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MEDICARE-MEDICAID CAPITATED FINANCIAL ALIGNMENT MODEL REPORTING REQUIREMENTS

Effective as of January 1, 2022; Issued November 1, 2021

Table of Contents

INTRODUCTION

The Medicare-Medicaid Financial Alignment Initiative is designed to test innovative models to better align Medicare and Medicaid financing and the services provided to Medicare-Medicaid enrollees.

The purpose of this document is to provide Medicare-Medicaid Plans (MMPs) with the reporting requirements for the capitated financial alignment model. It provides technical specifications to help assure a common understanding of the data to be reported by MMPs, to assist MMPs in preparing and submitting datasets, to ensure a high level of accuracy in the data reported to the Centers for Medicare & Medicaid Services (CMS) and the states, and to reduce the need for MMPs to correct and resubmit data.

The reporting requirements document is divided into three sections. The first section lists all Medicare Part C Reporting Requirements the MMPs are responsible for submitting via the Health Plan Management System (HPMS). The second section lists all Medicare Part D Reporting Requirements the MMPs are responsible for submitting via HPMS. Upon Office of Management and Budget (OMB) approval, MMPs are required to report these measures according to the existing specifications and must comply with the Part C and Part D data validation requirements.

The third section consists of the MMP-specific Core Reporting Requirements for the capitated financial alignment model. Specifications for these demonstration measures indicate their reporting frequency and due dates. MMPs are also required to comply with validation requirements for MMP-specific measures.

Measures should be reported at the contract level, unless otherwise indicated.

Definitions

The following terms are used throughout the document:

Medicare-Medicaid Plan (MMP): An MMP is a managed care plan that has entered into a three-way contract with CMS and the state in which the plan will operate. Note: some demonstrations might use different terms to refer to their plans, such as One Care plans in Massachusetts.

State: The state with which the MMP has contracted.

Health Plan Management System (HPMS): The CMS centralized information system used by MMPs to submit Part C, Part D, and MMP-specific core measure data.

Calendar Quarter: All quarterly measures are reported on calendar quarters. The four calendar quarters of each calendar year are defined as follows: January 1 to March 31, April 1 to June 30, July 1 to September 30, and October 1 to December 31.

Calendar Year: All annual measures are reported on a calendar year basis. For example, CY 2022 represents January 1, 2022 through December 31, 2022.

Passive Enrollment and Stopping Enrollment

Under the capitated financial alignment model, demonstrations may allow for passive enrollment. During passive enrollment, MMPs must demonstrate adequate performance across a range of measures to remain eligible to receive passive enrollment of beneficiaries. Failure to adequately meet any single measure or set of measures may result in CMS and the state ceasing enrollment. CMS and each state, through the Contract Management Team (CMT), will have the option to discontinue passive enrollment for MMPs for various reasons, including for MMPs failing to completely and accurately report measures or to adequately meet performance standards.

Quality Withhold Measures

CMS and each state established a set of quality withhold measures, and MMPs are required to meet established thresholds. Throughout this document, CMS core quality withhold measures are marked with the following symbol for Demonstration Year 1: ([i]) and the following symbol for Demonstration Years 2 through 9: ([ii]). Note that additional CMS core quality withhold measures are reported through other vehicles or venues, such as HEDIS® and CAHPS®.[1] Any state-specific exceptions to the CMS core quality withhold measures, along with definitions of Demonstration Years, are noted in the state-specific quality withhold appendices. Additional information on the withhold methodology can be found at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPQualityWithholdMethodologyandTechnicalNotes.html.

Reporting on Passively Enrolled and Opt-In Enrolled Members

When reporting all measures, MMPs should include all members who meet the criteria for inclusion in the measure, regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.

Reporting on Disenrolled and Retro-disenrolled Members

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

Due to retro-disenrollment of members, there may be instances where there is a lag between a member's effective disenrollment date and the date on which the MMP is informed about that disenrollment. This time lag might create occasional data

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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 they 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.

Data Submission

All MMPs will submit core measure data in accordance with the guidance in these reporting requirements. Submission requirements vary by measure, but most core measures are reported through HPMS.

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

Resubmission of MMP-Specific Core Measure Data to HPMS

MMPs must comply with the following steps to resubmit data for MMP-specific core measures after an established due date:

1. Email the applicable NORC HelpDesk to request resubmission.
    a. Specify in the email which measure(s) need resubmission;
    b. Specify for which reporting period(s) the resubmission is needed; and
    c. Provide a brief explanation for why the data need to be resubmitted.
2. After review of the request, the NORC HelpDesk will notify the MMP that the resubmission can be completed.
3. Resubmit data through HPMS.
4. Notify the NORC HelpDesk again after resubmission has been completed.

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

MEDICARE PART C REPORTING REQUIREMENTS

MMPs are required to report the following Part C reporting sections according to existing reporting requirements and technical specifications, which can be found on the CMS website at: https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/ReportingRequirements.html

Section VI. Rewards and Incentives Programs

Section VII. Payments to Providers

MEDICARE PART D REPORTING REQUIREMENTS

MMPs are required to report the following Part D reporting sections according to existing reporting requirements and technical specifications, which can be found on the CMS website at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxContracting_ReportingOversight.html

Section II. Medication Therapy Management Programs

Section III. Grievances

Section IV. Improving Drug Utilization Review Controls

Section V. Coverage Determinations, Redeterminations, and Reopenings

MMP-SPECIFIC CORE REPORTING REQUIREMENTS

Introduction

The Core Reporting Requirements section consists of measures developed for all capitated financial alignment demonstrations. State-specific appendices capture the reporting requirements specific to each state's demonstration. The core and state-specific measures supplement existing Medicare Part C and Part D Reporting Requirements, as well as measures that MMPs report via other vehicles or venues, such as HEDIS®, HOS, CAHPS® and state Medicaid agencies.[2] In addition, CMS and the states will 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.

Value Sets

The measure specifications in this section refer to code value sets that must be used to determine and report measure data element values. A value set is the complete set of codes used to identify a service or condition included in a measure. The Core Value Sets Workbook includes all value sets and codes needed to report certain MMP-specific measures included in the Core Reporting Requirements and is intended to be used in conjunction with the measure specifications outlined in this document. The Core Value Sets Workbook can be found on the CMS website at the following address: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html

Reporting Phases

There are three distinct types of reporting phases for demonstration measures: "Implementation," "Ongoing," and "Continuous Reporting."

The Implementation phase corresponds with the initial months of the demonstration and will be further defined in the Introduction section of each state-specific appendix. Monitoring will be more intensive during this phase to allow CMS and the state to quickly become aware of any performance or access issues. MMPs will report measures on the Implementation reporting timeline during the Implementation phase only.

The Ongoing phase begins at the inception of the demonstration and continues for the life of the demonstration. MMPs will report measures on the Ongoing reporting timeline during the Ongoing phase. Note: Measures that have both an Implementation and Ongoing phase should be reported concurrently (e.g., Core Measure 2.1, Members with

[2] HEDIS® is a registered trademark of NCQA. CAHPS® is a registered trademark of AHRQ.

an assessment completed within 90 days of enrollment). MMPs will cease reporting on the Implementation reporting timeline once the Implementation phase is complete. Some measures do not include an Ongoing phase, meaning data are collected only during the Implementation phase.

Continuous Reporting measures will be reported at the same frequency for the duration of the demonstration. The first reporting period for these measures coincides with the first reporting period of the Ongoing and Implementation phases.

Reporting timelines are defined in terms of calendar days, not business days. If a reporting due date for any core measure falls on a weekend or a federal holiday, MMPs may submit data on the following business day. Table 1 and Table 2 below are examples of reporting timelines that will be found throughout this section. The introduction of each state-specific appendix provides tables describing each state's Implementation, Ongoing, and Continuous Reporting periods.

Table 1. Sample Implementation and Ongoing Reporting Timeline

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
Example	Monthly, beginning after 90 days	Contract	Current Calendar 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**
Example	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

Table 2. Sample Continuous Reporting Timeline

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

Measure Specifications

Each measure specification includes information regarding the following subjects:

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.

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.

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

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

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

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

Section I. Access

1.1 Claims (excluding pharmacy point-of-sale [POS]) denied during the first 90 days of enrollment with the MMP, by reason for denial. – ***Retired***

1.2 Pharmacy point-of-sale (POS) claims denied during passive enrollment, by reason for denial.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
1. Access	Every 14 days during the first month of a wave of passive enrollment (subsequent submissions may be necessary for MMPs that meet or exceed the threshold or have an insufficient sample size)	Contract	14 days Ex: 12:00a.m. on January 1st through 11:59p.m. on January 14th and 12:00a.m. on January 15th through 11:59p.m. on January 28th.	5:00p.m. ET three days following the end of the reporting period Ex: Data is due by 5:00p.m. ET on January 17th for the reporting period that ends at 11:59p.m. ET on January 14th. Data is due by 5:00p.m. ET on January 31st for the reporting period that ends at 11:59p.m. ET on January 28th.

The list of pharmacy POS denied claims will be limited to claims denied for the following reasons: non-formulary, prior authorization, and step therapy. A template for providing these claims is located on the CMS website: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html

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.

- Required file format is Microsoft Excel file.
- The file name extension should be ".xlsx"
- File name= RX_(STATEABBREVIATION)_(CONTRACTID)_(REPORTING PERIOD)_(SUBMISSIONDATE).xlsx.

- Replace (STATEABBREVIATION) with the two-character state abbreviation (e.g., Massachusetts is MA), (CONTRACTID) with the contract ID, (REPORTINGPERIOD) with the month and year of the beginning of the reporting period in YYYYMM format (e.g., January 2022 would be 202201), and (SUBMISSIONDATE) with the year, month, and day of the submission in YYYYMMDD format (e.g., January 17, 2022 would be 20220117).
- The first worksheet in the template should be named “Rejected Claims.”
- The second worksheet in the template should be named “Key Acronyms.”
- The third worksheet in the template should be named “Addl Reject Codes_Pharmacy Msgs.”

