

**MEDICARE-MEDICAID  
CAPITATED FINANCIAL ALIGNMENT MODEL  
REPORTING REQUIREMENTS:  
VIRGINIA-SPECIFIC REPORTING  
REQUIREMENTS**

Effective as of April 1, 2014, Issued June 25, 2014

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## Virginia-Specific Reporting Requirements Appendix

### ***Introduction***

The measures in this appendix are required reporting for all MMPs in the Commonwealth Coordinated Care demonstration. CMS and the Commonwealth of Virginia reserve the right to update the measures in this appendix for subsequent demonstration years. These state-specific measures directly supplement the Medicare-Medicaid Capitated Financial Alignment: Core Reporting Requirements, which can be found at the following web address:

<http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html>

MMPs should refer to the core document for additional details regarding demonstration-wide definitions, reporting phases and timelines, and sampling methodology.

The core and state-specific measures supplement existing Part C and Part D reporting requirements, as well as measures that MMPs report via other vehicles or venues, such as HEDIS<sup>®1</sup>, HOS, and state-required HCBS Satisfaction Survey. CMS and the state will also track key utilization measures, which are not included in this document, using encounter and claims data. The quantitative measures are part of broader oversight, monitoring, and performance improvement processes that include several other components and data sources not described in this document.

### ***Definitions***

Calendar Quarter: All quarterly measures are reported on calendar quarters. The four calendar quarters of each calendar year will be as follows: 1/1 – 3/31, 4/1 – 6/30, 7/1 – 9/30, and 10/1 – 12/31.

Calendar Year: All annual measures are reported on a calendar year basis. Calendar year 2014 (CY1) will be an abbreviated year, with data reported for the time period beginning April 1, 2014 and ending December 31, 2014. Calendar year 2015 (CY2) will represent January 1, 2015 through December 31, 2015.

Implementation Period: The period of time starting with the first effective enrollment date until the end of the ninth month of the demonstration.

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<sup>1</sup> HEDIS<sup>®</sup> is a registered trademark of the National Committee of Quality Assurance (NCQA).

Long Term Services and Supports (LTSS): A variety of services and supports that help elderly individuals and/or individuals with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities.

Primary Care Provider: Nurse practitioners, physician assistants or physicians who are board certified or eligible for certification in one of the following specialties: family practice, internal medicine, general practice, obstetrics/gynecology, or geriatrics.

### ***Quality Withhold Measures***

CMS and each state will establish a set of quality withhold measures, and MMPs will be required to meet established thresholds. Throughout this document, these measures are marked with the following symbol: (†). This document only identifies Demonstration Year 1 (DY1) quality withhold measures. CMS and the Commonwealth of Virginia will update the reporting requirements to reflect quality withhold measures for subsequent demonstration years closer to the start of Demonstration Year 2 (DY2). Additional information on the withhold methodology and benchmarks will be provided at a later time.

## Virginia's Model of Care Assessment and Plan of Care Requirements

Appendix M from the Virginia three-way contract between CMS, the Commonwealth of Virginia, and the MMPs summarizes the demonstration requirements for completion of care assessments and plans of care for different populations affected by the demonstration. Measures related to care assessments and plans of care include VA1.1, VA1.2, and VA2.1.

### Appendix M. Health Risk Assessment and Plan of Care Requirements

Population	Implementation Health Risk Assessment (at program launch <sup>1</sup> )	Implementation of MCO Plan of Care (at program launch)	Initial Health Risk Assessment (for new Enrollees after program launch)	Initial Plan of Care (for new Enrollees after program launch)	Reassessment and POC Review	As Needed POC Revised	Level of Care Annual Reassessment
Community Well	Within 90 days of plan enrollment <sup>2</sup>	Within 90 days of enrollment (Plan must honor all existing POCs and PAs until the authorization ends or 180 days from enrollment, whichever is sooner <sup>3</sup> ).	Within 60 days of enrollment	Within 90 days of enrollment (Plan must honor all existing POCs and PAs until the authorization ends or 180 days from enrollment whichever is sooner).	By POC anniversary date	Upon triggering event such as a hospitalization or significant change in health or functional status	N/A
Vulnerable Subpopulation <sup>4</sup> (Excluding EDCD & nursing facility)	Within 60 days of plan enrollment	Within 90 days of enrollment (Plan must honor all existing POCs and PAs until the authorization ends or 180 days from enrollment, whichever is sooner).	Within 60 days of enrollment	Within 60 days of enrollment (Plan must honor all existing POCs and PAs until the authorization ends or 180 days from enrollment whichever is sooner).	By POC anniversary date	Upon triggering event such as a hospitalization or significant change in health or functional status	N/A
EDCD Vulnerable Subpopulation	Within 60 days of plan enrollment (must be face-to-face).	Within 90 days of enrollment (Plan must honor all existing POCs and PAs until the authorization ends or 180 days from enrollment, whichever is sooner). The POC must be developed and implemented by the MCO no later than the end date of any existing PA.	Within 30 days of enrollment (must be face-to-face).	Within 30 days of enrollment (Plan must honor all existing POCs and PAs until the authorization ends or 180 days from enrollment whichever is sooner).	By POC anniversary date, not to exceed 365 days <sup>5</sup> (must be face-to-face).	Upon triggering event such as a hospitalization or significant change in health or functional status	Plan conducts annual face to face assessment (functional) for continued eligibility for the EDCD Waiver. <sup>6</sup>

Population	Implementation Health Risk Assessment (at program launch <sup>1</sup> )	Implementation of MCO Plan of Care (at program launch)	Initial Health Risk Assessment (for new Enrollees after program launch)	Initial Plan of Care (for new Enrollees after program launch)	Reassessment and POC Review	As Needed POC Revised	Level of Care Annual Reassessment
Nursing Facility Vulnerable Subpopulation	Within 60 days of plan enrollment (must be face-to-face and incorporate MDS).	Within 90 days of enrollment. (Plan must honor all existing POCs for 180 days from enrollment).	Within 60 days of enrollment (must be face-to-face).	Within 60 days of enrollment (Plans must honor all existing POCs for 180 days from enrollment).	Follow MDS guidelines/time frames for quarterly and annual POC development	Upon triggering event such as a hospitalization or significant change in health or functional status	Plan works with facility on annual assessment (functional) for continued nursing facility placement.

- 1 "At Program Launch" includes the opt-in period and passive enrollment period during year 1 of the demonstration.
- 2 The clock starts at the effective date of enrollment and days are measured in calendar days.
- 3 Prior authorizations for Medicaid services will be provided in the enrollee's transition report.
- 4 Vulnerable Subpopulation is defined in Section 1 (Definition of Terms) of the Contract.
- 5 Plans must comply with requirements for the EDCD Waiver as established in 12 VAC 30-120-900 et. seq.
- 6 Local and Hospital Preadmission Screening Teams conduct the initial assessment for eligibility for LTSS (including nursing facility, EDCD Waiver, and PACE).

## Virginia's Implementation, Ongoing, and Continuous Reporting Periods

<b>Demonstration Year 1</b>			
<b>Phase</b>		<b>Dates</b>	<b>Explanation</b>
Continuous Reporting	Implementation Period	4-1-14 through 12-31-14	From the first effective enrollment date through the end of the ninth month of the demonstration.
	Ongoing Period	4-1-14 through 12-31-15	From the first effective enrollment date through the end of the first demonstration year.
<b>Demonstration Year 2</b>			
Continuous Reporting	Ongoing Period	1-1-16 through 12-31-16	From January 1st through the end of the second demonstration year.
<b>Demonstration Year 3</b>			
Continuous Reporting	Ongoing Period	1-1-17 through 12-31-17	From January 1st through the end of the third demonstration year.

**Data Submission**

All MMPs will submit data through an Excel template on a secure transmission site.

This site can be accessed at the following web address:

<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

The template is available for download at:

<http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html>

MMPs should follow the instructions below on how to properly name each data file submitted.

- Required File Format is Microsoft Excel File.
- The file name extension should be ".xls"
- File name= VA\_(CONTRACTID)\_(REPORTING PERIOD)\_(SUBMISSIONDATE).xls.
- Replace (CONTRACTID) with the contract ID, (REPORTINGPERIOD) with the year and month of the beginning of the reporting period in YYYYMM format (e.g., February 2014 would be 201402), and (SUBMISSIONDATE) with the year, month, and date of the submission in YYYYMMDD format (e.g., March 31, 2014 would be 20140331).

**Section VAI. Assessment**

VA1.1 Community Well members with a health risk assessment completed within 90 days of enrollment.<sup>1</sup>

<b>IMPLEMENTATION</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
VA1. Assessment	Monthly, beginning after 90 days	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
<b>ONGOING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Periods</b>	<b>Due Date</b>
VA1. Assessment	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of members classified as Community Well upon enrollment whose 90th day of enrollment occurred within the reporting period.	Total number of members classified as Community Well upon enrollment whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric
B.	Total number of Community Well members who were documented as unwilling to complete a health risk assessment within 90 days of enrollment.	Of the total reported in A, the number of Community Well members who were documented as unwilling to complete a health risk assessment within 90 days of enrollment.	Field Type: Numeric  Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of Community Well members the MMP was unable to locate, following three documented attempts within 90 days of enrollment.	Of the total reported in A, the number of Community Well members the MMP was unable to locate, following three documented attempts within 90 days of enrollment.	Field type: Numeric  Note: Is a subset of A.
D.	The number of Community Well members with a health risk assessment completed within 90 days of enrollment.	Of the total reported in A, the number of Community Well members with a health risk assessment completed within 90 days of enrollment.	Field type: Numeric  Note: Is a subset of A.

