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

Effective as of January 1, 2016, Issued January 6, 2016

Table of Contents

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 Model: 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®[1], HOS, and state-required network provider and member satisfaction, HCBS Satisfaction, and quality of life surveys. 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.

MMPs should contact the VA Help Desk at VAHelpDesk@norc.org with any questions about the Virginia state-specific appendix or the data submission process.

Definitions

Calendar Quarter: Most 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.

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

Year Start to End of the Quarter: Some quarterly measures are reported for the calendar year to the end of the reporting quarter. For calendar year 2016, these Year Start to End of the Quarter periods are: January 1, 2016 to March 31, 2016; January 1, 2016 to June 30, 2016; January 1, 2016 to September 30, 2016; and January 1, 2016 to December 31, 2016.

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

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.

Variations from the Core Reporting Requirements Document

Core Measure 9.2 – Nursing Facility (NF) Diversion

The following section provides additional guidance about identifying individuals enrolled in the MMP as “nursing home certifiable,” or meeting the nursing facility level of care (NF LOC), for the purposes of reporting Core 9.2.

Within Core 9.2, “nursing home certifiable” members are defined as “members living in the community, but requiring an institutional level of care” (see the Core Reporting Requirements). Virginia MMPs should use the Virginia Uniform Assessment Instrument (UAI) results, supplemented by claims, enrollment data, and medical transition reports, to categorize members as nursing home certifiable.

Individuals meeting nursing facility eligibility criteria, including both medical needs and functional capacity needs as stated on the UAI, should be considered nursing home certifiable. MMPs should use the following non-exclusive sources of data to supplement and confirm this information. Specifically:

- The Medical Transition Report (MTR) provided to MMPs by the state, which identifies waiver members by a single digit waiver code of 9 and

nursing home residents by a single digit waiver code of 1 or 2 under the column “Exception Indicator/Waiver Indicator” within the CCC MTR Waiver File. All waiver members and nursing home residents can be categorized as nursing home certifiable provided they meet nursing facility eligibility criteria during the Core 9.2 previous reporting period and all other criteria for this measure element.

- Claims data or rate cells to identify individuals using nursing home services or waiver services.

Quality Withhold Measures

CMS and the state will establish a set of quality withhold measures, and MMPs will be required to meet established thresholds. Throughout this document, state-specific quality withhold measures are marked with the following symbol for Demonstration Year 1: ([i]) and the following symbol for Demonstration Years 2 and 3: ([ii]). For more information about the state-specific quality withhold measures for Demonstration Year 1, refer to the Quality Withhold Technical Notes (DY 1): Virginia Specific Measures at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html. Additional information on the withhold methodology and benchmarks for Demonstration Years 2 and 3 will be provided at a later time.

Reporting on Disenrolled and Retro-disenrolled Members

Unless otherwise indicated in the reporting requirements, MMPs should report on all members enrolled in the demonstration who meet the definition of the data elements, regardless of whether that member was subsequently disenrolled from the MMP. Measure-specific guidance on how to report on disenrolled members is provided under the Notes section of each state-specific measure.

Due to retro-disenrollment of members, there may be instances where there is a lag between a member’s effective disenrollment date and the date on which the MMP is informed about that disenrollment. This time lag might create occasional data inaccuracies if an MMP includes members in reports who had in fact disenrolled before the start of the reporting period. If MMPs are aware at the time of reporting that a member has been retro-disenrolled with a disenrollment effective date prior to the reporting period (and therefore was not enrolled during the reporting period in question), then MMPs may exclude that member from reporting. Please note that MMPs are ***not*** required to re-submit corrected data should you be informed of a retro-disenrollment subsequent to a reporting deadline. MMPs should act upon their best and most current knowledge at the time of reporting regarding each member’s enrollment status.

Guidance on Assessments and Care Plans for Members with a Break in Coverage

Health Risk Assessments

If an MMP already completed a Health Risk Assessment (HRA) for a member that was previously enrolled, the MMP is not necessarily required to conduct a new HRA if the member rejoins the same MMP within one year of his/her most recent HRA. Instead, the MMP can:

1. Perform any risk stratification, claims data review, or other analyses as required by the three-way contract to detect any changes in the member's condition since the HRA was conducted; and

2. Ask the member (or his/her authorized representative) if there has been a change in the member's health status or needs since the HRA was conducted.

The MMP must document any risk stratification, claims data review, or other analyses that are performed to detect any changes in the member's condition. The MMP must also document its outreach attempts and the discussion(s) with the member (or his/her authorized representative) to determine if there was a change in the member's health status or needs.

If a change is identified, the MMP must conduct a new HRA within the timeframe prescribed by the contract. If there are no changes, the MMP is not required to conduct a new HRA unless requested by the member (or his/her authorized representative). Please note, if the MMP prefers to conduct HRAs on all re-enrollees regardless of status, it may continue to do so.

Once the MMP has conducted a new HRA as needed or confirmed that the prior HRA is still accurate, the MMP can mark the HRA as complete for the member's current enrollment. The MMP would then report that completion according to the specifications for Core 2.1 and Core 2.2 (and all applicable state-specific measures). When reporting these measures, the MMP should count the number of enrollment days from the member's most recent enrollment effective date, and should report the HRA based on the date the prior HRA was either confirmed to be accurate or a new HRA was completed.

If the MMP is unable to reach a re-enrolled member to determine if there was a change in health status, then the MMP may report that member as unable to be reached so long as the MMP made the requisite number of outreach attempts. If a re-enrolled member refuses to discuss his/her health status with the MMP, then the MMP may report that member as unwilling to participate in the HRA.

If the MMP did not complete a HRA for the re-enrolled member during his/her prior enrollment period, or if it has been more than one year since the member's HRA was completed, the MMP is required to conduct a HRA for the member within the timeframe prescribed by the contract. The MMP must make the

requisite number of attempts to reach the member (at minimum) after his/her most recent enrollment effective date, even if the MMP reported that the member was unable to be reached during his/her prior enrollment. Similarly, members that refused the HRA during their prior enrollment must be asked again to participate (i.e., the MMP may not carry over a refusal from one enrollment period to the next).

Plans of Care

If the MMP conducts a new HRA for the re-enrolled member, the MMP must revise the Plan of Care (POC) accordingly within the timeframe prescribed by the contract. Once the POC is revised, the MMP may mark the POC as complete for the member's current enrollment. If the MMP determines that the prior HRA is still accurate and therefore no updates are required to the previously completed POC, the MMP may mark the POC as complete for the current enrollment at the same time that the HRA is marked complete. The MMP would then follow the applicable state-specific measure specifications for reporting the completion. Please note, for purposes of reporting, the POC for the re-enrolled member should be classified as an *initial* POC.

If the MMP did not complete a POC for the re-enrolled member during his/her prior enrollment period, or if it has been more than one year since the member's POC was completed, the MMP is required to complete a POC for the member within the timeframe prescribed by the contract. The MMP must also follow the above guidance regarding reaching out to members that previously refused to participate or were not reached.

Annual Reassessments and POC Updates

The MMP must follow contract requirements regarding the completion of annual reassessments and updates to POCs. If the MMP determined that a HRA/POC from a member's prior enrollment was accurate and marked that HRA/POC as complete for the member's current enrollment, the MMP should count continuously from the date that the HRA/POC was completed in the prior enrollment period to determine the due date for the annual reassessment and POC update. For example, when reporting Core 2.3, the MMP should count 365 days from the date when the HRA was actually completed, even if that date was during the member's prior enrollment period.

Value Sets

The measure specifications in this document refer to code value sets that must be used to determine and report measure data element values. A value set is the complete set of codes used to identify a service or condition included in a measure. The Virginia State-Specific Value Sets Workbook includes all value sets and codes needed to report certain measures included in the Virginia-Specific Reporting Requirements and is intended to be used in conjunction with the measure specifications outlined in this document. The Virginia State-Specific

Value Sets Workbook can be found on the CMS website at the following address: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html.

Virginia's Implementation, Ongoing, and Continuous Reporting Periods

Demonstration Year 1			
Phase		**Dates**	**Explanation**
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.
Demonstration Year 2			
Continuous Reporting	Ongoing Period	1-1-16 through 12-31-16	From January 1st through the end of the second demonstration year.
Demonstration Year 3			
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 state-specific measure data through the web-based Financial Alignment Initiative (FAI) Data Collection System (unless otherwise specified in the measure description). All data submissions must be submitted to this site by 5:00 p.m. ET on the applicable due date. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

(Note: Prior to the first use of the system, all MMPs will receive an email notification with the username and password that has been assigned to their plan. This information will be used to log in to the FAI system and complete the data submission.)

All MMPs will submit core measure data in accordance with the Core Reporting Requirements. Submission requirements vary by measure, but most core measures are reported through the Health Plan Management System (HPMS).

Please note, late submissions may result in compliance action from CMS.

Resubmission of Data to the FAI Data Collection System or HPMS

MMPs must comply with the following steps to resubmit data after an established due date:

1. Email the VA HelpDesk (VAHelpDesk@norc.org) to request resubmission.
    - Specify in the email which measures need resubmission;
    - Specify for which reporting period(s) the resubmission is needed; and
    - Provide a brief explanation for why the data need to be resubmitted.
2. After review of the request, the VA HelpDesk will notify the MMP once the FAI Data Collection System and/or HPMS has been re-opened.
3. Resubmit data through the applicable reporting system.
4. Notify the VA HelpDesk again after resubmission has been completed.

Please note, requests for resubmission after an established due date may result in compliance action from CMS.

Section VAI. Assessment

VA1.1 Community Well members with a health risk assessment completed within 60 days of enrollment.[i, ii]

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
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.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members classified as Community Well upon enrollment whose 60th day of enrollment occurred within the reporting period.	Total number of members classified as Community Well upon enrollment whose 60th 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 60 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 60 days of enrollment.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of Community Well members the MMP was unable to reach, following three documented attempts within 60 days of enrollment.	Of the total reported in A, the number of Community Well members the MMP was unable to reach, following three documented attempts within 60 days of enrollment.	Field type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
D.	The number of Community Well members with a health risk assessment completed within 60 days of enrollment.	Of the total reported in A, the number of Community Well members with a health risk assessment completed within 60 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 reached to have a health risk assessment completed within 60 days of enrollment.
- Refused to have a health risk assessment completed within 60 days of enrollment.
- Had a health risk assessment completed within 60 days of enrollment.
- Were willing to participate and who could be reached 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. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- MMPs should refer to the Virginia 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 of enrollment. For purposes of reporting this measure, 60 days of enrollment will be equivalent to two full calendar months.
- 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 60 days of enrollment.
- For data element B, MMPs should report the number of members who were unwilling to participate in the health risk assessment if the member (or his or her authorized representative):
    - Affirmatively declines to participate in the assessment. Member communicates this refusal by phone, mail, fax, or in person.
    - Expresses willingness to complete the assessment but asks for it to be conducted after 60 days (despite being offered a reasonable opportunity to complete the assessment within 60 days). Discussions with the member must be documented by the MMP.
    - Expresses willingness to complete the assessment, but reschedules or is a no-show and then is subsequently non-responsive. Attempts to contact the member must be documented by the MMP.
    - Initially agrees to complete the assessment, but then declines to answer a majority of the questions in the assessment.
- For data element C, MMPs should report the number of members the MMP was unable to reach after three attempts to contact the member. MMPs should refer to the Virginia three-way contract or state guidance for any specific requirements pertaining to the method of outreach to members. MMPs must document each attempt to reach the member, including the method of the attempt (i.e., phone, mail, or email), as CMS and the state may validate this number. There may be instances when the MMP has a high degree of confidence that a member's contact information is correct, yet that member is not responsive to the MMP's outreach efforts. So long as the MMP follows the guidance regarding outreach attempts, these members may be included in the count for this data element.
- There may be certain circumstances that make it impossible or inappropriate to complete an assessment within 60 days of enrollment. For example, a member may be medically unable to respond and have no authorized representative to do so on their behalf, or a member may be experiencing an acute medical or behavioral health crisis that requires immediate attention and

outweighs the need for an assessment. However, MMPs should not include such members in the counts for data elements B and C.

- If a member's assessment was started but not completed within 60 days of enrollment, then the assessment should not be considered completed and, therefore, would not be counted in data elements B, C, or D. However, this member would be included in data element A.
- Community Well members are enrollees ages 21 and older who do not meet a Nursing Facility Level of Care (NFLOC) standard.

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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

VA1.2 Vulnerable subpopulation members, EDCD members, and nursing facility members with a health risk assessment completed within the required timeframe.[i, ii]

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
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.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members classified as EDCD members upon enrollment whose 30th day of enrollment occurred within the reporting period.	Total number of members classified as EDCD members upon enrollment whose 30th day of enrollment occurred within the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of EDCD members who were documented as unwilling to complete a health risk assessment within 30 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 30 days of enrollment.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of EDCD members the MMP was unable to reach, following three documented attempts within 30 days of enrollment.	Of the total reported in A, the number of EDCD members the MMP was unable to reach, following three documented attempts within 30 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 30 days of enrollment.	Of the total reported in A, the number of EDCD members with a health risk assessment completed within 30 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.

Element Letter	Element Name	Definition	Allowable Values
G.	Total number of nursing facility members the MMP was unable to reach, following three documented attempts within 60 days of enrollment.	Of the total reported in E, the number of nursing facility members the MMP was unable to reach, following three documented attempts within 60 days of enrollment.	Field type: Numeric Note: Is a subset of E.
H.	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.
I.	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.
J.	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 I, 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 I. Note: Exclude EDCD and NF members.

Element Letter	Element Name	Definition	Allowable Values
K.	Total number of all other vulnerable subpopulation members the MMP was unable to reach, following three documented attempts within 60 days of enrollment.	Of the total reported in I, the number of all other vulnerable subpopulation members the MMP was unable to reach, following three documented attempts within 60 days of enrollment.	Field type: Numeric Note: Is a subset of I. Note: Exclude EDCD and NF members.
L.	Total number of all other vulnerable subpopulation members with a health risk assessment completed within 60 days of enrollment.	Of the total reported in I, 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 I. 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.
- 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 30 days of enrollment.
- EDCD members upon enrollment who were unable to be reached to have a health risk assessment completed within 30 days of enrollment.