File Layout

Field Name	Field Description	Allowable Values
MBI	Medicare Beneficiary Identifier (MBI) refers to the number assigned to an individual for the purpose of identifying them as a Medicare beneficiary. MBI will be shown in the beneficiary's insurance card and it is on the basis of this number that a beneficiary’s Medicare claims are processed.	Field Type: Alpha-numeric
Member Enrollment Date	Identifies the date that each member enrolled. Enrollment eligibility begins on the 1st of the month. If a member has a gap in coverage, provide the most recent enrollment date.	Field Type: Date in MM/DD/YYYY format
Member Disenrollment Date	Identifies the date that each member disenrolled. Eligibility continues through the last day of the month that the member disenrolls.	Field Type: Date in MM/DD/YYYY format If a member is still enrolled during the reporting period, please insert 12/31/9999 to indicate the member is currently enrolled.
Cardholder ID	Insurance ID assigned to the cardholder or identification number used by the MMP. May be the same as MBI.	Field Type: Alpha-numeric

Field Name	Field Description	Allowable Values
CCN	Claim Control Number (CCN). A claim control number is a unique number given to each claim.	Field Type: Alpha-numeric
CMS Contract ID	Designation assigned by CMS that identifies a specific sponsor.	Field Type: Alpha-numeric
Plan Name	Plan Name	Field Type: Text
NDC 11 (no hyphens)	National Drug Code Drug products are identified and reported using a unique, three-segment number, called the National Drug Code (NDC), which serves as a universal product identifier for drugs. FDA publishes the listed NDC numbers and the information submitted as part of the listing information in the NDC.	Field Type: Numeric Note: 11-digit NDC code with no hyphens
Date of Service	Identifies date the prescription was filled. This date may be outside the reporting period as long as the associated Date of Rejection is after the Date of Service.	Field Type: Date in MM/DD/YYYY Format
Date of Rejection	Identifies the date the claim was rejected. The Date of Rejection must occur during the reporting period.	Field Type: Date in MM/DD/YYYY Format
Claim Quantity	Quantity dispensed expressed in metric decimal units.	Field Type: Numeric Allowable Values: >0
Claim Days Supply	Estimated number of days the prescription will last.	Field Type: Numeric Allowable Values: >0; < 999
Compound Code	Code indicating whether or not the prescription is a compound.	Field Type: Numeric Allowable Values: 0 = not specified 1 = not a compound 2 = compound
Rejection Category (1=NF, 2=PA, 3=ST)	Rejection Category: Use category 1 if the rejection is for Non-Formulary drug. Use category 2 if the rejection is for Prior Authorization. Use category 3 if the rejection is for Step Therapy.	Field Type: Numeric Allowable Values: 1=Non-Formulary 2=Prior Authorization 3=Step Therapy

Field Name	Field Description	Allowable Values
Reject Code 1	Reject code used in MMP's claim adjudication system.	Field Type: Alpha-numeric
Pharmacy Message 1	Reject Message used in MMP's claim adjudication system.	Field Type: Text
Reject Code 2	Reject code used in MMP's claim adjudication system.	Field Type: Alpha-numeric
Pharmacy Message 2	Reject Message used in MMP's claim adjudication system.	Field Type: Text
Reject Code 3	Reject code used in MMP's claim adjudication system.	Field Type: Alpha-numeric
Pharmacy Message 3	Reject Message used in MMP's claim adjudication system.	Field Type: Text
MMP must provide all reject codes and messaging, not limited to the number of fields in the "Rejected Claims" template. Please insert columns in the "Addl Reject Codes_Pharmacy Msgs" template as necessary.	Provide any additional reject codes and messaging.	

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.

- An audit of a sample of claims will be performed. Claims not excluded from the analysis will be flagged as "potentially inappropriate." A sample of up to 30 potentially inappropriate claims will be selected for further review, including: protected class drugs and non-protected class drugs. If at least 15 protected and 15 non-protected class drugs are submitted, 15 protected and 15 non-protected class drugs will be sampled. If fewer than 15 claims are submitted in either drug class, additional claims from the opposing drug class will be selected, until a sample of 30 is reached (e.g., 13 protected and 17 non-protected drugs). If the MMP submits fewer than 30 rejected claims, the sample will consist of all submitted rejected claims. MMPs will be required to review claims and address the following:
    - Was the claim an appropriate rejection? (Y/N).
    - Patient setting (e.g., nursing facility, acute care hospital, etc.).
    - Patient DOB.
    - Provide a brief explanation as to why the claim was appropriate or inappropriate, related to one of the three rejection categories.

  - Was the claim paid? (Y/N).
  - If the claim was paid, provide the date the claims was paid for the drug in question.

C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission. Any claims that do not pass validation will be excluded from the analysis. These checks will include the following:

- The CMS Contract ID is formatted as 5 alpha-numeric characters.
- The CMS Contract ID matches the submitting Contract ID.
- The NDC consists of 11 numeric characters.
- The NDC is a valid NDC.
- The Date of Service is in the MM/DD/YYYY format.
- The Date of Rejection is in the MM/DD/YYYY format.
- The Date of Rejection is during the reporting period.
- The Date of Rejection is on or after the Date of Service.
- The Rejection Category is 1, 2, or 3.
- The Claim Quantity is greater than zero.
- The Claim Days Supply is greater than zero.
- The Claim Days Supply is between 1 and 3 numeric characters (1-999).

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 calculate an overall score once MMPs have reviewed and provided comments.
- For all class drugs, the number of inappropriate denials (numerator) will be divided by the total number of potentially inappropriate claims sampled (denominator) to calculate an overall rate of inappropriate denials.
- For protected class drugs, the number of inappropriate denials (numerator) will be divided by the total number of potentially inappropriate claims for protected class drugs sampled (denominator) to calculate an overall rate of inappropriate denials.
- For non-protected class drugs, the number of inappropriate denials (numerator) will be divided by the total number of potentially inappropriate claims for non-protected class drugs sampled (denominator) to calculate an overall rate of inappropriate denials.

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

Definitions

- This measure assesses only the following three denial types: non-formulary, prior authorization, and step therapy.
  - Non-formulary drugs are drugs that are not on an MMP's formulary.
  - Prior Authorization is defined as approval that a member must get from the MMP before filing a prescription in order for the MMP to cover the

prescription. The MMP may require prior authorization for certain drugs.
    - Step Therapy is a coverage rule used by some MMPs that requires a member to try one or more similar, lower cost drugs to treat their condition before the MMP will cover the prescribed drug.

Reporting Period Guidance

- The reporting period for this measure will begin at the start of the passive enrollment period. Once reporting begins, members should be included regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- Passive enrollment periods may vary by state. MMPs should refer to their state's three-way contract for specific requirements.
- Reporting timelines are defined in terms of calendar days, not business days. If a reporting due date for Core Measure 1.2 falls on a weekend or holiday, MMPs may submit data on the following business day.

POS Claims Guidance

- MMPs should include all denied claims including adjusted and reprocessed claims, even if repeated claims are attempted on the same day.
- Denials ensuing from requests for early refills should be excluded.

Additional Submissions

- CMS reserves the right to extend the reporting frequency after the first wave of passive enrollment, if necessary.
- Subsequent 14-day submissions may be necessary for MMPs that meet or exceed the threshold or have an insufficient sample size. MMPs will receive an MMP-specific report indicating whether an MMP passed, failed, or had an insufficient sample size following the full 28-day period.
    - Any MMP that failed or had an insufficient sample size must undergo another round and must submit data during the next wave of passive enrollment (unless otherwise directed by the CMT).
    - For MMPs in states with monthly passive enrollment, the MMP must report the last 14 days of the next month of passive enrollment (i.e., days 14 through 28).
    - For MMPs with passive enrollment that is not month to month, the MMP must submit the first 14 days of the next wave of passive enrollment.
- MMPs that pass the first 28-day period will not need a subsequent round of review.

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

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://hsagonline.sharepoint.com/teams/FAI/

Section II. Assessment

2.1 Members with an assessment completed within 90 days of enrollment.[i]

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
2. Assessment	Monthly during the implementation period, beginning after 90 days of implementation	Contract	Current Calendar Month Ex: 1/1-1/31	By the end of the month following the last day of the reporting period Ex: Demo implementation is January 1, 2022; 90 days after enrollment is March 31, 2022; the first report is due by April 30, 2022.
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
2. Assessment	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period.	Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period.	Field type: Numeric
B.	Total number of members who were documented as unwilling to participate in the assessment within 90 days of enrollment.	Of the total reported in A, the number of members who were documented as unwilling to participate in the assessment and who never had an assessment completed within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A. Unwillingness to participate must be clearly documented.
C.	Total number of members the MMP was unable to reach, following three documented outreach attempts, to participate in the assessment within 90 days of enrollment.	Of the total reported in A, the number of members the MMP was unable to reach, following three documented outreach attempts, to participate in the assessment and who never had an assessment completed within 90 days of enrollment.	Field type: Numeric Note: Is a subset of A. Three outreach attempts must be clearly documented.
D.	Total number of members with an assessment completed within 90 days of enrollment.	Of the total reported in A, the number of members with an assessment completed within 90 days of enrollment.	Field type: Numeric Note: Is a subset of A. Completed assessments must be clearly documented.