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- Guidance will be forthcoming on the established threshold for this measure.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data elements B, C, and D are less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of members classified as Community Well upon enrollment who:

- Were unable to be located to have a health risk assessment completed within 90 days of enrollment.
- Refused to have a health risk assessment completed within 90 days of enrollment.
- Had a health risk assessment completed within 90 days of enrollment.
- Were willing to participate and who could be located who had a health risk assessment completed within 90 days of enrollment.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- MMPs should refer to Appendix M on page VA-5 as well as VA's three-way contract for specific requirements pertaining to a health risk assessment.
- The 90th day of enrollment should be based on each member's effective date.
- The effective date of enrollment is the first date of the member's coverage through the MMP.
- MMPs should include members classified as Community Well on the first effective date of enrollment in this measure, even if the member transitions to a nursing facility, EDCD waiver, or vulnerable subpopulation within the first 90 days of enrollment.
- Failed attempts to contact member to complete a health risk assessment must be documented and CMS and the state may validate this number.
- Community Well members are enrollees ages 21 and older who do not meet a Nursing Facility Level of Care (NFLOC) standard.
- During subsequent years of the demonstration (i.e., CY2, etc.), Community Well members must receive a health risk assessment within 60 days of enrollment.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address:  
<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

VA1.2 Vulnerable subpopulation members, EDCD members, and nursing facility members with a health risk assessment completed within 60 days of enrollment.<sup>i</sup>

<b>IMPLEMENTATION</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
VA1. Assessment	Monthly, beginning after 60 days	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
<b>ONGOING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Periods</b>	<b>Due Date</b>
VA1. Assessment	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of members classified as EDCD members upon enrollment whose 60th day of enrollment occurred within the reporting period.	Total number of members classified as EDCD members upon enrollment whose 60th day of enrollment occurred within the reporting period.	Field Type: Numeric
B.	Total number of EDCD members who were documented as unwilling to complete a health risk assessment within 60 days of enrollment.	Of the total reported in A, the number of EDCD members who were documented as unwilling to complete a health risk assessment within 60 days of enrollment.	Field Type: Numeric  Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of EDCD members the MMP was unable to locate, following three documented attempts within 60 days of enrollment.	Of the total reported in A, the number of EDCD members the MMP was unable to locate, following three documented attempts within 60 days of enrollment.	Field type: Numeric  Note: Is a subset of A.
D.	Total number of EDCD members with a health risk assessment completed within 60 days of enrollment.	Of the total reported in A, the number of EDCD members with a health risk assessment completed within 60 days of enrollment.	Field type: Numeric  Note: Is a subset of A.
E.	Total number of members classified as nursing facility members upon enrollment whose 60th day of enrollment occurred within the reporting period.	Total number of members classified as nursing facility members upon enrollment whose 60th day of enrollment occurred within the reporting period.	Field Type: Numeric
F.	Total number of nursing facility members who were documented as unwilling to complete a health risk assessment within 60 days of enrollment.	Of the total reported in E, the number of nursing facility members who were documented as unwilling to complete a health risk assessment within 60 days of enrollment.	Field Type: Numeric  Note: Is a subset of E.
G.	Total number of nursing facility members with a health risk assessment completed within 60 days of enrollment.	Of the total reported in E, the number of nursing facility members with a health risk assessment completed within 60 days of enrollment.	Field type: Numeric  Note: Is a subset of E.

Element Letter	Element Name	Definition	Allowable Values
H.	Total number of members classified as all other vulnerable subpopulation members upon enrollment whose 60th day of enrollment occurred within the reporting period.	Total number of members classified as all other vulnerable subpopulation members upon enrollment whose 60th day of enrollment occurred within the reporting period.	Field Type: Numeric  Note: Exclude EDCD and NF members.
I.	Total number of all other vulnerable subpopulation members who were documented as unwilling to complete a health risk assessment within 60 days of enrollment.	Of the total reported in H, the number of all other vulnerable subpopulation members who were documented as unwilling to complete a health risk assessment within 60 days of enrollment.	Field Type: Numeric  Note: Is a subset of H.  Note: Exclude EDCD and NF members.
J.	Total number of all other vulnerable subpopulation members the MMP was unable to locate, following three documented attempts within 60 days of enrollment.	Of the total reported in H, the number of all other vulnerable subpopulation members the MMP was unable to locate, following three documented attempts within 60 days of enrollment.	Field type: Numeric  Note: Is a subset of H.  Note: Exclude EDCD and NF members.
K.	Total number of all other vulnerable subpopulation members with a health risk assessment completed within 60 days of enrollment.	Of the total reported in H, the number of all other vulnerable subpopulation members with a health risk assessment completed within 60 days of enrollment.	Field type: Numeric  Note: Is a subset of H.  Note: Exclude EDCD and NF members.

- B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- Guidance will be forthcoming on the established threshold for this measure.
- C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.
- Confirm those data elements listed above as subsets of other elements.
  - MMPs should validate that data elements B, C, and D are less than or equal to data element A.
  - MMPs should validate that data elements F and G are less than or equal to data element E.
  - MMPs should validate that data elements I, J, and K are less than or equal to data element H.
  - All data elements should be positive values.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of members classified as:
- EDCD members upon enrollment who refused to have a health risk assessment completed within 60 days of enrollment.
  - EDCD members upon enrollment who were unable to be located to have a health risk assessment completed within 60 days of enrollment.
  - EDCD members upon enrollment who had a health risk assessment completed within 60 days of enrollment.
  - EDCD members upon enrollment who were willing to participate and who could be located who had a health risk assessment completed within 60 days of enrollment.
  - Nursing facility members upon enrollment who refused to have a health risk assessment completed within 60 days of enrollment.
  - Nursing facility members upon enrollment who had a health risk assessment completed within 60 days of enrollment.
  - Nursing facility members upon enrollment who were willing to participate and who could be located who had a health risk assessment completed within 60 days of enrollment.
  - All other vulnerable subpopulation members upon enrollment who refused to have a health risk assessment completed within 60 days of enrollment.
  - All other vulnerable subpopulation members upon enrollment who were unable to be located to have a health risk assessment completed within 60 days of enrollment.
  - All other vulnerable subpopulation members upon enrollment who had a health risk assessment completed within 60 days of enrollment.

- All other vulnerable subpopulation members upon enrollment who were willing to participate and who could be located who had a health risk assessment completed within 60 days of enrollment.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
  - MMPs should refer to VA’s three-way contract for specific requirements pertaining to a health risk assessment.
  - The 60th day of enrollment should be based on each member’s effective date.
  - The effective date of enrollment is the first date of the member’s coverage through the MMP.
  - Failed attempts to contact member to complete a health risk assessment must be documented and CMS and the state may validate this number.
  - Vulnerable subpopulation members are:
    - a. Individuals enrolled in the EDCD waiver;
    - b. Individuals with intellectual/developmental disabilities;
    - c. Individuals with cognitive or memory problems (e.g., dementia or traumatic brain injury);
    - d. Individuals with physical or sensory disabilities;
    - e. Individuals residing in nursing facilities;
    - f. Individuals with serious and persistent mental illnesses;
    - g. Individuals with end stage renal disease; and,
    - h. Individuals with complex or multiple chronic conditions.
  - Exclude EDCD and nursing facility members from the vulnerable subpopulation for the calculation of totals in data elements H-K. “All other vulnerable subpopulations” should only include vulnerable subpopulation members not in the EDCD waiver and not residing in a nursing facility.
  - An EDCD waiver is a CMS-approved §1915(c) waiver that covers a range of community support services offered to EDCD members. EDCD members are individuals who are elderly or who have a disability who would otherwise require a nursing facility level of care.
  - Health risk assessments for individuals enrolled in the EDCD Waiver and for individuals residing in nursing facilities must be conducted face-to-face. The health risk assessments for individuals residing in nursing facilities must also incorporate the MDS.
  - Minimum Data Set (MDS) is part of the federally-mandated process for assessing individuals receiving care in certified skilled nursing facilities in order to record their overall health status regardless of payer source. The process provides a comprehensive health risk

assessment of individuals' current health conditions, treatments, abilities, and plans for discharge. The MDS is administered to all residents upon admission, quarterly, yearly, and whenever there is a significant change in an individual's condition. Section Q is the part of the MDS designed to explore meaningful opportunities for nursing facility residents to return to community settings.

- During subsequent years of the demonstration (i.e., CY2, etc.), individuals enrolled in the EDCD Waiver must receive a health risk assessment within 30 days of enrollment.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address:

<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

VA1.3 EDCD waiver enrollees who received an annual LOC evaluation.

**Please note:** No MMP reporting is required for this measure; the DMAS Long Term Care Division will gather its data through the current §1915(c) HCBS waiver quality assurance process. MMPs are required to assist DMAS Longer Term Care Division with the waiver quality assurance process. More detail regarding the required assistance will be provided by DMAS.

VA1.4 EDCD waiver enrollees with service plans developed in accordance with Virginia's regulations and policies.

