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

Effective as of _____, 2014, Issued _____, 2014

Table of Contents

Ohio-Specific Reporting Requirements Appendix

Introduction

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

http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.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] and HOS. CMS and the states 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.

Quality Withhold Measures

CMS and the state will also establish a set of quality withhold measures, and MMPs will be required to meet established thresholds. Throughout this document, quality withhold measures for Demonstration Year 1 are marked with the following symbol: (ⁱ). CMS and the state of Ohio will update the quality withhold measures for subsequent demonstration years closer to the start of demonstration year 2 (DY2). Additional information on the withhold methodology and benchmarks will be provided at a later time.

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

Definitions

Implementation Period: The initial months of the demonstration during which plans will report to CMS and the state on a more intensive reporting schedule. The Implementation Period starts on the first effective enrollment date and continues until the end of the first 2015 calendar year quarter (May 1, 2014 – March 31, 2015).

Long Term Services and Supports (LTSS): A range of home and community based services designed to meet a Beneficiary's needs as an alternative to long term nursing facility care to enable a person to live as independently as possible. 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.

Primary Care Provider (PCP): Primary care physicians licensed by the state of Ohio and board certified in family practice, internal medicine, general practice, obstetrics/gynecology, or geriatrics, state licensed physician assistants, or a physician extender who is a registered nurse practitioner or advanced practice nurse or advanced practice nurse group practice within an acceptable specialty as required under state regulation.

Ohio's Implementation, Ongoing, and Continuous Reporting Periods

Demonstration Year 1			
Phase		**Dates**	**Explanation**
Continuous Reporting	Implementation Period	5-1-14 through 3-31-15	From the first effective enrollment date through the end of the first quarter of 2015.
	Ongoing Period	5-1-14 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 data through an Excel template on a secure transmission site. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

The template is available for download at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html

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

- Required File Format is Microsoft Excel File.
- The file name extension should be ".xls"
- File name= OH_(CONTRACTID)_(REPORTING PERIOD)_(SUBMISSIONDATE).xls.
- Replace (CONTRACTID) with the contract ID, (REPORTINGPERIOD) with the year and month of the beginning of the reporting period in YYYYMM format (e.g., February 2014 would be 201402), and (SUBMISSIONDATE) the year, month, and date of the submission in YYYYMMDD format (e.g., March 30, 2014 would be 20140330).

Section OHI. *Care Coordination*

OH1.1 Members with care plans within 90 days of enrollment.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH1. 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 Period**	**Due Date**
OH1. Care Coordination	Quarterly	Contract	Current Quarter Ex: 1/1– 3/31	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 are documented as unwilling or unable to complete a care plan within 90 days of enrollment.	Of the total reported in A, the number of members who are documented as unwilling to complete a care plan within 90 days of enrollment.	Field type: Numeric Note: Is a subset of A.

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

- 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 evaluate the percentage of:

- Members who were unable to be located to have a care plan completed within 90 days of enrollment.
- Members who refused to have a care plan completed within 90 days of enrollment.
- Members who had a care plan completed within 90 days of enrollment.
- Members who were willing to participate and who could be located who had a care plan 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.
- The 90th day of enrollment should be based on each member's enrollment effective date.
- The effective date of enrollment is the first date of the member's coverage through the MMP.
- MMPs should refer to OH's MOU and the three-way contract for specific requirements pertaining to a care plan.
- Failed attempts to contact member to complete a care plan must be documented and CMS and the state may validate this number.

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

OH1.2 Members with documented discussions of care goals.[i]

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH1. 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 Period**	**Due Date**
OH1. Care Coordination	Quarterly	Contract	Current Quarter Ex: 1/1– 3/31	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 a care plan developed.	Total number of members with a care plan developed during the reporting period.	Field Type: Numeric
B.	Total number of members sampled that met inclusion criteria.	Of the total reported in A, the number of members sampled that met inclusion criteria.	Field type: Numeric Note: Is a subset of A.
C.	Total number of members with evidence of creation of at least care goal documented in the care initial plan.	Of the total reported in B, the number of members with at least one documented discussion of care goals in the care plan.	Field Type: Numeric Note: Is a subset of B.

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

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

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

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

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

- CMS and the state will evaluate the percentage of members with a care plan developed in the reporting period who had at least one documented discussion of care goals in the care plan.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. A subset of all members that are eligible will be included in the sample.

- For reporting, the MMPs may elect to sample since this measure requires documentation review to identify the numerator. Sampling should be systematic to ensure all eligible individuals have an equal chance of inclusion. The sample size should be 411, plus oversample to allow for substitution.
- If an MMP does not elect to sample, data element B should be equal to data element A.

F. Care goal discussions can be completed as part of the initial development of the care plan; when care goals are discussed as part of the development of the care plan, the MMP should only include the care plan in B, when discussion of the care goal is clearly documented in the care plan.