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 the sum of data elements B, C, and D is less than or equal to data element A.
- MMPs should validate that members included in data element A were enrolled for at least 90 days and the 90th day of enrollment occurred within the reporting period.
- MMPs should validate that members included in data element A were enrolled as of the last day of the reporting period.
- MMPs should validate that members included in data element B were included in data element A.
- MMPs should validate that members included in data element C were included in data element A.
- MMPs should validate that members included in data element D were included in data element A.
- MMPs should validate that members reported in data element B were not reported in data elements C or D.
- MMPs should validate that members reported in data element C were not reported in data elements B or D.
- MMPs should validate that members reported in data element D were not reported in data elements B or C.
- MMPs should validate that members reported in data element B were clearly documented as unwilling to participate in the assessment within 90 days of enrollment.
- MMPs should validate that members reported in data element C had three outreach attempts clearly documented within 90 days of enrollment.
- MMPs should validate that members reported in data element D had a completed assessment clearly documented within 90 days of enrollment.

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 documented as unwilling to participate in the assessment and who never had an assessment completed within 90 days of enrollment.
    - Percentage = (B / A) * 100
- The MMP was unable to reach, following three documented outreach attempts, to participate in the assessment and who never had an assessment completed within 90 days of enrollment.
    - Percentage = (C / A) * 100

- Had an assessment completed within 90 days of enrollment.
    - Percentage = (D / A) * 100
- Were willing to participate and who could be reached who had an assessment completed within 90 days of enrollment.
    - Percentage = (D / (A – B – C)) * 100

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

Data Element A

- MMPs should only include those members who are currently enrolled as of the last day of the reporting period, including deceased members who were enrolled through the end of the reporting period. The last day of the reporting period is the anchor date, or the date on which all reported members must be enrolled in the MMP.
- The 90th day of enrollment should be based on each member's most recent effective enrollment date in the MMP. Members must be continuously enrolled from the most recent effective enrollment date through 90 days of enrollment with no gaps in enrollment.
- For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months. The 90th day of enrollment will always occur on the last day of the third month following a member's effective enrollment date.
    - When reporting quarterly results for Ongoing reporting periods, MMPs should report all members who reached their 90th day of enrollment at any point during the three months included in the quarter (e.g., members enrolled on May 1, June 1, and July 1 reached their 90th day of enrollment during the third quarter; therefore, these members should be included in Ongoing reporting for the third quarter as long as they were still enrolled on the last day of the reporting period).

Data Element B

- For data element B, MMPs should report the number of members who were documented as unwilling to participate in the assessment if a member (or the member's authorized representative):
    - Affirmatively declines to participate in the assessment, affirmatively declines care management activities overall, or refuses any contact with the MMP. The member may communicate the declination or refusal by phone, mail, fax, or in person. The declination or refusal must be documented by the MMP.
    - Expresses willingness to complete the assessment but asks for it to be conducted after 90 days (despite being offered a reasonable opportunity to complete the assessment within 90 days). Discussions with the member must be documented by the MMP.
    - Schedules an appointment to complete the assessment but cancels or is a no-show and then is subsequently non-responsive to additional

outreach attempts by the MMP. All attempts to contact the member must be documented by the MMP.
    - Initially agrees to complete the assessment, but then declines to answer a sufficient number of questions in the assessment, as determined by the MMP. The declination must be documented by the MMP.
- If a member was not reached after three outreach attempts, but then subsequently is reached and refuses the assessment within 90 days of enrollment, the member should be classified in data element B.

Data Element C

- For data element C, MMPs should report the number of members the MMP was unable to reach after three documented attempts to contact the member. MMPs should refer to their state's three-way contract or state guidance for any specific requirements pertaining to the method of outreach to members. MMPs must document each attempt to reach the member, including the method of the attempt (e.g., phone, mail, or email), as CMS and the state may validate this number. If less than three outreach attempts are made to the member within 90 days of enrollment, the member should not be included in data element C.
    - Note that the applicable three-way contract may require more than three outreach attempts. MMPs must continue to follow such contract requirements; however, for purposes of reporting this measure, MMPs may count a member under data element C following three outreach attempts.
- There may be instances when the MMP has a high degree of confidence that a member's contact information is correct, yet that member is not responsive to the MMP's outreach efforts. So long as the MMP follows the guidance regarding outreach attempts, these members may be included in the count for data element C.

Data Element D

- The assessment for this measure should be the comprehensive health risk assessment as applicable per state-specific guidance. The requirements pertaining to the assessment tool and how the tool should be administered (e.g., in-person, phone, etc.) may vary by state. The assessment tool should meet any state-specific criteria and include the appropriate domains as determined by the state. MMPs should refer to their state's three-way contract for specific requirements.
- If a member's assessment is in progress, but is not completed within 90 days of enrollment, then the assessment should not be considered completed, and therefore, the member should not be counted in data element D.
- If a member initially refused the assessment or could not be reached after three outreach attempts, but then subsequently completes the assessment within 90 days of enrollment, the member should be classified in data element D.

General Guidance

- Members reported in data elements B, C, and D must also be reported in data element A since these data elements are subsets of data element A. Additionally, data elements B, C, and D should be mutually exclusive (e.g., a member reported in data element B or C should not also be reported in data element D).
- MMPs should only report members with an initial assessment for this measure. For reporting of members with an annual reassessment, refer to Core Measure 2.3.
- Additional guidance is included in the state-specific reporting appendices. MMPs should refer to their state's reporting appendix for measure reporting variations from the Core Reporting Requirements and for information on reporting assessments completed by the MMP prior to a member's effective enrollment date, reporting assessments for members with a break in coverage, and reporting assessments completed previously by the MMP's affiliated product. Note that the applicability of such guidance varies across states.
- There may be certain circumstances that make it impossible or inappropriate to complete an assessment within the required timeframe. For example, a member may be medically unable to respond and have no authorized representative to do so on their behalf, or a member may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for an assessment. However, MMPs should not include such members in the counts for data elements B or C.
- For additional guidance on identifying each data element, including examples and scenarios for correctly reporting members who may meet the criteria for multiple data elements, please reference the Core Measure 2.1 FAQ document located on the CMS website: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

2.2 Members with an assessment completed.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
2. Assessment	Monthly	Contract	Current Calendar Month Ex: 1/1-1/31	By the end of the month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members with an assessment completed within the reporting period.	Total number of members with an assessment completed within the reporting period.	Field Type: Numeric
B.	Total number of members enrolled for 90 days or longer as of the last day of the reporting period.	Total number of members enrolled for 90 days or longer as of the last day of the reporting period.	Field type: Numeric Note: This data element should not be reported until 90 days after implementation.
C.	Total number of members enrolled for 90 days or longer who had an assessment completed.	Of the total reported in B, the number of members enrolled for 90 days or longer who had an assessment completed.	Field type: Numeric Note: Is a subset of B. Note: This data element should not be reported until 90 days after implementation.

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 C is less than or equal to data element B.

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 use enrollment data to evaluate the percentage of members:

- Who had an assessment completed within the reporting period.
  - Percentage = (A / Total Members Enrolled) * 100
- Enrolled for 90 days or longer as of the last day of the reporting period who had an assessment completed.
  - Percentage = (C / B) * 100

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

Data Element A

- MMPs should include all members who meet the criteria outlined in data 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).

Data Element B

- For data element B, MMPs should only include those members who are currently enrolled as of the last day of the reporting period, including deceased members who were enrolled through the end of the reporting period. The last day of the reporting period is the anchor date, or the date on which all reported members must be enrolled in the MMP.
- The 90th day of enrollment should be based on each member's most recent effective enrollment date in the MMP. Members must be continuously enrolled from the most recent effective enrollment date through at least 90 days of enrollment with no gaps in enrollment.
- For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months. The 90th day of enrollment will always occur on the last day of the third month following a member's effective enrollment date.

Data Element C

- The members reported in data element C could have had an assessment completed at any time prior to the end of the reporting period, not necessarily during the current reporting period.

General Guidance

- MMPs should only report members with an initial assessment for this measure. For reporting of members with an annual reassessment, refer to Core Measure 2.3.

- The assessment for this measure should be the comprehensive health risk assessment as applicable per state-specific guidance. The requirements pertaining to the assessment tool and how the tool should be administered (e.g., in-person, phone, etc.) may vary by state. The assessment tool should meet any state-specific criteria and include the appropriate domains as determined by the state. MMPs should refer to their state's three-way contract for specific requirements.
- Data element A will be reported after the first month following the beginning of the Implementation period, whereas data elements B and C will not be reported until after 90 days.

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

2.3 Members with an annual reassessment.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
2. Assessment	Annually	Contract	Calendar Year, beginning CY2	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 as of the last day of the current reporting period.	Total number of members enrolled as of the last day of the current reporting period.	Field Type: Numeric
B.	Total number of members who had an assessment completed during the previous reporting period.	Of the total reported in A, the number of members who had an assessment completed during the previous reporting period.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of members with a reassessment completed during the current reporting period.	Of the total reported in B, the number of members who had a reassessment completed during the current reporting period.	Field Type: Numeric Note: Is a subset of B.
D.	Total number of members with a reassessment completed within 365 days of the most recent assessment completed.	Of the total reported in C, the number of members with a reassessment completed during the current reporting period that occurred within 365 days of the most recent assessment completed during the previous reporting period.	Field Type: Numeric Note: Is a subset of C.
E.	Total number of members who did not have an assessment completed during the previous reporting period.	Of the total reported in A, the number of members enrolled for at least 90 continuous days during the previous reporting period who did not have an assessment completed during the previous reporting period.	Field Type: Numeric Note: Is a subset of A.
F.	Total number of members with an assessment completed during the current reporting period.	Of the total reported in E, the number of members who had an assessment completed during the current reporting period.	Field Type: Numeric Note: Is a subset of E.

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 elements B and E are less than or equal to data element A.
- MMPs should validate that data element C is less than or equal to data element B.
- MMPs should validate that data element D is less than or equal to data element C.
- MMPs should validate that data element F is less than or equal to data element E.