**Please note:** Details regarding reporting requirements associated with this measure are forthcoming.

**Section VAIL. Care Coordination**

VA2.1 Community Well members, vulnerable subpopulation members, EDCD members, and nursing facility members with a Plan of Care (POC) completed within 90 days of enrollment.<sup>i</sup>

<b>IMPLEMENTATION</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
VA2. Care Coordination	Monthly, beginning after 90 days	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
<b>ONGOING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Periods</b>	<b>Due Date</b>
VA2. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of members enrolled whose 90th day of enrollment occurred within the reporting period.	Total number of members enrolled whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric
B.	Total number of members who were documented as unwilling to complete a POC within 90 days of enrollment.	Of the total reported in A, the number of members who were documented as unwilling to complete a POC within 90 days of enrollment.	Field Type: Numeric  Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of members the MMP was unable to locate, following three documented attempts within 90 days of enrollment.	Of the total reported in A, the number of members the MMP was unable to locate, following three documented attempts within 90 days of enrollment.	Field Type: Numeric  Note: Is a subset of A.
D.	Total number of members with a POC completed within 90 days of enrollment.	Of the total reported in A, the number of members with a POC completed within 90 days of enrollment.	Field Type: Numeric  Note: Is a subset of A.
E.	Total number of members classified as Community Well upon enrollment whose 90th day of enrollment occurred within the reporting period.	Total number of members classified as Community Well upon enrollment whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric
F.	Total number of Community Well members who were documented as unwilling to complete a POC within 90 days of enrollment.	Of the total reported in E, the number of Community Well members who were documented as unwilling to complete a POC within 90 days of enrollment.	Field Type: Numeric  Note: Is a subset of E.
G.	Total number of Community Well members the MMP was unable to locate, following three documented attempts within 90 days of enrollment.	Of the total reported in E, the number of Community Well members the MMP was unable to locate, following three documented attempts within 90 days of enrollment.	Field Type: Numeric  Note: Is a subset of E.
H.	Total number of Community Well members with a POC completed within 90 days of enrollment.	Of the total reported in E, the number of Community Well members with a POC completed within 90 days of enrollment.	Field Type: Numeric  Note: Is a subset of E.

Element Letter	Element Name	Definition	Allowable Values
I.	Total number of members classified as EDCD members upon enrollment whose 90th day of enrollment occurred within the reporting period.	Total number of members classified as EDCD members upon enrollment whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric
J.	Total number of EDCD members who were documented as unwilling to complete a POC within 90 days of enrollment.	Of the total reported in I, the number of EDCD members who were documented as unwilling to complete a POC within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of I.
K.	Total number of EDCD members the MMP was unable to locate, following three documented attempts within 90 days of enrollment.	Of the total reported in I, the number of EDCD members the MMP was unable to locate, following three documented attempts within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of I.
L.	Total number of EDCD members with a POC completed within 90 days of enrollment.	Of the total reported in I, the number of EDCD members with a POC completed within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of I.
M.	Total number of members classified as nursing facility members upon enrollment whose 90th day of enrollment occurred within the reporting period.	Total number of members classified as nursing facility members upon enrollment whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
N.	Total number of nursing facility members who were documented as unwilling to complete a POC within 90 days of enrollment.	Of the total reported in M, the number of nursing facility members who were documented as unwilling to complete a POC within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of M.
O.	Total number of nursing facility members with a POC completed within 90 days of enrollment.	Of the total reported in M, the number of nursing facility members with a POC completed within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of M.
P.	Total number of members classified as all other vulnerable subpopulation members upon enrollment whose 90th day of enrollment occurred within the reporting period.	Total number of members classified as all other vulnerable subpopulation members upon enrollment whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric Note: Exclude EDCCD and NF members
Q.	Total number of all other vulnerable subpopulation members who were documented as unwilling to complete a POC within 90 days of enrollment.	Of the total reported in P, the number of all other vulnerable subpopulation members who were documented as unwilling to complete a POC within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of P. Note: Exclude EDCCD and NF members
R.	Total number of all other vulnerable subpopulation members the MMP was unable to locate, following three documented attempts within 90 days of enrollment.	Of the total reported in P, the number of all other vulnerable subpopulation members the MMP was unable to locate, following three documented attempts within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of P. Note: Exclude EDCCD and NF members

Element Letter	Element Name	Definition	Allowable Values
S.	Total number of all other vulnerable subpopulation members with a POC completed within 90 days of enrollment.	Of the total reported in P, the number of all other vulnerable subpopulation members with a POC completed within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of P. Note: Exclude EDCD and NF members

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- Guidance will be forthcoming on the established threshold for this measure.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data elements B, C, and D are less than or equal to data element A.
- MMPs should validate that data elements F, G, and H are less than or equal to data element E.
- MMPs should validate that data elements J, K, and L are less than or equal to data element I.
- MMPs should validate that data elements N and O are less than or equal to data element M.
- MMPs should validate that data elements Q, R, and S are less than or equal to data element P.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

CMS and the state will evaluate the percentage of members:

- Who were unable to be located to have a POC completed within 90 days of enrollment.
- Who refused to have a POC completed within 90 days of enrollment.
- Who had a POC completed within 90 days of enrollment.
- Who were willing to participate and who could be located who had a POC completed within 90 days of enrollment.

CMS and the state will evaluate the percentage of members classified as:

- Community Well upon enrollment who were unable to be located to have a POC completed within 90 days of enrollment.
- Community Well upon enrollment who refused to have a POC completed within 90 days of enrollment.

- Community Well upon enrollment who had a POC completed within 90 days of enrollment.
- Community Well upon enrollment who were willing to participate and who could be located who had a POC completed within 90 days of enrollment.
- EDCD members upon enrollment who were unable to be located to have a POC completed within 90 days of enrollment.
- EDCD members upon enrollment who refused to have a POC completed within 90 days of enrollment.
- EDCD members upon enrollment who had a POC completed within 90 days of enrollment.
- EDCD members upon enrollment who were willing to participate and who could be located who had a POC completed within 90 days of enrollment.
- Nursing facility members upon enrollment who refused to have a POC completed within 90 days of enrollment.
- Nursing facility members upon enrollment who had a POC completed within 90 days of enrollment.
- Nursing facility members upon enrollment who were willing to participate and who could be located who had a POC completed within 90 days of enrollment.
- All other vulnerable subpopulation members upon enrollment who were unable to be located to have a POC completed within 90 days of enrollment.
- All other vulnerable subpopulation members upon enrollment who refused to have a POC completed within 90 days of enrollment.
- All other vulnerable subpopulation members upon enrollment who had a POC completed within 90 days of enrollment.
- All other vulnerable subpopulation members upon enrollment who were willing to participate and who could be located who had a POC completed within 90 days of enrollment.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all Community Well, vulnerable subpopulation, EDCD, and nursing facility members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- MMPs should refer to VA's three-way contract for specific requirements pertaining to a POC.
- The 90th day of enrollment should be based on each member's effective date.
- The effective date of enrollment is the first date of the member's coverage through the MMP.
- MMPs should include members classified as Community Well, EDCD members, nursing facility members, or vulnerable subpopulation members on the first effective date of enrollment in

this measure, even if the member transitions to another subpopulation within the first 90 days of enrollment.

- Failed attempts to contact member to complete a POC must be documented and CMS and the state may validate this number.
- Community Well members are enrollees ages 21 and older who do not meet a Nursing Facility Level of Care (NFLOC) standard.
- Vulnerable subpopulation members are:
  - a. Individuals enrolled in the EDCD waiver;
  - b. Individuals with intellectual/developmental disabilities;
  - c. Individuals with cognitive or memory problems (e.g., dementia or traumatic brain injury);
  - d. Individuals with physical or sensory disabilities;
  - e. Individuals residing in nursing facilities;
  - f. Individuals with serious and persistent mental illnesses;
  - g. Individuals with end stage renal disease; and,
  - h. Individuals with complex or multiple chronic conditions.
- Exclude EDCD and nursing facility members from the vulnerable subpopulation for the calculation the totals in data elements P-S. “All other vulnerable subpopulation” should only include members not in the EDCD waiver and not residing in a nursing facility.
- An EDCD waiver is a CMS-approved §1915(c) waiver that covers a range of community support services offered to EDCD members. EDCD members are individuals who are elderly or who have a disability who would otherwise require a nursing facility level of care.
- During subsequent years of the demonstration (i.e., CY2, etc.), vulnerable subpopulation members and nursing facility members must have a POC completed within 60 days of enrollment.
- During subsequent years of the demonstration (i.e., CY2, etc.), EDCD members must have a POC completed within 30 days of enrollment.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address:  
<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

VA2.2 Members with documented discussions of care goals.<sup>1</sup>

<b>IMPLEMENTATION</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
VA2. Care Coordination	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
<b>ONGOING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Periods</b>	<b>Due Date</b>
VA2. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of members with a Plan of Care (POC) developed.	Total number of members with a POC developed during the reporting period.	Field Type: Numeric
B.	Total number of members sampled that met inclusion criteria.	Of the total reported in A, the number of members sampled that met inclusion criteria.	Field Type: Numeric  Note: Is a subset of A.
C.	Total number of members with at least one documented discussion of care goals in the POC.	Of the total reported in B, the number of members with at least one documented discussion of care goals in the POC.	Field Type: Numeric  Note: Is a subset of B.

