

D-SNP Dashboard Guide

This guide is designed to help you complete the D-SNP dashboard. Below you'll find instructions, definitions and other tips that will help you complete this required reporting tool. If you have questions that aren't answered here please contact vamltss@dmas.virginia.gov and use "D-SNP Dashboard Question" in the subject line.

GENERAL REQUIREMENTS

The reporting of the D-SNP dashboard is required in section 2.9.5.3 of the D-SNP contract.

The Dashboard is due on the 15th day, or the next closest business day, of each month.

Unless otherwise noted in the Dashboard or this guide the reporting period is always from the first to last day of the previous month.

Contractor is only expected to report on Medicare covered services for this dashboard.

TAB 1 – OPERATIONS

Reporting Period = In the parentheses enter the reporting period month and year. *(The workbook is coded so this information will be populated on the other tabs).*

Name of D-SNP = The name of the Health Plan offering the D-SNP. *(The workbook is coded so this information will be populated on the other tabs).*

Enrollment

Total enrollees as of the first day of this month = The total number of beneficiaries enrolled in your D-SNP as of the first day of the current month, NOT the reporting period. *(This is an exception to the reporting period rule noted above. If you are completing the report for a March 15 turn in date, you report the total number of enrolled beneficiaries as of March 1.)*

Total enrollees as of the first day of the previous month = The total number of beneficiaries enrolled in your D-SNP as of the first day of the previous reporting period. *(This is an exception to the reporting period rule noted above. If you are completing the report for a March 15 turn in date, you report the total number of enrolled beneficiaries as of February 1.)*

Total potential enrollees next month = The number of beneficiaries that have signed up to enroll with your plan with services beginning the following month. *(This is an exception to the reporting period rule noted above. If you are completing the report for a March 15 turn in date, you report the total number of prospective enrollees on April 1.)*

Enrollment Demographics

Alignment –

Number of Aligned enrollees = Number of enrollees enrolled in your D-SNP and your MLTSS plan. *(This is an exception to the reporting period rule noted above. If you are completing the report for a March 15 turn in date, you report the total number of aligned enrollees as of March 1.)*

Number of Unaligned enrollees = Number of enrollees ONLY enrolled in your D-SNP. *(This is an exception to the reporting period rule noted above. If you are completing the report for a March 15 turn in date, you report the total number of unaligned enrollees as of March 1.)*

Age –

Number of enrollees 65 + = Total number of enrollees 65 years of age and older. *(This is an exception to the reporting period rule noted above. If you are completing the report for a March 15 turn in date, you report the total number 65 and over as of March 1.)*

Number of enrollees under 65 = Total number of enrollees under 65 years of age. *(This is an exception to the reporting period rule noted above. If you are completing the report for a March 15 turn in date, you report the total number under 65 as of March 1.)*

Residence -

Number of enrollees in NF's = Total number of enrollees residing in Nursing Facility for either custodial or skilled nursing stay. *(This is an exception to the reporting period rule noted above. If you are completing the report for a March 15 turn in date, you report the total number in NF's as of March 1.)*

Number in Community Setting = Total number of enrollees residing in community setting including: Private residence, private residence of family or other care giver, group home or other similar congregate living residence, senior living residence and assisted living facility. *(This is an exception to the reporting period rule noted above. If you are completing the report for a March 15 turn in date, you report the total number in community setting as of March 1.)*

Number in other setting = Total number of enrollees that don't fall into one of the other two residence settings. This may include ICF/ID's and other inpatient hospital settings. *(This is an exception to the reporting period rule noted above. If you are completing the report for a March 15 turn in date, you report the total number in other setting as of March 1.)*

Behavioral Health –

Number of enrollees with SMI = Total number of enrollees that have are diagnosed with the one of the following disorders: Depression, Bi-polar disorder, schizophrenia and other psychotic disorders. *(This is an exception to the reporting period rule noted above. If you are completing the report for a March 15 turn in date, you report the total number with SMI as of March 1.)*

Number of enrollees receiving BH services = Total number of enrollees that have received behavioral health services during their enrollment. "BH Services" includes inpatient treatment and community based treatment BH treatment provider. It does not include those only receiving traditional BH medication through physician. *(This is an exception to the reporting period rule noted above. If you are completing the report for a March 15 turn in date, you report the total number of enrollees that have accessed BH services as of March 1.)*

Number of enrollees receiving SUD services = Total number of enrollees that have received substance use disorder services during their enrollment. *(This is an exception to the reporting period rule noted above. If you are completing the report for a March 15 turn in date, you report the total number of enrollees that have accessed SUD services as of March 1.)*

Health Risk Assessments and Plans of Care

The health plans are required to complete all fields asking for number completed over a period of time. The “Ratio” fields will be calculated automatically.

For all Health Risk Assessment and Plans of Care reporting elements in this section we consider “completed” as: All elements in the HRA/POC have been completed and the approved by the enrollee. However, if an enrollee refuses to participate in some or all of the HRA/POC process the HRA/POC can be considered completed if the health plan rep has completed all the elements possible without enrollee input.

Coordination with Medicaid Plan

This section only requires information for unaligned enrollees.

HRA and POC “completed” is defined the same as above.

“Medicaid Plan Presence Requested” counts in the affirmative if you’ve reached out to the Medicaid Plan contacts established under section 2.7 of the D-SNP contract by phone, email or in person at least 24 hours prior to the meeting.

Number of Unaligned enrollee ED visits = Total number of ED visit claims received during the reporting period regardless of the month the service was actually provided.

