

**MEDICARE-MEDICAID
CAPITATED FINANCIAL ALIGNMENT MODEL
REPORTING REQUIREMENTS:
RHODE ISLAND-SPECIFIC REPORTING
REQUIREMENTS**

Issued February 28, 2023

Table of Contents

- Rhode Island-Specific Reporting Requirements Appendix..... RI-3**
 - Introduction RI-3**
 - Definitions..... RI-3**
 - Variations from the Core Reporting Requirements Document RI-4**
 - Quality Withhold Measures RI-5**
 - Reporting on Assessments and Care Plans RI-6**
 - Reporting on Assessments and Care Plans Completed Prior to First Effective Enrollment Date..... RI-7**
 - Guidance on Assessments and Care Plans for Members with a Break in Coverage..... RI-7**
 - Reporting on Passively Enrolled and Opt-In Enrolled Members RI-9**
 - Reporting on Disenrolled and Retro-disenrolled Members..... RI-9**
 - Value Sets RI-10**
 - Rhode Island’s Implementation, Ongoing, and Continuous Reporting Periods..... RI-10**
 - Data Submission RI-11**
 - Resubmission of Data RI-11**
 - Section RI I. Care Coordination RI-12**
 - Section RI II. Enrollee Protections..... RI-28**
 - Section RI III. Organizational Structure and Staffing RI-31**
 - Section RI IV. Performance and Quality Improvement..... RI-31**

RHODE ISLAND-SPECIFIC REPORTING REQUIREMENTS APPENDIX

Introduction

The measures in this appendix are required reporting for the RI MMP participating in the Rhode Island Integrated Care Initiative Demonstration. CMS and the state reserve the right to update the measures in this appendix for subsequent demonstration years. These state-specific measures directly supplement the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements, which can be found at the following web address:

<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html>

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

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

The RI MMP should contact the RI HelpDesk at RIHelpDesk@norc.org with any questions about the Core Reporting Requirements, Rhode Island state-specific appendix, or the data submission process.

Definitions

All definitions for terms defined in this section and throughout this Reporting Requirements document apply whenever the term is used, unless otherwise noted.

Calendar Quarter: All quarterly measures are reported on calendar quarters. The four calendar quarters of each calendar year will be 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, Calendar Year (CY) 2023 represents January 1, 2023 through December 31, 2023.

Implementation Period: The initial months of the demonstration during which the RI MMP reported to CMS and the state on a more intensive reporting schedule. The

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

Implementation Period started on the first effective enrollment date and continued until the end of the first calendar year (July 1, 2016 – December 31, 2016).

Long Term Services and Supports (LTSS): A range of medical, social, or rehabilitation services a person needs over months or years in order to improve or maintain function or health, which are provided in the community or in a long-term care facility such as a nursing facility.

Primary Care Provider (PCP): A Health Care Professional selected by or assigned to the member to provide and coordinate the member's health care needs and to initiate and monitor referrals for specialized services when required. The PCP shall be a physician, physician assistant, or certified nurse practitioner in one of the following specialties: family medicine, general practice, gynecology, internal medicine, or geriatrics. PCPs shall meet the credentialing criteria established by the Contractor and approved by RI EOHHS. On a case-by-case basis, a PCP may also be a specialist who has an ongoing clinical relationship with a member, serves as the principal coordinating provider for the member's special health care needs, and plays a critical role in managing that member's care on a regular basis.

Variations from the Core Reporting Requirements Document

Core 2.1, 2.2, 2.3, and 3.2

As articulated in the Rhode Island three-way contract, the assessment and care plan tools used by the RI MMP vary by population. Assessment types include the Initial Health Screen (IHS), Comprehensive Functional Needs Assessment (CFNA), Wellness Assessment, and Discharge Opportunity Assessment. Care plan types include the Interdisciplinary Care Plan (ICP), Wellness Plan, and Community Transition Plan (CTP). See the "Reporting on Assessments and Care Plans" section for more information.

Core 2.1, 2.2, and 2.3 indicate that MMPs should report on "the comprehensive health risk assessment as applicable per state-specific guidance." Additionally, Core 3.2 indicates that "the care plan should meet any state-specific criteria." For the RI MMP, all assessment and care plan types are eligible for reporting under these core measures. Guidance for each measure is provided below:

- Core 2.1 – Members with an assessment completed within 90 days of enrollment.
 - The RI MMP should report the number of members with an initial assessment completed within 90 days of enrollment for all populations. If the RI MMP completed more than one type of initial assessment for a given member (e.g., both an IHS and a CFNA), that member should only be counted once when reporting Core 2.1.
- Core 2.2 – Members with an assessment completed.
 - The RI MMP should report the number of members with an initial assessment completed for all populations. If the RI MMP completed more than one type of initial assessment for a given member (e.g., both an IHS and a CFNA), that member should only be counted once when reporting Core 2.2.

- Core 2.3 – Members with an annual reassessment.
 - The RI MMP should report the number of members with an annual reassessment completed for all populations. The RI MMP should consult the Rhode Island three-way contract when determining the appropriate assessment tool to be used for the reassessment of members in each population. Although the three-way contract requires more frequent reassessment intervals depending on the type of assessment, only one annual reassessment should be counted for each member when reporting Core 2.3. Similarly, if the RI MMP completed more than one type of annual reassessment for a given member (e.g., both an IHS and a CFNA), only one annual reassessment should be counted for that member when reporting Core 2.3.
- Core 3.2 – Members with a care plan completed.
 - The RI MMP should report the number of members with an initial care plan completed that meets measure criteria. If the RI MMP completed more than one type of initial care plan for a given member (e.g., both CTP and ICP), that member should only be counted once when reporting Core 3.2.

Core 9.2

The following section provides additional guidance about identifying individuals enrolled in the RI MMP as “nursing home certifiable,” or meeting the nursing facility level of care (NF LOC), for the purposes of reporting Core 9.2.

Within Core 9.2, “nursing home certifiable” members are defined as “members living in the community, but requiring an institutional level of care” (see the Core Reporting Requirements for more information). The RI MMP should identify members as being nursing home certifiable if they are in capitation rate cell IC50 on the 834 enrollment file and they have been identified by the Office of Medical Review (OMR) as qualifying for the “highest” level of care. EOHHS will provide the RI MMP with a monthly report that includes information on the level of care determination for each member who is LTSS eligible.

Quality Withhold Measures

CMS and the state established a set of quality withhold measures, and the RI MMP is required to meet established thresholds. Throughout this document, state-specific quality withhold measures are marked with the following symbol for Demonstration Year 1: (i) and the following symbol for Demonstration Years 2 through 7: (ii). Note that additional state-specific quality withhold measures are reported separately through HEDIS. For more information about the state-specific quality withhold measures, refer to the Quality Withhold Technical Notes (DY 1): Rhode Island-Specific Measures and the Quality Withhold Technical Notes (DY 2-7): Rhode Island-Specific Measures at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination->

[Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPQualityWithholdMethodologyandTechnicalNotes.html](#)

Reporting on Assessments and Care Plans

As indicated in the Rhode Island three-way contract, assessment tools used by the RI MMP vary by population. Community-based members who are not receiving LTSS services and not otherwise identified as high-risk must receive an Initial Health Screen (IHS). Community-based members who are eligible for LTSS or who are otherwise determined to be high-risk must receive a Comprehensive Functional Needs Assessment (CFNA). Members residing in nursing facilities who have expressed the desire to return to the community must receive a Discharge Opportunity Assessment, and members residing in nursing facilities who do not wish to and/or are not able to transition safely to a community setting must receive a Wellness Assessment.