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 an assessment completed during the previous reporting period who had a reassessment completed during the current reporting period.
  - Percentage = (C / B) * 100
- Had an assessment completed during the previous reporting period who had a reassessment completed during the current reporting period that was within 365 days of the most recent assessment completed during the previous reporting period.
  - Percentage = (D / B) * 100
- Were enrolled for at least 90 continuous days during the previous reporting period who did not have an assessment completed during the previous reporting period but had an assessment completed during the current reporting period.
  - Percentage = (F / E) * 100

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

<u>Data Element A</u>

- MMPs should only include those members who are currently enrolled as of the last day of the reporting period, including deceased members who were enrolled through the end of the reporting period. The last day of the reporting period is the anchor date, or the date on which all reported members must be enrolled in the MMP.

<u>Data Element B</u>

- For reporting data element B, include all members who were enrolled as of the last day of the current reporting period who received an assessment (initial or reassessment) during the previous reporting period.

<u>Data Element C</u>

- For reporting data element C, include all members reported in data element B who had a reassessment completed at any time during the current reporting period.

Data Element D

- For reporting data element D, include all members reported in data element C who had a reassessment completed during the current reporting period that was completed within 365 days of the date of the member's most recent assessment (initial or reassessment) completed during the previous reporting period.
    - For example, if a member was assessed twice during CY 2021 (previous reporting period), first on May 15, 2021 and again on October 15, 2021, count 365 days continuously from October 15, 2021 to determine if a reassessment occurred within 365 days.
    - In this example, if the member completes a reassessment on September 15, 2022, they would be included in data element D for CY 2022 reporting. Conversely, if the member's reassessment was not completed until November 15, 2022, they would not be included in data element D for CY 2022 reporting. In either case, the member would be captured in data element C.
- For members who disenroll and reenroll in the MMP, MMPs should count 365 days continuously from the member's most recent assessment date within the previous reporting period, even if that assessment was conducted during the member's prior enrollment period.

Data Element E

- For reporting data element E, include all members who were enrolled as of the last day of the current reporting period, who were enrolled for at least 90 continuous days during the previous reporting period who did not receive an assessment (initial or reassessment) during the previous reporting period.
    - For members who disenroll and reenroll in the MMP, MMPs should include members who had any continuous enrollment of 90 days or more in the previous year, even if that enrollment preceded a break in coverage by the MMP.
    - 90 days of enrollment will be equivalent to three full calendar months.

Data Element F

- For reporting data element F, include all members reported in data element E who had an assessment completed at any time during the current reporting period.

General Guidance

- The assessment for this measure should be the comprehensive health risk assessment as applicable per state-specific guidance. The requirements pertaining to the assessment tool and how the tool should be administered (e.g., in-person, phone, etc.) may vary by state. The assessment tool should meet any state-specific criteria and include the appropriate domains as determined by the state. MMPs should refer to their state's three-way contract for specific requirements.

- For reporting all data elements, MMPs should report unduplicated counts of members meeting the criteria for each data element. Members with more than one assessment or reassessment completed during a reporting period should be reported only once in the relevant data elements.
- In certain circumstances, a member with a break in coverage who reenrolls in the MMP and has an assessment completed upon reenrollment during the current reporting period may be reported under both Core Measure 2.1 and Core Measure 2.3.
    - For example, consider a member that was previously assessed on June 15, 2021, subsequently disenrolled on October 1, 2021, reenrolled on January 1, 2022, assessed again on February 15, 2022, and remained enrolled as of December 31, 2022. The member would be counted in Quarter 1 2022 reporting for Core Measure 2.1 (data elements A and D) and in CY 2022 reporting for Core Measure 2.3 (data elements A, B, C, and D).
- The term “current reporting period” in data elements A, C, D, and F refers to the current calendar year. The term “previous reporting period” in data elements B, D, and E refers to the prior calendar year.
- This measure is reported starting with the MMP’s second year of operation (i.e., Calendar Year 2). All MMPs that have operated for at least two years must report the measure.

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

Section III. Care Coordination

3.1 Members, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted within 24 hours of discharge to the facility or primary care provider or other health care professional designated for follow-up care. (modified from NQF #0648) – ***Retired***

3.2 Members with a care plan completed within 90 days of enrollment.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
3. Care Coordination	Monthly during the implementation period, beginning after 90 days of implementation	Contract	Current Calendar Month Ex: 1/1-1/31	By the end of the month following the last day of the reporting period Ex: Demo implementation is January 1, 2022; 90 days after enrollment is March 31, 2022; the first report is due by April 30, 2022.
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
3. 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 whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period.	Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of 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 and who never had a care plan completed within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A. Unwillingness to participate must be clearly documented.
C.	Total number of members the MMP was unable to reach, following three documented outreach attempts, to complete a care plan within 90 days of enrollment.	Of the total reported in A, the number of members the MMP was unable to reach, following three documented outreach attempts, to complete a care plan and who never had a care plan completed within 90 days of enrollment.	Field type: Numeric Note: Is a subset of A. Three outreach attempts must be clearly documented.
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. Completed care plans must be clearly documented.

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 the sum of data elements B, C, and D is less than or equal to data element A.
- MMPs should validate that members included in data element A were enrolled for at least 90 days and the 90th day of enrollment occurred within the reporting period.
- MMPs should validate that members included in data element A were enrolled as of the last day of the reporting period.
- MMPs should validate that members included in data element B were included in data element A.
- MMPs should validate that members included in data element C were included in data element A.
- MMPs should validate that members included in data element D were included in data element A.
- MMPs should validate that members reported in data element B were not reported in data elements C or D.
- MMPs should validate that members reported in data element C were not reported in data elements B or D.
- MMPs should validate that members reported in data element D were not reported in data elements B or C.
- MMPs should validate that members reported in data element B were clearly documented as unwilling to complete the care plan within 90 days of enrollment.
- MMPs should validate that members reported in data element C had three outreach attempts clearly documented within 90 days of enrollment.
- MMPs should validate that members reported in data element D had a completed care plan clearly documented within 90 days of enrollment.

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 documented as unwilling to complete a care plan and who never had a care plan completed within 90 days of enrollment.
    - Percentage = (B / A) * 100
- The MMP was unable to reach, following three documented outreach attempts, to complete a care plan and who never had a care plan completed within 90 days of enrollment.
    - Percentage = (C / A) * 100

- Had a care plan completed within 90 days of enrollment.
    - Percentage = (D / A) * 100
- Were willing to participate and who could be reached who had a care plan completed within 90 days of enrollment.
    - Percentage = (D / (A – B – C)) * 100

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

Data Element A

- MMPs should only include those members who are currently enrolled as of the last day of the reporting period, including deceased members who were enrolled through the end of the reporting period. The last day of the reporting period is the anchor date, or the date on which all reported members must be enrolled in the MMP.
- The 90th day of enrollment should be based on each member's most recent effective enrollment date in the MMP. Members must be continuously enrolled from the most recent effective enrollment date through 90 days of enrollment with no gaps in enrollment.
- For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months. The 90th day of enrollment will always occur on the last day of the third month following a member's effective enrollment date.
    - When reporting quarterly results from Ongoing reporting periods, MMPs should report all members who reached their 90th day of enrollment at any point during the three months included in the quarter (e.g., members enrolled on May 1, June 1, and July 1 reached their 90th day of enrollment during the third quarter; therefore, these members should be included in Ongoing reporting for the third quarter as long as they were still enrolled on the last day of the reporting period).

Data Element B

- For data element B, MMPs should report the number of members who were documented as unwilling to complete a care plan if a member (or the member's authorized representative):
    - Affirmatively declines to complete the care plan, affirmatively declines care management activities overall, or refuses any contact with the MMP. The member may communicate the declination or refusal by phone, mail, fax, or in person. The declination or refusal must be documented by the MMP.
    - Expresses willingness to complete the care plan but asks for it to be conducted after 90 days (despite being offered a reasonable opportunity to complete the care plan within 90 days). Discussions with the member must be documented by the MMP.
    - Schedules an appointment to complete the care plan but cancels or is a no-show and then is subsequently non-responsive to additional

outreach attempts by the MMP. All attempts to contact the member must be documented by the MMP.
    - Initially agrees to complete the care plan, but then declines to participate in the development of the care plan. The declination must be documented by the MMP.
- If a member could not be reached after three outreach attempts, but then subsequently is reached and refuses to complete a care plan within 90 days of enrollment, the member should be classified in data element B.

Data Element C

- For data element C, MMPs should report the number of members the MMP was unable to reach after three documented attempts to contact the member. The three documented outreach attempts to contact the member must be for the purpose of completing the care plan.
    - If an MMP was able to reach a member for the purpose of completing only an assessment, at least three new and distinct outreach attempts for the purpose of completing the care plan must be made and documented.
    - However, if an MMP was unable to reach a member for the purpose of completing both an assessment and a care plan, and has documented three unsuccessful outreach attempts, the MMP is not expected to make additional outreach attempts about the completion of a care plan. The MMP would report this member in data element C.
- MMPs should refer to their state's three-way contract or state guidance for any specific requirements pertaining to the method of outreach to members. MMPs must document each attempt to reach the member, including the method of the attempt (e.g., phone, mail, or email), as CMS and the state may validate this number. If less than three outreach attempts are made to the member within 90 days of enrollment, the member should not be included in data element C.
    - Note that the applicable three-way contract may require more than three outreach attempts. MMPs must continue to follow such contract requirements; however, for purposes of reporting this measure, MMPs may count a member under data element C following three outreach attempts.
- There may be instances when the MMP has a high degree of confidence that a member's contact information is correct, yet that member is not responsive to the MMP's outreach efforts. So long as the MMP follows the guidance regarding outreach attempts, these members may be included in the count for data element C.