G. 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

OH1.3 Members with first follow-up visit within 30 days of discharge.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH1. Care Coordination	Quarterly	Contract	Current Quarter Ex: 1/1– 3/31	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 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 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 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 discharges that resulted in an ambulatory care follow-up visit within 30 days of the discharge from the hospital.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- The date of discharge must occur within the reporting period, but the follow-up may not be in the same reporting period.
- If a discharge occurs during the last month of the reporting period, look 30 days past the last day of the reporting period to identify the follow-up visit.
- A follow-up visit is defined as an ambulatory care follow-up visit to assess the member's health following a hospitalization. Codes to identify follow-up visits are provided in Table OH-1.
- Codes to identify inpatient discharges are provided in Table OH-2.
- Exclude discharges in which the patient was readmitted within 30 days after discharge to an acute or non-acute facility.

- Exclude discharges due to death. Codes to identify patients who have expired are provided in Table OH-3.

Table OH-1: Codes to Identify Ambulatory Health Services				
Description	**CPT**	**HCPCS**	**ICD-9-CM Diagnosis**	**UB Revenue**
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245			051x, 0520-0523, 0526-0529, 0982, 0983
Home services	99341-99345, 99347-99350			
Nursing facility care	99304-99310, 99315, 99316, 99318			0524, 0525
Domiciliary, rest home or custodial care services	99324-99328, 99334-99337			
Preventive medicine	99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429	G0344, G0402, G0438, G0439		
Ophthalmology and optometry	92002, 92004, 92012, 92014			
General medical examination			V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	

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

WITH

UB Type of Bill	***OR***	Any acute inpatient facility code
11x, 12x, 41x, 84x		

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

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

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

Section OHII. Enrollee Protections

OH2.1 The number of incident reports for members receiving LTSS.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH2. 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 Period**	**Due Date**
OH2. Enrollee Protections	Quarterly	Contract	Current Quarter Ex: 1/1– 3/31	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 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.

- 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 number of critical incident and abuse reports per 1,000 members receiving LTSS.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- It is possible for members to have more than one critical incident and/or abuse report during the reporting period. All critical incident and abuse reports during the reporting period should be counted.
- Incident refers to an actual, suspected or alleged event that is not consistent with the routine care of, and/or service delivery to, a member. Incidents include, but are not limited, to the following:
  1. Abuse: injury, confinement, control, intimidation or punishment of a member by another person that has resulted, or could reasonably be expected to result, in physical harm, pain, fear or mental anguish. This includes but is not limited to physical, emotional, verbal and/or sexual abuse, and use of restraint, seclusion or restrictive intervention that results in, or could reasonably be expected to result in physical harm, pain, fear or mental anguish to the member.
  2. Neglect: when there is a duty to do so, the failure to provide goods, services and/or treatment necessary to assure the health and welfare of a member.
  3. Exploitation: unlawful or improper act of using a member or a member's resources for monetary or personal benefit, profit, or gain.
  4. Misappropriation: depriving, defrauding, or otherwise the money, or real or personal property (including medication) by any means prohibited by law.
  5. Death of a member
  6. Hospitalization or emergency department visit as a result of: a) accident, injury or fall; b) illness or injury of an unknown cause or origin; or c) reoccurrence of an illness or medical condition within 7 calendar days of a member's discharge from the hospital.

7. Unauthorized use of restraint, seclusion and/or restrictive intervention that does not result in, or cannot reasonably be expected to result in, injury to the member.
8. An unexpected crisis in the member's family or environment that results in an inability to assure the member's health and welfare in his or her primary place of residence.
9. Inappropriate service delivery (e.g., medication administration errors including the member)
10. Actions on the part of the member that place the health and welfare of the member or others at risk (e.g., member cannot be located)

F. Data Submission - how MMPs will submit data collected to CMS and the State.

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

Section OHIII. Organizational Structure and Staffing

OH3.1 Waiver service coordinator training for supporting self-direction under the demonstration.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH4. Organizational Structure and Staffing	Annually	Contract	Demonstration 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 waiver service coordinators.	Total number of care coordinators in the MMP during the reporting period.	Field Type: Numeric
B.	Total number of waiver service coordinators that have undergone State-based training for supporting self-direction under the demonstration within the past 12 months.	Of the total reported in A, the number of care coordinators that have undergone State-based 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 waiver service coordinators that have undergone State-based 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 OH's three-way contract for specific requirements pertaining to a care coordinator.
- MMPs should refer to Section 2.5.3.3.5.4.1.5 of OH's three-way contract for specific requirements pertaining to training for supporting self-direction.
- A waiver service coordinator includes all full-time and part-time staff.
- If a waiver service coordinator was not currently with the MMP at the end of the reporting period, but was with the MMP for at least 30 days, they 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 transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

Section OHIV. Performance and Quality Improvement

OH 4.1 Nursing facility diversion.[i]

ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH4. Performance and Quality Improvement	Annually	Contract	Demonstration Year	N/A

(Please note: No MMP reporting is required for this measure to HSAG; ODM will gather the data necessary from MMPs: MMPs are required to assist ODM with the process and more detail regarding the required assistance will be provided by ODM.)