- EDCD members upon enrollment who had a health risk assessment completed within 30 days of enrollment.
- EDCD members upon enrollment who were willing to participate and who could be reached who had a health risk assessment completed within 30 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 were unable to be reached 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 reached 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 reached 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 reached 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. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Elements A, E, and I regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- MMPs should refer to the Virginia three-way contract for specific requirements pertaining to a health risk assessment.
- The 30th day of enrollment for EDCD members should be based on each member’s effective date of enrollment. For the purposes of reporting this measure, 30 days is equivalent to one full calendar month.
- The 60th day of enrollment for Nursing facility and all other vulnerable subpopulation members should be based on each

member's effective date of enrollment. For purposes of reporting this measure, 60 days is equivalent to two full calendar months.

- The effective date of enrollment is the first date of the member's coverage through the MMP.
- For data elements B, F, and J, MMPs should report the number of members who were unwilling to participate in the health risk assessment if the member (or his or her authorized representative):
    - Affirmatively declines to participate in the assessment. Member communicates this refusal by phone, mail, fax, or in person.
    - Expresses willingness to complete the assessment but asks for it to be conducted after the specified timeframe (despite being offered a reasonable opportunity to complete the assessment within that timeframe). Discussions with the member must be documented by the MMP.
    - Expresses willingness to complete the assessment, but reschedules or is a no-show and then is subsequently non-responsive. Attempts to contact the member must be documented by the MMP.
    - Initially agrees to complete the assessment, but then declines to answer a majority of the questions in the assessment.
- For data elements C, G, and K, MMPs should report the number of members the MMP was unable to reach after three attempts to contact the member. MMPs should refer to the Virginia three-way contract or state guidance for any specific requirements pertaining to the method of outreach to members. MMPs must document each attempt to reach the member, including the method of the attempt (i.e., phone, mail, or email), as CMS and the state may validate this number. There may be instances when the MMP has a high degree of confidence that a member's contact information is correct, yet that member is not responsive to the MMP's outreach efforts. So long as the MMP follows the guidance regarding outreach attempts, these members may be included in the count for this data element.
- There may be certain circumstances that make it impossible or inappropriate to complete an assessment within the specified timeframe. For example, a member may be medically unable to respond and have no authorized representative to do so on their behalf, or a member may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for an assessment. However, MMPs should <u>not</u> include such members in the counts for data elements B, C, F, G, J, and K.
- If a member's assessment was started but not completed within the specified timeframe, then the assessment should not be considered completed and, therefore, would <u>not</u> be counted in data elements

B, C, D, F, G, H, J, K, and L. However, this member would be included in data element A, E, or I.

- Vulnerable subpopulation members are:
  i. Individuals enrolled in the EDCD waiver;
  ii. Individuals with intellectual/developmental disabilities;
  iii. Individuals with cognitive or memory problems (e.g., dementia or traumatic brain injury);
  iv. Individuals with physical or sensory disabilities;
  v. Individuals residing in nursing facilities;
  vi. Individuals with serious and persistent mental illnesses;
  vii. Individuals with end stage renal disease; and,
  viii. 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 I-L. "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 Minimum Data Set (MDS).
- 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.

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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

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

Please note: No MMP reporting to NORC is required for this measure as part of the reporting requirements; MMPs should continue to follow the CCC LOCERI LOC reassessment process by directly working with DMAS' Long Term Care Division.

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

Please note: No MMP reporting to NORC is required for this measure as part of the reporting requirements; MMPs should continue to follow the CCC MMP Waiver Assurances Sampling Methodology and Other Expectations issued by DMAS in conducting waiver quality assurances and reporting directly to DMAS.

VA1.5 Community Well members, vulnerable subpopulation members, EDCD members, and nursing facility members with a reassessment.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
VA1. Assessment	Semi- Annual	Contract	Ex: 1/1-6/30 7/1-12/31	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 members classified as Community Well as of the first day of the reporting period eligible for an annual health risk reassessment during the reporting period.	Total number of members classified as Community Well as of the first day of the reporting period eligible for an annual health risk reassessment during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of eligible Community Well members with an annual health risk reassessment completed during the reporting period.	Of the total reported in A, the number of eligible Community Well members with an annual health risk reassessment completed during the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of eligible Community Well members whose first completed annual health risk reassessment during the reporting period was no more than 365 days from the last health risk assessment (or reassessment) or the member's enrollment date, whichever occurred last.	Of the total reported in B, the number of eligible Community Well members whose first completed annual health risk reassessment during the reporting period was no more than 365 days from the last health risk assessment (or reassessment) or the member's enrollment date, whichever occurred last.	Field type: Numeric Note: Is a subset of B.
D.	Total number of members classified as EDCD members as of the first day of the reporting period eligible for an annual health risk reassessment during the reporting period.	Total number of members classified as EDCD members as of the first day of the reporting period eligible for an annual health risk reassessment during the reporting period.	Field Type: Numeric
E.	Total number of eligible EDCD members with an annual health risk reassessment completed during the reporting period.	Of the total reported in D, the number of eligible EDCD members with an annual health risk reassessment completed during the reporting period.	Field Type: Numeric Note: Is a subset of D.

Element Letter	Element Name	Definition	Allowable Values
F.	Total number of eligible EDCD members whose first completed annual health risk reassessment during the reporting period was no more than 365 days from the last health risk assessment (or reassessment) or the member's enrollment date, whichever occurred last.	Of the total reported in E, the number of eligible EDCD members whose first completed annual health risk reassessment during the reporting period was no more than 365 days from the last health risk assessment (or reassessment) or the member's enrollment date, whichever occurred last.	Field type: Numeric Note: Is a subset of E.
G.	Total number of members classified as nursing facility members as of the first day of the reporting period eligible for an annual health risk reassessment during the reporting period.	Total number of members classified as nursing facility members as of the first day of the reporting period eligible for an annual health risk reassessment during the reporting period.	Field Type: Numeric
H.	Total number of eligible nursing facility members with an annual health risk reassessment completed during the reporting period.	Of the total reported in G, the number of eligible nursing facility members with an annual health risk reassessment completed during the reporting period.	Field Type: Numeric Note: Is a subset of G.

Element Letter	Element Name	Definition	Allowable Values
I.	Total number of eligible nursing facility members whose first completed annual health risk reassessment during the reporting period was no more than 365 days from the last health risk assessment (or reassessment) or the member's enrollment date, whichever occurred last.	Of the total reported in H, the number of eligible nursing facility members whose first completed annual health risk reassessment during the reporting period was no more than 365 days from the last health risk assessment (or reassessment) or the member's enrollment date, whichever occurred last.	Field type: Numeric Note: Is a subset of H.
J.	Total number of members classified as all other vulnerable subpopulation members as of the first day of the reporting period eligible for an annual health risk reassessment during the reporting period.	Total number of members classified as all other vulnerable subpopulation members as of the first day of the reporting period eligible for an annual health risk reassessment during the reporting period.	Field Type: Numeric
K.	Total number of all other vulnerable subpopulation members with an annual health risk reassessment completed during reporting period.	Of the total reported in J, the number of all other vulnerable subpopulation members with an annual health risk reassessment completed during the reporting period.	Field Type: Numeric Note: Is a subset of J.

Element Letter	Element Name	Definition	Allowable Values
L.	Total number of eligible all other vulnerable subpopulation members whose first completed annual health risk reassessment during the reporting period was no more than 365 days from the last health risk assessment (or reassessment) or the member's enrollment date, whichever occurred last.	Of the total reported in K, the number of eligible all other vulnerable subpopulation members whose first completed annual health risk reassessment during the reporting period was no more than 365 days from the last health risk assessment (or reassessment) or the member's enrollment date, whichever occurred last.	Field type: Numeric Note: Is a subset of K.

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.
- MMPs should validate that data element H is less than or equal to data element G.
- MMPs should validate that data element I is less than or equal to data element H.
- MMPs should validate that data element K is less than or equal to data element J.
- MMPs should validate that data element L is less than or equal to data element K.

- 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 eligible for an annual health risk reassessment who had a reassessment completed during the reporting period that was no more than 365 days from the completion date of the last health risk assessment (or reassessment) or enrollment date, whichever occurred last.
    - EDCD members eligible for an annual health risk reassessment who had a reassessment completed during the reporting period that was no more than 365 days from the completion date of the last health risk assessment (or reassessment) or enrollment date, whichever occurred last.
    - Nursing facility members eligible for an annual health risk reassessment who had a reassessment completed during the reporting period that was no more than 365 days from the completion date of the last health risk assessment (or reassessment) or enrollment date, whichever occurred last.
    - All other vulnerable subpopulation members eligible for an annual health risk reassessment who had a reassessment completed during of the reporting period that was no more than 365 days from the completion date of the last health risk assessment (or reassessment) or enrollment date, whichever occurred last.

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. Medicaid-only members should not be included.
    - MMPs should include all members who meet the criteria outlined in data elements A, D, G, and J, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
    - A members' Community Well, EDCD, nursing facility, or other vulnerable subpopulation status should be based on the members' status at the first day of the reporting period.
    - The assessment for this measure should be the comprehensive health risk reassessment.
    - For reporting members eligible for reassessment under data elements A, D, G, and J, report all members within their population in the same MMP who:
        - Received a reassessment health risk assessment within 365 days of their last health risk assessment (initial or reassessment) during the reporting period.

  - Were enrolled for 365 days continuously after their initial health risk assessment or their last health risk reassessment and did not receive a health risk reassessment within 365 days.
  - Did not receive an initial health risk assessment within 365 days of enrollment and reached the threshold of 365 days of continuous enrollment after initial enrollment without receiving a health risk reassessment.
- MMPs should refer to the "Guidance on Assessments and Care Plans for Members with a Break in Coverage" section.

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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

VA1.6 Community Well members, vulnerable subpopulation members, EDCD members, and nursing facility members' reassessment due to triggering event.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
VA1. Assessment	Semi- Annual	Contract	Ex: 1/1-6/30 7/1-12/31	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 health risk reassessments completed during the reporting period for members classified as Community Well as of the first day of the reporting period.	Total number of health risk reassessments completed during the reporting period for members classified as Community Well as of the first day of the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of health risk reassessments completed during the reporting period for members classified as Community Well that were due to a triggering event.	Of the total reported in A, the number of health risk reassessments completed during the reporting period for members classified as Community Well that were due to a triggering event.	Field type: Numeric Note: Is a subset of A.
C.	Total number of health risk reassessments completed during the reporting period for members classified as EDCD members as of the first day of the reporting period.	Total number of health risk reassessments completed during the reporting period for members classified as EDCD members as of the first day of the reporting period.	Field Type: Numeric
D.	Total number of health risk reassessments completed during the reporting period for members classified as EDCD members that were due to a triggering event.	Of the total reported in C, the number of health risk reassessments completed during the reporting period for members classified as EDCD members that were due to a triggering event.	Field type: Numeric Note: Is a subset of C.
E.	Total number of health risk reassessments completed during the reporting period for members classified as nursing facility members as of the first day of the reporting period.	Total number of health risk reassessments completed during the reporting period for members classified as nursing facility members as of the first day of the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
F.	Total number of health risk reassessments completed during the reporting period for members classified as nursing facility members that were due to a triggering event.	Of the total reported in E, the number of health risk reassessments completed during the reporting period for members classified as nursing facility members that were due to a triggering event.	Field type: Numeric Note: Is a subset of E.
G.	Total number of health risk reassessments completed during the reporting period for members classified as all other vulnerable subpopulation members as of the first day of the reporting period.	Total number of health risk reassessments completed during the reporting period for members classified as all other vulnerable subpopulation members as of the first day of the reporting period.	Field Type: Numeric Note: Exclude EDCD and NF members.
H.	Total number of health risk reassessments completed during the reporting period members classified as all other vulnerable subpopulation members that were due to a triggering event.	Of the total reported in G, the number of health risk reassessments completed during the reporting period for members classified as all other vulnerable subpopulation members that were due to a triggering event.	Field type: Numeric Note: Is a subset of G. 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.

- 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 D is less than or equal to data element C.
- MMPs should validate that data element F is less than or equal to data element E.
- MMPs should validate that data element H is less than or equal to data element G.
- 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 health risk reassessments completed during the reporting period for members classified as:

- Community Well as of the first day of the reporting period that were due to a triggering event.
- EDCD members as of the first day of the reporting period that were due to a triggering event.
- Nursing facility members as of the first day of the reporting period that were due to a triggering event.
- All other vulnerable subpopulation members as of the first day of the reporting period that were due to a triggering event.

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. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Elements A, C, E, and G regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- A members' Community Well, EDCD, nursing facility, or other vulnerable subpopulation status should be based on the members' status at the first day of the reporting period.
- This measure is evaluating reassessments, not a member's initial assessment.
- A triggering event is defined as a hospitalization or significant change in health or functional status (e.g., change in the ability to perform activities of daily living and instrumental activities of daily living).

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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

Section VAII. Care Coordination

VA2.1 Community Well members, vulnerable subpopulation members, EDCD members, and nursing facility members with a Plan of Care (POC) completed within the required timeframe.[i, ii]

CONTINUOUS REPORTING				
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.

Community Well Members

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

EDCD Member

Element Letter	Element Name	Definition	Allowable Values
E.	Total number of members classified as EDCD members upon enrollment whose 30th day of enrollment occurred within the reporting period.	Total number of members classified as EDCD members upon enrollment whose 30th day of enrollment occurred within the reporting period.	Field Type: Numeric
F.	Total number of EDCD members who were documented as unwilling to complete a POC within 30 days of enrollment.	Of the total reported in E, the number of EDCD members who were documented as unwilling to complete a POC within 30 days of enrollment.	Field Type: Numeric Note: Is a subset of E.
G.	Total number of EDCD members the MMP was unable to reach, following three documented attempts within 30 days of enrollment.	Of the total reported in E, the number of EDCD members the MMP was unable to reach, following three documented attempts within 30 days of enrollment.	Field Type: Numeric Note: Is a subset of E.

Element Letter	Element Name	Definition	Allowable Values
H.	Total number of EDCD members with a POC completed within 30 days of enrollment.	Of the total reported in E, the number of EDCD members with a POC completed within 30 days of enrollment.	Field Type: Numeric Note: Is a subset of E.

Nursing Facility Members

Element Letter	Element Name	Definition	Allowable Values
I.	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
J.	Total number of nursing facility members who were documented as unwilling to complete a POC within 60 days of enrollment.	Of the total reported in I, the number of nursing facility members who were documented as unwilling to complete a POC within 60 days of enrollment.	Field Type: Numeric Note: Is a subset of I.
K.	Total number of nursing facility members the MMP was unable to reach, following three documented attempts within 60 days of enrollment.	Of the total reported in I, the number of nursing facility members the MMP was unable to reach, following three documented attempts within 60 days of enrollment.	Field type: Numeric Note: Is a subset of I.
L.	Total number of nursing facility members with a POC completed within 60 days of enrollment.	Of the total reported in I, the number of nursing facility members with a POC completed within 60 days of enrollment.	Field Type: Numeric Note: Is a subset of I.

