) • DCF State Defined Designated Case Management (T20)/case management (S26) • State Designated Childrens Medical Services (T21)/public health agency (60) • State Defined non-Medical Residential Facility (T23)/residential treatment services (61) • State Defined non-Medical Residential Facility (T23)/rehabilitation (S04) • State Defined non-Medical Residential Facility (T23)/case management (S26) • State Defined ADAP Facility (T26)/rehabilitation (S04) • State Defined Department of Education (T27)/public health agency (60) • State Defined Case Rate Agency (T34)/state defined case rate services (S31) • Independent Billing High Tech Nurses (T36)/RN (S22) • Independent Billing High Tech Nurses (T36)/LPN (S23) • Licensed Alcohol Drug Counselor (T38)/addiction medicine (79)				• State Designated Childrens Medical Services (T21)/public health agency (60) • State Defined non-Medical Residential Facility (T23)/residential treatment services (61) • State Defined non-Medical Residential Facility (T23)/rehabilitation (S04) • State Defined non-Medical Residential Facility (T23)/case management (S26) • State Defined ADAP Facility (T26)/rehabilitation (S04) • State Defined Department of Education (T27)/public health agency (60) • State Defined Case Rate Agency (T34)/state defined case rate services (S31) • Independent Billing High Tech Nurses (T36)/RN (S22) • Independent Billing High Tech Nurses (T36)/LPN (S23) • Licensed Alcohol Drug Counselor (T38)/addiction medicine (79) • Licensed Physical Therapy Assistant (T41)/physical therapy (65) • Nutritional Educators (T44)/Diabetic Counselors (98) • Nutritional Educators (T44)/registered dieticians (S38) • Behavioral Analyst (T46)/board certified behavioral analyst (S50) • Behavioral Analyst (T46)/board certified assistant behavioral analyst (S51) • Family Supportive Housing (T47)/family supportive housing (S53) If the provider type and provider specialty cannot be verified as one of the permissible MDAAP professional types, the provider is not eligible for a MDAAP incentive.		

Requirements	Measures/Procedures	Data Source	Data Elements	Audit Plan Details	State's Audit Time frame	Notes
• Licensed Physical Therapy Assistant (T41)/physical therapy (65) • Nutritional Educators (T44)/Diabetic Counselors (98) • Nutritional Educators (T44)/registered dieticians (S38) • Behavioral Analyst (T46)/board certified behavioral analyst (S50) • Behavioral Analyst (T46)/board certified assistant behavioral analyst (S51) • Family Supportive Housing (T47)/family supportive housing (S53)						
4. Pre-screening and Post-payment audit. Provider must be licensed to practice in the State	For the submission of attestations, the pre-screener and post-payment auditor will review the provider Medicaid ID on the signed attestation submitted via email and look up the ID in MMIS and review the provider Medicaid status. Our existing Medicaid enrollment process ensures providers are properly licensed in the state.	• MMIS database/provider management module • Signed attestation submitted via email or software system	• Provider Status per MMIS/provider management module • Provider Medicaid ID	Post-payment Auditor reviews MMIS/provider management module screen to verify provider has '03 Active Participating' provider status associated with their Medicaid ID.	Checked as part of pre-screening & post-payment audit	VT GCH Demonstration approved 7/1/22 (11-W-00194/1); 8.3(a) MDAAP Eligibility
5. Pre-screening and Post-payment audit. Provider must be a Medicaid provider in the State	For the submission of attestations, the pre-screener and post-payment auditor will review the provider Medicaid ID on the signed attestation submitted via email and look up the ID in MMIS and review the provider Medicaid status.	• MMIS database/provider management module • Signed attestation submitted via email or software system	• Provider Status per MMIS/provider management module • Provider Medicaid ID	Post-payment Auditor reviews MMIS/provider management module screen to verify provider has '03 Active Participating' provider status associated with their Medicaid ID.	Checked as part of pre-screening & post-payment audit	VT GCH Demonstration approved 7/1/22 (11-W-00194/1); 8.3(a) MDAAP Eligibility