Based on the member's needs and the assessment conducted for the member, the RI MMP must also develop appropriate care plans that reflect the member's needs and goals. A Community Care Plan (CCP) is developed for all community-based members who are not receiving LTSS services and are not otherwise determined to be high-risk. An Interdisciplinary Care Plan (ICP) is developed for community-based members who are eligible for LTSS or who are otherwise determined to be high-risk. A Wellness Plan is developed for facility-based members who do not wish to and/or are not able to transition safely to the community, and a Community Transition Plan (CTP) is developed for facility-based members who wish to return to the community.

These distinct populations and their designated assessments and care plans are listed in the table below. For purposes of reporting data on assessment or care plan completion (Core 2.1, Core 2.2, Core 2.3, Core 3.2, and state-specific measures RI1.1, RI1.2, and RI1.3), the unit of reporting may differ as appropriate for the member's needs and risk level. Under the applicable measure, the RI MMP should report members with a completed assessment or care plan that meet measure criteria, regardless of the tool used. Throughout the RI Reporting Requirements, unless otherwise stated, the term "assessment" refers to all assessments, including the IHS, CFNA, Wellness Assessment, and Discharge Opportunity Assessment. Similarly, throughout the RI Reporting Requirements, unless otherwise stated, the term "care plan" refers to all care plans developed with member participation, including the ICP, Wellness Plan, and CTP.

Population	Assessment	Care Plan
Community-based, non-LTSS or not otherwise high-risk	IHS	CCP
Community-based, receiving LTSS or otherwise high-risk	CFNA	ICP
Facility-based, do not wish to return to community	Wellness Assessment	Wellness Plan
Facility-based, wish to return to community	Discharge Opportunity Assessment	CTP

Reporting on Assessments and Care Plans Completed Prior to First Effective Enrollment Date

The RI MMP may complete assessments prior to individuals' effective date of enrollment, provided that the MMP meets the requirements as articulated in the National MMP Enrollment and Disenrollment Guidance. Note that for individuals who are passively enrolled, the MMP may reach out to complete an assessment no sooner than 20 days before the individual's effective date of the passive enrollment.

For purposes of reporting data on assessments (Core 2.1 and Core 2.2), the RI MMP should report any assessments completed prior to the first effective enrollment date as if they were completed on the first effective enrollment date. For example, if a member's first effective enrollment date was June 1 and the assessment for that member was completed on May 25, the RI MMP should report the assessment as if it were completed on June 1.

The RI MMP should refer to the Core Reporting Requirements for detailed specifications for reporting Core 2.1 and Core 2.2. For example, Core 2.1 should only include members whose 90th day of enrollment occurred during the reporting period. Members enrolled into the RI MMP on June 1 would reach their 90th day (three full months) on August 31. Therefore, these members would be reported in the data submission for the Quarter 3 reporting period, even if their assessment was marked as complete on the first effective enrollment date (i.e., June 1).

The RI MMP must comply with contractually specified timelines regarding completion of a care plan following the assessment. In the event that a care plan is also finalized prior to the first effective enrollment date, the RI MMP should report completion of the care plan as if it were completed on the first effective enrollment date. For example, if a member's first effective enrollment date was June 1 and the care plan for that member was completed on May 27, the RI MMP should report the care plan as if it were completed on June 1.

Guidance on Assessments and Care Plans for Members with a Break in Coverage

Assessments

If the RI MMP already completed an assessment for a member that was previously enrolled, the RI MMP is not necessarily required to conduct a new assessment if the member rejoins the RI MMP within 180 days of their most recent assessment. Instead, the RI MMP can:

1. Perform any risk stratification, claims data review, or other analyses as required by the Rhode Island three-way contract to detect any changes in the member's condition since the assessment was conducted; and
2. Ask the member (or the member's authorized representative) if there has been a change in the member's health status or needs since the assessment was conducted.

The RI MMP must document any risk stratification, claims data review, or other analyses that are performed to detect any changes in the member's condition. The RI

MMP must also document its outreach attempts and the discussion(s) with the member (or the member's authorized representative) to determine if there was a change in the member's health status or needs.

If a change is identified, the RI MMP must conduct a new assessment (as appropriate for the member's needs and identified risk level) within the timeframe prescribed by the Rhode Island three-way contract. If there are no changes, the RI MMP is not required to conduct a new assessment unless requested by the member (or the member's authorized representative) but must plan to resume the member's reassessment cycle based on the member's most recent assessment, LTSS status, and latest risk stratification. Please note, if the RI MMP prefers to conduct new assessments on all re-enrollees regardless of status, it may continue to do so.

Once the RI MMP has conducted a new assessment as needed or confirmed that the prior assessment is still accurate, the RI MMP can mark the assessment as complete for the member's current enrollment. The RI MMP would then report that completion according to the specifications for Core 2.1 and Core 2.2. When reporting these measures, the RI MMP should count the 90 days from the member's most recent enrollment effective date and should report the assessment based on the date the prior assessment was either confirmed to be accurate or a new assessment was completed. Additionally, in certain circumstances a new assessment that has been completed for a member upon reenrollment may also be reported in Core 2.3.

If the RI MMP is unable to reach a re-enrolled member to determine if there was a change in health status, then the RI MMP may report that member as unable to be reached so long as the RI MMP made the requisite number of outreach attempts. If a re-enrolled member refuses to discuss their health status with the RI MMP, then the RI MMP may report that member as unwilling to participate in the assessment.

If the RI MMP did not complete an assessment for the re-enrolled member during their prior enrollment period, or if it has been more than 180 days since the member's assessment was completed, the RI MMP is required to conduct an assessment for the member (as appropriate for the member's needs and risk level) within the timeframe prescribed by the Rhode Island three-way contract. The RI MMP must make the requisite number of attempts to reach the member (at minimum) after their most recent enrollment effective date, even if the RI MMP reported that the member was unable to be reached during their prior enrollment. Similarly, members that refused the assessment during their prior enrollment must be asked again to participate (i.e., the RI MMP may not carry over a refusal from one enrollment period to the next).

Care Plans

If the RI MMP conducts a new assessment for the re-enrolled member, the RI MMP must revise the care plan accordingly (as appropriate for the member's needs and risk level) within the timeframe prescribed by the Rhode Island three-way contract. Once the care plan is revised, the RI MMP may mark the care plan as complete for the member's current enrollment. If the RI MMP determines that the prior assessment is still accurate and therefore no updates are required to the previously completed care plan, the RI MMP may mark the care plan as complete for the current enrollment at the same time that the assessment is marked complete. The RI MMP would then follow the Core 3.2

and applicable state-specific measure specifications for reporting the completion. Please note, for purposes of reporting, the care plan for the re-enrolled member should be classified as an *initial* care plan.

If the RI MMP did not complete a care plan for the re-enrolled member during their prior enrollment period, or if it has been more than 180 days since the member's care plan was completed, the RI MMP is required to complete a care plan for the member (as appropriate for the member's needs and risk level) within the timeframe prescribed by the three-way contract. The RI MMP must also follow the above guidance regarding reaching out to members who previously refused to participate or were not reached.

Reassessments and Care Plan Updates

The RI MMP must follow the three-way contract requirements regarding the completion of annual reassessments and updates to care plans. If the RI MMP determined that an assessment or care plan from a member's prior enrollment was accurate and marked that assessment or care plan as complete for the member's current enrollment, the RI MMP should count continuously from the date that the assessment or care plan was completed in the prior enrollment period to determine the due date for the annual reassessment and care plan update. For example, when reporting Core 2.3, the RI MMP should count 365 days from the date when the assessment was actually completed, even if that date was during the member's prior enrollment period.