All Other Vulnerable Subpopulation Members

Element Letter	Element Name	Definition	Allowable Values
M.	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
N.	Total number of all other vulnerable subpopulation members who were documented as unwilling to complete a POC within 60 days of enrollment.	Of the total reported in M, the number of all other vulnerable subpopulation members who were documented as unwilling to complete a POC within 60 days of enrollment.	Field Type: Numeric Note: Is a subset of M. Note: Exclude EDCD and NF members
O.	Total number of all other vulnerable subpopulation members the MMP was unable to reach, following three documented attempts within 60 days of enrollment.	Of the total reported in M, the number of all other vulnerable subpopulation members the MMP was unable to reach, following three documented attempts within 60 days of enrollment.	Field Type: Numeric Note: Is a subset of M. Note: Exclude EDCD and NF members
P.	Total number of all other vulnerable subpopulation members with a POC completed within 60 days of enrollment.	Of the total reported in M, the number of all other vulnerable subpopulation members with a POC completed within 60 days of enrollment.	Field Type: Numeric Note: Is a subset of M. 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, O, and P are less than or equal to data element M.
- 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 refused to have a POC completed within 90 days of enrollment.
- Community Well upon enrollment who were unable to be reached 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 reached who had a POC completed within 90 days of enrollment.
- EDCD members upon enrollment who refused to have a POC completed within 30 days of enrollment.
- EDCD members upon enrollment who were unable to be reached to have a POC completed within 30 days of enrollment.
- EDCD members upon enrollment who had a POC completed within 30 days of enrollment.
- EDCD members upon enrollment who were willing to participate and who could be reached who had a POC completed within 30 days of enrollment.
- Nursing facility members upon enrollment who refused to have a POC completed within 60 days of enrollment.
- Nursing facility members upon enrollment who were unable to be reached to have a POC completed within 60 days of enrollment.
- Nursing facility members upon enrollment who had a POC completed within 60 days of enrollment.
- Nursing facility members upon enrollment who were willing to participate and who could be reached who had a POC completed within 60 days of enrollment.
- All other vulnerable subpopulation members upon enrollment who refused to have a POC completed within 60 days of enrollment.
- All other vulnerable subpopulation members upon enrollment who were unable to be reached to have a POC completed within 60 days of enrollment.

- All other vulnerable subpopulation members upon enrollment who had a POC completed within 60 days of enrollment.
- All other vulnerable subpopulation members upon enrollment who were willing to participate and who could be reached who had a POC 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 Community Well, EDCD, nursing facility, and all other vulnerable subpopulation members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Elements A, E, I, and M regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- MMPs should refer to the Virginia three-way contract for specific requirements pertaining to a POC.
- The 90th, 60th, and 30th day of enrollment should be based on each member's effective date of enrollment. For purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months, 60 days of enrollment will be equivalent to two full calendar months, and 30 days of enrollment will be equivalent to one full calendar month.
- 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 30-90 days of enrollment.
- For data elements B, F, J, and N, MMPs should report the number of members who were unwilling to participate in the development of the POC if the member (or his or her authorized representative):
    - Affirmatively declines to participate in the POC. Member communicates this refusal by phone, mail, fax, or in person.
    - Expresses willingness to complete the POC but asks for it to be conducted after the specified timeframe (despite being offered a reasonable opportunity to complete the POC within that timeframe). Discussions with the member must be documented by the MMP.
    - Expresses willingness to complete the POC, but reschedules or is a no-show and then is subsequently non-responsive. Attempts to contact the member must be documented by the MMP.

  - Initially agrees to complete the POC, but then declines to participate in the POC.
- For data elements C, G, K, and O, MMPs should report the number of members the MMP was unable to reach after three attempts to contact the member. MMPs should refer to the Virginia three-way contract or state guidance for any specific requirements pertaining to the method of outreach to members. MMPs must document each attempt to reach the member, including the method of the attempt (i.e., phone, mail, or email), as CMS and the state may validate this number. There may be instances when the MMP has a high degree of confidence that a member's contact information is correct, yet that member is not responsive to the MMP's outreach efforts. So long as the MMP follows the guidance regarding outreach attempts, these members may be included in the count for this data element.
- There may be certain circumstances that make it impossible or inappropriate to complete a POC within the specified timeframe. For example, a member may be medically unable to respond and have no authorized representative to do so on their behalf, or a member may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for a POC. However, MMPs should <u>not</u> include such members in the counts for data elements B, C, F, G, J, K, N, and O.
- According to section 2.7.4.3 of the Virginia three-way contract, the member or his/her representative, as appropriate, must review and sign the initial POC and all subsequent revisions to the POC. The signature of the member or his/her representative on the established POC should be used as the marker for POC completion (i.e., data elements D, H, L, and P), with the exception of Community Well members. In the event the member or his/her representative, as appropriate, refuses to sign, or the member is not competent to sign, mark or assent to the established POC, the refusal or notation of incompetency should be used as the marker for POC completion.
  - Community Well members are exempt from the handwritten signature requirement. Communications between MMPs and Community Well members are often telephonic; therefore, verbal approval of the POC and electronic signature on the POC are acceptable for this population. MMPs are required to document the verbal approval and electronic signature process for authentication. These documentations must be available for audit and validation, upon request from CMS, DMAS, and their designees.
- The POC to be reviewed and signed by a member must be the POC finalized by the member's formal full Interdisciplinary Care Team (ICT) meeting based on the completed health risk assessment.

- If a member's POC was started but not completed within the specified timeframe, then the POC should not be considered completed and, therefore, would not be counted in data elements B, C, D, F, G, H, J, K, L, N, O, and P. However, this member would be included in data element A, E, I, or M.
- 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:
    i. Individuals enrolled in the EDCD waiver;
    ii. Individuals with intellectual/developmental disabilities;
    iii. Individuals with cognitive or memory problems (e.g., dementia or traumatic brain injury);
    iv. Individuals with physical or sensory disabilities;
    v. Individuals residing in nursing facilities;
    vi. Individuals with serious and persistent mental illnesses;
    vii. Individuals with end stage renal disease; and,
    viii. 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 M-P. "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.

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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

VA2.2 Members with documented discussions of care goals.[i]

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.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members with an initial Plan of Care (POC) completed.	Total number of members with an initial POC completed during the reporting period.	Field Type: Numeric
B.	Total number of members with at least one documented discussion of care goals in the initial POC.	Of the total reported in A, the number of members with at least one documented discussion of care goals in the initial POC.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of existing POCs revised.	Total number of existing POCs revised during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of revised POCs with at least one documented discussion of new or existing care goals.	Of the total reported in C, the number of revised POCs with at least one documented discussion of new or existing care goals.	Field Type: Numeric Note: Is a subset of C.

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 D is less 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 POC completed during the reporting period who had at least one documented discussion of care goals in the POC.
- POCs revised during the reporting period that had at least one documented discussion of new or existing care goals.

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. Medicaid-only members should not be included.
- MMPs should include all members and revised POCs for members that meet the criteria outlined in data element A or data element C, regardless if the members are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- Data element A should include all members with POCs that were completed for the first time during the reporting period (i.e., the member did not previously have a POC completed prior to the start

of the reporting period). There can be no more than one initial POC completed per member.

- MMPs should only include members in data element B when the discussion of care goals is clearly documented in the member's initial POC.
- Data element C should include all existing POCs that were revised during the reporting period. MMPs should refer to the Virginia three-way contract for specific requirements pertaining to updating the POC.
- MMPs should only include POCs in data element D when a new or previously documented care goal is discussed and is clearly documented in the member's revised POC. If the initial POC clearly documented the discussion of care goals, but those existing care goals were not revised or discussed, or new care goals are not discussed and documented during the revision of the POC, then that POC should not be reported in data element D.
- If a member has an initial POC completed during the reporting period, and has their POC revised during the same reporting period, then the member should be reported in data element A and the member's revised POC should be reported in data element C.
- If a member's POC is revised multiple times during the same reporting period, each revision should be reported in data element C. For example, if a member's POC is revised twice during the same reporting period, two POCs should be counted in data element C.
- According to section 2.7.4.3 of the Virginia three-way contract, the member or his/her representative, as appropriate, must review and sign the initial POC and all subsequent revisions to the POC. The signature of the member or his/her representative on the established POC should be used as the marker for POC completion (i.e., data elements A and C), with the exception of Community Well members. In the event the member or his/her representative, as appropriate, refuses to sign, or the member is not competent to sign, mark or assent to the established POC, the refusal or notation of incompetency should be used as the marker for POC completion.
    i. Community Well members are exempt from the handwritten signature requirement. Communications between MMPs and Community Well members are often telephonic; therefore, verbal approval of the POC and electronic signature on the POC are acceptable for this population. MMPs are required to document the verbal approval and electronic signature process for authentication. These documentations must be available for audit and validation, upon request from CMS, DMAS, and their designees.

- The POC to be reviewed and signed by a member must be the POC finalized by the member's formal full Interdisciplinary Care Team (ICT) meeting based on the completed health risk assessment.

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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

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

CONTINUOUS REPORTING				
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 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 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. Medicaid-only members should not be included.
- MMPs should include all hospital discharges for members who meet the criteria outlined in Element A and who were continuously enrolled from the date of the hospital discharge through 30 days after the hospital discharge, regardless if they are disenrolled as of the end of the reporting period.
- 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 the Ambulatory Visits #1 and Other Ambulatory Visits value set.
- Codes to identify inpatient discharges are provided in the Inpatient Stay value set.
- 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, using the Discharges due to Death value set.

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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

VA2.4 EDCD waiver enrollees with a service plan.

Please note: No MMP reporting to NORC is required for this measure as part of the reporting requirements; MMPs should continue to follow the CCC MMP Waiver Assurances Sampling Methodology and Other Expectations issued by DMAS in conducting waiver quality assurances and reporting directly to DMAS.

VA2.5 Service plans that were revised as needed.

Please note: No MMP reporting to NORC is required for this measure as part of the reporting requirements; MMPs should continue to follow the CCC MMP Waiver Assurances Sampling Methodology and Other Expectations issued by DMAS in conducting waiver quality assurances and reporting directly to DMAS.

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

Please note: No MMP reporting to NORC is required for this measure as part of the reporting requirements; MMPs should continue to follow the CCC MMP Waiver Assurances Sampling Methodology and Other Expectations issued by DMAS in conducting waiver quality assurances and reporting directly to DMAS.

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

Please note: No MMP reporting to NORC is required for this measure as part of the reporting requirements; MMPs should continue to follow the CCC MMP Waiver Assurances Sampling Methodology and Other Expectations issued by DMAS in conducting waiver quality assurances and reporting directly to DMAS.

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

Please note: No MMP reporting to NORC is required for this measure as part of the reporting requirements; MMPs should continue to follow the CCC MMP Waiver Assurances Sampling Methodology and Other Expectations issued by DMAS in conducting waiver quality assurances and reporting directly to DMAS.

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

CONTINUOUS REPORTING				
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.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of Community Well members enrolled at the beginning of the reporting period, who were continuously enrolled for the entire reporting period.	Total number of Community Well members enrolled at the beginning of the reporting period, who were continuously enrolled for the entire reporting period.	Field Type: Numeric
B.	Total number of new Community Well members enrolled during the reporting period, who were continuously enrolled for the remainder of the reporting period.	Total number of new Community Well members enrolled during the reporting period, who were continuously enrolled for the remainder of the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
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, who were continuously enrolled for the entire reporting period.	Total number of EDCD waiver members enrolled at the beginning of the reporting period, who were continuously enrolled for the entire reporting period.	Field Type: Numeric
F.	Total number of new EDCD waiver members enrolled during the reporting period, who were continuously enrolled for the remainder of the reporting period.	Total number of new EDCD waiver members enrolled during the reporting period, who were continuously enrolled for the remainder of the reporting period.	Field Type: Numeric
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.

Element Letter	Element Name	Definition	Allowable Values
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, who were continuously enrolled for the entire reporting period.	Total number of nursing facility members enrolled at the beginning of the reporting period, who were continuously enrolled for the entire reporting period.	Field Type: Numeric
J.	Total number of new nursing facility members enrolled during the reporting period, who were continuously enrolled for the remainder of the reporting period.	Total number of new nursing facility members enrolled during the reporting period, who were continuously enrolled for the remainder of 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. Medicaid-only members should not be included.
- Members must be continuously enrolled during the reporting period, with no gaps in enrollment, to be included in this measure.

- Exclude institutional stays less than 20 days.
- Exclude transitions that resulted in an admission or transfer to a hospital.
- For members who had more than one eligible transition during the reporting period, please only count the first eligible transition when reporting data for this measure. For example, if a Community Well member who enrolled on April 1 transitioned to a nursing facility on April 14, then transitioned back to Community Well on May 14, the member would only be reported in data elements A and D for the quarterly reporting period April 1 – June 30 (i.e., only the transition from Community Well to the nursing facility is reported).
- Data elements A, E, and I, include members who were enrolled in the MMP as of the first day of the reporting period. For example, a Community Well member enrolled on April 1 would be reported in data element A for the quarterly reporting period April 1 – June 30, because they were enrolled on the first day of the reporting period.
- Conversely, data elements B, F, and J include new members who were enrolled in the MMP during the reporting period. For example, a Community Well member enrolled on May 1 would be reported in data element B for the quarterly reporting period April 1 – June 30, because they were enrolled during the reporting period, and were not enrolled on the first day of the reporting period. Data elements B, F, and J only include members newly enrolled in the MMP, not members who transitioned between different subpopulations during the reporting period.

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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

VA2.10 MMPs with established work plan and systems in place for ensuring smooth transition to and from hospitals, nursing facilities, and the Community.[i]

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
VA2. Care Coordination	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.	Policies and procedures around timely identification of planned and unplanned transitions.	Policies and procedures around timely identification of planned and unplanned transitions, such as an internal data system mechanism to alert planned and unplanned transitions and contracted facilities reporting requirements for unplanned transitions.	Field Type: N/A Note: File will be uploaded to FTP site as a separate attachment.
B.	Policies and procedures around supporting members' moves between care settings.	Policies and procedures around supporting members' moves between care settings, including items to be completed by each care setting and around communicating with members or responsible parties.	Field Type: N/A Note: File will be uploaded to FTP site as a separate attachment.
C.	Policies and procedures to identify members at risk of transitions and reducing transitions.	Policies and procedures to identify members at risk of transitions and reducing transitions, such as how data are collected and analyzed at specified intervals to identify members who are at risk for a health status change and potential transition and how case managers contact at-risk members to assess needs and arrange appropriate services.	Field Type: N/A Note: File will be uploaded to FTP site as a separate attachment.