- B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- Guidance will be forthcoming on the established threshold for this measure.
- C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.
- Confirm those data elements listed above as subsets of other elements.
  - MMPs should validate that data element B is less than or equal to data element A and greater than or equal to data element C.
  - All data elements should be positive values.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
- CMS and the state will evaluate the percentage of members with a care plan developed in the reporting period who had at least one documented discussion of care goals in the POC.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. A subset of all members that are eligible will be included in the sample.
  - For reporting, the MMPs may elect to sample since this measure requires documentation review to identify the numerator. Sampling should be systematic to ensure all eligible individuals have an equal chance of inclusion. The sample size should be 411, plus oversample to allow for substitution. For further instructions on selecting the sample size, please see pages 35-36 of the Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements on CMS' Web site: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans>
  - If an MMP does not elect to sample, data element B should be equal to data element A.
  - Care goal discussions can be completed as part of the development of the initial POC; the MMP should only include the POC in data element C when care goals are clearly documented in the POC.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address:

<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

VA2.3 Members with first follow-up visit within 30 days of discharge.

<b>CONTINUOUS REPORTING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Periods</b>	<b>Due Date</b>
VA2. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the fourth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of hospital discharges.	Total number of hospital discharges during the reporting period.	Field Type: Numeric
B.	Total number of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge from the hospital.	Of the total reported in A, the number of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge from the hospital.	Field Type: Numeric  Note: Is a subset of A.

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the percentage of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of the discharge from the hospital.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- The date of discharge must occur within the reporting period, but the follow-up visit may not be in the same reporting period. For example, if a discharge occurs during the last month of the reporting period, look to the first month of the following reporting period to identify the follow-up visit.
- The member needs to be enrolled from the date of the hospital discharge through 30 days after the hospital discharge, with no gaps in enrollment.
- A follow-up visit is defined as an ambulatory care follow-up visit to assess the member's health following a hospitalization. Codes to identify follow-up visits are provided in Table VA-1.
- Codes to identify inpatient discharges are provided in Table VA-2.
- Exclude discharges in which the patient was readmitted within 30 days after discharge to an acute or non-acute facility.
- Exclude discharges due to death. Codes to identify patients who have expired are provided in Table VA-3.

<b>Table VA-1: Codes to Identify Ambulatory Health Services</b>				
<b>Description</b>	<b>CPT</b>	<b>HCPCS</b>	<b>ICD-9-CM Diagnosis</b>	<b>UB Revenue</b>
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245			051x, 0520-0523, 0526-0529, 0982, 0983
Home services	99341-99345, 99347-99350			
Nursing facility care	99304-99310, 99315, 99316, 99318			0524, 0525

Table VA-1: Codes to Identify Ambulatory Health Services				
Description	CPT	HCPCS	ICD-9-CM Diagnosis	UB Revenue
Domiciliary, rest home or custodial care services	99324-99328, 99334-99337			
Preventive medicine	9938-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429	G0344, G0402, G0438, G0439		
Ophthalmology and optometry	92002, 92004, 92012, 92014			
General medical examination			V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	

Table VA-2: Codes to Identify Inpatient Discharges		
Principal ICD-9-CM Diagnosis		MS-DRG
001-289, 317-999, V01-V29, V40-V90	<b>OR</b>	001-013, 020-042, 052-103, 113-117, 121-125, 129-139, 146-159, 163-168, 175-208, 215-264, 280-316, 326-358, 368-395, 405-425, 432-446, 453-517, 533-566, 573-585, 592-607, 614-630, 637-645, 652-675, 682-700, 707-718, 722-730, 734-750, 754-761, 765-770, 774-782, 789-795, 799-804, 808-816, 820-830, 834-849, 853-858, 862-872, 901-909, 913-923, 927-929, 933-935, 939-941, 947-951, 955-959, 963-965, 969-970, 974-977, 981-989, 998, 999

**WITH**

<b>UB Type of Bill</b>	<b>OR</b>	Any acute inpatient facility code
11x, 12x, 41x, 84x		

Table VA-3: Codes to Identify Patients who Expired
Discharge Status Code
20

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address:

<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

VA2.4 EDCD waiver enrollees with a service plan.

**Please note:** Details regarding reporting requirements associated with this measure are forthcoming.

VA2.5 Service plans that were revised as needed.

**Please note:** Details regarding reporting requirements associated with this measure are forthcoming.

VA2.6 EDCD waiver enrollees who received services specified in the service plan.

**Please note:** Details regarding reporting requirements associated with this measure are forthcoming.

VA2.7 EDCD waiver enrollee records that contain an appropriately completed and signed form that specifies a choice was offered.

**Please note:** Details regarding reporting requirements associated with this measure are forthcoming.

VA2.8 Case management records reviewed for documentation of a choice of waiver providers.

**Please note:** Details regarding reporting requirements associated with this measure are forthcoming.

VA2.9 Transition of members between Community, waiver, and long-term care services.

IMPLEMENTATION				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
VA2. Care Coordination	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	Reporting Frequency	Level	Reporting Periods	Due Date
VA2. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of Community Well members enrolled at the beginning of the reporting period.	Total number of Community Well members enrolled at the beginning of the reporting period.	Field Type: Numeric
B.	Total number of new Community Well members enrolled during the reporting period.	Total number of new Community Well members enrolled during the reporting period.	Field Type: Numeric
C.	Total number of Community Well members who transitioned to EDCD waiver services.	Of the total reported in A and B, the number of Community Well members who transitioned to EDCD waiver services during the reporting period.	Field Type: Numeric  Note: Is a subset of the sum of A and B.
D.	Total number of Community Well members who transitioned to a nursing facility.	Of the total reported in A and B, the number of Community Well members who transitioned to a nursing facility during the reporting period.	Field Type: Numeric  Note: Is a subset of the sum of A and B.
E.	Total number of EDCD waiver members enrolled at the beginning of the reporting period.	Total number of EDCD waiver members enrolled at the beginning of the reporting period.	Field Type: Numeric
F.	Total number of new EDCD waiver members enrolled during the reporting period.	Total number of new EDCD waiver members enrolled during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
G.	Total number of EDCD waiver members who transitioned to the Community.	Of the total reported in E and F, the number of EDCD waiver members who transitioned to the Community during the reporting period.	Field Type: Numeric  Note: Is a subset of the sum of E and F.
H.	Total number of EDCD waiver members who transitioned to a nursing facility.	Of the total reported in E and F, the number of EDCD waiver members who transitioned to a nursing facility during the reporting period.	Field Type: Numeric  Note: Is a subset of the sum of E and F.
I.	Total number of nursing facility members enrolled at the beginning of the reporting period.	Total number of nursing facility members enrolled at the beginning of the reporting period.	Field Type: Numeric
J.	Total number of new nursing facility members enrolled during the reporting period.	Total number of new nursing facility members enrolled during the reporting period.	Field Type: Numeric
K.	Total number of nursing facility members who transitioned to the Community.	Of the total reported in I and J, the number of nursing facility members who transitioned to the Community during the reporting period.	Field Type: Numeric  Note: Is a subset of the sum of I and J.
L.	Total number of nursing facility members who transitioned to EDCD waiver services.	Of the total reported in I and J, the number of nursing facility members who transitioned to EDCD waiver services during the reporting period.	Field Type: Numeric  Note: Is a subset of the sum of I and J.

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

- C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.
- Confirm those data elements listed above as subsets of other elements.
  - MMPs should validate that data elements C and D are less than or equal to the sum of data elements A and B.
  - MMPs should validate that data elements G and H are less than or equal to the sum of data elements E and F.
  - MMPs should validate that data elements K and L are less than or equal to the sum of data elements I and J.
  - All data elements should be positive values.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of:
- Community Well members enrolled at the beginning of the reporting period and new Community Well members enrolled during the reporting period who transitioned to EDCD waiver services during the reporting period.
  - Community Well members enrolled at the beginning of the reporting period and new Community Well members enrolled during the reporting period who transitioned to a nursing facility during the reporting period.
  - EDCD waiver members enrolled at the beginning of the reporting period and new EDCD waiver members enrolled during the reporting period who transitioned to the Community during the reporting period.
  - EDCD waiver members enrolled at the beginning of the reporting period and new EDCD waiver members enrolled during the reporting period who transitioned to a nursing facility during the reporting period.
  - Nursing facility members enrolled at the beginning of the reporting period and new nursing facility members enrolled during the reporting period who transitioned to the Community during the reporting period.
  - Nursing facility members enrolled at the beginning of the reporting period and new nursing facility members enrolled during the reporting period who transitioned to EDCD waiver services during the reporting period.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
  - Exclude institutional stays less than 20 days.
  - Exclude transitions that resulted in an admission or transfer to a hospital.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address:

<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

VA2.10 MMPs with established work plan and systems in place for ensuring smooth transition to and from hospitals, nursing facilities, and the Community.<sup>1</sup>

MMPs will use SNP 4: Care Transitions for this measure. MMPs should refer to pages 30-47 of the 2013 Special Needs Plans Structure & Process Measures for further detail on this measure:

[http://www.ncqa.org/Portals/0/Programs/SNP/2013\\_S&P\\_Measures\\_Final\\_2.6.14.pdf](http://www.ncqa.org/Portals/0/Programs/SNP/2013_S&P_Measures_Final_2.6.14.pdf)

VA2.11 Transitions (admissions and discharges) between hospitals, nursing facilities, and the Community.

