Updated Virginia-Specific Measure Specifications for CY 2015

Issued January 14, 2016

Note: Only the measures included in this document have updated specifications for CY 2015 reporting. All other measures for CY 2015 should be reported according to the specifications in the Virginia-Specific Reporting Requirements issued June 25, 2014.

Section VAI. Assessment

VA1.1 Community Well members with a health risk assessment completed within 90 days of enrollment.[i, ii]

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
VA1. Assessment	Monthly, beginning after 90 days	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
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 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

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of Community Well members who were documented as unwilling to complete a health risk assessment within 90 days of enrollment.	Of the total reported in A, the number of Community Well members who were documented as unwilling to complete a health risk assessment within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A.
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.	The number of Community Well members with a health risk assessment completed within 90 days of enrollment.	Of the total reported in A, the number of Community Well members with a health risk assessment completed within 90 days of enrollment.	Field type: Numeric Note: Is a subset of A.

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

- The quality withhold benchmark for CY 2015 is 90%.
- For withhold purposes, the measure is calculated as follows for CY 2015:

    i. Denominator: Total number of members classified as Community Well upon enrollment whose 90th day of enrollment occurred within the reporting period, excluding the total number of Community Well members who were documented as unwilling to complete a health risk assessment within 90 days of enrollment and the total number of Community Well members the MMP was unable to reach, following three documented attempts within 90 days of enrollment (Data Elements A, B, and C) summed over the applicable number of quarters.

    ii. Numerator: The number of Community Well members with a health risk assessment completed within 90 days of enrollment (Data Element D) summed over the applicable number of quarters.

- For more information, refer to the Quality Withhold Technical Notes (DY 1): Virginia-Specific Measures. Separate guidance will be forthcoming on the established threshold for this measure for DY 2 and 3.

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

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. 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 90th 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.
- The effective date of enrollment is the first date of the member's coverage through the MMP.
- MMPs should include members classified as Community Well on the first effective date of enrollment in this measure, even if the member transitions to a nursing facility, EDCD waiver, or vulnerable subpopulation within the first 90 days of enrollment.

- 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 90 days (despite being offered a reasonable opportunity to complete the assessment within 90 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 90 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 <u>not</u> include such members in the counts for data elements B and C.
- If a member's assessment was started but not completed within 90 days of enrollment, then the assessment should not be considered completed and, therefore, would <u>not</u> 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.

- During subsequent years of the demonstration (i.e., Demonstration Year 2, etc.), Community Well members must receive a health risk assessment within 60 days of enrollment.

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

- MMPs will submit data collected for this measure in the above specified format through a secure data 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 60 days of enrollment.[i, ii]

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
VA1. Assessment	Monthly, beginning after 60 days	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
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 60th day of enrollment occurred within the reporting period.	Total number of members classified as EDCD members upon enrollment whose 60th day of enrollment occurred within the reporting period.	Field Type: Numeric
B.	Total number of EDCD members who were documented as unwilling to complete a health risk assessment within 60 days of enrollment.	Of the total reported in A, the number of EDCD members who were documented as unwilling to complete a health risk assessment within 60 days of enrollment.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of EDCD 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 EDCD 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.
D.	Total number of EDCD members with a health risk assessment completed within 60 days of enrollment.	Of the total reported in A, the number of EDCD members with a health risk assessment completed within 60 days of enrollment.	Field type: Numeric Note: Is a subset of A.
E.	Total number of members classified as nursing facility members upon enrollment whose 60th day of enrollment occurred within the reporting period.	Total number of members classified as nursing facility members upon enrollment whose 60th day of enrollment occurred within the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
F.	Total number of nursing facility members who were documented as unwilling to complete a health risk assessment within 60 days of enrollment.	Of the total reported in E, the number of nursing facility members who were documented as unwilling to complete a health risk assessment within 60 days of enrollment.	Field Type: Numeric Note: Is a subset of E.
G.	Total number of nursing facility members 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.

Element Letter	Element Name	Definition	Allowable Values
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.
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.