Requirements	Measures/Procedures	Data Source	Data Elements	Audit Plan Details	State's Audit Time frame	Notes
6. Pre-screening and audit screening. Provider cannot be sanctioned or otherwise deemed ineligible to receive payments from the State	For the manual submission of attestations, the pre-screener and post-payment auditor will review the provider Medicaid ID on the signed attestation submitted via email and look up the ID in MMIS and review the provider Medicaid status. Our existing Medicaid enrollment process ensures providers are in good standing and have no sanctions.	• MMIS database/provider management module • Signed attestation submitted via email or software system	• Provider Status per MMIS/provider management module • Provider Medicaid ID	Post-payment Auditor reviews MMIS/provider management module screen to verify provider has '03 Active Participating' provider status associated with their Medicaid ID.	Checked as part of pre-screening & post-payment audit	VT GCH Demonstration approved 7/1/22 (11-W-00194/1); 8.3(a) MDAAP Eligibility
7. Pre-screening. Providers must NOT be one of the following HITECH provider types: physician, dentist, certified nurse midwife, nurse practitioner, physician assistant, podiatrist, optometrist, chiropractor, pediatrician, and acute care hospital	The pre-screening reviewer will review the Medicaid provider type and provider specialty on the signed attestation submitted via email and compare it to a reference list of ineligible HITECH provider type and specialty combinations and verify the provider type/specialty combination per the attestation is not one of the unallowable HITECH provider types.	Reference list of HITECH provider types • MMIS/ provider management module • Signed attestation submitted via email or software solution	• Provider Medicaid ID • Provider type and specialty codes per MMIS/provider management module • HITECH provider types per reference list • Medicaid provider type and specialty per attestation	The pre-screening reviewer would review the provider type and provider specialty on the signed attestation submitted via email and compare it to a reference list of ineligible HITECH provider type and specialty combinations and verify the provider type/specialty combination per the attestation is not one of the unallowable HITECH provider types. MDAAP providers must NOT be one of the following HITECH provider types: • Physicians (provider type code 005) • Dentists (provider type code 004) • Certified nurse midwives (provider type code T06 with specialty code 042 midwife) • Nurse Practitioners (provider type code T06) • Physician Assistants (provider type code T37) • Podiatrists (provider type doe 006) • Optometrists (provider type code 007) • Chiropractors (provider type code 018) • Pediatricians (provider type code 005 with specialty code pediatric medicine 037) • Acute care hospitals (provider type code 001) If the provider type/specialty is verified as one of the HITECH professional types, the provider is not eligible for MDAAP	Pre-screening	VT GCH Demonstration approved 7/1/22 (11-W-00194/1); 8.3(d) MDAAP Unallowable Expenditures
8. Post-payment Audit. Providers must NOT be one of the following HITECH provider types: physician, dentist,	The post-payment auditor will review the provider type and specialty on the	• MMIS database/provider	• Provider Medicaid ID	If needed, use MMIS Provider NPI-Medicaid ID Cross Reference (PRNX) to look up Medicaid ID number of provider. Use the Provider Type/Specialty (PRTS) MMIS	Post-payment Audit	VT GCH Demonstration approved

Requirements	Measures/Procedures	Data Source	Data Elements	Audit Plan Details	State's Audit Time frame	Notes