Data Element D

- The requirements for care plan development may vary by state. The care plan should meet any state-specific criteria and include the appropriate domains as determined by the state. MMPs should refer to their state's three-way contract for specific requirements.

- If a member's care plan is in progress, but is not completed within 90 days of enrollment, then the care plan should not be considered completed, and therefore, the member should not be counted in data element D.
- MMPs should only report completed care plans where the member or the member's authorized representative was involved in the development of the care plan.
- If a member initially refused to complete a care plan or could not be reached after three outreach attempts, but then subsequently completes a care plan within 90 days of enrollment, the member should be classified in data element D.

General Guidance

- Members reported in data elements B, C, and D must also be reported in data element A since these data elements are subsets of data element A. Additionally, data elements B, C, and D should be mutually exclusive (e.g., a member reported in data element B or C should not also be reported in data element D).
- MMPs should only report members with an initial care plan for this measure.
- Additional guidance is included in the state-specific reporting appendices. MMPs should refer to their state's reporting appendix for measure reporting variations from the Core Reporting Requirements and for information on reporting care plans completed by the MMP prior to a member's effective enrollment date, reporting care plans for members with a break in coverage, and reporting care plans completed previously by the MMP's affiliated product. Note that the applicability of such guidance varies across states.
- There may be certain circumstances that make it impossible or inappropriate to complete a care plan within the required timeframe. For example, a member may be medically unable to participate and have no authorized representative to do so on their behalf, or a member may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for a care plan. However, MMPs should not include such members in the counts for data elements B or C.
- For additional guidance on identifying each data element, including examples and scenarios for correctly reporting members who may meet the criteria for multiple data elements, please reference the Core Measure 3.2 FAQ document located on the CMS website: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html.

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

Section IV. Enrollee Protections

4.1 Part D Appeals. – ***Retired***; *see Part D Reporting Requirements Section V – Coverage Determinations, Redeterminations, and Reopenings for required reporting*.

4.2 Grievances and Appeals.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
4. Enrollee Protections	Monthly	Contract	Current Calendar 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**
4. Enrollee Protections	Annually	Contract	Calendar Quarters 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 final quarterly reporting period

Note: MMPs should report all **non-Part D (i.e., Part C, Medicaid, and supplemental benefit) grievances and appeals for data elements A-S**, in addition to reporting the already required Medicare Part D appeals and grievances as follows:

- Part D grievances are reported according to Part D Reporting Requirements (see Part D Section III Grievances);
- Part D appeals are reported according to Part D Reporting Requirements (see Part D Section V Coverage Determinations, Redeterminations, and Reopenings);

Medicare Part D Reporting Requirements can be found on the CMS website at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxContracting_ReportingOversight.html.

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.

Grievances

Element Letter	Element Name	Definition	Allowable Values
A.	Total Grievances – Total number of grievances.	Total number of grievances for which the MMP provided notification of its decision during the reporting period.	Field Type: Numeric
B.	Grievance Timeliness – Total number of grievances for which the MMP provided timely notification of its decision.	Of the total reported in A, the number of grievances for which the MMP provided timely notification of its decision during the reporting period.	Field Type: Numeric. Note: Is a subset of A.
C.	Grievance Category – Total number of grievances related to access to care.	Of the total reported in A, the number of grievances related to access to care for which the MMP provided notification of its decision during the reporting period.	Field Type: Numeric Note: Is a subset of A.
D.	Grievance Category – Total number of grievances related to transportation.	Of the total reported in A, the number of grievances related to transportation for which the MMP provided notification of its decision during the reporting period.	Field Type: Numeric. Note: Is a subset of A.
E.	Grievance Category – Total number of grievances related to billing.	Of the total reported in A, the number of grievances related to billing for which the MMP provided notification of its decision during the reporting period.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
F.	Grievance Category – Total number of grievances related to home health/personal care.	Of the total reported in A, the number of grievances related to home health/personal care for which the MMP provided notification of its decision during the reporting period.	Field Type: Numeric. Note: Is a subset of A.
G.	Grievance Category – Total number of other grievances not related to categories mentioned above.	Of the total reported in A, the number of other grievances not related to categories mentioned above for which the MMP provided notification of its decision during the reporting period.	Field Type: Numeric Note: Is a subset of A.

Appeals

Element Letter	Element Name	Definition	Allowable Values
H.	Total Appeals – Total number of appeals.	Total number of appeals for which the MMP provided notification of its decision during the reporting period.	Field Type: Numeric
I.	Appeal Timeliness – Total number of appeals for which the MMP provided timely notification of its decision.	Of the total reported in H, the number of appeals for which the MMP provided timely notification of its decision during the reporting period.	Field Type: Numeric Note: Is a subset of H.
J.	Appeal Decision – Total number of appeals for which the MMP's decision was fully favorable.	Of the total reported in H, the number of appeals for which the MMP provided notification of a fully favorable decision within the reporting period.	Field Type: Numeric Note: Is a subset of H.

Element Letter	Element Name	Definition	Allowable Values
K.	Appeal Decision – Total number of appeals for which the MMP's decision was partially favorable.	Of the total reported in H, the number of appeals for which the MMP provided notification of a partially favorable decision within the reporting period.	Field Type: Numeric Note: Is a subset of H.
L.	Appeal Decision – Total number of appeals for which the MMP's decision was adverse.	Of the total reported in H, the number of appeals for which the MMP provided notification of an adverse decision within the reporting period.	Field Type: Numeric Note: Is a subset of H.
M.	Appeal Category – Total number of appeals related to denial or limited authorization of specialty services.	Of the total reported in H, the number of appeals related to denial or limited authorization of specialty services for which the MMP provided notification of its decision during the reporting period.	Field Type: Numeric Note: Is a subset of H.
N.	Appeal Category – Total number of appeals related to denial or limited authorization of HCBS services.	Of the total reported in H, the number of appeals related to denial or limited authorization of HCBS services for which the MMP provided notification of its decision during the reporting period.	Field Type: Numeric Note: Is a subset of H.

Element Letter	Element Name	Definition	Allowable Values
O.	Appeal Category – Total number of appeals related to denial or limited authorization of institutional services.	Of the total reported in H, the number of appeals related to denial or limited authorization of institutional services for which the MMP provided notification of its decision during the reporting period.	Field Type: Numeric Note: Is a subset of H.
P.	Appeal Category – Total number of appeals related to denial or limited authorization of mental health services.	Of the total reported in H, the number of appeals related to denial or limited authorization of mental health services for which the MMP provided notification of its decision during the reporting period.	Field Type: Numeric Note: Is a subset of H.
Q.	Appeal Category – Total number of appeals related to denial or limited authorization of substance use treatment services.	Of the total reported in H, the number of appeals related to denial or limited authorization of substance use treatment services for which the MMP provided notification of its decision during the reporting period.	Field Type: Numeric Note: Is a subset of H.
R.	Appeal Category – Total number of post-service payment appeals.	Of the total reported in H, the number of post-service payment appeals for which the MMP provided notification of its decision during the reporting period.	Field Type: Numeric Note: Is a subset of H. Note: This data element should <u>not</u> include post-service payment appeals from contract providers.

Element Letter	Element Name	Definition	Allowable Values
S.	Appeal Category – Total number of other appeals not related to categories mentioned above.	Of the total reported in H, the number of other appeals not related to categories mentioned above for which the MMP provided notification of its decision during the reporting period.	Field Type: Numeric Note: Is a subset of H.

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 the sum of data elements C, D, E, F, and G is equal to data element A.
- MMPs should validate that the sum of data elements J, K, and L is equal to data element H.
- MMPs should validate that the sum of data elements M, N, O, P, Q, R, and S is equal to data element H.

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 use enrollment data to evaluate the following per 10,000 member months:

- Total number of grievances
  - Rate = (A / Total Member Months) * 10,000
- Total number of grievances related to:
  - Access to care
    - Rate = (C / Total Member Months) * 10,000
  - Transportation
    - Rate = (D / Total Member Months) * 10,000
  - Billing
    - Rate = (E / Total Member Months) * 10,000
  - Home health/personal care
    - Rate = (F / Total Member Months) * 10,000
  - Other grievances
    - Rate = (G / Total Member Months) * 10,000
- Total number of appeals
  - Rate = (H / Total Member Months) * 10,000

- Total number of appeals related to:
    - Denial or limited authorization of specialty services
        - Rate = (M / Total Member Months) * 10,000
    - Denial or limited authorization of HCBS services
        - Rate = (N / Total Member Months) * 10,000
    - Denial or limited authorization of institutional services
        - Rate = (O / Total Member Months) * 10,000
    - Denial or limited authorization of mental health services
        - Rate = (P / Total Member Months) * 10,000
    - Denial or limited authorization of substance use treatment services
        - Rate = (Q / Total Member Months) * 10,000
    - Post-service payment appeals
        - Rate = (R / Total Member Months) * 10,000
    - Other appeals
        - Rate = (S / Total Member Months) * 10,000

CMS and the state will evaluate the percentage of appeals for which the MMP's decision was:

- Fully favorable
    - Percentage = (J / H) * 100
- Partially favorable
    - Percentage = (K / H) * 100
- Adverse
    - Percentage = (L / H) * 100

CMS and the state will evaluate the percentage of:

- Grievances for which the MMP provided timely notification of its decision
    - Percentage = (B / A) * 100
- Appeals for which the MMP provided timely notification of its decision
    - Percentage = (I / H) * 100

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

<u>Grievances</u>

- If a member files a grievance and then files a subsequent grievance on the same issue prior to the MMP's decision or deadline for decision notification (whichever is earlier), the issue is counted as one grievance.
- If a member files a grievance and then files a subsequent grievance on the same issue after the MMP's decision or deadline for decision notification (whichever is earlier), the issue is counted as a separate grievance.
- MMPs should include oral grievances, even if the oral grievance was resolved during the call.
- MMPs should exclude grievances that were withdrawn or dismissed. MMPs should also exclude grievances only made through the CMS Complaints Tracking Module.