Reporting on Passively Enrolled and Opt-In Enrolled Members

When reporting all Rhode Island state-specific measures, the RI MMP 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.

Reporting on Disenrolled and Retro-disenrolled Members

Unless otherwise indicated in the Reporting Requirements, the RI MMP should report on all Medicare-Medicaid members enrolled in the demonstration who meet the definition of the data elements at the time of the reporting deadline, regardless of whether that member was subsequently disenrolled from the RI MMP. Measure-specific guidance on how to report on disenrolled members is provided under the Notes section of each state-specific 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 RI MMP is informed about that disenrollment. This time lag might create occasional data inaccuracies if the RI MMP includes members in reports who had in fact disenrolled before the start of the reporting period. If the RI MMP is 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 the RI MMP may exclude that member from reporting. Please note that the RI MMP is *not* required to re-submit corrected data should it be informed of a retro-disenrollment subsequent to a reporting deadline. The RI MMP should act upon its best

and most current knowledge at the time of reporting regarding each member's enrollment status.

Value Sets

The measure specifications in this document 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 Rhode Island-Specific Value Sets Workbook includes all value sets and codes needed to report certain measures included in the Rhode Island-Specific Reporting Requirements and is intended to be used in conjunction with the measure specifications outlined in this document. The Rhode Island-Specific Value Sets Workbook will be posted 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>

Rhode Island's Implementation, Ongoing, and Continuous Reporting Periods

Phase		Dates	Explanation
Demonstration Year 1			
Continuous Reporting	Implementation Period	7-1-16 through 12-31-16	From July 1, 2016 through the end of the first calendar year.
	Ongoing Period	7-1-16 through 12-31-17	From July 1, 2016 through the end of the first demonstration year.
Demonstration Year 2			
Continuous Reporting	Ongoing Period	1-1-18 through 12-31-18	From January 1, 2018 through the end of the second demonstration year.
Demonstration Year 3			
Continuous Reporting	Ongoing Period	1-1-19 through 12-31-19	From January 1, 2019 through the end of the third demonstration year.
Demonstration Year 4			
Continuous Reporting	Ongoing Period	1-1-20 through 12-31-20	From January 1, 2020 through the end of the fourth demonstration year.
Demonstration Year 5			
Continuous Reporting	Ongoing Period	1-1-21 through 12-31-21	From January 1, 2021 through the end of the fifth demonstration year.

Phase		Dates	Explanation
Demonstration Year 6			
Continuous Reporting	Ongoing Period	1-1-22 through 12-31-22	From January 1, 2022 through the end of the sixth demonstration year.
Demonstration Year 7			
Continuous Reporting	Ongoing Period	1-1-23 through 12-31-23	From January 1, 2023 through the end of the seventh demonstration year.

Data Submission

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

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

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

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

Resubmission of Data

The RI MMP must comply with the following steps to resubmit data after an established due date:

1. Email the RI HelpDesk (RIHelpDesk@norc.org) 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 RI HelpDesk will notify the RI MMP once the FAI DCS and/or HPMS has been re-opened.
3. Resubmit data through the applicable reporting system.
4. Notify the RI HelpDesk again after resubmission has been completed.

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

Section RI I. Care Coordination

RI1.1 Members with Interdisciplinary Care Plans or Wellness Plans within 15 days of a completed assessment.¹

IMPLEMENTATION				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
RI1. Care Coordination	Monthly	Contract	Current Month Ex: 1/1-1/31	By the end of the second month following the last day of the reporting period
ONGOING				
Reporting Section	Reporting Frequency	Level	Reporting Periods	Due Date
RI1. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members with a Comprehensive Functional Needs Assessment (CFNA) completed within the reporting period who were continuously enrolled for 15 days following completion of the CFNA.	Total number of members with a CFNA completed within the reporting period who were continuously enrolled for 15 days following completion of the CFNA.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of members who were documented as unwilling to complete an Interdisciplinary Care Plan (ICP) within 15 days of completion of the CFNA.	Of the total reported in A, the number of members who were documented as unwilling to complete an ICP within 15 days of completion of the CFNA.	Field type: Numeric Note: Is a subset of A.
C.	Total number of members the MMP was unable to reach, following three documented outreach attempts, within 15 days of completion of the CFNA.	Of the total reported in A, the number of members the MMP was unable to reach, following three documented outreach attempts, within 15 days of completion of the CFNA.	Field type: Numeric Note: Is a subset of A.
D.	Total number of members with an ICP completed within 15 days of completion of the CFNA.	Of the total reported in A, the number of members with an ICP completed within 15 days of completion of the CFNA.	Field Type: Numeric Note: Is a subset of A.
E.	Total number of members with a completed ICP signed or initialed by a PCP, specialist, LTC, or other provider.	Of the total reported in D, the number of members with a completed ICP signed or initialed by a PCP, specialist, LTC, or other provider.	Field Type: Numeric Note: Is a subset of D.
F.	Total number of members with a Wellness Assessment completed within the reporting period who were continuously enrolled for 15 days following completion of the Wellness Assessment.	Total number of members with a Wellness Assessment completed within the reporting period who were continuously enrolled for 15 days following completion of the Wellness Assessment.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
G.	Total number of members who were documented as unwilling to complete a Wellness Plan within 15 days of completion of the Wellness Assessment.	Of the total reported in F, the number of members who were documented as unwilling to complete a Wellness Plan within 15 days of completion of the Wellness Assessment.	Field type: Numeric Note: Is a subset of F.
H.	Total number of members the MMP was unable to reach, following three documented outreach attempts, within 15 days of completion of the Wellness Assessment.	Of the total reported in F, the number of members the MMP was unable to reach, following three documented outreach attempts, within 15 days of completion of the Wellness Assessment.	Field type: Numeric Note: Is a subset of F.
I.	Total number of members with a Wellness Plan completed within 15 days of completion of the Wellness Assessment.	Of the total reported in F, the number of members with a Wellness Plan completed within 15 days of completion of the Wellness Assessment.	Field Type: Numeric Note: Is a subset of F.
J.	Total number of members with a completed Wellness Plan signed or initialed by a PCP, specialist, LTC, or other provider.	Of the total reported in I, the number of members with a completed Wellness Plan signed or initialed by a PCP, specialist, LTC, or other provider.	Field Type: Numeric Note: Is a subset of I.

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 the RI MMP over time, CMS and the state will apply threshold checks.

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

- The RI MMP should validate that data elements B, C, and D are less than or equal to data element A.
- The RI MMP should validate that data element E is less than or equal to data element D.
- The RI MMP should validate that data elements G, H, and I are less than or equal to data element F.
- The RI MMP should validate that data element J is less than or equal to data element I.

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 have an ICP completed within 15 days of completion of the CFNA.
 - Percentage = $(B / A) * 100$
- Were unable to be reached to have an ICP completed within 15 days of completion of the CFNA.
 - Percentage = $(C / A) * 100$
- Had an ICP completed within 15 days of completion of the CFNA.
 - Percentage = $(D / A) * 100$
- Had a completed ICP signed or initialed by a PCP, specialist, LTC, or other provider.
 - Percentage = $(E / D) * 100$
- Were willing to participate and who could be reached who had an ICP completed within 15 days of completion of the CFNA.
 - Percentage = $(D / (A - B - C)) * 100$
- Were willing to participate and who could be reached who had an ICP completed and signed or initialed by a PCP, specialist, LTC, or other provider.
 - Percentage = $(E / (A - B - C)) * 100$
- Were documented as unwilling to have a Wellness Plan completed within 15 days of completion of the Wellness Assessment.
 - Percentage = $(G / F) * 100$
- Were unable to be reached to have a Wellness Plan completed within 15 days of completion of the Wellness Assessment.
 - Percentage = $(H / F) * 100$
- Had a Wellness Plan completed within 15 days of completion of the Wellness Assessment.
 - Percentage = $(I / F) * 100$
- Had a completed Wellness Plan signed or initialed by a PCP, specialist, LTC, or other provider.
 - Percentage = $(J / I) * 100$
- Were willing to participate and who could be reached who had a Wellness Plan completed within 15 days of completion of the Wellness Assessment.