<b>CONTINUOUS REPORTING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Periods</b>	<b>Due Date</b>
VA2. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the fourth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of member months during the reporting period.	Total number of member months during the reporting period.	Field Type: Numeric

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
B.	Total number of inpatient hospital discharges to nursing facilities.	Of the total reported in A, the number of inpatient hospital discharges to nursing facilities during the reporting period.	Field Type: Numeric
C.	Total number of inpatient hospital discharges to the Community.	Of the total reported in A, the number of inpatient hospital discharges to the Community during the reporting period.	Field Type: Numeric
D.	Total number of inpatient hospital admissions from the Community.	Of the total reported in A, the number of inpatient hospital admissions from the Community during the reporting period.	Field Type: Numeric
E.	Total number of nursing facility admissions from the Community.	Of the total reported in A, the number of nursing facility admissions from the Community during the reporting period.	Field Type: Numeric
F.	Total number of nursing facility discharges to the Community.	Of the total reported in A, the number of nursing facility discharges to the Community during the reporting period.	Field Type: Numeric
G.	Total number of inpatient hospital admissions from nursing facilities.	Of the total reported in A, the number of inpatient hospital admissions from nursing facilities during the reporting period.	Field Type: Numeric
H.	Total number of unplanned transitions.	Of the total reported in A, the number of unplanned transitions for members moving to and from the hospital during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
I.	Total number of planned transitions.	Of the total reported in A, the number of planned transitions for members moving to and from the hospital during the reporting period.	Field Type: Numeric
J.	Total number of transitions where the member's PCP was notified of the transition within 1 business day of the transition.	Of the sum of B, C, D, E, F, and G, the number of transitions where the member's PCP was notified of the transition within 1 business day of the transition during the reporting period.	Field Type: Numeric  Note: Is a subset of the sum of B, C, D, E, F, and G.
K.	Total number of discharges with documented participation in the discharge plan by the care coordinator and the member, or the member's representative.	Of the sum of B, C, and F, the number of discharges with documented participation in the discharge plan by the care coordinator and the member, or the member's representative during the reporting period.	Field Type: Numeric  Note: Is a subset of the sum of B, C, and F.

- B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will perform an outlier analysis.
  - As data are received from MMPs over time, CMS and the state will apply threshold checks.
- C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.
- MMPs should validate that data element J is less than or equal to the sum of data elements B, C, D, E, F, and G.
  - MMPs should validate that data element K is less than or equal to the sum of data elements B, C, and F.
  - All data elements should be positive values.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate:

- Inpatient hospital discharges to nursing facilities during the reporting period per 1,000 member months.
- Inpatient hospital discharges to the Community during the reporting period per 1,000 member months.
- Inpatient hospital admissions from the Community during the reporting period per 1,000 member months.
- Nursing facility admissions from the Community during the reporting period per 1,000 member months.
- Nursing facility discharges to the Community during the reporting period per 1,000 member months.
- Inpatient hospital admissions from nursing facilities during the reporting period per 1,000 member months.
- Unplanned transitions for members moving to and from the hospital during the reporting period per 1,000 member months.
- Planned transitions for members moving to and from the hospital during the reporting period per 1,000 member months.
- Percentage of transitions where the member's PCP was notified of the transition within 1 business day of the transition during the reporting period.
- Percentage of discharges with documented participation in the discharge plan by the care coordinator and the member, or the members representative during the reporting period.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- A transition is the movement (i.e., admission or discharge) of a member from one care setting to another as the member's health status changes; for example, moving from home to a hospital as the result of an exacerbation of a chronic condition or moving from the hospital to a rehabilitation facility after surgery.
- Inpatient hospital admissions and discharges are based on the CMS 2 midnight rule. The 2 midnight rule requires members to be admitted to the hospital for a minimum of 2 midnights to be considered an inpatient hospital admission. For further guidance on applying the 2 midnight rule, please review the FAQ posted on CMS' Web site:  
[http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/Questions\\_andAnswersRelatingtoPatientStatusReviewsforPosting\\_31214.pdf](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/Questions_andAnswersRelatingtoPatientStatusReviewsforPosting_31214.pdf)
- A planned transition is a scheduled transition, which includes scheduled procedures, elective surgery or a decision to enter a long-term care facility.
- An unplanned transition is an unscheduled transition, which includes an emergency leading to a hospital admission from the emergency department.

- The total number of transitions reported in data element J includes all transitions related to movement between the Community, hospital, and nursing facility.
- Data element K is limited to hospital and nursing facility discharges with documented participation in the discharge plan by the care coordinator and the member, or the member's representative.
- Exclude outpatient hospitalizations.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address:  
<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

**Section VAIII. Enrollee Protections**

VA3.1 The number of critical incident and abuse reports for members receiving LTSS.

<b>IMPLEMENTATION</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
VA3. Enrollee Protections	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
<b>ONGOING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Periods</b>	<b>Due Date</b>
VA3. Enrollee Protections	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of members receiving LTSS.	Total number of members receiving LTSS during the reporting period.	Field Type: Numeric
B.	Total number of critical incident and abuse reports.	Of the total reported in A, the number of critical incident and abuse reports during the reporting period.	Field Type: Numeric  Note: Is a subset of A.

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- All data elements should be positive values.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
- CMS and the state will evaluate the number of critical incident and abuse reports per 1,000 members receiving LTSS.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
  - It is possible for members to have more than one critical incident and/or abuse report during the reporting period. All critical incident and abuse reports during the reporting period should be counted.
  - Critical incident refers to any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a member.
  - Abuse refers to:
    1. Willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish;
    2. Knowing, reckless, or intentional acts or failures to act which cause injury or death to an individual or which places that individual at risk of injury or death;
    3. Rape or sexual assault;
    4. Corporal punishment or striking of an individual;
    5. Unauthorized use or the use of excessive force in the placement of bodily restraints on an individual; and
    6. Use of bodily or chemical restraints on an individual which is not in compliance with federal or state laws and administrative regulations.
- F. Data Submission – how MMPs will submit data collected to CMS and the state.
- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address:  
<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>
- VA3.2 Documentation of abuse, neglect, or exploitation and safety concerns or risk in the physical environment.
- Please note:** Details regarding reporting requirements associated with this measure are forthcoming.

## Section VAIV. Organizational Structure and Staffing

### VA4.1 Americans with Disabilities Act (ADA) compliance.

IMPLEMENTATION				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
VA4. Organizational Structure and Staffing	Semi-Annually	Contract	Ex: 1/1 – 6/30	By the end of the second month following the last day of the reporting period
ONGOING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
VA4. Organizational Structure and Staffing	Annually	Contract	Calendar Year	By the end of the second month following the last day of the reporting period

- A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	ADA Compliance Plan.	ADA Compliance Plan (including training activities).	Field Type: N/A Note: File will be uploaded to FTP site as a separate attachment.
B.	Identification of the Compliance or Quality Officer responsible for ADA compliance.	Identification of the Compliance or Quality Officer responsible for ADA compliance.	Field Type: N/A Note: File will be uploaded to FTP site as a separate attachment.

- B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- To be determined.
- C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.
- To be determined.

- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
- To be determined.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should refer to VA’s three-way contract for specific requirements pertaining to ADA requirements and compliance.
- F. Data Submission – how MMPs will submit data collected to CMS and the state.
- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address:  
<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>
  - For data submission, each data element above should be uploaded as a separate attachment.
  - Required File Format is Microsoft Word File.
  - The file name extension should be “.docx”
  - File name= VA\_(CONTRACTID)\_(REPORTING PERIOD)\_(SUBMISSIONDATE)\_(ELEMENTNAME).docx.
  - Replace (CONTRACTID) with the contract ID, (REPORTINGPERIOD) with the year and month of the beginning of the reporting period in YYYYMM format (e.g., February 2014 would be 201402), (SUBMISSIONDATE) with the year, month, and date of the submission in YYYYMMDD format (e.g., March 31, 2014 would be 20140331), and (ELEMENTNAME) with the element name listed below.
  - For element letter “A”, the (ELEMENTNAME) should be (PLAN).
  - For element letter “B”, the (ELEMENTNAME) should be (OFFICER).

VA4.2 Care coordinator training for supporting self-direction under the demonstration.

<b>IMPLEMENTATION</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
VA4. Organizational Structure and Staffing	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the first month following the last day of the reporting period
<b>ONGOING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
VA4. Organizational Structure and Staffing	Annually	Contract	Calendar Year	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of FTE care coordinators.	Total number of FTE care coordinators in the MMP during the reporting period.	Field Type: Numeric
B.	Total number of FTE care coordinators that have undergone training for supporting self-direction under the demonstration.	Of the total reported in A, the number of FTE care coordinators that have undergone training for supporting self-direction under the demonstration.	Field Type: Numeric  Note: Is a subset of A.

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

- C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.
- Confirm those data elements listed above as subsets of other elements.
  - MMPs should validate that data element B is less than or equal to data element A.
  - All data elements should be positive values.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
- CMS and the state will evaluate the percentage of FTE care coordinators that have undergone training for supporting self-direction.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should refer to VA’s three-way contract for specific requirements pertaining to a care coordinator.
  - MMPs should refer to VA’s three-way contract for specific requirements pertaining to training for supporting self-direction.
  - A care coordinator includes all full-time and part-time staff.
  - FTE is full time equivalent. FTE is based on the average number of hours worked per week. For example, a care coordinator who works an average of 35 hours a week counts as one FTE. A care coordinator who works an average of 17.5 hours a week counts as half an FTE.
- F. Data Submission – how MMPs will submit data collected to CMS and the state.
- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address:  
<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

## VA4.3 Licensure/certification requirements for new EDCD waiver providers.

<b>CONTINUOUS REPORTING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Periods</b>	<b>Due Date</b>
VA4. Organizational Structure and Staffing	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of new EDCD waiver providers who obtained the appropriate licensure/certification requirements.	Total number of new EDCD waiver providers enrolled during the reporting period who obtained the appropriate licensure/certification requirements.	Field Type: Numeric
B.	Total number of new EDCD waiver providers who obtained the appropriate licensure/certifications prior to service provision.	Of the total reported in A, the number of new EDCD waiver providers who obtained the appropriate licensure/certifications prior to service provision.	Field Type: Numeric  Note: Is a subset of A.