Element Letter	Element Name	Definition	Allowable Values
D.	Policies and procedures around annual smooth transition management performance for the key steps mentioned in data elements A to C.	Policies and procedures around annual smooth transition management performance for the key steps mentioned in data elements A to C.	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.

- MMPs must submit policies and procedures that align with the requirements outlined in this measure specification. If deficiencies are identified in the MMP's policies and procedures, the MMP will be notified and provided with the opportunity to correct the deficiencies.

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

- All policies and procedures should be implemented with supporting documentation.

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

- CMS, DMAS and DMAS's EQRO contractor will evaluate the policies and procedures, and their backup documentation to demonstrate their implementation.

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

- A transition is the movement 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.
- A planned transition includes a scheduled procedure, elective surgery or a decision to enter a long-term care facility.
- An unplanned transition includes an emergency leading to a hospital admission from the emergency department.

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 (Timely Identification).
- For element letter "B", the (ELEMENTNAME) should be (Supporting Members Movement).
- For element letter "C", the (ELEMENTNAME) should be (Identify Members at Risk).
- For element letter "D", the (ELEMENTNAME) should be (Annual Smooth Transition).

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

CONTINUOUS REPORTING				
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 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 member months during the reporting period.	Total number of member months during the reporting period.	Field Type: Numeric
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

Element Letter	Element Name	Definition	Allowable Values
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
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 manager 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 manager 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.

- 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 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 manager and the member, or the member's representative during the reporting period.

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

- MMPs should include all discharges and admissions for members who meet the criteria outlined in all data elements, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- 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

- 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.
- Data elements H and I are limited to planned and unplanned transitions for members moving to and from the hospital from the community and nursing facilities during the reporting period (i.e., hospital admissions from the community and nursing facilities, and hospital discharges to the community and nursing facilities).
- 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 manager and the member, or the member's representative.
- Data element K is intended to capture pre-discharge interactions between a member or the member's representative and care managers, not post-discharge interactions.
- Exclude outpatient hospitalizations.
- Data element J, per state and statutory regulations for behavioral health, MMPs are required to obtain consent from the member before notifying his/her primary care provider (PCP).

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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

VA2.12 Community Well members, vulnerable subpopulation members, EDCD members with an annual Plan of Care (POC) Reviewed or Revised.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
VA2. Care Coordination	Semi- Annual	Contract	Ex: 1/1-6/30 7/1-12/31	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 members classified as Community Well as of the first day of the reporting period eligible for a plan of care (POC) review or revision during the reporting period.	Total number of members classified as Community Well as of the first day of the reporting period eligible for a POC review or revision during the reporting period.	Field Type: Numeric
B.	Total number of eligible Community Well members with a POC review or revision completed during the reporting period.	Of those reported in A, the number of eligible Community Well members with a POC review or revision completed during the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of eligible Community Well members whose first POC review or revision completed during the reporting period was no more than 365 days from the last POC or the member's enrollment date, whichever occurred last.	Of the total reported in B, the number of eligible Community Well members whose first POC review or revision completed during the reporting period was no more than 365 days from the last POC or the member's enrollment date, whichever occurred last.	Field type: Numeric Note: Is a subset of B.

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of members classified as EDCD members as of the first day of the reporting period eligible for a POC review or revision during the reporting period.	Total number of members classified as EDCD members as of the first day of the reporting period eligible for a POC review or revision during the reporting period.	Field Type: Numeric
E.	Total number of eligible EDCD members with a POC review or revision completed during reporting period.	Of those reported in D, the number of eligible EDCD members with a POC review or revision completed during the reporting period.	Field Type: Numeric Note: Is a subset of D.
F.	Total number of eligible EDCD members whose first POC review or revision completed during the reporting period was no more than 365 days from the last POC or the member's enrollment date, whichever occurred last.	Of the total reported in E, the number of eligible EDCD members whose first POC review or revision completed during the reporting period was no more than 365 days from the last POC or the member's enrollment date, whichever occurred last.	Field type: Numeric Note: Is a subset of E.
G.	Total number of members classified as nursing facility members as of the first day of the reporting period eligible for a POC review or revision during the reporting period.	Total number of members classified as nursing facility members as of the first day of the reporting period eligible for a POC review or revision during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
H.	Total number of eligible nursing facility members with a POC review or revision completed during the reporting period.	Of those reported in G, the number of eligible nursing facility members with a POC review or revision completed during the reporting period.	Field Type: Numeric Note: Is a subset of G.
I.	Total number of eligible nursing facility members whose first POC review or revision completed during the reporting period was no more than 365 days from the last POC or the member's enrollment date, whichever occurred last.	Of the total reported in H, the number of eligible nursing facility members whose first POC review or revision completed during the reporting period was no more than 365 days from the last POC or the member's enrollment date, whichever occurred last.	Field type: Numeric Note: Is a subset of H.
J.	Total number of members classified as all other vulnerable subpopulation members as of the first day of the reporting period eligible for a POC review or revision during the reporting period.	Total number of members classified as all other vulnerable subpopulation members as of the first day of the reporting period eligible for a POC review or revision during the reporting period.	Field Type: Numeric
K.	Total number of eligible all other vulnerable subpopulation members with a POC review or revision completed during the reporting period.	Of those reported in J, the number of eligible all other vulnerable subpopulation members with a POC review or revision completed during the reporting period.	Field Type: Numeric Note: Is a subset of J.

Element Letter	Element Name	Definition	Allowable Values
L.	Total number of eligible all other vulnerable subpopulation members whose first POC review or revision completed during the reporting period was no more than 365 days from the last POC or the member's enrollment date, whichever occurred last.	Of the total reported in K, the number of eligible all other vulnerable subpopulation members whose first POC review or revision completed during the reporting period was no more than 365 days from the last POC or the member's enrollment date, whichever occurred last.	Field type: Numeric Note: Is a subset of K.

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.
- MMPs should validate that data element H is less than or equal to data element G.
- MMPs should validate that data element I is less than or equal to data element H.
- MMPs should validate that data element K is less than or equal to data element J.
- MMPs should validate that data element L is less than or equal to data element K.
- 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 eligible for a POC review or revision who had a POC review or revision completed during the reporting period that was no more than 365 days from the completion date of the last POC or enrollment date, whichever occurred last.
- EDCD members eligible for a POC review or revision who had a POC review or revision completed during the reporting period that was no more than 365 days from the completion date of the last POC or enrollment date, whichever occurred last.
- Nursing facility members eligible for a POC review or revision who had a POC review or revision completed during the reporting period that was no more than 365 days from the completion date of the last POC or enrollment date, whichever occurred last.
- All other vulnerable subpopulation members eligible for a POC review or revision who had a POC review or revision completed during the reporting period that was no more than 365 days from the completion date of the last POC or enrollment date, whichever occurred last.

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. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in data elements A, D, G, and J, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- A members' Community Well, EDCD, nursing facility, or other vulnerable subpopulation status should be based on the members' status at the first day of the reporting period.
- For reporting member eligible for POC review or revision under data element A, D, G, and J, report all members within their population in the same MMP who:
    - Received a POC review or revision within 365 days of their last POC (initial or reassessment) during the reporting period.
    - Were enrolled for 365 days continuously after their initial POC or their last POC review or revision and did not receive a POC review or revision within 365 days.
    - Did not receive an initial POC within 365 days of enrollment and reached the threshold of 365 days of continuous enrollment after initial enrollment without receiving a POC review or revision.

- MMPs should refer to the "Guidance on Assessments and Care Plans for Members with a Break in Coverage" section.

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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

VA2.13 Community Well members, vulnerable subpopulation members, EDCD members, and nursing facility members' POC review or revision due to triggering event.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
VA2. Care Coordination	Semi- Annual	Contract	Ex: 1/1-6/30 7/1-12/31	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 POC reviews or revisions completed during the reporting period for members classified as Community Well as of the first day of the reporting period.	Total number of POC reviews or revisions completed during the reporting period for members classified as Community Well as of the first day of the reporting period.	Field Type: Numeric
B.	Total number of POC reviews or revisions completed during the reporting period for members classified as Community Well that were due to a triggering event.	Of the total reported in A, the number of POC reviews or revisions completed during the reporting period for members classified as Community Well that were due to a triggering event.	Field type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of POC reviews or revisions completed during the reporting period for members classified as EDCD members as of the first day of the reporting period.	Total number of POC reviews or revisions completed during the reporting period for members classified as EDCD members as of the first day of the reporting period.	Field Type: Numeric
D.	Total number of POC reviews or revisions completed during the reporting period for members classified as EDCD members that were due to a triggering event.	Of the total reported in C, the number of POC reviews or revisions completed during the reporting period for members classified as EDCD members that were due to a triggering event.	Field type: Numeric Note: Is a subset of C.
E.	Total number of POC reviews or revisions completed during the reporting period for members classified as nursing facility members as of the first day of the reporting period.	Total number of POC reviews or revisions completed during the reporting period for members classified as nursing Facility members as of the first day of the reporting period.	Field Type: Numeric
F.	Total number of POC reviews or revisions completed during the reporting period for members classified as nursing facility members that were due to a triggering event.	Of the total reported in E, the number of POC reviews or revisions completed during the reporting period for members classified as nursing facility members that were due to a triggering event.	Field type: Numeric Note: Is a subset of E.

Element Letter	Element Name	Definition	Allowable Values
G.	Total number of POC reviews or revisions completed during the reporting period for members classified as all other vulnerable subpopulation members as of the first day of the reporting period.	Total number of POC reviews or revisions completed during the reporting period for members classified as all other vulnerable subpopulation members as of the first day of the reporting period.	Field Type: Numeric Note: Exclude EDCD and NF members.
H.	Total number of POC reviews or revisions completed during the reporting period for members classified as all other vulnerable subpopulation members that were due to a triggering event.	Total number of POC reviews or revisions completed during the reporting period for members classified as all other vulnerable subpopulation members that were due to a triggering event.	Field type: Numeric Note: Is a subset of G. 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.

- 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 D is less than or equal to data element C.
- MMPs should validate that data element F is less than or equal to data element E.
- MMPs should validate that data element H is less than or equal to data element G.
- 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 POC reviews or revisions completed during the reporting period for members classified as:

- Community Well as of the first day of the reporting period that were due to a triggering event.
- EDCD members as of the first day of the reporting period that were due to a triggering event.
- Nursing facility members as of the first day of the reporting period that were due to a triggering event.
- All other vulnerable subpopulation members as of the first day of the reporting period that were to a triggering event.

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. Medicaid-only members should not be included.
- MMPs should include all reassessments for members who meet the criteria outlined in Elements A, C, E, and G regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- A members' Community Well, EDCD, nursing facility, or other vulnerable subpopulation status should be based on the members' status at the first day of the reporting period.
- This measure is evaluating existing POCs that are reviewed or revised, not a members initial POC.
- A triggering event is defined as a hospitalization or significant change in health or functional status (e.g., change in the ability to perform activities of daily living and instrumental activities of daily living).

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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

VA2.14 Medication Reconciliation Post-Discharge.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
VA2. Care Coordination	Annually	Contract	Calendar Year	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 inpatient discharges during the reporting period.	Total number of inpatient discharges that occurred between January 1 and December 1 during the reporting period.	Field Type: Numeric
B.	Total number of inpatient discharges for which a medication reconciliation was conducted by a prescribing practitioner, clinical pharmacist or registered nurse on the date of discharge through 30 days after the inpatient discharge (31 days total).	Of the total reported in A, the number of inpatient discharges for which a medication reconciliation was conducted by a prescribing practitioner, clinical pharmacist, or registered nurse on the date of discharge through 30 days after the inpatient discharge (31 days total).	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 inpatient discharges from January 1–December 1 of the reporting period for which a medication reconciliation was conducted by a prescribing practitioner, clinical pharmacist, or registered nurse on the date of discharge through 30 days of the inpatient discharge during the reporting period (31 days total).

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. Medicaid-only members should not be included.
- MMPs should include all inpatient discharges for members who meet the criteria outlined in Element A and were continuously enrolled from the date of discharge through 30 days after the discharge, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- The denominator for this measure is based on discharges, not members.
- If a member has more than one discharge, include all discharges on or between January 1 and December 1 of the reporting period. To identify acute and nonacute inpatient discharges:
    i. Identify all acute and nonacute inpatient stays (Inpatient Stay value set)
    ii. Identify the discharge date for the stay
- Medication reconciliation is a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.
- Medication Reconciliation can be identified using the Medication Reconciliation value set.
- For data element A, if the discharge is followed by a readmission or direct transfer to an acute or nonacute inpatient care setting on the date of discharge through 30 days after discharge (31 total days), count only the last discharge. To identify readmissions during the 31-day period:
    i. Identify all acute and nonacute inpatient stays (Inpatient Stay value set)
    ii. Identify the admission date for the stay (the admission date must occur during the 31-day period)

iii. Identify the discharge date for the stay (the discharge date is the event date)

- MMPs must identify "transfers" using their own methods and then confirm the acute or nonacute inpatient care setting using the Inpatient Stay value set.
- For data element A, exclude both the initial and the readmission/direct transfer discharges if the last discharge occurs after December 1 of the reporting period.
- Members must be continuously enrolled in the MMP from the date of discharge through 30 days after discharge with no gap in enrollment, to be included in this measure.
- If a member remains in an acute or non-acute care setting through December 1 of the reporting period, a discharge is not included in the measure for this member, but the MMP must have a method for identifying the member's status for the remainder of the reporting period, and may not assume the member remained admitted based only on the absence of a charge before December 1.

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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

Section VAIII. Enrollee Protections

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

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
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
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
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.

Element Letter	Element Name	Definition	Allowable Values
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

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. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Element A regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- For data element B, MMPs should include all new critical incident and abuse cases that are reported during the reporting period, regardless if the case status is open or closed as of the last day of the reporting period.
- Critical incident and abuse reports could be reported by the MMP or any provider, and are not limited to only those providers defined as LTSS providers.
- 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:
    i. Willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish;
    ii. 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;
    iii. Rape or sexual assault;
    iv. Corporal punishment or striking of an individual;
    v. Unauthorized use or the use of excessive force in the placement of bodily restraints on an individual; and
    vi. 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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

VA3.2 Documentation of abuse, neglect, or exploitation and safety concerns or risk in the physical environment.