- Percentage = $(I / (F - G - H)) * 100$
- Were willing to participate and who could be reached who had a Wellness Plan completed and signed or initialed by a PCP, specialist, LTC, or other provider.
 - Percentage = $(J / (F - G - H)) * 100$

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

Data Elements A and F

- The RI MMP should include all members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members with a CFNA completed within the reporting period regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- For data element A, the RI MMP should include members with either an initial assessment or a reassessment completed using the CFNA. The RI MMP should count the member in data element A every time a CFNA is completed during the reporting period.
 - For example, if a member had a CFNA completed twice during the reporting period, the member is counted twice in data element A.
- The RI MMP should include all members who meet the criteria outlined in data element F, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members with a Wellness Assessment completed within the reporting period regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- For data element F, the RI MMP should include members with either an initial assessment or a reassessment completed using the Wellness Assessment. The RI MMP should count the member in data element F every time a Wellness Assessment is completed during the reporting period.
 - For example, if a member had a Wellness Assessment completed twice during the reporting period, the member is counted twice in data element F.

Data Elements B and G

- For data elements B and G, the RI MMP should report the number of members who were unwilling to participate in the development of the ICP or Wellness Plan, respectively, if a member (or the member's authorized representative):
 - Affirmatively declines to participate in the ICP or Wellness Plan, affirmatively declines care management activities overall, or refuses any contact with the RI 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 RI MMP.
 - Expresses willingness to complete the ICP or Wellness Plan, but asks for it to be conducted after 15 days following the completion of the CFNA or Wellness Assessment, respectively (despite being offered a

- reasonable opportunity to complete it within 15 days). Discussions with the member must be documented by the RI MMP.
- Schedules an appointment to complete the ICP or Wellness Plan, but cancels or is a no-show and then is subsequently non-responsive to additional outreach attempts by the RI MMP. All attempts to contact the member must be documented by the RI MMP.
 - Initially agrees to complete the ICP or Wellness Plan, but then declines to participate in the development of the ICP or Wellness Plan. The declination must be documented by the RI MMP.
 - If a member was not reached after three outreach attempts, but then subsequently is reached and refuses to complete the ICP or Wellness Plan within 15 days of the CFNA or Wellness Assessment, the member should be classified in data element B or G, respectively.

Data Elements C and H

- For data elements C and H, the RI MMP should report the number of members it was unable to reach after three attempts to contact the member. The RI MMP should refer to the Rhode Island three-way contract or state guidance for any specific requirements pertaining to the method of outreach to members.
- The RI MMP 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.
- There may be instances when the RI MMP has a high degree of confidence that a member's contact information is correct, yet that member is not responsive to the RI MMP's outreach efforts. So long as the RI MMP follows the guidance regarding outreach attempts, these members may be included in the count for data elements C or H.

Data Elements D and I

- The RI MMP should only report completed ICPs or Wellness Plans where the member or the member's authorized representative was involved in the development of the ICP or Wellness Plan.
- The CFNA or Wellness Assessment must be completed within the reporting period, but the ICP or Wellness Plan may not be completed within the same reporting period.
 - For example, if the CFNA is completed less than 15 days before the end of the quarterly reporting period (e.g., March 18), then the RI MMP should look up to 15 days past the end of the reporting period to identify whether an ICP was completed.
- If a member initially refused the ICP or Wellness Plan or could not be reached after three outreach attempts, but then subsequently completes the ICP or Wellness Plan within 15 days of the CFNA or Wellness Assessment, the member should be classified in data element D or I, respectively.

Data Elements E and J

- For data elements E and J, the MMP should report based on only completed ICPs or Wellness Plans signed or initialed by a PCP, specialist, LTC, or other provider.
- The member's ICP or Wellness Plan must have been completed within 15 days of the CFNA or Wellness Assessment, but the signature or initials may have been obtained at any time after completion. A signature or initials can be obtained in hard copy, electronically, or as an electronic signature.
- Other communication (e.g., email or telephone) from a provider can be substituted for a signature, as long as there is documentation of the receipt of the information.

General Guidance

- The RI MMP should refer to the Rhode Island three-way contract for specific requirements pertaining to the CFNA, ICP, Wellness Assessment, and Wellness Plan.
- Subset data elements B, C, and D, as well as subset data elements G, H, and I should be mutually exclusive (e.g., a member reported in data element B or C should not also be reported in data element D). This is true for data elements B, C, and D for members with a CFNA completed within the reporting period and for data elements G, H, and I for members with a Wellness Assessment completed within the reporting period.
- There may be certain circumstances that make it impossible or inappropriate to complete an ICP or Wellness Plan within 15 days of the CFNA or Wellness Assessment.
 - For example, a member may become 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 ICP or Wellness Plan. However, the RI MMP should not include such members in the counts for data elements B, C, G, and H.
- If an ICP or Wellness Plan was started but not completed within 15 days of completion of the CFNA or Wellness Assessment, then the ICP or Wellness Plan should not be considered completed and, therefore, the member would not be counted in data elements B, C, D, E, G, H, I, or J. However, this member would be included in data elements A or F if the member had a CFNA or Wellness Assessment completed, respectively, within the reporting period.

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

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

RI1.2 Members with a care plan completed.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Periods	Due Date
RI1. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members enrolled for 90 days or longer as of the end of the reporting period.	Total number of members enrolled for 90 days or longer as of the end of the reporting period who were currently enrolled as of the last day of the reporting period.	Field Type: Numeric
B.	Total number of members who had an initial care plan completed as of the end of the reporting period.	Of the total reported in A, the number of members who had an initial care plan completed as of the end of the reporting period.	Field type: Numeric Note: Is a subset of A.

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

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

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

- The RI MMP 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.
- CMS and the state will evaluate the percentage of members enrolled for 90 days or longer who had an initial care plan completed as of the end of the reporting period.
 - $\text{Percentage} = (B / A) * 100$
- 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 RI MMP. Members must be continuously enrolled from the most recent effective enrollment date through 90 days of enrollment (or longer) with no gaps in enrollment.
- For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months.

Data Element B

- Care plans reported in data element B should include all types of care plans (i.e., Interdisciplinary Care Plans, Wellness Plans, and Community Transition Plans) as appropriate for each member.
- The care plans reported in data element B could have been completed at any time from the member's first day of enrollment through the end of the reporting period.
- The RI MMP should only report completed care plans in data element B when the member or the member's authorized representative was involved in the development of the care plan.

General Guidance

- The RI MMP should refer to the Rhode Island three-way contract for specific requirements pertaining to care plan completion.
- F. Data Submission – how the RI MMP will submit data collected to CMS and the state.
- The RI MMP will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>

RI1.3 Members with documented discussions of care goals.

IMPLEMENTATION				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
RI1. Care Coordination	Monthly	Contract	Current Month Ex: 1/1-1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	Reporting Frequency	Level	Reporting Periods	Due Date
RI1. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members with an initial care plan completed.	Total number of members with an initial care plan completed during the reporting period.	Field Type: Numeric
B.	Total number of members with at least one documented discussion of care goals in the initial care plan.	Of the total reported in A, the number of members with at least one documented discussion of care goals in the initial care plan.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of existing care plans revised.	Total number of existing care plans revised during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of revised care plans with at least one documented discussion of new or existing care goals.	Of the total reported in C, the number of revised care plans with at least one documented discussion of new or existing care goals.	Field Type: Numeric Note: Is a subset of C.

- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will perform an outlier analysis.
 - As data are received from the RI MMP over time, CMS and the state will apply threshold checks.
- C. Edits and Validation Checks – validation checks that should be performed by the RI MMP prior to data submission.
- The RI MMP should validate that data element B is less than or equal to data element A.
 - The RI MMP should validate that data element D is less than or equal to data element C.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of:
- Members with an initial care plan completed during the reporting period who had at least one documented discussion of care goals in the initial care plan.
 - Percentage = $(B / A) * 100$
 - Existing care plans revised during the reporting period that had at least one documented discussion of new or existing care goals.
 - Percentage = $(D / C) * 100$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Data Element A

- The RI MMP should include all members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- Data element A should include all members whose care plan was created for the first time during the reporting period (i.e., the member did not previously have a care plan of any type completed prior to the start of the reporting period). There can be no more than one initial care plan per member.

- Only care plans that included participation from the member (or the member's authorized representative) in the completion of the care plan should be reported.

Data Element B

- The RI MMP should only include members in data element B when the discussion of care goals with the member (or the member's authorized representative) is clearly documented in the member's initial care plan.

Data Element C

- The RI MMP should include all care plans for members who meet the criteria outlined in data element C, regardless of whether the members are disenrolled as of the end of the reporting period (i.e., include all care plans regardless of whether the members are currently enrolled or disenrolled as of the last day of the reporting period).
- Data element C should include all existing care plans that were revised during the reporting period. The RI MMP should refer to the Rhode Island three-way contract for specific requirements pertaining to updating the care plan.
- Only care plans that included participation from the member (or the member's authorized representative) in the revision to the care plan should be reported.
- If a member previously had a care plan completed, but had a new care plan of a different type completed during the reporting period, the new care plan should be reported as a revised care plan.
 - For example, a member with a Community Transition Plan completed in a prior reporting period who had an Interdisciplinary Care Plan completed for the first time during the reporting period should be reported as having a revised care plan completed, even though the type of care plan revised differs from the initial care plan completed.
- If a member's care plan is revised multiple times during the same reporting period, each revision should be reported in data element C.
 - For example, if a member's care plan is revised twice during the same reporting period, two care plans should be counted in data element C.

Data Element D

- The RI MMP should only include care plans in data element D when a new or previously documented care goal is discussed with the member (or the member's authorized representative) and is clearly documented in the member's revised care plan.
- If the initial care plan clearly documented the discussion of care goals, but those existing care goals were not revised or discussed, or new care goals are not discussed and documented during the revision of the care plan, then that care plan should not be reported in data element D.

General Guidance

- Care plans reported in this measure (both initial and revised) should include all types of care plans (i.e., Interdisciplinary Care Plans, Wellness Plans, and Community Transition Plans) as appropriate for each member.
- If a member has an initial care plan completed during the reporting period, and has their care plan revised during the same reporting period, the member should be reported in data element A and the member’s revised care plan should be reported in data element C.

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

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

RI1.4 Members with first follow-up visit within 30 days of hospital discharge.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
RI1. Care Coordination	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of acute inpatient hospital discharges.	Total number of acute inpatient hospital discharges that occurred during the reporting period for members who were continuously enrolled from the date of the inpatient hospital discharge through 30 days after the inpatient hospital discharge, with no gaps in enrollment.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of acute inpatient hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge from the inpatient hospital stay.	Of the total reported in A, the number of acute inpatient hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge from the inpatient hospital stay.	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 the RI MMP over time, CMS and the state will apply threshold checks.
- C. Edits and Validation Checks – validation checks that should be performed by the RI MMP prior to data submission.
- The RI MMP 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. CMS and the state will:
- Evaluate the percentage of acute inpatient hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of the discharge from the inpatient hospital stay.
 - $\text{Percentage} = (B / A) * 100$
 - Use enrollment data to evaluate the total number of acute inpatient hospital discharges per 10,000 member months during the reporting period.
 - $\text{Rate} = (A / \text{Total Member Months}) * 10,000$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Data Element A

- The RI MMP should include all acute inpatient hospital discharges 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 acute inpatient hospital discharges, not members.
- To identify all acute inpatient hospital discharges during the reporting period:
 - Identify all acute and nonacute inpatient stays (Inpatient Stay value set).

- Exclude nonacute inpatient stays (Nonacute Inpatient Stay value set).
- Identify the discharge date for the stay. The date of discharge must be within the reporting period.
- Report on all inpatient stays identified with discharges within the reporting period, including denied and pended claims.

Additionally, the RI MMP should use UB Type of Bill codes 11x, 12x, 41x, and 84x or any acute inpatient facility code to identify discharges from an inpatient hospital stay.

- If the discharge is followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period, count only the last discharge for reporting in data element A. To identify readmissions and direct transfers to an acute inpatient care setting:
 - Identify all acute and nonacute inpatient stays (Inpatient Stay value set).
 - Exclude nonacute inpatient stays (Nonacute Inpatient Stay value set).
 - Identify the admission date for the stay.

Data Element A Exclusions

- Exclude discharges for members who use hospice services or elect to use a hospice benefit at any time between the hospital discharge date and 30 days following the hospital discharge. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record, claims/encounter data (Hospice Encounter value set; Hospice Intervention value set), or supplemental data.
- Exclude discharges due to death, using the Discharges due to Death value set.
- Exclude from data element A any discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period. To identify readmissions and direct transfers to a nonacute inpatient care setting:
 - Identify all acute and nonacute inpatient stays (Inpatient Stay value set).
 - Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay value set) on the claim.
 - Identify the admission date for the stay.

These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.

- For example, the following direct transfers/readmissions should be excluded from this measure:
 - An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1 (a direct transfer).
 - An inpatient discharge on June 1, followed by a readmission to a hospital on June 15 (readmission within 30 days).

Data Element B

- The date of discharge must occur within the reporting period, but the follow-up visit may not be in the same reporting period.
 - For example, if a discharge occurs during the last month of the reporting period, look to the first month of the following reporting period to identify the follow-up visit.
- A follow-up visit is defined as an ambulatory care follow-up visit to assess the member's health following a hospitalization. Codes to identify follow-up visits are provided in the Ambulatory Visits value set, Other Ambulatory Visits value set, and Telephone Visits value set.
- The RI MMP should report ambulatory care follow-up visits based on all visits identified, including denied and pended claims, and including encounter data as necessary in cases where follow-up care is included as part of a bundled payment covering the services delivered during the inpatient stay. The RI MMP should use all information available, including encounter data supplied by providers, to ensure complete and accurate reporting.

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

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

Section RI II. Enrollee Protections

RI2.1 The number of critical incident and abuse reports for members receiving LTSS.

