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

Effective as of May 1, 2014, Issued December 19, 2014

Table of Contents

Ohio-Specific Reporting Requirements Appendix

Introduction

The measures contained in this appendix are required reporting for all MMPs in the Ohio MyCare 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/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html

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

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

MMPs should contact the OH Help Desk at OHHelpDesk@norc.org with any questions about the Core Reporting Requirements, Ohio state-specific appendix, or the data submission process.

Definitions

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

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

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

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 need 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 MyCare Demonstration Reporting Population

Because some members in Ohio receive Medicare and Medicaid coverage through MyCare Ohio while others receive only their Medicaid benefits through MyCare Ohio, the distinction between these members for reporting purposes is clarified as follows.

For the purpose of all Core and state-specific reporting, Ohio MMPs are to report only on members enrolled to receive both Medicare and Medicaid benefits through the MMP. Ohio MMPs should only report on members who are enrolled in the MMP's Medicare-Medicaid MyCare program. MMPs should not include members who are enrolled in the Medicaid-only portion of MyCare. Of note, passive enrollment for the Medicare-Medicaid MyCare Demonstration in Ohio begins in January 2015. Data reported after passive enrollment should include both members who opt in[2] and members who are passively enrolled into the MMP at any point. Plans can identify this information on the enrollment file using the enrollment source codes in the CMS DTRR file. Code J represents state-submitted passive enrollment and Code L represents opt-in population or MMP beneficiary election. Reporting of both Core measures in HPMS and state-specific measures via the FAI Data Collection System should exclude data for

[2] For the Ohio Capitated Financial Alignment Demonstration, "opt-in" specifically refers to members who choose to actively enroll in a MMP at any point during the demonstration. Passive enrollment does not include members who were are automatically enrolled into a Medicaid-only program with an affiliated MMP.

members who are Medicaid-only and should only include Medicare-Medicaid enrollees.

Variation from the Core Document

Core 2.1 and Core 2.2
Due to MyCare Ohio's inclusion of a Medicaid-only product, in addition to a Medicare-Medicaid, there are some caveats to the reporting of the core measures that pertain to assessments (i.e., Core Measure 2.1 and Core Measure 2.2).

Some members who were previously enrolled in MMPs' affiliated Medicaid-only programs will be passively enrolled into the Medicare-Medicaid program on January 1, 2015. Since the assessments used in MyCare are the same, regardless of whether a member is in a Medicaid-only product or the MMP, MMPs will not be required to complete an additional assessment for individuals who have previously received a comprehensive initial assessment in the Medicaid-only MyCare program or from another MyCare MMP. As such, for formerly Medicaid-only members with an initial assessment completed prior to January 2015, MMPs are to report those assessments as having been completed in the **January 2015 monthly reporting period**.

Similarly, if a member in a MyCare Medicaid-only product opted out of passive enrollment in January, but subsequently chose to opt in to an MMP affiliated with the plan in which they were previously enrolled, the MMP does not need to complete a new assessment as long as the prior assessment was completed less than one year prior to opting in to the MMP. In this case, the MMP should report the assessment as having been completed in the month of opt-in.

For members not continuously enrolled, MMPs will not be required to complete additional assessments, provided that the member was previously enrolled with the MMP within the prior 90 days.

MMPs should refer to the Core reporting requirements for detailed specifications for reporting Core 2.1 and Core 2.2. For example, Core 2.1 should only include members whose 90th day of enrollment occurred during the reporting period. Members enrolled into the Medicare-Medicaid MyCare Program on January 1, 2015 would reach their 90th day (3 full months) on March 31, 2015. Therefore these members would be reported in the data submission for the March monthly reporting period, even if their assessment was completed in the January 2015 monthly reporting period.

MMPs will be required to contact enrollees to ensure there are no changes to the health status or additional needs as a result of expanded coverage per the requirements in Section 2.5.3.2.3.7 of the three-way contract and update the member care plan as necessary. For instance, a person whose hypertension was

well maintained under Medicare FFS and Medicare Part D may need support through transition to the new plan. This information may have been captured in the assessment but not specifically addressed since it was covered through a separate benefit. Necessary updates should be made to the member care plan. MMPs should not report these contacts through Core 2.1 or 2.2, however.