Please note: No MMP reporting to NORC is required for this measure as part of the reporting requirements; MMPs should continue to follow the CCC MMP Waiver Assurances Sampling Methodology and Other Expectations issued by DMAS in conducting waiver quality assurances and reporting directly to DMAS.

Section VAIV. Organizational Structure and Staffing

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

CONTINUOUS REPORTING				
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 that describes the policies and procedures for maintaining ADA compliance.	Field Type: N/A Note: File will be uploaded to FTP site as a separate attachment.
B.	ADA Compliance or Quality Officer.	Identification of the staff person 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.

- MMPs must submit an ADA Compliance Plan that aligns with the requirements outlined in this measure specification. If deficiencies are identified in the MMP's ADA Compliance Plan or the policies/procedures described therein, the MMP will be notified and provided with the opportunity to correct the deficiencies.

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

- Confirm that all required information is included in each element as outlined below.
- Confirm that the reported ADA Compliance Plan is the most current plan in a readable format.
- Confirm that the reported ADA Compliance Officer or Quality Officer is the current staff member in the position.

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 verify that each reported element follows the requirements outlined below. CMS and the state may request documentation to support the plan's implementation to achieve and maintain ADA compliance.

- **ADA Compliance Plan (Element A)** – The ADA Compliance Plan should clearly describe the policies and procedures for maintaining compliance with the ADA requirements. The plan can either be part of the organization's overall compliance plan or a separate document that just describes ADA compliance. The plan should include:
    i. Process for maintaining ADA compliance
    ii. Person and committee responsible for oversight
    iii. Description of training for network provider staff
    iv. Description of training for Interdisciplinary Care Team members
    v. Description of provider site assessment for compliance and frequency of assessment
    vi. Description of how non-compliant findings are remediated, including:
        1. Process for documenting non-compliance
        2. Process for documenting actions taken to remediate non-compliance
        3. Individual(s) responsible for remediation
        4. Timeline for remediation
        5. Monitoring and oversight of the remediation process
    vii. Committee meeting minutes to validate oversight of the ADA Compliance Plan
    viii. Annual assessment of the ADA Compliance Plan, including:
        1. Assessment of completion of planned activities and that the objectives of the plan were met
        2. Identification of issues or barriers that impacted meeting the objectives of the work plan
        3. Recommended interventions to overcome barriers and issues identified
        4. Overall effectiveness of the ADA Compliance Plan
- **ADA Compliance or Quality Officer (Element B)** – This document should identify the staff person responsible for ADA compliance and also provide his/her job description.

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

- MMPs should refer to the Virginia three-way contract for specific requirements pertaining to ADA physical access compliance.
- The ADA Compliance Officer or Quality Officer may be the same individual that serves as the MMP Compliance Officer.

- MMPs should refer to the following links for additional guidance on physical access for individuals with mobility disabilities: http://www.ada.gov/medcare_mobility_ta/medcare_ta.htm and http://www.adachecklist.org

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 manager training for supporting self-direction under the demonstration.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
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
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.	Total number of FTE care managers.	Total number of FTE care managers in the MMP during the reporting period.	Field Type: Numeric
B.	Total number of FTE care managers that have undergone training for supporting self-direction under the demonstration.	Of the total reported in A, the number of FTE care managers 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 managers 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 the Virginia three-way contract for specific requirements pertaining to a care manager.
- MMPs should refer to the Virginia three-way contract for specific requirements pertaining to training for supporting self-direction.
- A care manager 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 manager who works an average of 35 hours a week counts as one FTE. A care manager who works an average of 17.5 hours a week counts as half an FTE.
- The training referenced in data element B is defined within the training plan submitted by the MMP to DMAS for review.

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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

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

Please note: No MMP reporting to NORC is required for this measure as part of the reporting requirements; MMPs should continue to follow the CCC MMP Waiver Assurances Sampling Methodology and Other Expectations issued by DMAS in conducting waiver quality assurances and reporting directly to DMAS.

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

Please note: No MMP reporting to NORC is required for this measure as part of the reporting requirements; MMPs should continue to follow the CCC MMP Waiver Assurances Sampling Methodology and Other Expectations issued by DMAS in conducting waiver quality assurances and reporting directly to DMAS.

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

Please note: No MMP reporting to NORC is required for this measure as part of the reporting requirements; MMPs should continue to follow the CCC MMP Waiver Assurances Sampling Methodology and Other Expectations issued by DMAS in conducting waiver quality assurances and reporting directly to DMAS.

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

Please note: No MMP reporting to NORC is required for this measure as part of the reporting requirements; MMPs should continue to follow the CCC MMP Waiver Assurances Sampling Methodology and Other Expectations issued by DMAS in conducting waiver quality assurances and reporting directly to DMAS.

VA4.7 EDCD waiver provider staff training requirements.

Please note: No MMP reporting to NORC is required for this measure as part of the reporting requirements; MMPs should continue to follow the CCC MMP Waiver Assurances Sampling Methodology and Other Expectations issued by DMAS in conducting waiver quality assurances and reporting directly to DMAS.

VA4.8 Consumer-directed employees who are trained.

Please note: No MMP reporting to NORC is required for this measure as part of the reporting requirements; MMPs should continue to follow the CCC MMP Waiver Assurances Sampling Methodology and Other Expectations issued by DMAS in conducting waiver quality assurances and reporting directly to DMAS.

Section VAV. Performance and Quality Improvement

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

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.

- 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.
- 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. Medicaid-only members should not be included.
- 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 the Severe Mental Illness Diagnosis value set. 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 the Ambulatory Visits #1 and Other Ambulatory Visits value sets.

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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

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

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
VA5. Performance and Quality Improvement	Semi-Annually, beginning CY 2016	Contract	Ex: 1/1 – 6/30 7/1 – 12/31	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.	Total number of members 21-65 years of age who were continuously enrolled in the MMP for the entire reporting period with a diagnosis of SMI.	Field Type: Numeric
B.	Total number of members who were employed full- or part-time or temporarily employed at any point during the reporting period.	Of the total reported in A, the number of members who were employed full- or part-time or temporarily employed at any point during the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members diagnosed with SMI who were newly enrolled in the MMP.	Total number of members diagnosed with SMI who were newly enrolled in the MMP during the reporting period.	Field Type: Numeric
D.	Total number of members enrolled in the MMP who had a new diagnosis of SMI.	Total number of members enrolled in the MMP who had a new diagnosis of SMI during the reporting period.	Field Type: Numeric
E.	Total number of members who received at least one meaningful care management service within 30 days of enrollment.	Of the total reported in C, the number of members who received at least one meaningful care management service within 30 days of enrollment.	Field Type: Numeric Note: Is a subset of C.

Element Letter	Element Name	Definition	Allowable Values
F.	Total number of members who received at least one meaningful care management service within 30 days of SMI diagnosis date.	Of the total reported in D, the number of members who received at least one meaningful care management service within 30 days of SMI diagnosis date.	Field Type: Numeric Note: Is a subset of D.
G.	Total number of members who received at least five additional meaningful care management services within 90 days of enrollment.	Of the total reported in C, the number of members who received at least five additional meaningful care management services within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of C.
H.	Total number of members who received at least five additional meaningful care management services within 90 days of SMI diagnosis date.	Of the total reported in D, the number of members who received at least five additional meaningful care management services within 90 days of SMI diagnosis date.	Field Type: Numeric Note: Is a subset of D.

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 elements E and G are less than or equal to data element C.
- MMPs should validate that data elements F and H are less than or equal to data element D.
- 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 diagnosed with SMI who were continuously enrolled for the entire reporting period and who were employed full- or part-time or temporarily employed at any point during the reporting period.
- CMS and the state will also evaluate the percentage of members:
    i. Diagnosed with SMI who were newly enrolled in the MMP during the reporting period who received at least one meaningful care management service within 30 days of enrollment.
    ii. Enrolled in the MMP who had a new diagnosis of SMI during the reporting period who received at least one meaningful care management service within 30 days of SMI diagnosis date.
    iii. Diagnosed with SMI who were newly enrolled in the MMP during the reporting period who received at least five additional meaningful care management services within 90 days of enrollment.
    iv. Enrolled in the MMP who had a new diagnosis of SMI during the reporting period who received at least five additional meaningful care management services within 90 days of SMI diagnosis date.

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. Medicaid-only members should not be included.
- 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.
- The diagnosis of SMI reported in data element A could have occurred at any time, and not necessarily during the current reporting period (i.e., the member may have been diagnosed with SMI prior to the start of the current reporting period). If the MMP has access to historical data prior to the start of the demonstration, the MMP is encouraged use this information to identify the SMI diagnosis. However, if the MMP does not have access to historical data, then the diagnosis of SMI could have occurred at any time since the first effective date of the demonstration.

- Reporting of Element B is based on members' self-reported employment status. Include members who self-reported that they were employed full- or part-time or were temporarily employed for any length of time during the reporting period.
- Meaningful care management services include meaningful member-to-care manager encounters and targeted case management services provided by Community Service Boards (CSBs). Meaningful member-to-care manager encounters only include direct communication between a member and his/her care manager over the phone or face-to-face. Voicemail message, letters, and no-show appointments are examples of outreach attempts that should not be counted as meaningful care management services.
- For purposes of reporting this measure, the 30 day and 90 day time periods in data elements E-H are equivalent to one and three full calendar months, respectively.
- For data element E, members must be enrolled from the date of enrollment through 30 days following their effective enrollment date, with no gaps in enrollment to be included in this measure.
- For data element F, members must be enrolled from the day of SMI diagnosis through 30 days following the SMI diagnosis date, with no gaps in enrollment to be included in this measure.
- For data element G, members must be enrolled from the date of enrollment through 90 days following their effective enrollment date, with no gaps in enrollment to be included in this measure.
- For data element G, the date of enrollment must occur within the reporting period, but the receipt of meaningful care management services may not be in the same reporting period. For example, if a member is enrolled during the last three months of the reporting period, look up to the third month of the following reporting period to identify the receipt of meaningful care management services.
- For data element H, members must be enrolled from the day of SMI diagnosis through 90 days following the SMI diagnosis date, with no gaps in enrollment to be included in this measure.
- For data element H, the date of SMI diagnosis must occur within the reporting period, but the receipt of meaningful care management services may not be in the same reporting period. For example, if a member is newly diagnosed with SMI during the last three months of the reporting period, look up to the third month of the following reporting period to identify the receipt of meaningful care management services.
- Codes to identify mental illness diagnosis are provided in the Severe Mental Illness Diagnosis value set. Members with a principal diagnosis code of severe mental illness should be included in this measure.

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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

VA5.3 Adjudicated clean claims.[i, ii]

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
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.

Element Letter	Element Name	Definition	Allowable Values
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 traditional Medicaid covered EDCD waiver services.	Of the total reported in A, the number of adjudicated clean claims for traditional Medicaid covered EDCD waiver services during the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of adjudicated clean claims for traditional Medicaid covered EDCD waiver services paid using the correct rate within 14 days of receipt.	Of the total reported in B, the number of adjudicated clean claims for traditional Medicaid covered EDCD waiver services paid using the correct rate within 14 days of receipt.	Field Type: Numeric Note: Is a subset of B.

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

Element Letter	Element Name	Definition	Allowable Values
I.	Total number of adjudicated clean claims for traditional Medicaid covered behavioral health services paid using the correct rate within 14 days of receipt.	Of the total reported in H, the number of adjudicated clean claims for traditional Medicaid covered behavioral health services paid using the correct rate within 14 days of receipt.	Field Type: Numeric Note: Is a subset of H.
J.	Total number of adjudicated clean claims for traditional Medicaid covered behavioral health services paid using the correct rate within 30 days of receipt.	Of the total reported in H, the number of adjudicated clean claims for traditional Medicaid covered behavioral health services paid using the correct rate within 30 days of receipt.	Field Type: Numeric Note: Is a subset of H.
K.	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, nursing facility, and behavioral health services claims.
L.	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 K, 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 K. Exclude EDCD, nursing facility, and behavioral health services claims.
M.	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 K, 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 K. Exclude EDCD, nursing facility, and behavioral health services claims.

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, and K 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.
- 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 traditional Medicaid covered EDCD waiver services that were paid using the correct rate within 14 days of receipt.
- Adjudicated clean claims for traditional Medicaid covered EDCD waiver services that were paid using the correct rate within 30 days of receipt.
- Adjudicated clean claims for traditional Medicaid covered nursing facility services that were paid using the correct rate within 14 days of receipt.
- Adjudicated clean claims for traditional Medicaid covered nursing facility services that were paid using the correct rate within 30 days of receipt.
- Adjudicated clean claims for traditional Medicaid covered behavioral health services that were paid using the correct rate within 14 days of receipt.
- Adjudicated clean claims for traditional Medicaid covered behavioral health 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.

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
- MMPs should include all adjudicated clean claims for members who meet the criteria outlined in all element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- 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 the Virginia three-way contract for more information regarding timely provider payments.
- Other traditional Medicaid covered services include all services that would be paid by Medicaid historically excluding EDCD waiver and NF services, behavioral health services, transportation services, and Public Partnerships LLC (PPL) services.
- Exclude nursing facilities, EDCD services, and LTC pharmacies within a nursing facility from other traditional Medicaid covered services.
- Report the number of adjudicated clean claims for Medicaid including crossover claims.
- A "clean" claim is one that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.
- Do not include reprocessed claims.
- Transportation clean claims should be included in other traditional Medicaid clean claims (Data Element K).

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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

VA5.4 Adherence to Antipsychotic Medications for Individuals with Schizophrenia.