IMPLEMENTATION				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
RI2. Enrollee Protections	Monthly	Contract	Current Month Ex: 1/1-1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	Reporting Frequency	Level	Reporting Periods	Due Date
RI2. Enrollee Protections	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 receiving LTSS.	Total number of members receiving LTSS during the reporting period.	Field Type: Numeric
B.	Total number of critical incident and abuse reports.	Of the total reported in A, the number of critical incident and abuse reports during the reporting period.	Field Type: Numeric

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

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

- C. Edits and Validation Checks – validation checks that should be performed by the RI 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 evaluate the:
- Number of critical incident and abuse reports per 1,000 members receiving LTSS during the current reporting period.
 - Rate = $(B / A) * 1,000$
 - Average number of critical incident and abuse reports for members receiving LTSS during the prior four reporting periods (i.e., rolling year).
 - Average number = Sum of B for prior four reporting periods / 4
 - Weighted average number of critical incident and abuse reports per 1,000 members receiving LTSS during the prior four reporting periods.
 - Rate = $(\text{Sum of B for prior four reporting periods} / \text{Sum of A for prior four reporting periods}) * 1,000$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Definitions

- Critical incident refers to any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety, or well-being of a member, including falls, unplanned hospitalizations, financial exploitation, police-involved incidents, and disasters.
- Abuse refers to:
 - Willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish;
 - Knowing, reckless, or intentional acts or failures to act which cause injury or death to an individual or which place that individual at risk of injury or death;
 - Rape or sexual assault;
 - Corporal punishment or striking of an individual;
 - Unauthorized use or the use of excessive force in the placement of bodily restraints on an individual; and
 - Use of bodily or chemical restraints on an individual which is not in compliance with federal or state laws and administrative regulations.

Data Element A

- The RI MMP should include all members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- Members receiving LTSS can be identified as enrolled under IC50 and IC60 capitation cells on the 834 enrollment file.

Data Element B

- For data element B, the RI MMP should include all new critical incident and abuse cases that are reported during the reporting period, regardless of whether the case status is open or closed as of the last day of the reporting period.
 - Critical incident and abuse reports could be reported by the RI MMP or any provider and are not limited to only those providers defined as LTSS providers.
 - It is possible for members to have more than one critical incident and/or abuse report during the reporting period. All critical incident and abuse reports during the reporting period should be counted.
- F. Data Submission – how the RI MMP will submit data collected to CMS and the state.
- The RI MMP will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>

Section RI III. Organizational Structure and Staffing

RI3.1 Care manager training for supporting self-direction under the demonstration.
– *Retired*

Section RI IV. Performance and Quality Improvement

RI4.1 Long-term care overall balance.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
RI4. Performance and Quality Improvement	Annually	Contract	Calendar Year, beginning DY2	By the end of the sixth 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 continuously enrolled in the MMP.	Total number of members continuously enrolled in the MMP during the reporting period.	Field Type: Numeric
B.	Total number of members who did not reside in a nursing facility (NF) for a long stay at the time of enrollment.	Of the total reported in A, the number of members who did not reside in a NF for a long stay at the earliest point of their enrollment during the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members who did not reside in a NF for a long stay.	Of the total reported in B, the number of members who did not reside in a NF for a long stay during the 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 the RI MMP over time, CMS and the state will apply threshold checks.
- C. Edits and Validation Checks – validation checks that should be performed by the RI MMP prior to data submission.
- The RI MMP should validate that data element B is less than or equal to data element A.
 - The RI MMP 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 who did not reside in a nursing facility (NF) for a long stay at the earliest point of their enrollment during the reporting period, CMS and the state will evaluate the percentage of members who did not reside in a NF for a long stay during the reporting period.
 - $\text{Percentage} = (C / B) * 100$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Data Element A

- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during the reporting period (i.e., January through December). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a one-month gap in coverage (i.e., a member whose coverage lapses for two months [60 days] is not considered continuously enrolled).

Data Element B

- For data element B, the RI MMP should include members who did not reside in a nursing facility at the earliest point in their enrollment OR members who did reside in a nursing facility at the earliest point in their enrollment, but only had a short stay in the nursing facility (i.e., less than 101 days).
- To establish a member's nursing facility long stay status for data element B, use the member's status from the earliest point of enrollment during the current reporting period. The RI MMP should look up to 101 days into the previous reporting period to determine the length of the nursing facility stay.
 - For members enrolled on January 1 of the reporting period, use the members' status (i.e., did not reside in a nursing facility for a long stay) as of January 1 of the current reporting period.
 - For members enrolled after January 1 of the reporting period, use the members' status (i.e., did not reside in a nursing facility for a long stay) on the first day of enrollment during the reporting period.

- For example, if a member enrolls on April 1 and does not reside in a nursing facility at the time of enrollment, the member would be reported in data element B.

Data Element C

- To establish a member's nursing facility long stay status for data element C, the RI MMP should evaluate the entire period in which the member was enrolled to determine if the member had 101 days or longer in a nursing facility during the reporting period.
- Members who had a length of stay in a nursing facility of 101 days or longer during the reporting period should not be reported in data element C.
- Only count nursing facility days that occurred during the current reporting period.

General Guidance

- When determining a long stay:
 - If a member is transferred from the nursing facility to an acute care facility and then is readmitted to any nursing facility within 30 days, the transfer and subsequent readmission does not disrupt the count of cumulative days.
 - For example, if a member is transferred from the nursing facility to the hospital on day 93 and is subsequently readmitted to the same nursing facility 24 days later, this will be counted as the same long stay episode. The member's first day back in the nursing facility (i.e., the day the member is readmitted to the nursing facility) will count as day 94 for that episode, not as day 1.
 - If a member is transferred from the nursing facility to another nursing facility, the transfer does not disrupt the count of cumulative days.
 - For example, if a member is transferred from one nursing facility to another on day 93 and remains in the new nursing facility for 24 days, this will be counted as the same long stay episode. The member would have 117 total days of cumulative nursing facility services.
 - If a member is transferred from the nursing facility to an acute care facility and then is readmitted to any nursing facility after 30 days, the date of readmission is the start of a new episode in the nursing facility and will count as day 1 towards the member's cumulative days in facility.
- Codes to identify a discharge or transfer are provided in the Discharges/Transfers value set.
- Nursing facility services provided by Medicaid, Medicare, or other state agency-certified nursing homes primarily include:
 - Skilled nursing or medical care and related services;
 - Rehabilitation needed due to injury, disability, or illness;

- Long-term care: health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition;
- Custodial care: non-medical care, such as help with daily activities like bathing and dressing.

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

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

RI4.2 High-risk nursing facility residents with pressure ulcers.ⁱⁱ

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
RI4. Performance and Quality Improvement	Annually	Contract	Calendar Year	By the end of the sixth 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 long-stay nursing facility residents with a selected target assessment who meet the definition of high-risk.	Total number of long-stay nursing facility residents with a selected target assessment who met the definition of high-risk.	Field Type: Numeric
B.	Total number of long-stay nursing facility residents with a selected target assessment who had Stage II-IV or unstageable pressure ulcers present.	Of the total reported in A, the number of long-stay nursing facility residents with a selected target assessment who had Stage II-IV or unstageable pressure ulcers present.	Field Type: Numeric Note: Is a subset of A.

- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- The quality withhold benchmark is 5% for DY 2 through 6 and 7% for DY 7. For more information, refer to the Quality Withhold Technical Notes (DY 2-7): Rhode Island-Specific Measures.
- C. Edits and Validation Checks – validation checks that should be performed by the RI MMP prior to data submission.
- The RI MMP 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.
- CMS and the state will evaluate the percentage of long-stay nursing facility residents who meet the definition of high-risk with a selected target assessment that indicates Stage II-IV or unstageable pressure ulcers are present.
 - $\text{Percentage} = (B / A) * 100$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Definitions

- A long stay is an episode with cumulative days in a facility greater than or equal to 101 days as of the end of the target period. Long stays may include one or more interruptions, indicated by Interrupted Stay (A0310G1 = [1]).
- An interrupted stay is when during a stay, the resident has an interruption in their stay and resumes the same stay within three consecutive calendar days.
- The target period is the span of time that defines the quality measures' reporting period (e.g., a calendar year).
- Cumulative days in facility (CDIF) is the total number of days within an episode during which the resident was in the facility. It is the sum of the number of days within each stay included in an episode. Definitions for "stay" and "episode" can be found immediately following guidance on CDIF. If an episode consists of more than one stay separated by periods of time outside the facility (e.g., hospitalizations), and/or one or more stays with interruptions lasting three calendar days or less, only those days within the facility would count towards CDIF. Any days outside the facility (e.g., hospital, home, etc.) would not count towards the CDIF total.
- A stay is the period of time between a resident's entry into a facility and either (a) a discharge or (b) the end of the target period, whichever comes first. A stay may include interrupted stays lasting three calendar days or less.
- An episode is the period of time spanning one or more stays. An episode begins with an admission and ends with either (a) a discharge or (b) the end of the target period, whichever comes first.