Core 2.3
For Core 2.3, Members with an annual reassessment, MMPs should determine whether members are eligible for an annual reassessment using the actual date an assessment was completed, even if that date occurred when the member was enrolled in the Medicaid-only MyCare program.

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.

In addition to the quality withhold measures identified in this appendix and the core reporting requirements document, the following measure from The Medicare-Medicaid Capitated Financial Alignment: Core Reporting Requirements will be a quality withhold measure for MMPs participating in the Ohio MyCare Demonstration:

- Measure 9.2 Nursing Facility Diversion

Additional information on The Medicare-Medicaid Capitated Financial Alignment: Core Reporting Requirements can be found at the following web address:

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

Reporting on Disenrolled and Retro-disenrolled Members

Unless otherwise indicated in the reporting requirements, MMPs should report on all Medicare-Medicaid members enrolled in the demonstration who meet the definition of the data elements, regardless of whether that member was subsequently disenrolled from the MMP. Measure-specific guidance on how to

report on disenrolled members is provided under the Notes section of each state-specific measure.

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

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 state-specific measure data through the web-based Financial Alignment Initiative (FAI) Data Collection System (unless otherwise specified in the measure description). All data submissions must be submitted to this site by 5:00p.m. ET on the applicable due date. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

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

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

Resubmission of Data to the FAI Data Collection System or HPMS

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

1. Email the OH HelpDesk to request resubmission.
    - Specify in the email which measures need resubmission;
    - Specify for which reporting period(s) the resubmission is needed; and
    - Provide a brief explanation for why the data need to be resubmitted.

2. After review of the request, the OH HelpDesk will notify the MMP once the FAI Data Collection System and/or HPMS has been re-opened.

3. Resubmit data through the applicable reporting system.

4. Notify the OH HelpDesk again after resubmission has been completed.

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 Periods**	**Due Date**
OH1. 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 care plan within 90 days of enrollment.	Of the total reported in A, the number of members who were 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.
- Who refused to have a care plan completed within 90 days of enrollment.
- Who had a care plan completed within 90 days of enrollment.
- 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 enrolled voluntarily or was passively enrolled. Medicaid-only members should not be included.

- The 90th day of enrollment should be based on each member's enrollment effective date. 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 all members who meet the criteria outlined in Element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members whose 90th day of enrollment occurred within the reporting period regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- 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.
- For Medicare-Medicaid members who were formerly Medicaid-only members prior to January 2015, MMPs are still required to contact enrollees to ensure that there are no changes to health status or additional needs as a result of expanded coverage. MMPs must make necessary updates to the care plan accordingly.

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

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 Periods**	**Due Date**
OH1. 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 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 with at least one documented discussion of care goals in the care plan.	Of the total reported in A, 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 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 who had 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 enrolled voluntarily or was passively enrolled. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- 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 data element B, when discussion of the care goal is clearly documented in the care plan.
- For Medicare-Medicaid members who were formerly Medicaid-only members prior to January 2015, MMPs are still required to contact enrollees to ensure that there are no changes to health status or additional needs as a result of expanded coverage. MMPs must make necessary updates to the care plan accordingly.

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

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

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
OH1. 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 inpatient hospital discharges	Total number of inpatient hospital discharges during the reporting period.	Field Type: Numeric
B.	Total number of inpatient 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 inpatient 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 inpatient 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 inpatient hospital discharges for members regardless of whether the member enrolled voluntarily or was passively enrolled. Medicaid-only members should not be included.
- MMPs should include all inpatient 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 (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The date of discharge must occur within the reporting period, but the follow-up 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 to be included in this measure.
- 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 transferred or 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		
11x, 12x, 41x, 84x	***OR***	Any acute inpatient facility code

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

Section OHII. Organizational Structure and Staffing

OH2.1 Waiver service coordinator training for supporting self-direction under the demonstration.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH2. Organizational Structure and Staffing	Annually	Contract	Calendar Year	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of waiver service coordinators.	Total number of waiver service coordinators employed for at least 30 days in the MMP during the reporting period.	Field Type: Numeric
B.	Total number of waiver service coordinators that have undergone MCOP training for supporting self-direction under the demonstration.	Of the total reported in A, the number of waiver service coordinators that have undergone MCOP 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 MCOP 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 waiver 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 collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

Section OHIII. Performance and Quality Improvement

OH3.1 Long-term care overall balance.[i]

Please note: No MMP reporting is required for this measure; 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.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH3. Performance and Quality Improvement	Annually	Contract	Calendar Year	N/A

OH3.2 Long-term care rebalancing.