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 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 age 21-64 with schizophrenia.	Total number of members age 21-64 with schizophrenia, who were continuously enrolled in the MMP during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric
B.	Total number of members who received a proportion of days covered (PDC) of at least 80% for their antipsychotic medications during the reporting period.	Of the total reported in A, the number of members who received a PDC of at least 80% for their antipsychotic medications 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 21–64 years of age during the reporting period with schizophrenia who achieved a PDC of at least 80% for their antipsychotic medications 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. Medicaid-only members should not be included.
- For data element A, members meet at least one of the following criteria:
    i. At least one acute inpatient encounter with any diagnosis of schizophrenia.
    ii. At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or non-acute inpatient setting, on different dates of service with any diagnosis of schizophrenia.
- The index prescription start date (IPSD) refers to the earliest prescription dispensing date for any antipsychotic medication during the reporting period.
- Treatment Period refers to the period of time beginning on the IPSD through the last day of the reporting period.
- The proportion of days covered (PDC) refers to the number of days a member is covered by at least one antipsychotic medication prescription, divided by the number of days in the treatment period.
- Oral medication dispensing event refers to one prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days' supply by 30 and round down to the convert. For example, a 100-day prescription is equal to three dispensing events.
    i. Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, use the prescription with the longest days' supply. Use the Drug ID to determine of the prescriptions are the same or different.
- Long-acting injections dispensing event refers to injections, which count as one dispensing event. Multiple J codes or National Drug Codes (NDCs) for the same or different medication on the same day are counted as a single dispensing event.

- Follow the instructions below to determine how to calculate the number of days covered for oral medications
    i. If multiple prescriptions for the same or different oral medications are dispensed on the same day, calculate number of days covered by an antipsychotic medication (for data element B) using the prescription with the longest days' supply.
    ii. If multiple prescriptions for different oral medications are dispensed on different days, count each day within the treatment period only once toward data element B.
    iii. If multiple prescriptions for the same oral medication are dispensed on different days, sum the days' supply and use the total to calculate the number of days covered by an antipsychotic medication (for data element B).
        1. For example, if three antipsychotic prescriptions for the same oral medication are dispensed on different days, each with a 30-day supply; sum the days' supply for a total of 90 days covered by an oral antipsychotic (even if there is overlap). Use the drug ID provided on the NDC list to determine if the prescriptions are the same or different.
- To calculate the number of days covered for long acting injections (for data element B), use the days' supply specified for the medication in Table VA-1.
    i. For multiple J Codes or NDCs for the same or different medications on the same day, use the medication with the longest days' supply.
    ii. For multiple J Codes or NDCs for the same or different medications on different days with overlapping days' supply, count each day within the treatment period only once toward data element B.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during each year of continuous enrollment (i.e., the reporting period). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
- Follow the steps outlined below to identify the eligible population for data element A:
        1. Identify members with schizophrenia as those who met at least one of the following criteria during the reporting period:
            a. At least one acute inpatient encounter with any diagnosis of schizophrenia. Either of the following combinations meets criteria:

i. BH Stand Alone Acute Inpatient value set ***with*** Schizophrenia value set.
ii. BH Acute Inpatient value set ***with*** BH Acute Inpatient POS value set ***and*** Schizophrenia value set.

b. At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or non-acute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the follow code combinations meet criteria:
i. BH Stand Alone Outpatient/PH/IOP value set ***with*** Schizophrenia value set.
ii. BH Outpatient/PH/IOP value set ***with*** BH Outpatient/PH/IOP POS value set ***and*** Schizophrenia value set.
iii. ED value set ***with*** Schizophrenia value set.
iv. BH ED value set ***with*** BH ED POS value set ***and*** Schizophrenia value set.
v. BH Stand Alone Nonacute Inpatient value set ***with*** Schizophrenia value set.
vi. BH Nonacute Inpatient value set ***with*** BH Nonacute Inpatient POS value set ***and*** Schizophrenia value set.

2. Identify required exclusions. Exclude members who met at least one of the following during the reporting period:
a. A diagnosis of dementia (Dementia value set).
b. Did not have at least two antipsychotic medication dispensing events. There are two ways to identify dispensing events: by claim/encounter data and by pharmacy data. The MMP must use both methods to identify dispensing events, but an event need only be identified by one method to be counted.
i. Claim/encounter data. An antipsychotic medication (Long-Acting Injections 14 Days Supply value set or Long-Acting Injections 28 Days Supply value set).
ii. Pharmacy data. Dispensed an antipsychotic medication on an ambulatory basis (Table VA-1).

- Follow the steps outlined below to identify <u>numerator compliance</u> (data element B).
1. Identify the IPSD. The IPSD is the earliest dispensing event for any antipsychotic medication (Table VA-1;

Long-Acting Injections 14 Days Supply value set; Long-Acting Injections 28 Days Supply value set) during the reporting period.
2. To determine the treatment period, calculate the number of days beginning on the IPSD through the end of the reporting period.
3. Count the days covered by at least one antipsychotic medication (Table VA-1; Long-Acting Injections 14 Days Supply value set; Long-Acting Injections 28 Days Supply value set) during the treatment period. To ensure that days' supply that extend beyond the reporting period are not counted, subtract any days' supply that extends beyond December 31 of the reporting period.
4. Calculate the member's PDC using the following equation. Round to two decimal places, using the .5 rule.

$$\frac{\textbf{Total days covered by an antipsychotic medication in the treatment period (Step 3)}}{\textbf{Total days in treatment period (Step 2)}}$$

5. Sum the number of members whose PDC is ≥80% for their treatment period.

Table VA-1: Antipsychotic Medications

Description	Prescription	Covered Days
Miscellaneous antipsychotic agents (oral)	• Aripiprazole • Asenapine • Clozapine • Haloperidol • Iloperidone • Loxapine • Lurisadone • Molindone • Olanzapine • Paliperidone • Pimozide • Quetiapine • Quetiapine fumarate • Risperidone • Ziprasidone	
Phenothiazine antipsychotics (oral)	• Chlorpromazine • Fluphenazine • Perphenazine • Perphenazine-amitriptyline • Prochlorperazine • Thioridazine • Trifluoperazine	
Psychotherapeutic combinations (oral)	• Fluoxetine-olanzapine	
Thioxanthenes (oral)	• Thiothixene	

Table VA-1: Antipsychotic Medications			
Description	**Prescription**		**Covered Days**
Long-acting injections	• Aripiprazole • Fluphenazine decanoate • Haloperidol decanoate	• Olanzapine • Paliperidone palmitate	28 days' supply
	• Risperidone		14 days' supply

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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

VA5.5 Antidepressant Medication Management.

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 third 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 age 21 and older, with a diagnosis of major depression and who were treated with antidepressant medication.	Total number of members age 21 and older, with a diagnosis of major depression and who were treated with antidepressant medication during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of members who had at least 84 days (12 weeks) of continuous treatment with antidepressant medication beginning on the index prescription start date (IPSD) through 114 days after the IPSD (115 days total).	Of the total reported in A, the number of members who had at least 84 days (12 weeks) of continuous treatment with antidepressant medication beginning on the IPSD through 114 days after the IPSD (115 days total).	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members who had at least 180 days (6 months) of continuous treatment with antidepressant medication beginning on the IPSD through 231 days after the IPSD (232 days total).	Of the total reported in A, the number of members who had at least 180 days (6 months) of continuous treatment with antidepressant medication beginning on the IPSD through 231 days after the IPSD (232 days total)	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 and C 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 age 21 years and older with a diagnosis of major depression who had at least:

- 84 days (12 weeks) of continuous treatment with antidepressant medication beginning on the IPSD through 114 days after the IPSD (115 days total).
- 180 days (6 months) of continuous treatment with antidepressant medication beginning on the IPSD through 231 days after the IPSD (232 days total)

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. Medicaid-only members should not be included.
- The Intake Period is the 12-month window starting on May 1 of the previous calendar year and ending on April 30 of the current calendar year.
- The Index Prescription Start Date (IPSD) is defined as the earliest prescription dispensing date for an antidepressant medication during the Intake Period.
- Negative Medication History is defined as a period of 105 days prior to the IPSD when the member had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.
- Treatment days are defined as the actual number of calendar days covered with prescriptions within the specified 180-day (6-month) measurement interval. For Effective Continuation Phase Treatment, a prescription of 90 days (3 months) supply dispensed on the 151st day will have 80 days counted in the 231-day interval.
- The member must be continuously enrolled for 105 days prior to the IPSD through 231 days after the IPSD, with no more than one gap in enrollment.
- The member must be 21 years and older as of April 30 of the current calendar year.
- To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
- Follow the steps below to identify the eligible population for data element A.
    1. Determine the IPSD. Identify the date of the earliest dispensing event for an antidepressant medication (Table VA-2) during the Intake Period.
    2. Exclude members who did not have a diagnosis of major depression in an inpatient, outpatient, ED, intensive outpatient, or partial hospitalization setting during the 121-day period from 60 days prior to the IPSD through the ISPD and the 60 days after the IPSD. Members who meet any of the following criteria remain in data element A:

a. An outpatient visit, intensive outpatient encounter or partial hospitalization with any diagnosis of major depression. Either of the following code combinations meets criteria:
    i. AMM Stand Alone Visits value set ***with*** Major Depression value set.
    ii. AMM Visits value set ***with*** AMM POS value set ***and*** Major Depression value set.
b. An ED visit (ED value set) *with* any diagnosis of major depression (Major Depression value set).
c. An acute or nonacute inpatient discharge with any diagnosis of major depression (Major Depression value set). To identify acute and nonacute inpatient discharges:
    i. Identify all acute and nonacute inpatient stays (Inpatient Stay value set)
    ii. Identify the discharge date for the stay. For a direct transfer, use the discharge date from the last discharge.

3. Test for Negative Medication History. Exclude members who filled a prescription for antidepressant medication 105 days prior to the IPSD.
4. Calculate continuous enrollment. Members must be continuously enrolled 105 days prior to the IPSD through 231 days after the IPSD.

- For calculating Effective Acute Phase Treatment (data element B), members must have at least 84 days (12 weeks) of continuous treatment with antidepressant medication (Table VA-2) during the 114-days after the IPSD (115 total days). The continuous treatment allows gaps in medication treatment up to a total of 30 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.
    - Regardless of the number of gaps, there may be no more than 30 gap days. Count any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days).
- For calculating the Effective Continuation Phase Treatment (data element C), members must have at least 180 days (6 months) of continuous treatment with antidepressant medication (Table VA-2) beginning on the IPSD through 231 days after the IPSD (232 total days). Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 232-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

  - Regardless of the number of gaps, there may be no more than 51 gap days. Count any combination of gaps (e.g., two washout gaps of 25 days each, or two washout gaps of 10 days each and one treatment gap of 10 days).
- MMPs may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date, and units of service. MMPs whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the period specified.
- Instead of annual reporting for a calendar year, it should be reported quarterly with calendar year to the end of current quarter reporting period.

Table VA-2: Antidepressant Medications

Description	Prescription	
Miscellaneous antidepressants	• Bupropion • Vortioxetine	• Vilazodone
Monoamine oxidase inhibitors	• Isocarboxazid • Phenelzine	• Selegiline • Tranylcypromine
Phenylpiperazine antidepressants	• Nefazodone	• Trazodone
Psychotherapeutic combinations	• Amitriptyline-chlordiazepoxide • Amitriptyline-perphenazine	• Fluoxetine-olanzapine
SNRI antidepressants	• Desvenlafaxine • Duloxetine	• Venlafaxine Levomilnacipran
SSRI antidepressants	• Citalopram • Escitalopram • Fluoxetine	• Fluvoxamine • Paroxetine • Sertraline
Tetracyclic antidepressants	• Maprotiline	• Mirtazapine
Tricyclic antidepressants	•Amitriptyline • Amoxapine • Clomipramine • Desipramine • Doxepin (>6 mg)	• Imipramine • Nortriptyline • Protriptyline • Trimipramine

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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

Section VAVI. Systems

VA6.1 Plan Enrollee Medical Record.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
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
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
VA6. Systems	Semi-Annually	Contract	Ex: 1/1 – 6/30 7/1 – 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.	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. Medicaid-only members should not be included.
- 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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

Section VAVII. Utilization

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

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
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
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
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.

Element Letter	Element Name	Definition	Allowable Values
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. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- 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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

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

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
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.

Element Letter	Element Name	Definition	Allowable Values
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. Medicaid-only members should not be included.
- 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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

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

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
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.

Element Letter	Element Name	Definition	Allowable Values
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. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- 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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

VA7.4 Average length of receipt in HCBS.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
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.

Element Letter	Element Name	Definition	Allowable Values
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. Medicaid-only members should not be included.

- MMPs should include all members who meet the criteria outlined in Element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of 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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

VA7.5 Plan All-Cause Readmissions.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
VA7. Utilization	Quarterly	Contract	Year Start to End of the Quarter Ex: 1/1/16-3/31/16 1/1/16-6/30/16 1/1/16-9/30/16 1/1/16-12/31/16	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 index hospital stays for members age 21-64 during the reporting period.	Total number of index hospital stays for members age 21-64 during the reporting period.	Field Type: Numeric
B.	Total number of index hospital stays that resulted in a 30-day readmission for members age 21-64 during the reporting period.	Of the total reported in A, the number of index hospital stays that resulted in a 30-day readmission for members age 21-64 during the reporting period.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Average adjusted probability of readmission for members age 21-64.	Average adjusted probability of readmission for members age 21-64.	Field Type: Numeric
D.	Total number of index hospital stays for members age 65 and older during the reporting period.	Total number of index hospital stays for members age 65 and older during the reporting period.	Field Type: Numeric
E.	Total number of index hospital stays that resulted in a 30-day readmission for members age 65 and older during the reporting period.	Of the total reported in D, the number of index hospital stays that resulted in a 30-day readmission for members age 65 and older during the reporting period.	Field Type: Numeric Note: Is a subset of D.
F.	Average adjusted probability of readmission for members age 65 and older.	Average adjusted probability of readmission for members age 65 and older.	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.

- 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 elements E is less than or equal to data element D.
- 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:

- Observed readmissions for members age 21-64.
- Adjusted readmissions for members age 21-64.
- Observed readmissions for members age 65 and older.
- Adjusted readmissions for members age 65 and older.

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. Medicaid-only members should not be included.
- This measure should be reported cumulatively on a quarterly basis, beginning with Q1. For example, the first reporting period will be January 1 through March 31 (i.e., end of quarter 1) and the second reporting period will be January 1 through June 30 (i.e., the end of quarter 2).
- Index Hospital Stay (IHS) refers to an acute inpatient stay with a discharge during the current reporting period.
- Index Admission Date is the IHS admission date.
- Index Discharge Date is the IHS discharge date. The index discharge date must during the current reporting period.
- Index Readmission Stay is an acute inpatient stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.
- Index Readmission Date is the admission date associated with the Index Readmission Stay.
- A planned hospital stay is when the hospital stay meets criteria as outlined in Step 5 below.
- The classification period is 365 days prior to and including an Index Discharge Date.
- The member must be continuously enrolled for the 365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date with no more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge Date.
- The date of the hospital index stay must occur within the reporting period, but the readmission may not be in the same reporting period. For example, if a hospital index stay occurs during the last month of the reporting period, look to the first month of the following reporting period to identify the readmission.
- The denominator for this measure is based on discharges, not members. Include all acute inpatient discharges for members who had one or more discharges during the current reporting period.
- Follow the steps below to identify acute inpatient stays (data elements A and D):
    1. Identify all acute inpatient discharges during the current reporting period. To identify acute inpatient discharges:
        a. Identify all acute and nonacute inpatient stays (Inpatient Stay value set)
        b. Exclude nonacute inpatient stays (Nonacute Inpatient Stay value set)
        c. Identify the discharge date for the stay.