- A grievance involving multiple issues should be reported under each applicable category and also counted the corresponding number of times under data element A.
    - For example, if the MMP receives a grievance that involves two issues – access to care and billing – the grievance would be reported under both data elements C and E and reported twice under data element A.
- Access to care grievances reported in data element C should include grievances related to inability to get an appointment with a provider, excessive wait times for an appointment with a provider, inability to access a provider who demonstrates cultural competency, inability to access a provider who can communicate with the member in their primary language or via a translation service, and inability to access a provider that offers sufficient accommodations for the member's disability. Note that this category does not include grievances related to transportation used to access providers, as those grievances would be reported under data element D.
- Home health/personal care grievances reported in data element F should include all grievances related to home health/personal care benefits, such as (but not limited to) issues with the demeanor of the home health/personal care aide, tardiness/absenteeism from the home health/personal care aide, and quality of home health/personal care provided.

Appeals

- Only appeals decided by the MMP should be included in the measure (i.e., do not include appeal decisions made by the Independent Review Entity, Quality Improvement Organization, and/or state fair hearing agency).
- Include appeals that were requested by the member, the member's authorized representative, or a provider making the request on behalf of the member. Do not include appeals from contract providers that are governed under the contractual arrangement between the MMP and the provider.
- MMPs should exclude appeals that were withdrawn or dismissed.
- For data elements M through Q, appeals related to the denial or limited authorization of a service should also include reductions, suspensions, or terminations of a previously authorized service.
- Data elements M through S are mutually exclusive.
- For data element M, specialty services are defined as any service or medical care provided or directed by a "specialist" (as opposed to a Primary Care Provider) that would not be a service offered by a Primary Care Provider or fitting into another category.
    - Specialty service providers should include occupational/physical/speech therapy, dental, vision, transportation, and durable medical equipment.
    - Primary Care Provider will be defined in the state-specific appendix.
- For data element R, MMPs should include all payment disputes (i.e., requests for payment and requests for adjustment to the paid amount), regardless if the appeal is made by the member, the member's authorized representative, or a non-contract provider who signed a Waiver of Liability. Duplicate

payment appeals should be counted only once. Do not include payment disputes from contract providers.

General Guidance

- As noted above, MMPs should report all non-Part D (i.e., Part C, Medicaid, and supplemental benefit) grievances and appeals under this measure.
- There are no minimum enrollment criteria for this measure. All grievances and appeals should be reported regardless of how long a member has been enrolled in the MMP or if they have disenrolled from the MMP prior to the end of the reporting period.
- The date the MMP notified the member of its decision should be used to assess which reporting period the grievance or appeal should be reported within.
    - For example, if a grievance was received on March 24 and the MMP provided notification of its decision on April 4, then the grievance would be included in the second quarter when reporting this measure.
- MMPs should refer to their state's three-way contract for definitions of timely grievance and appeal resolution for purposes of reporting data elements B and I.

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

Section V. Organizational Structure and Staffing

5.1 Care coordinator to member ratio.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
5. Organizational Structure and Staffing	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
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
5. 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 full time equivalent (FTE) care coordinators working on the Demonstration.	Total number of FTE care coordinators working on the Demonstration as of the last day of the reporting period.	Field Type: Numeric
B.	Total number of FTE care coordinators assigned to care management and conducting assessments.	Of the total reported in A, the number of FTE care coordinators assigned to care management and conducting assessments during the reporting period.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of FTE care coordinators that left the MMP.	Total number of FTE care coordinators that left the MMP 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.

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

Note: This measure is not adjusted for case mix, and care coordination will vary for each demonstration and each MMP's care plan model structure. Therefore, this measure will be used solely to track care coordination investments and changes in each MMP's care coordinator to member ratio longitudinally.

CMS and the state will:

- Use enrollment data to evaluate the number of members per FTE care coordinator.
  - Rate = (Total Members Enrolled / A)
- Evaluate the percentage of FTE care coordinators who were assigned to care management and conducting assessments.
  - Percentage = (B / A) * 100
- Evaluate the percentage of FTE care coordinators that left the MMP during the reporting period.
  - Percentage = (C / (C + A)) * 100

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

Definitions

- MMPs should refer to their state's three-way contract for the definition of care coordinator. Different terms may be used in different states.
- FTE is defined as full time equivalent.

Data Element C

- Data element C includes care coordinators who are assigned to a different role within the MMP.

General Guidance

- To calculate the number of FTE care coordinators, add up all of the care coordinators' work hours during the reporting period and divide this value by the number of normal working hours for one full-time employee that occurred during the reporting period.
    - In instances where care coordinators support multiple lines of business, include only the time associated with the demonstration/MMP.
- For all data elements, FTE reported values should be rounded to the nearest positive integer.
- All part-time and full-time care coordinators will be counted, regardless of whether they are subcontracted or employed directly by the MMP.

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

5.2 Annual staffing worksheets. – ***Retired***

5.3 Establishment of consumer advisory board or inclusion of consumers on a pre-existing governance board consistent with contractual requirements.[i]

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

MMPs will be required to submit information on each consumer advisory board and/or governance board meeting during the annual reporting period. One template per meeting should be completed and submitted. A template for providing information is located on the CMS website: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html

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.	Date.	Date each meeting occurred during the annual reporting period.	Field Type: Numeric Note: Date in YYYYMMDD Format. Note: MMPs should input data into the template provided by CMS.
B.	Total number of board members invited.	Count of all consumer advisory board/governance board members invited to the meeting.	Field Type: Numeric Note: MMPs should input data into the template provided by CMS.
C.	Total number of board members in attendance.	Count of all consumer advisory board/governance board members in attendance either in-person or remotely.	Field Type: Numeric Note: MMPs should input data into the template provided by CMS. Note: Is a subset of B.
D.	Total number of board members invited who are actual beneficiaries or family caregivers.	Count of board members invited who are actual beneficiaries or family caregivers. Professional advocates should not be included unless they are also members or caregivers for members of the MMP.	Field Type: Numeric Note: MMPs should input data into the template provided by CMS. Note: Is a subset of B.

Element Letter	Element Name	Definition	Allowable Values
E.	Total number of board members who are actual beneficiaries or family caregivers in attendance.	Count of board members who are actual beneficiaries or family caregivers in attendance either in-person or remotely. Professional advocates should not be included unless they are also members or caregivers for members of the MMP.	Field Type: Numeric Note: MMPs should input data into the template provided by CMS. Note: Is a subset of both C and D.
F.	Agenda.	Agenda for each meeting during the annual period.	Field Type: N/A Note: MMPs should input data into the template provided by CMS.
G.	Minutes.	Minutes for each meeting held during the annual reporting period.	Field Type: N/A Note: MMPs should input data into the template provided by CMS.

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.

- Meeting dates are within the performance period.
- MMPs should validate that the number of members reported in data element C is a subset of the number of members reported in data element B.
- MMPs should validate that the number of members reported in data element D is a subset of the number of members reported in data element B.
- MMPs should validate that the number of members reported in data element E is a subset of the number of members reported in each of the data elements C and D.

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 board meetings per quarter.
- Number of board meetings per quarter with beneficiaries or family caregivers in attendance.
- Percentage of invited board members who are beneficiaries or family caregivers.
    - (Sum of D across meetings) / (Sum of B across meetings) * 100
- Percentage of board members in attendance who are beneficiaries or family caregivers.
    - (Sum of E across meetings) / (Sum of C across meetings) * 100

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

- MMPs should submit one Microsoft Word template per meeting.
- For reporting data elements B, C, D, and E, MMPs should only include established consumer advisory board/governance board members.
- MMPs should only include a total count of the members who satisfy each data element; MMPs are no longer required to provide the full names of the members/board members.

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

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://hsagonline.sharepoint.com/teams/FAI/
- Required File Format is Microsoft Word File.
- The file name extension should be ".docx".
- File name = (STATEABBREVIATION)_(CONTRACTID)_(REPORTING PERIOD)_(MEETINGDATE).docx.
- Replace (STATEABBREVIATION) with the two-character state abbreviation (e.g., Massachusetts is MA), (CONTRACTID) with the contract ID, (REPORTINGPERIOD) with the year of the reporting period in YYYY format (e.g., 2022), (MEETINGDATE) with the year, month, and date of the meeting in YYYYMMDD format (e.g., March 31, 2022 would be 20220331).
- MMPs should refer to their state's reporting appendix for measure reporting variations from the Core Reporting Requirements and additional fields required in the file name, as applicable.

Section VI. Performance and Quality Improvement

6.1 Screening for Clinical Depression and Follow-up Plan. (modified from NQF #0418)[ii] – ***Retired***

Section VII. Provider Network

7.1 Medicare Provider Network.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
7. Provider Network	Annually	Contract	Current network as of the date of submission.	By the third Tuesday of September

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.	MMP Health Service Delivery Provider Table	Refer to MMP Medicare Network Submission Guidance for data definitions.	Field Type: Data Entry
B.	MMP Health Service Delivery Facility Table	Refer to MMP Medicare Network Submission Guidance for data definitions.	Field Type: Data Entry

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 assess Health Service Delivery (HSD) tables against Medicare MMP standards that are available on the CMS website.

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

- Confirm HSD tables will properly upload into HPMS using the plan upload functionality.
- MMPs should validate that MMP Medicare Networks meet MMP standards using the plan upload functionality prior to the MMP Medicare Network Annual submission.

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

- CMS will assess the submitted HSD tables against the MMP Medicare Network Standards.

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

- MMPs should refer to the MMP Medicare Network Submission Guidance that will be issued separately for the relevant reporting year and posted on the CMS website: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPApplicationandAnnualRequirements.html.

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

Section VIII. Systems

8.1 Long Term Services and Supports (LTSS) clean claims paid within 30 days, 60 days, and 90 days.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
8. Systems	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 LTSS clean claims paid within the reporting period.	Total number of LTSS clean claims paid within the reporting period.	Field Type: Numeric
B.	Total number of clean claims paid within 30 calendar days of receipt.	Of the total reported in A, the number of clean claims paid within 30 calendar days of receipt.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of clean claims paid within 60 calendar days of receipt.	Of the total reported in A, the number of clean claims paid within 60 calendar days of receipt.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of clean claims paid within 90 calendar days of receipt.	Of the total reported in A, the number of clean claims paid within 90 calendar days of receipt.	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.

- MMPs should validate that data elements B, C, and D are less than or equal to data element A.

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 LTSS clean claims that were paid within:

- 30 calendar days of receipt.
  - Percentage = (B / A) * 100
- 60 calendar days of receipt.
  - Percentage = (C / A) * 100
- 90 calendar days of receipt.
  - Percentage = (D / A) * 100

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

Definitions

- Long Term Services and Supports (LTSS) will be defined in the state-specific appendix.
- A clean claim is one that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.

General Guidance

- The 30-, 60-, and 90-day cutoffs should be calculated using individual calendar days, unlike Core Measures 2.1, 2.2, 2.3, and 3.2 where “90 days of enrollment” is considered equivalent to three full calendar months.
- MMPs should include LTSS clean claims if they were paid during the reporting period. LTSS clean claims submitted during the reporting period, but not paid during the reporting period, should not be included.

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

Section IX. Utilization

9.1 Emergency department (ED) behavioral health services utilization.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
9. Utilization	Annually	Contract	Calendar Quarters 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 final quarterly 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 ED visits with a principal diagnosis related to behavioral health.	Total number of ED visits with a principal diagnosis related to behavioral health 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.

- N/A.

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 use enrollment data to evaluate the total number of ED visits with a principal diagnosis related to behavioral health per 10,000 member months during the reporting period.
    - Rate = (A / Total Member Months) * 10,000

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

Data Element A

- MMPs should include all ED visits with a principal diagnosis related to behavioral health for members who meet the criteria outlined in data 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).
- MMPs should use the ED value set to identify ED visits. MMPs should use facility claims to identify ED visits.
- MMPs should use the Mental Health Diagnosis value set to identify a behavioral health diagnosis.
- If there are two different ED visits with the same date of service within the reporting period (and there are two separate, adjudicated claims), then both ED visits should be reported in data element A. Adjudicated claims refers to claims that are in final status, including paid claims and denied claims. Pending claims should not be included.

Data Element A Exclusion

- MMPs should exclude ED visits followed by admission to an acute or nonacute inpatient care setting (same or different facility as ED visit) on the date of the ED visit. To identify admissions to an acute or nonacute inpatient care setting:
    - Identify all acute and nonacute inpatient stays (Inpatient Stay value set)
    - Identify the admission date for the stay

  An ED visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay and should be excluded from data element A.

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

9.2 Nursing Facility (NF) Diversion.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
9. Utilization	Annually	Contract	Calendar Year, beginning CY2	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members who were continuously enrolled in the MMP for at least 5 out of the last 6 months during the previous reporting period ***and*** continuously enrolled in the MMP for at least 11 out of 12 months during the current reporting period.	Total number of members who were continuously enrolled in the MMP for at least 5 out of the last 6 months during the previous reporting period ***and*** continuously enrolled in the MMP for at least 11 out of 12 months during the current reporting period.	Field Type: Numeric
B.	Total number of members who were classified as nursing home certifiable for more than 100 continuous days during the previous reporting period who did not reside in a NF for more than 100 continuous days during the previous reporting period.	Of the total reported in A, the number of members who were classified as nursing home certifiable for more than 100 continuous days during the previous reporting period who did not reside in a NF for more than 100 continuous days during the previous reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members who did not reside in a NF for more than 100 continuous days during the current reporting period.	Of the total reported in B, the number of members who did not reside in a NF for more than 100 continuous days during the current reporting period.	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.

- 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.
- MMPs should validate that data element C is less than or equal to data element B.

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

- For members classified as nursing home certifiable for more than 100 continuous days during the previous reporting period who did not reside in a NF for more than 100 continuous days during the previous reporting period, CMS and the state will evaluate the percentage of members who did not reside in a NF for more than 100 continuous days during the current reporting period.
    - Percentage = (C / B) * 100

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

Data Element A

- For the purposes of this measure, the “previous reporting period” is defined as the previous calendar year. The “current reporting period” is defined as the current calendar year.
    - For example, for data submitted on February 28, 2023, the previous reporting period is January 1, 2021 – December 31, 2021, and the current reporting period is January 1, 2022 – December 31, 2022.
- The member must be enrolled as of the last day of both the previous and current reporting periods to be included in this measure.
- For reporting members in data element A, members must meet both continuous enrollment criteria in order to be included in this data element. Therefore, the member must be continuously enrolled as a Medicare-Medicaid member in the MMP for at least 5 out of the last 6 months during the previous reporting period ***and*** continuously enrolled as a Medicare-Medicaid member in the MMP for at least 11 out of 12 months during the current reporting period. Members meeting these criteria for only one of the reporting periods should not be included in data element A.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during each reporting period (i.e., July through December [previous reporting period] and January through December [current reporting

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

Data Element A Exclusions

- MMPs should exclude members who are transitioned to hospice services in either the current or previous reporting periods when reporting this measure. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Encounter and Hospice Intervention value sets), or supplemental data.
- MMPs should exclude members who expired in either the current or previous reporting period when reporting this measure using the Discharges due to Death value set.

Data Element B

- Nursing home certifiable members are defined as members living in the community but requiring an institutional level of care. Additionally, members who have a stay in a NF may be considered nursing home certifiable depending on the length of stay. MMPs should refer to their state's specific definition for additional information.
- To identify members for inclusion in data element B, MMPs should first identify all members who were nursing home certifiable for more than 100 continuous days at any point during the previous reporting period (January through December). Then, MMPs should exclude any of these members who resided in a NF for at least 101 continuous days during the previous reporting period.
    - For example, a member who entered a NF on September 4 and remained there on December 31 of the previous reporting period has more than 100 continuous days in a NF in the previous reporting period (119 days within the previous reporting period) and would not be included in data element B. A member who entered a NF on October 4 of the previous reporting period and remained there through February 1 of the current reporting period would not have more than 100 continuous days in a NF during the previous reporting period (residing there only 89 days during the previous reporting period) and would be included in data element B as long as they were nursing home certifiable for more than 100 continuous days during the previous reporting period.
    - MMPs should use all available data to document and confirm a member's status as nursing home certifiable. In the event of missing data for members who had a single, 1-month-long gap in coverage during the previous reporting period and who were documented as nursing home certifiable before the 1-month gap and after the 1-month

gap, MMPs may assume that the member was nursing home certifiable during the 1-month gap.

Data Element C

- For reporting data element C, MMPs should exclude all members who reached their 101st continuous day of a NF stay during the current reporting period. This may include members who entered the NF within the **previous** reporting period as well as members who entered the NF during the **current** reporting period.
    - For example, a member who entered a NF on October 4 of the previous reporting period and remained there on February 1 of the current reporting period reached their 101st day on January 13 and, therefore, would be excluded from data element C. Alternatively, a member who entered a NF on August 1 of the current reporting period and remained there on December 31 of the current reporting period reached their 101st day on November 9 and would also be excluded from data element C.

General Guidance

- For data elements B and C, when determining the number of continuous days a member resided in the NF, if a member is transferred or discharged from the NF and then is readmitted to any NF within 30 days, the transfer/discharge and subsequent readmission do not disrupt the count of continuous days.
    - For example, if a member is transferred from the NF to the hospital on day 57 and is subsequently readmitted to the same or a different NF 29 days later, this will be counted as the same episode. The member's first day after returning to a NF (i.e., the day the member is readmitted to the NF) will count as day 58 for that episode, not as day 1.
    - If a member is transferred from the NF and then is readmitted to any NF after 30 days, the date of readmission is the start of a new episode in the NF and will count as day 1 toward the member's continuous days in the facility.
- NF services are those services provided by nursing homes certified by Medicaid, Medicare, or other state agencies. NF includes skilled nursing facilities (not Adult Family Care Homes [AFCH], Assisted Living Facilities [ALF], Intermediate Care Facilities [ICF], or Supportive Living Facilities [SLF]).
- This measure is reported starting with the MMP's second year of operation (i.e., Calendar Year 2). All MMPs that have operated for at least two years must report the measure.

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

9.3 Minimizing Institutional Length of Stay.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
9. Utilization	Annually	Contract	Calendar Year, beginning CY2	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 admissions to institutional facilities.	Total number of admissions to institutional facilities between July 1 of the year prior to the reporting period and June 30 of the current reporting period for members who were continuously enrolled from the date of the institutional facility admission (IFA) through 160 days following the IFA date, with no gaps in enrollment.	Field Type: Numeric
B.	Total number of discharges from an institutional facility to the community during the current reporting period that occurred within 100 days or less of admission.	Of the total reported in A, the number of discharges from an institutional facility to the community during the current reporting period that occurred within 100 days or less of admission.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of expected discharges to the community.	Total number of expected discharges to the community for all admissions in data element A.	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.
- MMPs should validate that data element C is less than or equal to data element A.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. An observed performance rate, expected performance rate, and the ratio of observed to expected rates are reported.