certified nurse midwife, nurse practitioner, physician assistant, podiatrist, optometrist, chiropractor, pediatrician, and acute care hospital	signed attestation submitted via email and compare it to the provider type and specialty reported in MMIS for the Medicaid ID and verify the provider type/specialty combination is not one of the unallowable HITECH provider types.	management module • Signed attestation submitted via email or software system	• Provider Type & Provider Specialty per MMIS/provider management module • Medicaid provider type and specialty per attestation	screen/provider management module to see the provider type and specialty associated with the Medicaid ID in the MMIS. MDAAP providers must NOT be one of the following HITECH provider types: • Physicians (provider type code 005) • Dentists (provider type code 004) • Certified nurse midwives (provider type code T06 with specialty code 042 midwife) • Nurse Practitioners (provider type code T06) • Physician Assistants (provider type code T37) • Podiatrists (provider type doe 006) • Optometrists (provider type code 007) • Chiropractors (provider type code 018) • Pediatricians (provider type code 005 with specialty code pediatric medicine 037) • Acute care hospitals (provider type code 001) If the provider type/specialty is verified as one of the HITECH professional types, the provider is not eligible for MDAAP.		7/1/22 (11-W-00194/1); 8.3(d) MDAAP Unallowable Expenditures
9. For each provider/practice attesting with group patient volume, a group definition must be provided containing the complete set of billing NPIs and Medicaid IDs across all of their client service programs defining the group	For providers attesting with group patient volume, review the group definition.to ensure all required fields are included. Use the MMIS to look up the list of billing NPIs and Medicaid IDs defining the group to confirm these NPIs and IDs are associated with the attesting umbrella organization. A software solution may have the ability for providers to upload a group definition with their applications.	• Group definition document • MMIS/ provider management module	• For Group patient volume; the complete set of billing NPIs and Medicaid IDs across all of their client service programs defining the group • MMIS screen details for provider name, FEIN, and address such as the PRGI General Information Screen and the Provider Mnemonic	Pre-screening reviewer will evaluate the group definition file supplied by the provider for completeness, including: • confirming the set of billing NPIs and Medicaid IDs defining the group is present; • lookup billing NPIs and Medicaid IDs in MMIS (screens such as PRGI and PRIQ) to confirm all NPIs and Medicaid IDs are associated with the attesting umbrella organization. Please note that an organization may have multiple NPIs and Medicaid IDs associated with different functions or programs. Any deficiencies will be communicated to the provider and corrections requested. If the provider is attesting to group patient volume and does not supply a complete group definition, then analysis cannot be completed, and they will be deemed ineligible to receive an incentive.	Pre-screening and repeated as part of post-payment audit	VT GCH Demonstration approved 7/1/22 (11-W-00194/1); 8.3(a) MDAAP Eligibility The calculation/compilation of the Group Patient Volume must incorporate ALL encounters under the practice's set of billing NPIs and Medicaid IDs.

Requirements	Measures/Procedures	Data Source	Data Elements	Audit Plan Details	State's Audit Time frame	Notes
			Inquiry PRIQ screen.			
10. Post-payment Audit. If selected for audit, providers must supply a patient volume spreadsheet file documenting encounters in the Medicaid numerator and the denominator. Data for the following fields must be supplied: Billing NPI, Billing provider Medicaid ID, patient unique ID, Medicaid Recipient unique ID, Medicaid State, patient encounter date, and for all group attestations based on a subpart of the billing provider NPI, the clinic name, practice name, service location, or organizational subpart NPI. For the patient volume reporting period, the provider may choose between the prior calendar year and 12 months prior to the attestation for the 90-day period. Note that Designated Agency and Specialized Service Agency providers will use the Vermont Agency of Human Services Department of Mental Health Fiscal Year 2022 Statistical Report for their Medicaid patient volume and will not supply a patient volume spreadsheet.	