Number of Unaligned enrollee ED visits info sent to the Medicaid Plan = Of the total from the previous measure how many were submitted to the responsible Medicaid Plan during the reporting period.

Number of Unaligned with Chronic Illness/Conditions = Total number of enrollees for the reporting period that have one of the fifteen Chronic Conditions established by the SNP Chronic Condition Panel. This list can be found in section 20.1.2 of Chapter 16b of the Medicare Managed Care Manual (<https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/Downloads/Chapter-16b.pdf>).

Grievances and Appeals

Self-explanatory

Staffing

Number of Care Coordinator FTE's working on Virginia D-SNP = Total number of care coordinators working on the Virginia D-SNP, either part time or full time. Those that work on the Virginia D-SNP full time count as 1.00 FTE. If an employee spend a quarter of their time working on the Virginia D-SNP and the rest of their time working on other lines of business they count as 0.25 FTE.

Ratio of enrollees to Care Coordinators = This needs to be calculated by you. If you have 50 enrollees and 5 FTE the ratio is 1:10.

TAB 2 – CLAIMS

For the measures in rows 4, 6, 8, 10 and 12 the reporting period is from the first to last day of the previous month.

Number of Paid Clean Claims that Exceeded 30 Days and **Number of Paid Clean Claims that Exceed 90 Days to Resolution** (rows 14 and 16 respectively) are total claims paid for the entire year not just the previous month.

TAB 3 – BEHAVIORAL HEALTH

Psychiatric Hospital Readmission

Number of Discharges This Month = Total count of enrollees that have been discharged from inpatient stay due to psychiatric issues regardless of the month they were admitted.

Of those discharged this and previous month(s), number readmitted after 30 days = Running count of all inpatient psychiatric readmission between 30 and 180 days of discharge.

Percent readmitted after 30 days = Count of readmission between 30 and 180 days (from above measure) divided by total psychiatric hospital discharges multiplied by 100.

Of those discharged this and previous month(s), number readmitted after 180 days = Running count of all inpatient psychiatric readmission after 180 days.

Percent readmitted after 180 days = Count of readmission after 180 days (from above measure) divided by total psychiatric hospital discharges multiplied by 100.

Post Discharge Follow-up

All measures asking for a percent are calculated automatically.

Number of Discharges = Count of the total number of beneficiaries that have been discharged from inpatient psychiatric hospital.

Number that had follow-up with Care Coordinator within 7 days = The number of those discharged from inpatient psychiatric hospital that met with, in-person or by phone, their health plan care coordinator within 7 days of being discharged.

Number that had follow-up with Case Manager within 7 days = The number of those discharged from inpatient psychiatric hospital that met with, in-person or by phone, their Case Manager within 7 days of being discharged. *(It is understood that not all beneficiaries will have a case manager. They still will count as not having a follow-up meeting. If it is determined that it is having a significant impact on this measure we will adjust in consultation with contracted D-SNPs.)*

Number that had follow-up with Therapist within 30 days = The number of those discharged from inpatient psychiatric hospital that met with, in-person or by phone, their therapist within 30 days of being discharged. *(It is understood that not all beneficiaries will have a therapist. They still will count as not having a follow-up meeting. If it is determined that it is having a significant impact on this measure we will adjust in consultation with contracted D-SNPs.)*

Number that had follow-up with Psychiatrist within 30 days = The number of those discharged from inpatient psychiatric hospital that met with, in-person or by phone, their psychiatrist within 30 days of being discharged. *(It is understood that not all beneficiaries will have a psychiatrist. They still will count as not having a follow-up meeting. If it is determined that it is having a significant impact on this measure we will adjust in consultation with contracted D-SNPs.)*

Crisis Care

Number of Partial Hospitalization discharges this month = Count of the number of beneficiaries that have been discharged from a nonresidential treatment program that provides diagnostic and treatment services on a level of intensity similar to an inpatient program, but on less than a 24-hour basis.

TAB 4 – NURSING FACILITY

NF Residence

Total Count = Total count of enrollees residing in NF. This should equal the count from the Operations tab. *(This is an exception to the reporting period rule noted above. If you are completing the report for a March 15 turn in date, you report the total number in NF's as of March 1.)*

New This Month = Total count of enrollees that entered a NF during the reporting period.

Discharged this Month = Total count of enrollees that left a NF during the reporting period. *(This count should include enrollees that entered during the reporting period that subsequently left during the same reporting period.)*

Number who requested NF care this month that were diverted to less restrictive level of care = Total count of the enrollees that were diverted from NF level of care to a less restrictive level of care. "Less Restrictive" includes any non-institutional setting.

Average length of stay = Total number of NF days for enrollees that have been discharged from a NF divided by the total number enrollees that have been discharged from a NF. *(This is for the total all year not just for the reporting period.)*

Discharge Report

Discharge to Home, non-hospice = Total number of enrollees discharged from NF during the reporting period to their home without hospice.

Discharge to Other Residential Facility including Acute Care Facility, non-hospice = Total number of enrollees discharged from NF during the reporting period to another residential facility. "Residential Facility" includes: hospital, another NF, ICF/ID and ALF.

Discharge Other Community Setting = Total number of enrollees discharged from NF during the reporting period to a community setting that does not include their home or hospice. "Other Community Setting" includes: senior living, group home, family or other care givers private residence and other congregate living facility.

Discharge to hospice = Total number of enrollees discharged from NF during the reporting period to hospice, including hospice in a facility or home.

Other = Total number of enrollees discharged from NF during the reporting period to a setting that is not captured in the other categories.