- For the total number of admissions to institutional facilities, CMS and the state will evaluate the percentage of observed discharges from an institutional facility to the community during the current reporting period that occurred within 100 days or less of admission. (Observed Performance Rate)
  - Percentage = (B / A) * 100
- For the total number of admissions to institutional facilities, CMS and the state will evaluate the percentage of expected discharges from an institutional facility to the community during the current reporting period that occurred within 100 days or less of admission. (Expected Performance Rate)
  - Percentage = (C / A) * 100
- CMS and the state will evaluate the ratio of observed to expected discharge rates.
  - Observed Performance Rate / Expected Performance Rate

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

Definitions

- An institutional facility (i.e., institution) is a Medicaid- or Medicare-certified nursing facility providing skilled nursing/medical care; rehabilitation needed due to injury, illness or disability; and long-term care (also referred to as

"custodial care") or Medicaid certified Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

- An institutional facility admission (IFA) is an admission to the institutional setting directly from the community between July 1 of the year prior to the reporting period and June 30 of the current reporting period. Includes admissions to the institutional setting from the hospital setting only if the member lived in a community residence prior to the hospital admission.
- A discharge to the community is a discharge to a community residence from the institutional facility for all IFA between July 1 of the year prior to the reporting period and October 31 of the current reporting period. Includes discharges to the hospital setting only if the member was discharged from the hospital to a community residence between July 1 of the year prior to the reporting period and October 31 of the current reporting period.
- A community residence refers to any residence that is not an institutional facility. This may include assisted living, adult foster care, home, or another residential setting that is not defined as an institution.
- The classification period is the 180 days prior to and including the IFA date.

Data Element A

- Report on all paid claims only.
- For the purposes of this measure the "year prior to the reporting period" is defined as the previous calendar year. The "current reporting period" is defined as the current calendar year.
    - For example, for data submitted on April 30, 2023, the previous calendar year is 2021 and the current calendar year is 2022.
- MMPs should include all IFAs for members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period.
- The denominator for this measure is based on admissions, not members.
- To identify all new IFAs:
    - Step 1: Identify all new admissions to institutional facilities (i.e., do not include admissions for continuing stays) between July 1 of the year prior to the reporting period and June 30 of the current reporting period (Institutional Facility value set).
    - Step 2: Remove admissions that are direct transfers from another institution. If the original admission date to the institutional facility is prior to July 1 of the year prior to the reporting period, exclude both the original admission and the transfer admission from the measure. Otherwise, keep the original admission date as the date of new IFA. A direct transfer is when the discharge date from the first institutional facility setting precedes the admission date to a second institutional facility setting by one calendar day or less. For example:
        - An institutional facility discharge on June 1, followed by an admission to another institutional facility setting on June 1, is a direct transfer.

        - An institutional facility discharge on June 1, followed by an admission to an institutional facility setting on June 2, is a direct transfer.
        - An institutional facility discharge on June 1, followed by an admission to another institutional facility setting on June 3, is not a direct transfer; these are two distinct new institutional facility stays.
    - Step 3: Remove admissions to the institutional facility from the hospital when the hospital admission originated from an institution. Keep the original IFA date (that preceded the admission to the hospital) as the date of the new IFA.
    - Step 4: Remove admissions that result in death in the institution or death within one day of discharge from the institution.
    - Step 5: If the member is discharged to the hospital and remains in the hospital at the end of the current reporting period or dies in the hospital, exclude the admission from the count of IFA.
    - Step 6: Calculate continuous enrollment. Remove admissions for members who do not meet the continuous enrollment criteria.

Data Element B

- Report on all paid claims only.
- To identify the count of discharges from an institutional facility to a community residence:
    - Step 1: Look for the location of the first discharge for each IFA in between July 1 of the year prior to the reporting period and October 31 of the current reporting period and:
        - If the member is discharged to the community, calculate length of stay (LOS) as the date of institution discharge minus the IFA date.
        - If there is no discharge, calculate LOS as the date of the last day of the current reporting period minus the IFA date.
        - If the member is discharged from the institution to a hospital, look for the hospital discharge and location of discharge from the hospital. If the member is discharged from the hospital to a community residence, calculate LOS as the date of hospital discharge minus the IFA date.
            - For example, consider a member who is admitted to a skilled nursing facility (SNF) from a hospital. After 50 days at the SNF, the member develops an infection and is admitted to a hospital for 14 days. The member is discharged to home from the hospital on day 15. The LOS is 64 days, or the date of hospital discharge minus the IFA date.
        - If the member is discharged from a hospital to the institution, repeat Step 1 until there is a discharge to the community or the end of the current reporting period.

- For example, consider a member who is discharged from a hospital to a SNF for recovery. After 50 days at the SNF, the member develops an infection and is admitted to a hospital for 14 days. The member is discharged from the hospital back to the SNF and is then discharged to home on day 41 of their second stay at the SNF. The LOS is 104 days, starting from the date of the IFA through the discharge home date.
- If the member is discharged to a different institution (i.e., a transfer), repeat Step 1 until there is a discharge to the community or the end of the current reporting period.
- When counting the duration of each stay within the reporting period, include the day of entry (admission) but not the day of discharge unless the admission and discharge occurred on the same day, in which case the number of days in the stay is equal to one.

- Step 2: Using information from Step 1, identify all IFA with length of stay of less than or equal to 100 days. This should include only discharges to the community (either directly from the institution or from the institution to the hospital to a community residence).
- Step 3: Remove discharge if the member was hospitalized, died or was re-admitted to the institution within 60 days of the day of discharge.

<u>Data Element C</u>

- Data element C should be rounded and reported to two decimal places using standard round to nearest rules. For example, a value of 4.7346 rounds down to 4.73, while a value of 4.7352 rounds up to 4.74.

Risk Adjustment Determination

- Report on all paid claims only.
- For each IFA, use the following steps to identify risk adjustment categories based on age and gender, dual eligibility, diagnoses from the IFA, and number of hospital stays and months of enrollment in the classification period.
  - Age and Gender
    - Determine the member's age and gender on the date of IFA and assign to the following categories:
      - Female age 18-44
      - Female age 45-64
      - Female age 65-74
      - Female age 75-84
      - Female age 85+
      - Male age 18-44
      - Male age 45-64
      - Male age 65-74
      - Male age 75-84
      - Male age 85+

- Dual eligibility
  - Determine the member's dual eligibility status on the date of IFA. All members should be identified as dually eligible.
- Diagnoses
  - Assign all applicable Chronic Conditions Data Warehouse (CCW) code(s) to the IFA based on the IFA's diagnoses using the CCW Categories value set.
  - For direct transfers, use all diagnoses that occurred during the episode (i.e., original admission diagnoses and direct transfer's diagnoses).
  - Exclude diagnoses that cannot be mapped to the Risk Adjustment Weights value set.
- Number of hospital stays
  - Determine if the member had any acute hospitalizations in the six months prior to the reporting period. Classify the total count of acute hospitalizations as 0, 1, or 2 or more.
- Days of enrollment in MMP
  - Determine the number of days the member has been enrolled in the MMP prior to the IFA date. Classify the total days of enrollment as less than 180 days or greater than or equal to 180 days.

Risk Adjustment Weighting

- For each IFA, use the following steps to identify risk adjustment weights based on age and gender, dual eligibility, diagnoses from the IFA, and number of hospital stays and months of enrollment in the classification period. Risk adjustment weights are provided in the Risk Adjustment Weights value set.
  - Step 1: Identify the base risk weight. The base risk weight will be the same for all members.
  - Step 2: Link the age and gender weights for each IFA.
    - The Male age 18-44 category is the reference category and does not have a weight assigned.
  - Step 3: Link the dual eligibility weight for each IFA. The dual eligibility weight will be assigned to all members.
  - Step 4: For each IFA with an admission CCW category, link the CCW category weight.
  - Step 5: For each IFA with one or more hospitalizations prior to IFA, link the number of hospitalizations weight.
    - There is no weight assigned to zero hospitalizations prior to the IFA because it is the reference category.
  - Step 6: For each IFA with six months or more of enrollment prior to the IFA, link the six months enrollment weight.
    - There is no weight assigned to each IFA with less than six months of enrollment (in the MMP) prior to the IFA because it is the reference category.

  - Step 7: Sum all weights associated with the IFA (i.e., base, age and gender, dual eligibility, qualified CCW categories, number of hospitalizations, and six months of enrollment weight) to calculate the expected estimated probability of successful discharge to the community for each IFA.
    - Expected Discharge Probability = [exp(sum of weights for IFA)] / [1+exp(sum of weights for IFA)]
      Note: "exp" refers to the exponential or antilog function
  - Step 8: Calculate the count of successful discharges to the community. The count of expected discharges is the sum of the estimated discharge probability calculated in Step 7 for each IFA.
    - Count of Expected Discharges = Σ(Estimated Discharge Probability)
- As an example, Table 3 on the following page provides a sample calculation of expected discharge probability for a hypothetical member with the following characteristics: male; 88 years old; dual eligibility; had two pre-period hospital stays; and had a stroke.

General Guidance

- This measure is reported starting with the MMP's second year of operation (i.e., Calendar Year 2). All MMPs that have operated for at least two years must report the measure.

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

Table 3. Expected Discharge Probability Example

Base Risk Weight	Age	Gender	Age and Gender Weight	Dual Eligibility Weight	Number of Hospital Stays	Number of Hospital Stays Weight	ICD-10 Diagnosis Codes	CCW	CCW Weight	6+ Months of Enrollment	Sum of Weights	Expected Discharge Probability
-0.9966	88	Male	0.4395	0.1157	2	-0.4930	G45.9	Stroke	-0.5140	0	-1.4484	0.1902

In this example, the expected probability of having a successful discharge during the reporting period for this member is:

$$Expected\ Discharge\ Probability = \frac{exp(-0.9966 + 0.4395 + 0.1157 - 0.4930 - 0.5140)}{1 + exp(-0.9966 + 0.4395 + 0.1157 - 0.4930 - 0.5140)} = 0.1902$$