- The target assessment selection period is the most recent three months (the long-stay target period).

Data Element A

- For data element A, residents are defined as high-risk if they meet or one more of the following three criteria on the target assessment:
 - Impaired bed mobility or transfer indicated, by either or both of the following:
 - Bed mobility, self-performance (G0110A1 = [3,4,7,8])
 - Transfer, self-performance (G0110B1 = [3,4,7,8])
 - Comatose (B0100 = [1])
 - Malnutrition or at risk of malnutrition (I5600 = [1]) (checked)

Data Element A Exclusion

- The RI MMP should exclude any long-stay resident from data element A that meets the following criteria:
 - Target assessment is an OBRA admission assessment (A0310A = [01]) or a PPS 5-day assessment (A0310B = [01])
 - If the resident is not included in the numerator (the resident did not meet the pressure ulcer conditions for the numerator) and any of the following conditions are true:
 - M0300B1 = [-]
 - M0300C1 = [-]
 - M0300D1 = [-]
 - M0300E1 = [-]
 - M0300F1 = [-]
 - M0300G1 = [-]

Data Element B

- For data element B, long-stay residents with a selected target assessment must meet the following condition:
 - Stage II-IV or unstageable pressure ulcers are present, as indicated by any of the following six conditions:
 - M0300B1 = [1,2,3,4,5,6,7,8, or 9] *or*
 - M0300C1 = [1,2,3,4,5,6,7,8, or 9] *or*
 - M0300D1 = [1,2,3,4,5,6,7,8, or 9] *or*
 - M0300E1 = [1,2,3,4,5,6,7,8, or 9] *or*
 - M0300F1 = [1,2,3,4,5,6,7,8, or 9] *or*
 - M0300G1 = [1,2,3,4,5,6,7,8, or 9].

General Guidance

- The following rules are used when computing CDIF:
 - When counting the number of days until the end of the episode, counting stops with:
 - The last record in the target period if that record is a discharge assessment (A0310F = [10,11]),

- The last record in the target period if that record is a death in facility (A0310F = [12]), or
 - The end of the target period is reached, whichever is earlier.
- When counting the duration of each stay within an episode, include the day of entry (A1600) but not the day of discharge (A2000) unless the entry and discharge occurred on the same day in which case the number of days in the stay is equal to 1.
 - For example, if a resident is admitted on Monday and discharged the following day (Tuesday), the duration of that episode would be one day.
- While death in facility records (A0310F = [12]) end CDIF counting, these records are not used as target records because they contain only tracking information and do not include clinical information necessary for quality measure calculation.
- The start of a stay is either:
 - An admission entry (A0310F = [01] and A1700 = [1]), or
 - A reentry (A0310F = [01] and A1700 = [2]).
- The end of a stay is the earliest of the following:
 - Any discharge assessment (A0310F = [10,11]), or
 - A death in facility tracking record (A0310F = [12]), or
 - The end of the target period.
- An episode starts with:
 - An admission entry (A0310F = [01] and A1700 = [1]).
- The end of an episode is the earliest of the following:
 - A discharge assessment with return not anticipated (A0310F = [10]), or
 - A discharge assessment with return anticipated (A0310F = [11]) but the resident did not return within 30 days of discharge, or
 - A death in facility tracking record (A0310F = [12]), or
 - The end of the target period.
- An admission entry record (A0310F = [01] and A1700 = [1]) is required when any one of the following occurs:
 - Resident has never been admitted to this facility before, or
 - Resident has been in this facility previously and was discharged return not anticipated, or
 - Resident has been in this facility previously and was discharged return anticipated and did not return within 30 days of discharge.
- Qualifying reasons for assessment (RFA) for the target assessment selection period are:
 - A0310A = [01,02,03,04,05,06] or
 - A0310B = [01] or
 - A0310F = [10,11].
- When selecting the target assessment, it is the latest assessment that meets the following criteria:
 - It is contained within the resident's selected episode,
 - It has a qualifying RFA, and
 - Its target date is no more than 120 days before the end of the episode.

- The target assessment need not have a target date within the target period, but it must occur within 120 days of the end of the resident’s episode (either the last discharge in the target period or the end of the target period if the episode is ongoing). The 120 days allows 93 days between quarterly assessments plus an additional 27 days to allow for late assessments. The target assessment represents the resident’s status at the end of the episode.

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

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

RI4.3 Nursing facility residents experiencing one or more falls with a major injury.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
RI4. Performance and Quality Improvement	Annually	Contract	Calendar Year	By the end of the sixth 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 long-stay nursing facility residents.	Total number of long-stay nursing facility residents with one or more look-back scan assessments.	Field Type: Numeric
B.	Total number of long-stay nursing facility residents with one or more look-back scan assessments that indicate one or more falls that resulted in major injury.	Of the total reported in A, the number of long-stay nursing facility residents with one or more look-back scan assessments that indicate one or more falls that resulted in major injury.	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 the RI MMP over time, CMS and the state will apply threshold checks.
- C. Edits and Validation Checks – validation checks that should be performed by the RI MMP prior to data submission.
- The RI MMP 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.
- CMS and the state will evaluate the percentage of long-stay nursing facility residents with one or more look-back scan assessments that indicate one or more falls that resulted in major injury in the target period or look-back period.
 - $\text{Percentage} = (B / A) * 100$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Definitions

- A long stay is an episode with cumulative days in a facility greater than or equal to 101 days as of the end of the target period. Long stays may include one or more interruptions, indicated by Interrupted Stay (A0310G1 = [1]).
- An interrupted stay is when during a stay, the resident has an interruption in their stay and resumes the same stay within three consecutive calendar days.
- The target period is the span of time that defines the quality measures' reporting period (e.g., a calendar year).
- Cumulative days in facility (CDIF) is the total number of days within an episode during which the resident was in the facility. It is the sum of the number of days within each stay included in an episode. Definitions for “stay” and “episode” can be found immediately following guidance on CDIF. If an episode consists of more than one stay separated by periods of time outside the facility (e.g., hospitalizations), and/or one or more stays with interruptions lasting three calendar days or less, only those days within the facility would count towards CDIF. Any days outside the facility (e.g., hospital, home, etc.) would not count towards the CDIF total.
- A stay is the period of time between a resident's entry into a facility and either (a) a discharge or (b) the end of the target period, whichever comes first. A stay may include interrupted stays lasting three calendar days or less.
- An episode is the period of time spanning one or more stays. An episode begins with an admission and ends with either (a) a discharge or (b) the end of the target period, whichever comes first.
- For look-back scan assessments, scan all qualifying RFAs within the current episode that have target dates no more than 275 days prior to the target assessment.

Data Element A Exclusion

- A resident is excluded if the following is true for all look-back scan assessments:
 - The number of falls with major injury was not coded (J1900C = [-]).