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

- C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.
- Confirm those data elements listed above as subsets of other elements.
  - MMPs should validate that data element B is less than or equal to data element A.
  - All data elements should be positive values.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
- CMS and the state will evaluate the percentage of new EDCD waiver providers enrolled during the reporting period who obtained the appropriate licensure/certifications prior to service provision.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should refer to Chapter 2 of the Elderly or Disabled with Consumer Directed Services Provider Manual to identify waiver provider qualifications. This manual can be accessed via the following web address:  
<https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>
  - EDCD waiver providers that require licensure/certification include Adult Day Health Care providers, etc.
  - “Prior to service provision” means before the EDCD waiver provider provides services to any member enrolled in the demonstration.
- F. Data Submission – how MMPs will submit data collected to CMS and the state.
- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address:  
<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

VA4.4 Continuing licensure/certification requirements for EDCD waiver providers.

<b>CONTINUOUS REPORTING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Periods</b>	<b>Due Date</b>
VA4. Organizational Structure and Staffing	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of licensed/certified EDCD waiver providers.	Total number of licensed/certified EDCD waiver providers in the MMP during the reporting period.	Field Type: Numeric
B.	Total number of licensed/certified EDCD waiver providers that continued to meet applicable licensure/certification requirements following initial enrollment.	Of the total reported in A, the number of licensed/certified EDCD waiver providers that continued to meet applicable licensure/certification requirements following initial enrollment.	Field Type: Numeric Note: Is a subset of A.

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

- C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.
- Confirm those data elements listed above as subsets of other elements.
  - MMPs should validate that data element B is less than or equal to data element A.
  - All data elements should be positive values.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
- CMS and the state will evaluate the percentage of licensed/certified EDCD waiver providers that continued to meet applicable licensure/certification requirements following initial enrollment.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should refer to Chapter 2 of the Elderly or Disabled with Consumer Directed Services Provider Manual to identify waiver provider qualifications. This manual can be accessed via the following web address:  
<https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>
  - EDCD waiver providers that require licensure/certification include Adult Day Health Care providers, etc.
- F. Data Submission – how MMPs will submit data collected to CMS and the state.
- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address:  
<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

VA4.5 Non-licensed/non-certified EDCD waiver provider enrollment.

<b>CONTINUOUS REPORTING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Periods</b>	<b>Due Date</b>
VA4. Organizational Structure and Staffing	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

- A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of new non-licensed/non-certified EDCD waiver provider enrollments.	Total number of new non-licensed/non-certified EDCD waiver provider enrollments during the reporting period.	Field Type: Numeric
B.	Total number of new non-licensed/non-certified EDCD waiver provider enrollments that met EDCD waiver provider qualifications.	Of the total reported in A, the number of new non-licensed/non-certified EDCD waiver provider enrollments that met EDCD waiver provider qualifications.	Field Type: Numeric Note: Is a subset of A.

- B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will perform an outlier analysis.
  - As data are received from MMPs over time, CMS and the state will apply threshold checks.
- C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.
- Confirm those data elements listed above as subsets of other elements.
  - MMPs should validate that data element B is less than or equal to data element A.
  - All data elements should be positive values.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
- CMS and the state will evaluate the percentage of new non-licensed/non-certified EDCD waiver provider enrollments during the reporting period that met EDCD waiver provider qualifications.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should refer to Chapter 2 of the Elderly or Disabled with Consumer Directed Services Provider Manual to identify waiver provider qualifications. This manual can be accessed via the following web address:

<https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>

- Non-licensed/non-certified EDCD waiver providers include Personal Emergency Response System providers, Transition Coordinators, etc.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address:

<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

VA4.6 EDCD waiver provider agency direct support staff with criminal background checks.

**Please note:** Details regarding reporting requirements associated with this measure are forthcoming.

VA4.7 EDCD waiver provider staff training requirements.

**Please note:** Details regarding reporting requirements associated with this measure are forthcoming.

VA4.8 Consumer-directed employees who are trained.

**Please note:** Details regarding reporting requirements associated with this measure are forthcoming.

### Section VAV. Performance and Quality Improvement

VA5.1 Members with Severe Mental Illness (SMI) receiving primary care services.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
VA5. Performance and Quality Improvement	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

- A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members with an SMI diagnosis.	Total number of members who were continuously enrolled in the MMP during the reporting period with an SMI diagnosis during the reporting period.	Field Type: Numeric
B.	Total number of members with an SMI diagnosis who received primary care services.	Of the total reported in A, the number of members with an SMI diagnosis who received primary care services during the reporting period.	Field Type: Numeric Note: Is a subset of A.

- B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will perform an outlier analysis.
  - As data are received from MMPs over time, CMS and the state will apply threshold checks.

- C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.
- Confirm those data elements listed above as subsets of other elements.
  - MMPs should validate that data element B is less than or equal to data element A.
  - All data elements should be positive values.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
- CMS and the state will evaluate the percentage of members with an SMI diagnosis during the reporting period who received primary care services during the reporting period.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
  - During CY1, members must be continuously enrolled in the MMP for six months during the reporting period, with no gaps in enrollment, to be included in this measure.
  - Beginning CY2, members must be continuously enrolled in the MMP for 11 out of 12 months during the reporting period to be included in this measure.
  - Codes to identify mental illness diagnosis are provided in Table VA-4. Members with a principal diagnosis code of severe mental illness should be included in this measure.
  - Codes to identify primary care services are provided in Table VA-5.

**Table VA-4: Codes to Identify Severe Mental Illness Diagnosis**

ICD-9-CM Diagnosis
295–299

**Table VA-5: Codes to Identify Ambulatory Health Services**

Description	CPT	HCPCS	ICD-9-CM Diagnosis	UB Revenue
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245			051x, 0520-0523, 0526-0529, 0982, 0983
Home services	99341-99345, 99347-99350			
Nursing facility care	99304-99310, 99315, 99316, 99318			0524, 0525

<b>Table VA-5: Codes to Identify Ambulatory Health Services</b>				
<b>Description</b>	<b>CPT</b>	<b>HCPCS</b>	<b>ICD-9-CM Diagnosis</b>	<b>UB Revenue</b>
Domiciliary, rest home or custodial care services	99324-99328, 99334-99337			
Preventive medicine	99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429	G0344, G0402, G0438, G0439		
Ophthalmology and optometry	92002, 92004, 92012, 92014	S0620, S0621		
General medical examination			V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address:

<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

VA5.2 Recovery-oriented measures for persons with Severe Mental Illness (SMI) receiving mental health services.

<b>CONTINUOUS REPORTING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
VA5. Performance and Quality Improvement	Semi-Annually (after initial 9 months)	Contract	Ex: 1/1 – 6/30	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members 21-65 years of age diagnosed with SMI who were admitted to the CSB Mental Health Services Program.	Total number of members 21-65 years of age who were continuously enrolled for six months during the reporting period, diagnosed with SMI, who were admitted to the CSB Mental Health Services Program during the 12 months prior to the last day of the reporting period.	Field Type: Numeric
B.	Total number of members who had at least one mental health case management service of any duration.	Of the total reported in A, the number of members who had at least one mental health case management service of any duration during the 12 months prior to the last day of the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members who were employed full- or part-time or received individual or group supported employment at any point during the 12 months prior to the last day of the reporting period.	Of the total reported in B, the number of members who were employed full- or part-time or received individual or group supported employment at any point during the 12 months prior to the last day of the reporting period.	Field Type: Numeric Note: Is a subset of B.

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of members diagnosed with SMI who were admitted to the CSB Mental Health Services Program.	Total number of members who were continuously enrolled for six months during the reporting period, diagnosed with SMI, who were admitted to the CSB Mental Health Services Program during the 12 months prior to the last day of the reporting period.	Field Type: Numeric
E.	Total number of members who received one hour of case management services within 30 days of admission to the CSB Mental Health Services Program.	Of the total reported in D, the number of members who received one hour of case management services within 30 days of admission to the CSB Mental Health Services Program.	Field Type: Numeric Note: Is a subset of D.
F.	Total number of members who received at least five additional hours of mental health case management services within 90 days of admission to the CSB Mental Health Services Program.	Of the total reported in E, the number of members who received at least five additional hours of mental health case management services within 90 days of admission to the CSB Mental Health Services Program.	Field Type: Numeric Note: Is a subset of E.

- B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will perform an outlier analysis.
  - As data are received from MMPs over time, CMS and the state will apply threshold checks.
- C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.
- Confirm those data elements listed above as subsets of other elements.