Evaluate patient volume file to ensure all required fields are included. For individual patient volume, confirm the billing NPI and Medicaid ID in the patient volume file matches MDAAP attesting provider NPI and Medicaid ID For provider attesting with group patient volume, compare the group definition (step #8 above) to the practice/billing NPIs and Medicaid IDs supplied in the patient volume spreadsheet. The billing NPIs and Medicaid IDs in the patient volume file should align with the billing NPIs and Medicaid IDs in the group definition. Review attested patient volume period in attestation and compare to dates of encounters in patient volume file to ensure alignment. For providers that are a State of Vermont Designated Agency or Specialized Service Agency, review the VT Agency of Human Services Department of	• Provider submitted supporting patient volume file for numerator and denominator • Group definition document • Signed attestation submitted via email or secure system VT Agency of Human Services Department of Mental Health Fiscal Year	• Patient volume file with the following fields: BillingNPI, Billing provider Medicaid ID, patient unique ID, Medicaid Recipient unique ID, Medicaid State, patient encounter date, and for all group attestations based on a subpart of the billing provider NPI, the clinic name, practice name, service location, or organizational subpart NPI • Patient volume data range • Patient volume date range per attestation VT AHS Dept Mental Health FY2022	Post-payment auditor will evaluate the patient volume file supplied by the provider for completeness, including: • confirming data is provided for all required fields; • for individual patient volume, confirm the billing NPI and Medicaid ID in the patient volume file matches the billing provider NPI and Medicaid ID in MMIS; • for group patient volume, confirm the billing NPIs and Medicaid IDs in the group definition align with the billing NPIs and Medicaid IDs in the patient volume file; • comparing the attested patient volume period to the patient volume file to confirm alignment. For the manual submission of attestations, the post-payment auditor would review the patient volume date range on the signed attestation submitted via email and compare it to the patient volume date range in the patient volume file and check to ensure the date range is for 90 days and that it is appropriate (90-days and either in the prior calendar year or 12 months prior to the attestation date). The provider must be using a 90-day patient volume date range either in the prior calendar year of 12 months prior to the attestation date to be eligible for MDAAP. Any deficiencies will be communicated to the provider and corrections requested. If the provider does not supply complete patient volume data, then analysis cannot be completed and they will be deemed ineligible to receive an incentive. For providers that are a State of Vermont Designated Agency or Specialized Service Agency, review the Vermont Agency of Human Services Department of Mental Health Fiscal Year 2022 Statistical Report, prepared May 2023. Specifically, review Table 2-4, Responsibility for Fee of Clients Served, to identify the	Post-payment audit	VT GCH Demonstration approved 7/1/22 (11-W-00194/1); 8.3(a) MDAAP Eligibility

Requirements	Measures/Procedures	Data Source	Data Elements	Audit Plan Details	State's Audit Time frame	Notes
	Mental Health Fiscal Year 2022 Statistical Report, specifically, Table 2-4 Responsibility For Fee of Clients Served, to identify the percentage of clients served that are covered by Medicaid.	2022 Statistical Report (https://mentalhealth.vermont.gov/reports-forms-and-manuals/reports/statistical-reports-and-data)	Statistical Report Table 2-4 Percent clients served covered by Medicaid	percentage of clients served that are covered by Medicaid. Identify the percent of clients that are covered by Medicaid for the provider and verify that it is greater than or equal to 20%.		