Note: Include acute discharges from any type of facility (including behavioral healthcare facilities).

2. ***Acute-to-acute transfers:*** Keep the original admission date as the Index Admission Date, but use the transfer's discharge date as the Index Discharge Date. MMPs must identify "transfers" using their own methods and then confirm the acute inpatient care setting using the process in step 1.
3. Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.
4. Exclude hospital stays for the following reasons:
    a. The member died during the stay
    b. A principal diagnosis of pregnancy (Pregnancy value set)
    c. A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions value set)

    Note: For hospital stays where there was an acute-to-acute transfer (identified in step 2), use both the original stay and the transfer stay to identify exclusions in this step.
5. For all acute inpatient discharges identified using steps 1-4, determine if there was a planned hospital stay within 30 days. To identify planned hospital stays, identify all acute inpatient discharges during the reporting period:
    a. Identify all acute and nonacute inpatient stays (Inpatient Stay value set)
    b. Exclude nonacute inpatient stays (Nonacute Inpatient Stay value set)
    c. Identify the admission date for the stay.
    d. Exclude any hospital stay as an Index Hospital Stay if the admission date of the *first* stay within 30 days meets any of the following criteria:
        i. A principal diagnosis of maintenance chemotherapy (Chemotherapy value set)
        ii. A principal diagnosis of rehabilitation (Rehabilitation value set)
        iii. An organ transplant (Kidney Transplant value set, Bone Marrow Transplant value set, Organ Transplant Other than Kidney value set)
        iv. A potentially planned procedure (Potentially Planned Procedures value

set) without a principal acute diagnosis (Acute Condition value set)

Note: For hospital stays where there was an acute-to-acute transfer (identified in step 2), use only the original stay to identify planned hospital stays in this step (i.e., do not use diagnoses and procedures from the transfer stay)

Example 1: For a member with the following acute inpatient stays, exclude stay 1 as an Index Hospital Stay

- Stay 1(*January 30-February 1 of the reporting period*): Acute inpatient discharge with a principal diagnosis of COPD.
- Stay 2 (*February 5-7 of the reporting period*): Acute inpatient discharge with a principal diagnosis of maintenance chemotherapy.

Example 2: For a member with the following acute inpatient stays, exclude stays 2 and 3 as Index Hospital Stays in the following scenario.

- Stay 1 (January 15-17 of the reporting period): Acute inpatient discharge with a principal diagnosis of diabetes.
- Stay 2 (January 30-February 1 of the reporting period): Acute inpatient discharge with a principal diagnosis of COPD
- Stay 3 (February 5-7 of the reporting period): Acute inpatient discharge with an organ transplant.
- Stay 4 (February 10-15 of the reporting period): Acute inpatient discharge with a principal diagnosis of rehabilitation

6. Calculate continuous enrollment
7. Assign each acute inpatient stay to one age (21-64 or 65 and older) category.

Risk Adjustment Determination

- For each IHS, use the following steps to identify risk adjustment categories based on the presences of surgeries, discharge condition, comorbidity, age and gender.
- Surgeries - Determine if the member underwent surgery during the inpatient stay. Download the list of codes from the NCQA web site (Table HCC-Surg) and use it to identify surgeries. Consider an IHS to include a surgery if at least one procedure code in Table HCC-

Surg is present from any provider between the admission and discharge dates.

- Discharge Conditions - Assign a discharge Clinical Condition (CC) category code to the IHS based on its primary discharge diagnosis, using Table PCR-DischCC (downloadable from the NCQA web site). For acute-to-acute transfers, use the transfer's primary discharge diagnosis.
    - Exclude diagnoses that cannot be mapped to Table PCR-DischCC.
- Comorbidities
    1. Identify all diagnoses for encounters during the classification period. Include the following when identifying encounters:
        a. Outpatient visits (Outpatient value set)
        b. Observation visits (Observation value set)
        c. Non-acute inpatient encounters (Nonacute Inpatient value set)
        d. Acute inpatient encounters (Acute Inpatient value set)
        e. ED visits (ED value set)
    - Exclude the primary discharge diagnosis on the IHS.
    2. Assign each diagnosis to one comorbid Clinical Condition (CC) category using Table CC—Comorbid (downloadable from the NCQA web site).
        a. Exclude all diagnoses that cannot be assigned to a comorbid CC category. For members with no qualifying diagnoses from face-to-face encounters, skip to the Risk Adjustment Weighting section.
        b. All digits must match exactly when mapping diagnosis codes to the comorbid CCs.
    3. Determine HCCs for each comorbid CC identified. Refer to Table VA-3, HCC—Rank for examples. Download the full list of codes from the NCQA web site.
        a. For each stay's comorbid CC list, match the comorbid CC code to the comorbid CC code in the table and assign:
            i. The ranking group
            ii. The rank
            iii. The HCC
        b. For comorbid CCs that do not match to Table HCC—Rank, use the comorbid CC as the HCC and assign a rank of 1.

c. Note: One comorbid CC can map to multiple HCCs; each HCC can have one or more comorbid CCs.

4. Assess each ranking group separately and select only the highest ranked HCC in each ranking group using the *Rank* column (1 is the highest rank possible).
    a. Drop all other HCCs in each ranking group, and de-duplicate the HCC list if necessary.
    b. Example: Assume a stay with the following comorbid CCs: CC-85, CC-17, and CC- 19 (assume no other CCs).
        i. CC-85 does not have a map to the ranking table and becomes HCC-85.
        ii. HCC-17 and HCC-19 are part of Diabetes Ranking Group 1. Because CC-17 is ranked higher than CC-19 in Ranking Group Diabetes 1, the comorbidity is assigned as HCC-17 for Ranking Group 1.
        iii. The final comorbidities for this discharge are HCC-17 and HCC-85.

Table VA-3: Example HCC—Rank

Ranking Group	CC	Description	Rank	HCC
NA	CC-85	Congestive Heart Failure	NA	HCC-85
Diabetes 1	CC-17	Diabetes with Acute Complications	1	HCC-17
	CC-18	Diabetes with Chronic Complications	2	HCC-18
	CC-19	Diabetes without Complication	3	HCC-19

5. Identify combination HCCs listed in Table VA-4, HCC—Comb for examples. Download the full list of codes from the NCQA web site.
    a. Some combinations suggest a great amount of risk when observed together. For example, when diabetes *and* CHF are present, an increased amount of risk is evident. Additional HCCs are selected to account for these relationships.
    b. Compare each stay's list of unique HCCs to those in the HCC column in Table HCC—Comb and assign any additional HCC conditions.
    c. For fully nested combinations (e.g., the diabetes/CHF combination is nested in the diabetes/ CHF/renal combination), use only

the more comprehensive pattern. In this example, only the diabetes/CHF/renal combination is counted.

d. For overlapping combinations (e.g., the CHF, COPD combination overlaps the CHF/renal/ diabetes combination), use both sets of combinations. In this example, both CHF/COPD and CHF/renal/diabetes combinations are counted.
e. Based on the combinations, a member can have none, one or more of these added HCCs.
f. Example: For a stay with comorbidities HCC-17 and HCC-85 (assume no other HCCs), assign HCC-901 in addition to HCC-17 and HCC-85. This does *not* replace HCC-17 or HCC-85.

Table VA-4: Example HCC—Comb Combination: Diabetes and CHF

Comorbid HCC	Comorbid HCC	Comorbid HCC	Combination HCC
HCC-17	HCC-85	NA	HCC-901
HCC-18	HCC-85	NA	HCC-901
HCC-19	HCC-85	NA	HCC-901

Risk Adjustment Weighting

- For each IHS, use the following steps to identify risk adjustment weights based on presence of surgeries, discharge condition, comorbidity, age and gender. Download the full list of codes from the NCQA web site.
    1. For each IHS with a surgery, link the surgery weight.
        a. For ages 21-64: Use Table PCR-MA-OtherWeights-Under65
        b. For age 65 and older: Use Table PCR-MA-OtherWeights-65plus.
    2. For each IHS with a discharge CC Category, link the primary discharge weights.
        a. For ages 21-64: Use Table PCR-MA-DischCC-Weight-Under65
        b. For age 65 and older: Use Table PCR-MA-DischCC- Weight-65plus.
    3. For each IHS with a comorbidity HCC Category, link the weights.
        a. For ages 21-64: Use Table PCR-MA-ComorbHCC-Weight-Under65
        b. For age 65 and older: Use Table PCR-MA-ComorbHCC-Weight-65plus.
    4. Link the age and gender weights for each IHS.

a. For ages 21-64: Use Table PCR-MA-OtherWeights-Under65
b. For age 65 and older: Use Table PCR-MA-OtherWeights-65plus.

5. Identify the base risk weight.
    a. For ages 21-64: Use Table PCR-MA-OtherWeights-Under65
    b. For age 65 and older: Use Table PCR-MA-OtherWeights-65plus.
6. Sum all weights associated with the IHS (i.e., presence of surgery, primary discharge diagnosis, comorbidities, age, gender and base risk weight).
7. Use the formula below to calculate the adjusted probability of a readmission based on the sum of the weights for each IHS.

$$\text{Adjusted probability of readmission} = \frac{e^{(\sum \text{WeightsforIHS})}}{1 + e^{(\sum \text{WeightsforIHS})}}$$

OR

Adjusted probability of readmission =
[exp (sum of weights for IHS)] / [1 + exp (sum of weights for IHS)] “exp” refers to the exponential or antilog function.

8. Use the formula below and the adjusted probability of readmission calculated in Step 7 to calculate the variance for each IHS.

    Variance = Adjusted probability of readmission x (1 – Adjusted probability of readmission)

    a. Example: If the adjusted probability of readmission is 0.1518450741 for an IHS, then the variance for this IHS is 0.1518450741 x 0.8481549259 = 0.1287881476
    b. Note: The variance is calculated at the IHS level. MMPs must sum the variances for each age and total category when populating the Total Variance cells in the reporting tables.

- To identify numerator compliance (data elements B and E), identify discharges that have at least one acute readmission for any diagnosis within 30 days of the Index Discharge Date, using the following steps:
    1. Identify all acute inpatient stays with an admission date during the reporting period. To identify acute inpatient admissions:

a. Identify all acute and nonacute inpatient stays (Inpatient Stay value set)
b. Exclude nonacute inpatient stays (Nonacute Inpatient Stay value set)
c. Identify the admission date for the stay.

2. ***Acute-to-acute transfers****:* Keep the original admission date as the Index Admission Date, but use the transfer's discharge date as the Index Discharge Date. MMPs must identify "transfers" using their own methods and then confirm the acute inpatient care setting using the steps above.
3. Exclude acute inpatient hospital discharges with a principal diagnosis of pregnancy (Pregnancy value set) or for a condition originating in the perinatal period (Perinatal Conditions value set).
4. For each IHS, determine if any of the acute inpatient stays have an admission date within 30 days after the Index Discharge Date.

- For reporting data elements A and D, count the number of IHS for each age group.
- Follow the steps below to report risk adjustment:
    1. Calculate the average adjusted probability for each IHS for each age and the overall total.
        a. MMPs must calculate the probability of readmission for each hospital stay within the applicable age group to calculate the average. For the total age category, the probability of readmission for all hospital stays in the age categories must be averaged together; MMPs cannot take the average of the average adjusted probabilities reported for each age.
    2. Round to four decimal places using the .5 rule.
        a. Note: Do not take the average of the cells in the reporting table.
        b. Repeat for each subsequent age group.
    3. Calculate the total (sum) variance for each age and the overall total.
    4. Round to four decimal places using the .5 rule.
- For reporting data elements B and E, count the number of IHS with a readmission within 30 days for each age group.

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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

VA7.6 Adults' Access to Preventive/Ambulatory Health Services.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
VA7. Utilization	Quarterly	Contract	Year Start to End of the Quarter Ex: 1/1/16-3/31/16 1/1/16-6/30/16 1/1/16-9/30/16 1/1/16-12/31/16	By the end of the third 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 21-64 years old.	Total number of members 21-64 years old who were continuously enrolled in the MMP during the reporting period and who were enrolled on the last day of the reporting period.	Field Type: Numeric
B.	Total number of members 21-64 years old with one or more ambulatory or preventive care visits during the reporting period.	Of the total reported in A, the number of members 21-64 years old with one or more ambulatory or preventive care visits during the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members 65 years and older.	Total number of members 65 years and older who were continuously enrolled in the MMP during the reporting period and who were enrolled on the last day of the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of members 65 years and older with one or more ambulatory or preventive care visits during the reporting period.	Of the total reported in C, the number of members 65 years and older with one or more ambulatory or preventive care visits during the reporting period.	Field Type: Numeric Note: Is a subset of C.

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 D is less 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:

- 21-64 years old with one or more ambulatory or preventive care visits during the reporting period.
- 65 years and older with one or more ambulatory or preventive care visits 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. Medicaid-only members should not be included.
- This measure should be reported cumulatively on a quarterly basis, beginning with Q1. For example, the first reporting period will be January 1 through March 31 (i.e., end of quarter 1) and the second reporting period will be January 1 through June 30 (i.e., the end of quarter 2).
- For the reporting period January 1 – December 31, the member should be continuously enrolled during the reporting period with no

more than one gap in enrollment of up to 45 days during the reporting period. To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

- For the reporting periods January 1 – March 31, January 1 – June 30, and January 1 – September 30, the member must be continuously enrolled during the reporting period with no gaps in enrollment.
- Members must be enrolled on the last day of the reporting period to be included in this measure.
- Codes to identify preventive/ambulatory health services are provided in the Ambulatory Visits #2 and Other Ambulatory Visits value set.