- MMPs should validate that data element B is less than or equal to data element A.
- MMPs should validate that data element C is less than or equal to data element B.
- MMPs should validate that data element E is less than or equal to data element D.
- MMPs should validate that data element F is less than or equal to data element E.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

CMS and the state will evaluate the percentage of members age 21-65 years of age diagnosed with SMI who were admitted to the CSB Mental Health Services Program during the 12 months prior to the last day of the reporting period who:

- Had at least one mental health case management service of any duration during the 12 months prior to the last day of the reporting period.
- Who were employed full- or part-time or received individual or group supported employment at any point during the 12 months prior to the last day of the reporting period.

CMS and the state will evaluate the percentage of members diagnosed with SMI who were admitted to the CSB Mental Health Services Program during the 12 months prior to the last day of the reporting period who:

- Who received one hour of case management services within 30 days of admission to the CSB Mental Health Services Program.
- Who received one hour of case management services within 30 days of admission to the CSB Mental Health Services Program who received at least five additional hours of mental health case management services within 90 days of admission to the CSB Mental Health Services Program.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- CSB refers to community service boards. CSBs are the point of entry into the publicly-funded system of mental health, intellectual disability, and substance abuse services.
- Employed Full Time: Employed 35 hours a week or more; includes Armed Forces. This does not include individuals receiving supported or sheltered employment (sheltered employment are programs that provide work in a non-integrated setting that is

compensated in accordance with the Fair Labor Standards Act for individuals with disabilities who are not ready, are unable, or choose not to enter into competitive employment in an integrated setting).

- Employed Part Time: Employed less than 35 hours a week. This does not include an individual receiving supported or sheltered employment.
- Supported Employment: Services especially for individuals with development disabilities facing severe impediments to employment due to the nature and complexity of their disabilities, irrespective of age or vocational potential to enable them to work in settings in which persons without disabilities are typically employed. The two models are individual supported employment and group supported employment:
  - i. Individual supported employment is defined as intermittent support, usually provided one-on-one by a job coach to an individual in a supported employment position who, during most of the time on the job site, performs independently.
- Group supported employment is defined as continuous support provided by staff to eight or fewer individuals with disabilities in an Enclave, Work Crew, and Entrepreneurial model or Benchwork model.
- Include members who were employed full- or part-time or received individual or group supported employment for any length of time during the reporting period.
- For data element E, members must be enrolled from the day of admission to the CSB Mental Health Services Program through 30 days following admission to the CSB Mental Health Services Program, with no gaps in enrollment.
- For data element E, the date of admission must occur within the reporting period, but the receipt of case management services may not be in the same reporting period. For example, if a member is admitted during the last month of the reporting period, look to the first month of the following reporting period to identify the receipt of case management services.
- For data element F, members must be enrolled from the day of admission to the CSB Mental Health Services Program through 90 days following admission to the CSB Mental Health Services Program, with no gaps in enrollment.
- For data element F, the date of admission must occur within the reporting period, but the receipt of case management services may not be in the same reporting period. For example, if a member is admitted during the last month of the reporting period, look to the third month of the following reporting period to identify the receipt of case management services.

- Codes to identify mental illness diagnosis are provided in Table VA-6. Members with a principal diagnosis code of severe mental illness should be included in this measure.
- MMPs should refer to the Community Mental Health Rehabilitation Services Provider Manual for more information regarding CSBs. This manual can be accessed via the following web address: <https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>
- The first reporting period for this measure will begin on January 1, 2015 to allow for a look-back period of adequate length and to align semi-annual reporting with the calendar year.

<b>Table VA-6: Codes to Identify Severe Mental Illness Diagnosis</b>	
<b>ICD-9-CM Diagnosis</b>	
295–299	

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: <https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

VA5.3 Adjudicated clean claims.<sup>i</sup>

<b>CONTINUOUS REPORTING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Periods</b>	<b>Due Date</b>
VA5. Performance and Quality Improvement	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of adjudicated clean claims.	Total number of adjudicated clean claims during the reporting period.	Field Type: Numeric
B.	Total number of adjudicated clean claims for EDCD covered services.	Of the total reported in A, the number of adjudicated clean claims for EDCD covered services during the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of adjudicated clean claims for EDCD covered services paid using the correct rate within 14 days of receipt.	Of the total reported in B, the number of adjudicated clean claims for EDCD covered services paid using the correct rate within 14 days of receipt.	Field Type: Numeric Note: Is a subset of B.
D.	Total number of adjudicated clean claims for EDCD covered services paid using the correct rate within 30 days of receipt.	Of the total reported in B, the number of adjudicated clean claims for EDCD covered services paid using the correct rate within 30 days of receipt.	Field Type: Numeric Note: Is a subset of B.
E.	Total number of adjudicated clean claims for nursing facility covered services.	Of the total reported in A, the number of adjudicated clean claims for nursing facility covered services during the reporting period.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
F.	Total number of adjudicated clean claims for nursing facility covered services paid using the correct rate within 14 days of receipt.	Of the total reported in E, the number of adjudicated clean claims for nursing facility covered services paid using the correct rate within 14 days of receipt.	Field Type: Numeric  Note: Is a subset of E.
G.	Total number of adjudicated clean claims for nursing facility covered services paid using the correct rate within 30 days of receipt.	Of the total reported in E, the number of adjudicated clean claims for nursing facility covered services paid using the correct rate within 30 days of receipt.	Field Type: Numeric  Note: Is a subset of E.
H.	Total number of adjudicated clean claims for other traditional Medicaid covered services.	Of the total reported in A, the number of adjudicated clean claims for other traditional Medicaid covered services during the reporting period.	Field Type: Numeric  Note: Is a subset of A.  Exclude EDCD and nursing facility claims.
I.	Total number of adjudicated clean claims for other traditional Medicaid covered services paid using the correct rate within 14 days of receipt.	Of the total reported in H, the number of adjudicated clean claims for other traditional Medicaid covered services paid using the correct rate within 14 days of receipt.	Field Type: Numeric  Note: Is a subset of H.  Exclude EDCD and nursing facility claims.
J	Total number of adjudicated clean claims for other traditional Medicaid covered services paid using the correct rate within 30 days of receipt.	Of the total reported in H, the number of adjudicated clean claims for other traditional Medicaid covered services paid using the correct rate within 30 days of receipt.	Field Type: Numeric  Note: Is a subset of H.  Exclude EDCD and nursing facility claims.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
K.	Total number of adjudicated clean claims for physicians during the reporting period.	Of the total reported in A, the number of adjudicated clean claims for physicians during the reporting period.	Field Type: Numeric Note: Is a subset of A.
L.	Total number of adjudicated clean claims for physicians paid using the correct rate within 30 days of receipt.	Of the total reported in K, the number of adjudicated clean claims for physicians paid using the correct rate within 30 days of receipt.	Field Type: Numeric Note: Is a subset of K.
M.	Total number of adjudicated clean claims for physicians paid using the correct rate within 90 days of receipt.	Of the total reported in K, the number of adjudicated clean claims for physicians paid using the correct rate within 90 days of receipt.	Field Type: Numeric Note: Is a subset of K.
N.	Total number of adjudicated clean electronic claims for pharmacy during the reporting period.	Of the total reported in A, the number of adjudicated clean electronic claims for pharmacy during the reporting period.	Field Type: Numeric Note: Is a subset of A.
O.	Total number of adjudicated clean electronic claims for pharmacy paid using the correct rate within 14 days of receipt.	Of the total reported in N, the number of adjudicated clean electronic claims for pharmacy paid using the correct rate within 14 days of receipt.	Field Type: Numeric Note: Is a subset of N.
P.	Total number of adjudicated clean paper claims for pharmacy during the reporting period.	Of the total reported in A, the number of adjudicated clean paper claims for pharmacy during the reporting period.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
Q.	Total number of adjudicated clean paper claims for pharmacy paid using the correct rate within 30 days of receipt.	Of the total reported in P, the number of adjudicated clean paper claims for pharmacy paid using the correct rate within 30 days of receipt.	Field Type: Numeric  Note: Is a subset of P.

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- Guidance will be forthcoming on the established threshold for this measure.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data elements B, E, H, K, N, and P are less than or equal to data element A.
- MMPs should validate that data elements C and D are less than or equal to data element B.
- MMPs should validate that data elements F and G are less than or equal to data element E.
- MMPs should validate that data element I and J are less than or equal to data element H.
- MMPs should validate that data elements L and M are less than or equal to data element K.
- MMPs should validate that data element O is less than or equal to data element N.
- MMPs should validate that data element Q is less than or equal to data element P.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of:

- Adjudicated clean claims for EDCD covered services that were paid using the correct rate within 14 days of receipt.
- Adjudicated clean claims for EDCD covered services that were paid using the correct rate within 30 days of receipt.
- Adjudicated clean claims for nursing facility covered services that were paid using the correct rate within 14 days of receipt.
- Adjudicated clean claims for nursing facility covered services that were paid using the correct rate within 30 days of receipt.