11. Post-payment Audit. Providers must have at least 20% Medicaid patient volume for a consecutive 90-day period. The provider may choose between the prior calendar year and 12 months prior to the attestation for the 90-day period. Note that Designated Agency and Specialized Service Agency providers will use the Vermont Agency of Human Services Department of Mental Health Fiscal Year 2022 Statistical Report for their Medicaid patient volume and will not supply a patient volume spreadsheet.	**Patient Volume Date Range Verification:** **T**he post-payment auditor would review the patient volume date range on the signed attestation submitted via email and compare it to the patient volume date range in the patient volume file and check to ensure the date range is for 90 days and that it is appropriate (90-days and either in the prior calendar year or 12 months prior to the attestation date). **Numerator for Patient Volume Verification:** Verify Medicaid Patient Volume Numerator: Obtain documentation from the provider to support their total patient encounters and review the documentation for reasonableness (e.g.,	• Signed attestation submitted via email or software system • Signed attestation submitted via email or software system	• Patient volume • Reporting Period • Patient volume date range per attestation • Provider Attested Numerator • Note, a MMIS/BOBJ query can also be used to differentiate encounters by	**Date Range:** The post-payment auditor would review the patient volume date range on the signed attestation submitted via email and compare it to the patient volume date range in the patient volume file and check to ensure the date range is for 90 days and that it is appropriate (90-days and either in the prior calendar year or 12 months prior to the attestation date). The provider must be using a 90-day patient volume date range either in the prior calendar year of 12 months prior to the attestation date to be eligible for MDAAP. Any deficiencies will be communicated to the provider and corrections requested. If the provider does not supply complete patient volume data, then analysis cannot be completed and they will be deemed ineligible to receive an incentive. **Numerator Verification:** • Import the patient volume file into MS Access for numerator analysis. Use fields for encounter date, billing NPI, billing Medicaid ID, patient unique ID, Medicaid recipient unique ID, and Medicaid state. Remove duplicates and limit the encounter data to the attested 90-day patient volume period. • The list of VT Medicaid patients obtained from the provider's dataset is run against VT MMIS	Patient volume date range is confirmed as part of post-payment audit	VT GCH Demonstration approved 7/1/22 (11-W-00194/1); 8.3(a) MDAAP Eligibility

Requirements	Measures/Procedures	Data Source	Data Elements	Audit Plan Details	State's Audit Time frame	Notes
	looks relatively complete, time period is appropriate, etc.) Analyze the submitted patient volume data using MS Access. For the numerator analysis, use fields for encounter date, billing NPI, billing provider Medicaid ID, patient unique ID, Medicaid recipient unique ID, and Medicaid state. Remove duplicates and limit the encounter data to the attested 90-day patient volume period. Evaluate Vermont Medicaid recipient eligibility on encounter dates using MMIS data. A BOBJ query of the VT MMIS database can be run to help validate the Medicaid patient volume numerator and evaluate it for reasonableness. **Denominator for Patient Volume Verification:** Obtain documentation from the provider to support their total patient encounters and review the documentation for reasonableness (e.g., looks relatively complete, time period is appropriate, etc.) Analyze the submitted patient volume	• Provider submitted supporting patient volume documents for numerator and denominator • MMIS/BOBJ query • VT Medicaid recipient eligibility data from BOBJ query of VT MMIS eligibility data	billing location, which may be helpful when a provider practices at more than one site. • Provider documented numerator for in-state and out-of-state Medicaid encounters • VT MMIS Medicaid recipient eligibility numerator • Calculated Numerator per State MMIS/BOBJ query. • Provider Attested Denominator • Provider documented denominator • Provider documented numerator/Provider	eligibility data (via a BOBJ query with an in-list statement containing the Medicaid Recipient Unique ID numbers) to obtain Medicaid eligibility dates within the 90-day patient volume rage for each patient, which is then used in Microsoft Access to confirm the Medicaid eligibility for each patient on the encounter dates documented by the provider. The VT MMIS Eligibility numerator plus documented out-of-state numerator/documented denominator volume must be at least 19.5% (rounded up to 20%) for the provider to be eligible. • A BOBJ query of the VT MMIS database can be run to help validate the Medicaid patient volume numerator and evaluate it for reasonableness. This query is for VT Medicaid claims only and is based on NPI and or Medicaid ID. Limitations of the query include that it may not be able to document all encounters that are part of global charge bundled services, mental health case rate, or Medicaid mental health or developmental waiver services, and it only captures paid claims. This query will capture all paid encounters for a provider at all locations, and for MDAAP patient volume, providers may only use one clinical site, they are not required to calculate patient volume across all practice sites. A MMIS/BOBJ query can also be used to differentiate encounters by billing location, which may be helpful when a provider practices at more than one site. **Denominator Verification:** • The VT MMIS Eligibility numerator plus documented out-of-state numerator/documented denominator volume must be at least 19.5% (rounded up to 20%) for the provider to be eligible. • Compare the patient volume percentage per the signed attestation to the documentation that was provided by the provider, and the VT MMIS Eligibility numerator plus documented out-of-state numerator/documented	Patient volume threshold verification (numerator & denominator) is part of post-payment audit	