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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

VA7.7 Mental Health Utilization.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
VA7. Utilization	Quarterly	Contract	Year Start to End of the Quarter Ex: 1/1/16-3/31/16 1/1/16-6/30/16 1/1/16-9/30/16 1/1/16-12/31/16	By the end of the third 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 age 21-64 as of the end of the reporting period.	Total number of members age 21-64 as of the end of the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of member months during the reporting period for members age 21-64.	Total number of member months during the reporting period for members age 21-64.	Field Type: Numeric
C.	Total number of members age 21-64 who received inpatient Mental Health Services during the reporting period.	Of the total reported in A, the number of members age 21-64 who received inpatient Mental Health Services during the reporting period.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of members age 21-64 who received intensive outpatient/partial hospitalization Mental Health Services during the reporting period.	Of the total reported in A, the number of members age 21-64 who received intensive outpatient/partial hospitalization Mental Health Services during the reporting period.	Field Type: Numeric Note: Is a subset of A.
E.	Total number of members age 21-64 who received outpatient/ED Mental Health Services during the reporting period.	Of the total reported in A, the number of members age 21-64 who received outpatient/ED Mental Health Services during the reporting period.	Field Type: Numeric Note: Is a subset of A.
F.	Total number of members age 21-64 who received any Mental Health Services during the reporting period.	Of the total reported in A, the number of members age 21-64 who received any Mental Health Services during the reporting period.	Field Type: Numeric Note: Is a subset of A.
G.	Total number of members age 65 and older as of the end of the reporting period.	Total number of members age 65 and older as of the end of the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
H.	Total number of member months for members age 65 and older at the end of the reporting period.	Of the total reported in G, the number of member months for members age 65 and older during the reporting period.	Field Type: Numeric
I.	Total number of members age 65 and older who received inpatient Mental Health Services during the reporting period.	Of the total reported in G, the number of members age 65 and older who received inpatient Mental Health Services during the reporting period.	Field Type: Numeric Note: Is a subset of G.
J.	Total number of members 65 and older who received intensive outpatient/partial hospitalization Mental Health Services during the reporting period.	Of the total reported in G, the number of members 65 and older who received intensive outpatient/partial hospitalization Mental Health Services during the reporting period.	Field Type: Numeric Note: Is a subset of G.
K.	Total number of members age 65 and older who received outpatient/ED Mental Health Services during the reporting period.	Of the total reported in G, the number of members age 65 and older who received outpatient/ED Mental Health Services during the reporting period.	Field Type: Numeric Note: Is a subset of G.
L.	Total number of members age 65 and older who received any Mental Health Services during the reporting period.	Of the total reported in G, the number of members age 65 and older who received any Mental Health Services during the reporting period.	Field Type: Numeric Note: Is a subset of G.

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, D, E, and F are subsets of data element A.
- MMPs should validate that the sum of data elements C, D, and E are equal to data element F.
- MMPs should validate that data elements I, J, K, and L are subsets of data element G.
- MMPs should validate that the sum of data elements I, J, and K are equal to data element L.
- 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:

- 21-64 who received inpatient mental health services during the reporting period.
- 21-64 who received outpatient/ED mental health services during the reporting period.
- 21-64 who received intensive outpatient or partial hospitalization mental health services during the reporting period.
- 21-64 who received any mental health services during the reporting period.
- 65 and older who received inpatient mental health services during the reporting period.
- 65 and older who received outpatient/ED mental health services during the reporting period.
- 65 and older intensive outpatient or partial hospitalization mental health services during the reporting period.
- 65 and older who received any mental health 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 who received mental health benefits regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all member months for members who meet the criteria outlined in Elements A and G, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).

- This measure should be reported cumulatively on a quarterly basis, beginning with Q1. For example, the first reporting period will be January 1 through March 31 (i.e., end of quarter1) and the second reporting period will be January 1 through June 30 (i.e., the end of quarter 2).
- Count members who received inpatient, intensive outpatient, partial hospitalization, and outpatient/ED mental health services for each respective data element. Count members only once for each data element, regardless of the number of visits.
- Count members in data elements F and L only if the member had a least one inpatient, intensive outpatient, partial hospitalization, outpatient or ED claim/encounter during the reporting period.
- For members who had more than one encounter, count only the first encounter in the reporting period and report the member in the respective age category as of the date of service or discharge.
- Member months refers to the number of months each Medicare-Medicaid member was enrolled in the MMP in the year. Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable. Determine member months using the 30th of the month. This date must be used consistent from member to member, month to month and from year to year. For example, if Ms. X is currently enrolled in the MMP on January 30, Ms. X contributes one member month in January.
- For data elements B and H, use the members' age on the specified day of each month to determine the age group to which member months will be contributed. For example, if an MMP tallies members on the 30th of each month and Ms. X turns 65 on April 3 and is enrolled for the entire year, then she contributes three member months (January, February, March) to the 21 – 64 age group category and nine months to the 65 and older age group category.
- To determine inpatient mental health, include acute and nonacute inpatient discharges from either a hospital or a treatment facility with a mental health principal diagnosis (Mental Health Diagnosis value set). To identify acute and nonacute inpatient discharges:
    i. Identify all acute and nonacute inpatient stays (Inpatient Stay value set)
    ii. Identify the discharge date for the stay.
- To determine intensive outpatient/partial hospitalization, include intensive outpatient/partial hospitalization claims/encounters in conjunction with principal mental health diagnosis. Use any of the following code combinations:
    - MPT Stand Alone IOP/PH value set ***with*** Mental Health Diagnosis value set
    - MPT IOP/PH Group 1 value set ***with*** POS 52 value set ***and*** Mental Health Diagnosis value set

    - MPT IOP/PH Group 1 value set ***with*** POS 53 value set ***and*** Mental Health Diagnosis value set, where the MMP can confirm that the visits was in an intensive outpatient or partial hospitalization setting (POS 53 is not specific to setting)
    - MPT IOP/PH Group 2 value set ***with*** POS 52 value set ***and*** Mental Health Diagnosis value set billed by a mental health practitioner
    - MPT IOP/PH Group 2 value set ***with*** POS 53 value set ***and*** Mental Health Diagnosis value set, where the MMP can confirm that the visit was in an intensive outpatient or partial hospitalization setting (POS 53 is not specific to setting) and billed by a mental health practitioner
- Count services provided by physicians and non physician practitioners.
- Exclude services determine inpatient based on type of bill, place of service or location of service codes
- To determine Outpatient and ED mental health visits, include outpatient and ED claims/encounters in conjunction with a principal mental health diagnosis. Use any of the following code combinations:
    - MPT Stand Alone Outpatient Group 1 value set ***with*** Mental Health Diagnosis value set
    - Observation value set ***with*** Mental Health Diagnosis value set billed by a mental health practitioner
    - ED value set ***with*** Mental Health Diagnosis value set billed by a mental health practitioner
    - MPT Outpatient /ED value set ***with*** MPT Outpatient/ED POS value set ***and*** Mental Health Diagnosis value set
    - MPT Outpatient/ED value set ***with*** POS 53 value set ***and*** Mental Health Diagnosis value set, where the MMP can confirm that the visit was in an outpatient or ED setting (POS 53 is not specific to setting)
    - MPT Stand Alone Outpatient Group 2 value set ***with*** Mental Health Diagnosis value set billed by a mental health practitioner
- Count services provided by physicians and non physician practitioners.
- Only include observation stays and ED visits that do not result in inpatient stays.

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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

VA7.8 Care Management Utilization.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
VA7. Utilization	Semi-Annually	Contract	Ex: 1/1 – 6/30 7/1 – 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 member months for members classified as Community Well during the reporting period.	Total number of member months for members classified as Community Well during the reporting period.	Field Type: Numeric
B.	Total number of Community Well members who had zero (0) care manager encounters during the reporting period.	Total number of Community Well members who had zero (0) care manager encounters during the reporting period.	Field Type: Numeric
C.	Total number of Community Well members who had 1-2 care manager encounters during the reporting period.	Total number of Community Well members who had 1-2 care manager encounters during the reporting period.	Field Type: Numeric
D.	Total number of Community Well members who had 3-4 care manager encounters during the reporting period.	Total number of Community Well members who had 3-4 care manager encounters during the reporting period.	Field Type: Numeric
E.	Total number of Community Well members who had 5-6 care manager encounters during the reporting period.	Total number of Community Well members who had 5-6 care manager encounters during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
F.	Total number of Community Well members who had 7 or more care manager encounters during the reporting period.	Total number of Community Well members who had 7 or more care manager encounters during the reporting period.	Field Type: Numeric
G.	Total number of member months for members classified as EDCD during the reporting period.	Total number of member months for members classified as EDCD during the reporting period.	Field Type: Numeric
H.	Total count of EDCD members who had zero (0) care manager encounters during the reporting period.	Total number of EDCD members who had zero (0) care manager encounters during the reporting period.	Field Type: Numeric
I.	Total number of EDCD members who had 1-2 care manager encounters during the reporting period.	Total number of EDCD members who had 1-2 care manager encounters during the reporting period.	Field Type: Numeric
J.	Total number of EDCD members who had 3-4 care manager encounters during the reporting period.	Total number of EDCD members who had 3-4 care manager encounters during the reporting period.	Field Type: Numeric
K.	Total number of EDCD members who had 5-6 care manager encounters during the reporting period.	Total number of EDCD members who had 5-6 care manager encounters during the reporting period.	Field Type: Numeric
L.	Total number of EDCD members who had 7 or more care manager encounters during the reporting period.	Total number of EDCD members who had 7 or more care manager encounters during the reporting period.	Field Type: Numeric
M.	Total number of member months for members classified as nursing facility members during the reporting period.	Total number of member months for members classified as nursing facility members during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
N.	Total number of nursing facility members who had zero (0) care manager encounters during the reporting period.	Total number of nursing facility members who had zero (0) care manager encounters during the reporting period.	Field Type: Numeric
O.	Total number of nursing facility members who had 1-2 care manager encounters during the reporting period.	Total number of nursing facility members who had 1-2 care manager encounters during the reporting period.	Field Type: Numeric
P.	Total number of nursing facility members who had 3-4 care manager encounters during the reporting period.	Total number of nursing facility members who had 3-4 care manager encounters during the reporting period.	Field Type: Numeric
Q.	Total number of nursing facility members who had 5-6 care manager encounters during the reporting period.	Total number of nursing facility members who had 5-6 care manager encounters during the reporting period.	Field Type: Numeric
R.	Total number of nursing facility members who had 7 or more care manager encounters during the reporting period.	Total number of nursing facility members who had 7 or more care manager encounters during the reporting period.	Field Type: Numeric
S.	Total number of member months for members classified as all other vulnerable subpopulation members during the reporting period.	Total number of member months for members classified as all other vulnerable subpopulation members during the reporting period.	Field Type: Numeric Note: Exclude EDCD and NF members.
T.	Total number of all other vulnerable subpopulation members who had zero (0) care manager encounters during the reporting period.	Total number of all other vulnerable subpopulation members who had zero (0) care manager encounters during the reporting period.	Field Type: Numeric Note: Exclude EDCD and NF members.

Element Letter	Element Name	Definition	Allowable Values
U.	Total number of all other vulnerable subpopulation members who had 1-2 care manager encounters during the reporting period.	Total number of all other vulnerable subpopulation members who had 1-2 care manager encounters during the reporting period.	Field Type: Numeric Note: Exclude EDCD and NF members.
V.	Total number of all other vulnerable subpopulation members who had 3-4 care manager encounters during the reporting period.	Total number of all other vulnerable subpopulation members who had 3-4 care manager encounters during the reporting period.	Field Type: Numeric Note: Exclude EDCD and NF members.
W.	Total number of all other vulnerable subpopulation members who had 5-6 care manager encounters during the reporting period.	Total number of all other vulnerable subpopulation members who had 5-6 care manager encounters during the reporting period.	Field Type: Numeric Note: Exclude EDCD and NF members.
X.	Total number of all other vulnerable subpopulation members who had 7 or more care manager encounters during the reporting period.	Total number of all other vulnerable subpopulation members who had 7 or more care manager encounters during the reporting period.	Field Type: Numeric 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.

- 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 members classified as:

- Community Well who had zero (0) care manager encounters during the reporting period per 1,000 member months.

- Community Well who had 1-2 care manager encounters during the reporting period per 1,000 member months.
- Community Well who had 3-4 care manager encounters during the reporting period per 1,000 member months.
- Community Well who had 5-6 care manager encounters during the reporting period per 1,000 member months.
- Community Well who had 7 or more care manager encounters during the reporting period per 1,000 member months.
- EDCD who had zero (0) care manager encounters during the reporting period per 1,000 member months.
- EDCD who had 1-2 care manager encounters during the reporting period per 1,000 member months.
- EDCD who had 3-4 care manager encounters during the reporting period per 1,000 member months.
- EDCD who had 5-6 care manager encounters during the reporting period per 1,000 member months.
- EDCD who had 7 or more care manager encounters during the reporting period per 1,000 member months.
- Nursing facility members who had zero (0) care manager encounters during the reporting period per 1,000 member months.
- Nursing facility members who had 1-2 care manager encounters during the reporting period per 1,000 member months.
- Nursing facility members who had 3-4 care manager encounters during the reporting period per 1,000 member months.
- Nursing facility members who had 5-6 care manager encounters during the reporting period per 1,000 member months.
- Nursing facility members who had 7 or more care manager encounters during the reporting period per 1,000 member months.
- All other vulnerable subpopulation members who had zero (0) care manager encounters during the reporting period per 1,000 member months.
- All other vulnerable subpopulation members who had 1-2 care manager encounters during the reporting period per 1,000 member months.
- All other vulnerable subpopulation members who had 3-4 care manager encounters during the reporting period per 1,000 member months.
- All other vulnerable subpopulation members who had 5-6 care manager encounters during the reporting period per 1,000 member months.
- All other vulnerable subpopulation members who had 7 or more care manager encounters during the reporting period per 1,000 member months.

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. Medicaid-only members should not be included.
- MMPs should include all members who had any enrollment during the reporting period, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- MMPs should only include the meaningful member-to-care manager encounters, which only includes direct communication between a member and his/her care manager over the phone or face-to-face. Voicemail messages, letters, and no-show appointments should not be counted under this measure.
- 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:

  ix. Individuals enrolled in the EDCD waiver;
  x. Individuals with intellectual/developmental disabilities;
  xi. Individuals with cognitive or memory problems (e.g., dementia or traumatic brain injury);
  xii. Individuals with physical or sensory disabilities;
  xiii. Individuals residing in nursing facilities;
  xiv. Individuals with serious and persistent mental illnesses;
  xv. Individuals with end stage renal disease; and,
  xvi. Individuals with complex or multiple chronic conditions.

- Exclude EDCD and nursing facility members from the vulnerable subpopulation in data elements S through X "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.

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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org