OH 4.2 Long-term care overall balance.[i]

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH4. Performance and Quality Improvement	Annually	Contract	Demonstration Year	N/A

(Please note: No MMP reporting is required for this measure to HSAG; ODM will gather the data necessary from MMPs: MMPs are required to assist ODM with the process and more detail regarding the required assistance will be provided by ODM. Subsequent to ODM establishing the methodology for this measure, this appendix will be updated to include the measure specifications.)

OH 4.3 Nursing facility residents whose need for help with Activities of Daily Living (ADLs) has increased.

ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH4. Performance and Quality Improvement	Quarterly	Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	N/A

(Please note: No MMP reporting is required for this measure to HSAG; ODM will gather the data necessary from MDS data: MMPs are required to assist ODM with the process and more detail regarding the required assistance will

be provided by ODM. Subsequent to ODM establishing the methodology for this measure, this appendix will be updated to include the measure specifications.)

OH 4.4 Nursing facility residents who have/had a catheter inserted and left in their bladder.

ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH4. Performance and Quality Improvement	Quarterly	Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	N/A

(Please note: No MMP reporting is required for this measure to HSAG; ODM will gather the data necessary from MDS data: MMPs are required to assist ODM with the process and more detail regarding the required assistance will be provided by ODM. Subsequent to ODM establishing the methodology for this measure, this appendix will be updated to include the measure specifications.)

OH 4.5 Nursing facility residents who were physically restrained.

ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH4. Performance and Quality Improvement	Quarterly	Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	N/A

(Please note: No MMP reporting is required for this measure to HSAG; ODM will gather the data necessary from MDS data: MMPs are required to assist ODM with the process and more detail regarding the required assistance will be provided by ODM. Subsequent to ODM establishing the methodology for this measure, this appendix will be updated to include the measure specifications.)

OH 4.6 Nursing facility residents experiencing one or more falls with a major injury.

ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH4.	Quarterly	Contract	1/1-3/31	N/A

Performance and Quality Improvement			4/1-6/30 7/1-9/30 10/1-12/31	

(Please note: No MMP reporting is required for this measure to HSAG; ODM will gather the data necessary from MDS data: MMPs are required to assist ODM with the process and more detail regarding the required assistance will be provided by ODM. Subsequent to ODM establishing the methodology for this measure, this appendix will be updated to include the measure specifications.)

OH 4.7 Nursing facility residents with a urinary tract infection.

ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH 4. Performance and Quality Improvement	Quarterly	Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	N/A

(Please note: No MMP reporting is required for this measure to HSAG; ODM will gather the data necessary from MDS data: MMPs are required to assist ODM with the process and more detail regarding the required assistance will be provided by ODM. Subsequent to ODM establishing the methodology for this measure, this appendix will be updated to include the measure specifications.)

OH 4.8 Long-term care rebalancing.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH4. Performance and Quality Improvement	Annually	Contract	Demonstration Year	N/A

(Please note: No MMP reporting is required for this measure; ODM will gather the data necessary: MMPs are required to assist ODM with the process and more detail regarding the required assistance will be provided by ODM. Subsequent to ODM establishing the methodology for this measure, this appendix will be updated to include the measure specifications.)

OH 4.9 Long-term care transition measure.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH4. Performance and Quality Improvement	Annually	Contract	Demonstration Year	N/A

(Please note: No MMP reporting is required for this measure; ODM will gather the data necessary: MMPs are required to assist ODM with the waiver quality assurance process and more detail regarding the required assistance will be provided by ODM. Subsequent to ODM establishing the methodology for this measure, this appendix will be updated to include the measure specifications.)

Section OHV. System

OH5.1 ICDS Centralized Enrollee Record.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH5. 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**
OH5. Systems	Annually	Contract	Demonstration Year	By the end of the second month following the last day of the reporting period

(Please note: No MMP reporting is required for this measure; ODM will gather the data necessary: MMPs are required to assist ODM with the waiver quality assurance process and more detail regarding the required assistance will be provided by ODM.)

Section OHVI. Utilization

OH 6.1 Unduplicated members receiving HCBS and unduplicated members receiving nursing facility services.

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

OH6. Utilization	Annually	Contract	Demonstration 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 members receiving HCBS.	Total number of members receiving HCBS during the reporting period.	Field Type: Numeric
B.	Total number of members receiving nursing facility services.	Total number of members receiving nursing facility services 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 obtain enrollment data and will evaluate the following:
    1. The percentage of members receiving HCBS.
    2. The percentage of members receiving nursing facility services.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- Members receiving HCBS should only be counted for data element A (unduplicated).

- Members receiving nursing facility services should only be counted for data element B (unduplicated).
- HCBS refers to Home and Community Based Services.

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

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

OH 6.2 Average length of receipt in HCBS.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH6. Utilization	Annually	Contract	Demonstration 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 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 the HCBS waiver.	Of the total reported in A, the number of days members were enrolled in the HCBS waiver 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 received HCBS.

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

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

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

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