- Adjudicated clean claims for other traditional Medicaid covered services that were paid using the correct rate within 14 days of receipt.
- Adjudicated clean claims for other traditional Medicaid covered services that were paid using the correct rate within 30 days of receipt.
- Adjudicated clean claims for physicians that were paid using the correct rate within 30 days of receipt.
- Adjudicated clean claims for physicians that were paid using the correct rate within 90 days of receipt.
- Adjudicated clean electronic claims for pharmacy that were paid using the correct rate within 14 days of receipt.
- Adjudicated clean paper claims for pharmacy that were paid using the correct rate within 30 days of receipt.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should refer to Chapter 5 of the Provider Manual to identify adjudicated claim requirements. This manual can be accessed via the following web address:  
<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>
- Clean claims include claims with errors originating from the Contractor's claims systems, but do not include claims from a provider who is under investigation for fraud or abuse, or claims under review for Medical Necessity.
- Please refer to page 171 of the VA three-way contract for more information regarding timely provider payments.
- Other traditional Medicaid covered services include LTSS outside of EDCD waiver and NF services, community behavioral health services, etc.
- Exclude nursing facilities, EDCD services, and LTC pharmacies within a nursing facility from other traditional Medicaid covered services.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address:  
<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

**Section VAVI. Systems**

## VA6.1 Plan Enrollee Medical Record.

<b>IMPLEMENTATION</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
VA6. Systems	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
<b>ONGOING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
VA6. Systems	Semi-Annually	Contract	Ex: 1/1 – 6/30	By the end of the second month following the last day of the reporting period

- A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Number of members whose race data are collected and maintained in the Plan Enrollee Medical Record.	Number of members enrolled at the end of the reporting period whose race data are collected and maintained in the Plan Enrollee Medical Record.	Field Type: Numeric
B.	Number of members whose ethnicity data are collected and maintained in the Plan Enrollee Medical Record.	Number of members enrolled at the end of the reporting period whose ethnicity data are collected and maintained in the Plan Enrollee Medical Record.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
C.	Number of members whose primary language data are collected and maintained in the Plan Enrollee Medical Record.	Number of members enrolled at the end of the reporting period whose primary language data are collected and maintained in the Plan Enrollee Medical Record.	Field Type: Numeric
D.	Number of members whose homelessness data are collected and maintained in the Plan Enrollee Medical Record.	Number of members enrolled at the end of the reporting period whose homelessness data are collected and maintained in the Plan Enrollee Medical Record.	Field Type: Numeric
E.	Number of members whose disability type data are collected and maintained in the Plan Enrollee Medical Record.	Number of members enrolled at the end of the reporting period whose disability type data are collected and maintained in the Plan Enrollee Medical Record.	Field Type: Numeric

- B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will perform an outlier analysis.
  - As data are received from MMPs over time, CMS and the state will apply threshold checks.
- C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.
- All data elements should be positive values.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
- CMS and the state will obtain enrollment information from CMS' Web site and will evaluate the percentage of members whose:
    - Race data are collected and maintained in the Plan Enrollee Medical Record.
    - Ethnicity data are collected and maintained in the Plan Enrollee Medical Record.

- Primary language data are collected and maintained in the Plan Enrollee Medical Record.
- Homelessness data are collected and maintained in the Plan Enrollee Medical Record.
- Disability type data are collected and maintained in the Plan Enrollee Medical Record.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- For all data elements, please include the total number of members whose status is document in the Plan Enrollee Medical Record, regardless of the value.
  - i. For example, data element D captures the number of members whose homelessness data are collected and maintained in the Plan Enrollee Medical Record. MMPs should report the total number of members who have this information documented, even if the member is not homeless. The number reported should not simply represent the number of documented homeless members.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address:  
<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

**Section VAVII. Utilization**

VA7.1 EDCD waiver members who used consumer-directed services.

<b>IMPLEMENTATION</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
VA7. Utilization	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the first month following the last day of the reporting period
<b>ONGOING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Periods</b>	<b>Due Date</b>
VA7. Utilization	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of members who are covered under an EDCD waiver.	Total number of members who are covered under an EDCD waiver during the reporting period.	Field Type: Numeric
B.	Total number of EDCD waiver members who used consumer-directed services.	Of the total reported in A, the number of EDCD waiver members who used consumer-directed services during the reporting period.	Field Type: Numeric  Note: Is a subset of A.

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

- C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.
- Confirm those data elements listed above as subsets of other elements.
  - MMPs should validate that data element B is less than or equal to data element A.
  - All data elements should be positive values.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
- CMS and the state will evaluate the percentage of EDCD waiver members who used consumer-directed services during the reporting period.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should include all EDCD waiver members regardless of whether the waiver member was enrolled through passive enrollment or opt-in enrollment.
  - Consumer-directed services are support services that are necessary to enable an individual to remain at or return home rather than enter an institution. Services may include assistance with bathing, dressing, toileting, transferring, and nutritional support necessary for consumers to remain in their own homes or in the community. Services can also include supervision, respite, and companion services.
- F. Data Submission – how MMPs will submit data collected to CMS and the state.
- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address:  
<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

VA7.2 EDCD waiver members who experienced an increase or decrease in authorized personal care hours or respite care hours.

<b>CONTINUOUS REPORTING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Periods</b>	<b>Due Date</b>
VA7. Utilization	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of members who were covered under an EDCD waiver.	Total number of members who were continuously enrolled in the MMP during the reporting period who were covered under an EDCD waiver for the entire reporting period.	Field Type: Numeric
B.	Total number of EDCD waiver members whose authorized personal care hours decreased.	Of the total reported in A, the number of EDCD waiver members whose authorized personal care hours decreased during the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of EDCD waiver members whose authorized personal care hours increased.	Of the total reported in A, the number of EDCD waiver members whose authorized personal care hours increased during the reporting period.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of EDCD waiver members whose authorized respite care hours decreased.	Of the total reported in A, the number of EDCD waiver members whose authorized respite care hours decreased during the reporting period.	Field Type: Numeric Note: Is a subset of A.
E.	Total number of EDCD waiver members whose authorized respite care hours increased.	Of the total reported in A, the number of EDCD waiver members whose authorized respite care hours increased during the reporting period.	Field Type: Numeric Note: Is a subset of A.

- B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will perform an outlier analysis.
  - As data are received from MMPs over time, CMS and the state will apply threshold checks.
- C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.
- Confirm those data elements listed above as subsets of other elements.
  - MMPs should validate that data elements B, C, D, and E are less than or equal to data element A.
  - All data elements should be positive values.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of EDCD waiver members whose authorized:
- Personal care hours decreased during the reporting period.
  - Personal care hours increased during the reporting period.
  - Respite care hours decreased during the reporting period.
  - Respite care hours increased during the reporting period.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should include all EDCD waiver members regardless of whether the waiver member was enrolled through passive enrollment or opt-in enrollment.
  - The EDCD waiver member must be continuously enrolled in the MMP during the reporting period, with no gaps in enrollment.
  - Personal care services means long-term maintenance or support services necessary to enable the individual to remain at or return home rather than enter a nursing facility. Personal care services

are provided to individuals in the areas of activities of daily living, access to the community, monitoring of self-administered medications or other medical needs, and the monitoring of health status and physical condition. Where the individual requires assistance with activities of daily living, and where specified in the plan of care, such supportive services may include assistance with instrumental activities of daily living. Services may be provided in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities.

- Respite care services means those short-term personal care services provided to individuals who are unable to care for themselves because of the absence of or need for the relief of the unpaid caregiver who normally provides the care.
- Authorized hours are service hours authorized by a county social worker. The social worker will assess the types of services the member needs and the number of hours the county will authorize for each of these services.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address:

<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

VA7.3 Unduplicated members receiving HCBS and unduplicated members receiving nursing facility services.

<b>CONTINUOUS REPORTING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
VA7. Utilization	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of members.	Total number of members who were continuously enrolled in the MMP for six months during the reporting period.	Field Type: Numeric
B.	Total number of members receiving HCBS.	Of the total reported in A, the number of members receiving HCBS during the reporting period who did not receive nursing facility services during the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members receiving nursing facility services.	Of the total reported in A, the number of members receiving nursing facility services during the reporting period who did not receive HCBS during the reporting period.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of members receiving both HCBS and nursing facility services during the reporting period.	Of the total reported in A, the number of members receiving both HCBS and nursing facility services during the reporting period.	Field Type: Numeric Note: Is a subset of A.

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

- C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.
- Confirm those data elements listed above as subsets of other elements.
  - MMPs should validate that data elements B, C, and D are less than or equal to data element A.
  - All data elements should be positive values.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
- CMS and the state will obtain enrollment data from CMS' Web site and will evaluate the percentage of members receiving:
    - HCBS during the reporting period who did not receive nursing facility services during the reporting period.
    - Nursing facility services during the reporting period who did not receive HCBS during the reporting period.
    - Both HCBS and nursing facility services during the reporting period.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
  - Members receiving HCBS should only be counted for data element B (unduplicated). Members receiving nursing facility services should only be counted for data element C (unduplicated). Members receiving both HCBS and nursing facility services should only be counted for data element D (unduplicated). Data elements B, C, and D are mutually exclusive.
  - Unduplicated means a member should only be counted once for the type of service they receive. For example, if a member received nursing facility services in two different facilities during the reporting period, they would only count once towards members receiving nursing facility services during the reporting period (data element C).
  - Include members who were receiving HCBS or nursing facility services for any length of time during the reporting period.
  - HCBS refers to Home and Community Based Services.
- F. Data Submission – how MMPs will submit data collected to CMS and the state.
- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address:  
<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

## VA7.4 Average length of receipt in HCBS.

<b>CONTINUOUS REPORTING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
VA7. Utilization	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of members receiving HCBS.	Total number of members receiving HCBS during the reporting period.	Field Type: Numeric
B.	Total number of days members were enrolled in HCBS.	Of the total reported in A, the number of days members were enrolled in HCBS during the reporting period.	Field Type: Numeric

B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the number of days members were enrolled in HCBS during the reporting period.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- HCBS refers to Home and Community Based Services.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address:

<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>