- The quality withhold benchmark for CY 2015 is 90%.
- For withhold purposes, the measure is calculated as follows for CY 2015:

    i. Denominator: Total number of members classified as vulnerable subpopulation members, EDCD members, and nursing facility members whose 60th day of enrollment occurred within the reporting period, excluding the total number of vulnerable subpopulation, EDCD, and nursing facility members who were documented as unwilling to complete a health risk assessment within 60 days of enrollment and the total number of vulnerable subpopulation, EDCD, and nursing facility members the MMP was unable to reach, following three documented

attempts within 60 days of enrollment (Data Element A+E+I-B-C-F-G-J-K) summed over 4 quarters.

ii. Numerator: The total number of vulnerable subpopulation, EDCD, and nursing facility members with a health risk assessment completed within 60 days of enrollment (Data Elements D, H, and L) summed over 4 quarters.

- For more information, refer to the Quality Withhold Technical Notes (DY 1): Virginia-Specific Measures. Separate guidance will be forthcoming on the established threshold for this measure for DY 2 and 3.

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 60 days of enrollment.
- EDCD members upon enrollment who were unable to be reached to have a health risk assessment completed within 60 days of enrollment.
- EDCD members upon enrollment who had a health risk assessment completed within 60 days of enrollment.
- EDCD members upon enrollment who were willing to participate and who could be reached who had a health risk assessment completed within 60 days of enrollment.
- Nursing facility members upon enrollment who refused to have a health risk assessment completed within 60 days of enrollment.
- Nursing facility members upon enrollment who 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 60th day of enrollment 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 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 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 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 <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 60 days of enrollment, 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 MDS.
- Minimum Data Set (MDS) is part of the federally-mandated process for assessing individuals receiving care in certified skilled nursing facilities in order to record their overall health status regardless of payer source. The process provides a comprehensive health risk assessment of individuals' current health conditions, treatments, abilities, and plans for discharge. The MDS is administered to all residents upon admission, quarterly, yearly, and whenever there is a significant change in an individual's condition. Section Q is the part of the MDS designed to explore meaningful opportunities for nursing facility residents to return to community settings.
- During subsequent years of the demonstration (i.e., Demonstration Year 2, etc.), individuals enrolled in the EDCD Waiver must receive a health risk assessment within 30 days of enrollment.

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

- MMPs will submit data collected for this measure in the above specified format through a secure data 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 90 days of enrollment.[i, ii]

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
VA2. Care Coordination	Monthly, beginning after 90 days	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
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 enrolled whose 90th day of enrollment occurred within the reporting period.	Total number of members enrolled whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric
B.	Total number of members who were documented as unwilling to complete a POC within 90 days of enrollment.	Of the total reported in A, the number of members who were documented as unwilling to complete a POC within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A.

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

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

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

Element Letter	Element Name	Definition	Allowable Values
S.	Total number of all other vulnerable subpopulation members the MMP was unable to reach, following three documented attempts within 90 days of enrollment.	Of the total reported in Q, the number of all other vulnerable subpopulation members the MMP was unable to reach, following three documented attempts within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of Q. Note: Exclude EDCD and NF members
T.	Total number of all other vulnerable subpopulation members with a POC completed within 90 days of enrollment.	Of the total reported in Q, the number of all other vulnerable subpopulation members with a POC completed within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of Q. 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.

- The quality withhold benchmark for CY 2015 is set as the percentage achieved by the highest scoring MMP minus 10 percentage points.
- For withhold purposes, the measure is calculated as follows for CY 2015:
    i. Denominator: Total number of members whose 90th day of enrollment occurred within the reporting period, excluding the total number of members who were documented as unwilling to complete a POC within 90 days of enrollment and the total number of members the MMP was unable to reach, following three documented attempts within 90 days of enrollment (Data Element A-B-C) summed over the applicable number of quarters.
    ii. Numerator: The total number of members with a POC completed within 90 days of enrollment (Data Element D) summed over the applicable number of quarters.
- For more information, refer to the Quality Withhold Technical Notes (DY 1): Virginia-Specific Measures. Separate guidance will be forthcoming on the established threshold for this measure for DY 2 and 3.