Requirements	Measures/Procedures	Data Source	Data Elements	Audit Plan Details	State's Audit Time frame	Notes
	data using MS Access. For the denominator analysis, use fields for encounter date,, patient unique ID, billing NPI, and billing Medicaid ID. Remove duplicates and limit the encounter data to the attested 90-day patient volume period Compare the patient volume percentage per the signed attestation to the documentation that was provided by the provider, and the VT MMIS Eligibility numerator plus documented out-of-state numerator/documented denominator ratio. Determine if the provider's attestation is reasonably consistent with the submitted documentation. For providers that are a State of Vermont Designated Agency or Specialized Service Agency, review the VT Agency of Human Services Department of Mental Health Fiscal Year 2022 Statistical Report, specifically, Table 2-4 Responsibility For Fee of Clients Served, to identify the percentage of clients served that are covered by Medicaid.	VT Agency of Human Services Department of Mental Health Fiscal Year 2022 Statistical Report (https://mentalhealth.vermont.gov/reports-forms-and-manuals/reports/statistical-reports-and-data)	documented denominator VT MMIS Medicaid recipient eligibility numerator plus documented out-of-state numerator /Provider documented denominator VT AHS Dept Mental Health FY2022 Statistical Report Table 2-4 Percent clients served covered by Medicaid	denominator ratio. Determine if the provider's attestation is reasonably consistent with the submitted documentation. Any deficiencies will be communicated to the provider and corrections requested. If the provider does not supply complete patient volume data, then analysis cannot be completed, and they will be deemed ineligible to receive an incentive. Providers have the ability to amend their attested 90-day patient volume reporting period in order to find a timeframe that meets the 20% Medicaid patient volume requirement. For providers that are a State of Vermont Designated Agency or Specialized Service Agency, review the Vermont Agency of Human Services Department of Mental Health Fiscal Year 2022 Statistical Report, prepared May 2023. Specifically, review Table 2-4, Responsibility for Fee of Clients Served, to identify the percentage of clients served that are covered by Medicaid. Identify the percent of clients that are covered by Medicaid for the provider and verify that it is greater than or equal to 20%.		

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12. Providers must have at least one clinical location within the State of Vermont, used in the calculation of patient volume where the provider is participating in MDAAP, which is using or intends to use Certified EHR Technology or other HIT systems that have been approved for and meet the requirements of the MDAAP	Review provider's attestation for location(s) participating in MDAAP for patient volume and compare it with the location(s) given on the supporting documentation and in the MMIS. Confirm the location is within the state of Vermont and is not out of state The post-payment auditor will review the provider/organization address on the signed attestation submitted via email and compare it to the address on supporting documentation and in the MMIS.	• MMIS/provider management module • Provider-submitted documentation supporting that a location used for the patient volume is participating in MDAAP Signed attestation	• Practice location per submitted documentation such as MDAAP participation agreement, or statement signed by provider, CIO, IT manager or equivalent, • Provider/organization address per attestation • Practice Location per MMIS	The post-payment auditor will review the provider/organization address on the signed attestation submitted via email and compare it to the supplied supporting documentation such as the provider or participation agreement. If no such file is attached, then request documentation from provider/practice. The provider may have their CIO, IT manager, or equivalent; attest in writing that one or more clinical locations used in the calculation of patient volume is participating in MDAAP. Confirm the address on the attestation and supporting documentation align and the address is within the State of Vermont and not out of state. Review address data from MMIS to confirm alignment and location within the state of Vermont. Confirm the address on the attestation and supporting documentation align and the address is within the State of Vermont and not out of state. Review address data from MMIS to confirm alignment and location within the State of Vermont.	Post-payment Audit	VT GCH Demonstration approved 7/1/22 (11-W-00194/1); 8.3(a) MDAAP Eligibility