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.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH3. Performance and Quality Improvement	Annually	Contract	Calendar Year	N/A

OH3.3 Nursing facility residents whose need for help with Activities of Daily Living (ADLs) has increased.

Please note: No MMP reporting is required for this measure; ODM will gather the data necessary from MDS. 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.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
OH3. 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	N/A

Please refer to the MDS 3.0 Quality Measure User's Manual for further detailed specifications on this measure: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-QM-User%E2%80%99s-Manual-V80.pdf

OH3.4 Nursing facility residents who have/had a catheter inserted and left in their bladder.

Please note: No MMP reporting is required for this measure; 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.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
OH3. 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	N/A

Please refer to the MDS 3.0 Quality Measure User's Manual for further detailed specifications on this measure: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-QM-User%E2%80%99s-Manual-V80.pdf

OH3.5 Nursing facility residents who were physically restrained.

Please note: No MMP reporting is required for this measure; ODM will gather the data necessary from MDS. 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.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
OH3. 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	N/A

Please refer to the MDS 3.0 Quality Measure User's Manual for further detailed specifications on this measure: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-QM-User%E2%80%99s-Manual-V80.pdf

OH3.6 Nursing facility residents experiencing one or more falls with a major injury.

Please note: No MMP reporting is required for this measure; ODM will gather the data necessary from MDS. 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.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
OH3. 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	N/A

Please refer to the MDS 3.0 Quality Measure User's Manual for further detailed specifications on this measure: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-QM-User%E2%80%99s-Manual-V80.pdf

OH3.7 Nursing facility residents with a urinary tract infection.

Please note: No MMP reporting is required for this measure; ODM will gather the data necessary from MDS. 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.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
OH3. 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	N/A

Please refer to the MDS 3.0 Quality Measure User's Manual for further detailed specifications on this measure: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-QM-User%E2%80%99s-Manual-V80.pdf

Section OHIV. Systems

OH4.1 MyCare Centralized Enrollee Record.

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.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH4. Systems	Monthly	Contract	Current Month Ex: 1/1 – 1/31	N/A
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH4. Systems	Annually	Contract	Calendar Year	N/A

Section OHV. Utilization

OH5.1 Unduplicated members receiving HCBS and unduplicated members receiving nursing facility services.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH5. Utilization	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

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

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

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of members receiving both HCBS and nursing facility services during the reporting period.	Of the total reported in A, the number of members receiving both HCBS and nursing facility services during the reporting period.	Field Type: Numeric Note: Is a subset of A.

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

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

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

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

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

- CMS and the state will obtain enrollment data and will evaluate the percentage of members who received:
    - HCBS during the reporting period who did not receive nursing facility services during the reporting period.
    - Nursing facility services during the reporting period who did not receive HCBS during the reporting period.
    - Both HCBS and nursing facility services during the reporting period.

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

- MMPs should include all members regardless of whether the member enrolled voluntarily or was passively enrolled. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).

- Members must be continuously enrolled for six months during the reporting period, with no gaps in enrollment, to be included in this measure.
- Members receiving only HCBS should be counted for data element B (unduplicated). Members receiving only nursing facility services should be counted for data element C (unduplicated). Members receiving both HCBS and nursing facility services should be counted for data element D (unduplicated). Data elements B, C, and D are mutually exclusive.
- Unduplicated means a member should only be counted once for the type of service they receive. For example, if a member received nursing facility services in two different facilities during the reporting period, they would only count once toward members receiving nursing facility services during the reporting period (data element C).
- Include members who were receiving HCBS or nursing facility services for any length of time during the reporting period.
- HCBS refers to Home and Community Based Services.

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

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org