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.
- MMPs should validate that data elements R, S, and T are less than or equal to data element Q.
- All data elements should be positive values.

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

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

CMS and the state will also 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 90 days of enrollment.
- EDCD members upon enrollment who were unable to be reached to have a POC completed within 90 days of enrollment.
- EDCD members upon enrollment who had a POC completed within 90 days of enrollment.
- EDCD members upon enrollment who were willing to participate and who could be reached who had a POC completed within 90 days of enrollment.
- Nursing facility members upon enrollment who refused to have a POC completed within 90 days of enrollment.
- Nursing facility members upon enrollment who were unable to be reached to have a POC completed within 90 days of enrollment.
- Nursing facility members upon enrollment who had a POC completed within 90 days of enrollment.

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

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

- MMPs should include all Community Well, 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, M, and Q, 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 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.
- The effective date of enrollment is the first date of the member's coverage through the MMP.
- MMPs should include members classified as Community Well, EDCD members, nursing facility members, or vulnerable subpopulation members on the first effective date of enrollment in this measure, even if the member transitions to another subpopulation within the first 90 days of enrollment.
- For data elements B, F, J, N, and R, 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 90 days (despite being offered a reasonable opportunity to complete the POC within 90 days).

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, O, and S, 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 90 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 a POC. However, MMPs should <u>not</u> include such members in the counts for data elements B, C, F, G, J, K, N, O, R, and S.
- 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, P, and T), 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 90 days of enrollment, 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, P, R, S, and T. However, this member would be included in data element A, E, I, M, or Q.
- 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 Q-T. "All other vulnerable subpopulation" should only include members not in the EDCD waiver and not residing in a nursing facility.
- An EDCD waiver is a CMS-approved §1915(c) waiver that covers a range of community support services offered to EDCD members. EDCD members are individuals who are elderly or who have a disability who would otherwise require a nursing facility level of care.
- During subsequent years of the demonstration (i.e., Demonstration Year 2, etc.), vulnerable subpopulation members and nursing facility members must have a POC completed within 60 days of enrollment.
- During subsequent years of the demonstration (i.e., Demonstration Year 2, etc.), EDCD members must have a POC completed within 30 days of enrollment.

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

- MMPs will submit data collected for this measure in the above specified format through a secure data 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.

- The quality withhold benchmark for CY 2015 is 95%.
- For withhold purposes, the measure is calculated as follows for CY 2015:
    i. Denominator: Total number of members with an initial POC completed (Data Element A) summed over 4 quarters.
    ii. Numerator: Total number of members with a documented discussion of care goals in the initial POC (Data Element B) summed over 4 quarters.
- For more information, refer to the Quality Withhold Technical Notes (DY 1): Virginia-Specific Measures.

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

Element Letter	Element Name	Definition	Allowable Values
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

VA2.10 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.
    - The quality withhold benchmark for CY 2015 is 100% compliance.

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).

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).

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

VA5.3 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.
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.

Element Letter	Element Name	Definition	Allowable Values
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.
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.

Element Letter	Element Name	Definition	Allowable Values
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.

- The quality withhold benchmark for CY 2015 is 90%.
- For withhold purposes, the measure is calculated as follows for CY 2015:
    i. Denominator: Total number of adjudicated clean claims for EDCD covered services, traditional Medicaid covered nursing facility services, traditional Medicaid covered behavioral health services, and other traditional Medicaid covered services (Data Elements, B, E, H, and K) summed over 4 quarters.
    ii. Numerator: Total number of adjudicated clean claims for EDCD covered services paid within 14 days of receipt, traditional Medicaid covered nursing facility services paid within 14 days of receipt, traditional Medicaid covered behavioral health services paid within 14 days of receipt, and other traditional Medicaid covered services paid within

14 days of receipt (Data Elements C,F, I, and L) summed over 4 quarters.

- For more information, refer to the Quality Withhold Technical Notes (DY 1): Virginia-Specific Measures. Separate guidance will be forthcoming on the established threshold for this measure for DY 2 and 3.

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