Data Element B

- A resident has one or more falls that resulted in major injury if the look-back scan assessment indicates J1900C = [1,2].

General Guidance

- The following rules are used when computing CDIF:
 - When counting the number of days until the end of the episode, counting stops with:
 - The last record in the target period if that record is a discharge assessment (A0310F = [10,11]),
 - The last record in the target period if that record is a death in facility (A0310F = [12]), or
 - The end of the target period is reached, whichever is earlier.
 - When counting the duration of each stay within an episode, include the day of entry (A1600) but not the day of discharge (A2000) unless the entry and discharge occurred on the same day in which case the number of days in the stay is equal to 1.
 - For example, if a resident is admitted on Monday and discharged the following day (Tuesday), the duration of that episode would be one day.
 - While death in facility records (A0310F = [12]) end CDIF counting, these records are not used as target records because they contain only tracking information and do not include clinical information necessary for quality measure calculation.
- The start of a stay is either:
 - An admission entry (A0310F = [01] and A1700 = [1]), or
 - A reentry (A0310F = [01] and A1700 = [2]).
- The end of a stay is the earliest of the following:
 - Any discharge assessment (A0310F = [10,11]), or
 - A death in facility tracking record (A0310F = [12]), or
 - The end of the target period.
- An episode starts with:
 - An admission entry (A0310F = [01] and A1700 = [1]).
- The end of an episode is the earliest of the following:
 - A discharge assessment with return not anticipated (A0310F = [10]), or
 - A discharge assessment with return anticipated (A0310F = [11]) but the resident did not return within 30 days of discharge, or
 - A death in facility tracking record (A0310F = [12]), or
 - The end of the target period.
- An admission entry record (A0310F = [01] and A1700 = [1]) is required when any one of the following occurs:

- Resident has never been admitted to this facility before, or
- Resident has been in this facility previously and was discharged return not anticipated, or
- Resident has been in this facility previously and was discharged return anticipated and did not return within 30 days of discharge.
- Qualifying reasons for assessment (RFA) for look-back scan assessments are:
 - A0310A = [01,02,03,04,05,06] or
 - A0310B = [01] or
 - A0310F = [10,11].
- When selecting the look-back scan assessment, include the target assessment and all qualifying earlier assessments in the scan. Include an earlier assessment in the scan if it meets all of the following conditions:
 - It is contained within the resident's episode,
 - It has a qualifying RFA,
 - Its target date is on or before the target date for the target assessment, and
 - Its target date is no more than 275 days prior to the target date of the target assessment.

The target assessment and qualifying earlier assessments are scanned to determine whether certain events or conditions occurred during the look-back period.

- The purpose of the look-back scan is to determine whether such events or conditions occurred during the look-back period. These measures trigger if the event or condition of interest occurred any time during a one year period. A 275-day time period is used to include up to three quarterly OBRA assessments. The earliest of these assessments would have a look-back period of up to 93 days which would cover a total of about one year. All qualifying RFAs with target dates in this time period are examined to determine whether the event or condition of interest occurred at any time during the time interval.

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

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

RI4.4 Antipsychotic use in persons with dementia. – **Retired**

RI4.5 Skilled nursing facility discharges to the community.^{i,ii}

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
RI4. Performance and Quality Improvement	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members admitted to a skilled nursing facility (SNF) from an acute hospital during the prior 12 months who did not have a stay in a nursing facility in the 100 days prior to the SNF admission.	Total number of members admitted to a SNF from an acute hospital during the prior 12 months who did not have a stay in a nursing facility in the 100 days prior to the SNF admission, and who were continuously enrolled from the date of the SNF admission through 30 days following the discharge from the SNF to the community, with no gaps in enrollment.	Field Type: Numeric
B.	Total number of members who were discharged back to the community alive from a SNF within 100 days of admission <u>and</u> remained out of any SNF for at least 30 days.	Of the total reported in A, the number of members who were discharged back to the community alive (i.e., private home, apartment, board/care, assisted living, or group home) from a SNF within 100 days of admission <u>and</u> remained out of any SNF for at least 30 days following the discharge.	Field Type: Numeric Note: Is a subset of A.

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

- The quality withhold benchmark is 65% for DY 2, 67% for DY 3, and 69% for DY 4 through 7. For more information, refer to the Quality Withhold Technical Notes (DY 2-7): Rhode Island-Specific Measures.
- C. Edits and Validation Checks – validation checks that should be performed by the RI MMP prior to data submission.
- The RI MMP 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.
- CMS and the state will evaluate the percentage of members admitted from an acute hospital to the SNF over the prior 12 months who did not have a stay in any nursing facility in the 100 days prior to the SNF admission, who were discharged back to the community alive from the SNF within 100 days of admission and who remained out of any SNF for at least 30 days following that discharge.
 - $\text{Percentage} = (B / A) * 100$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Data Element A

- The RI MMP should include all members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- Data element A is based on MDS item “A1800 Entered From” being coded as “03 Acute Care Hospital.” This information would appear on the MDS admission assessments, either the 5-day SNF PPS or 14-day OBRA Admission.
- The RI MMP should include members who expire during the reporting period in the denominator if they meet all of the criteria outlined in data element A.

Data Element A Exclusion

- The RI MMP should exclude the following:
 - Any member with a stay in a SNF for any reason during the 100 days prior to the acute hospital admission.
 - Any member less than 55 years of age.
 - Anyone with missing data for the “entered from” or “discharge status” MDS items (A1800 or A2100).

Data Element B

- Members who expire during the reporting period should not be counted as a discharge to the community and should not be counted in data element B.

- Data element B is based on MDS item “A1200 Discharge Status” being coded as “01 Community.” This information would appear on the MDS discharge assessments.
- The RI MMP should include members who have an interruption in the SNF stay (e.g., hospital admission). If the member is readmitted to the same SNF following the event and discharged back to the community within 100 days of their initial admission to that SNF, then they are counted in data element B.

General Guidance

- This measure was adapted from the PointRight Pro 30 measure. However, risk adjustment will not be required when reporting this measure. The RI MMP will report the actual rate only.

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

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

RI4.6 Skilled nursing facility hospital admissions.^{i,ii}

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
RI4. Performance and Quality Improvement	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members admitted to a skilled nursing facility (SNF) from an acute hospital who had an MDS admission assessment during the prior 12 months.	Total number of members admitted to a SNF from an acute hospital who had an MDS admission assessment during the prior 12 months.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of members readmitted to any hospital from the SNF within 30 days of admission.	Of the total reported in A, the number of members readmitted to any hospital (excluding emergency room [ER] only visits) from the SNF within 30 days of admission.	Field Type: Numeric Note: Is a subset of A.

- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- The quality withhold benchmark is 12% for DY 2 through 7. For more information, refer to the Quality Withhold Technical Notes (DY 2-7): Rhode Island-Specific Measures.
- C. Edits and Validation Checks – validation checks that should be performed by the RI MMP prior to data submission.
- The RI MMP 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.
- CMS and the state will evaluate the percentage of members admitted to a SNF from an acute hospital who had an MDS admission assessment who were readmitted to any hospital (excluding ER-only visits) from the SNF within 30 days of admission.
 - $\text{Percentage} = (B / A) * 100$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Data Element A

- The RI MMP should include all members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- The source of the MDS admission assessment is either the 5-day SNF PPS or the 14-day OBRA Admission assessment.

Data Element B

- To identify data element B, the RI MMP should use the indication on the MDS discharge assessment.

Data Element B Exclusion

- The RI MMP should exclude from data element B any transfers from the SNF to any hospital for an ER-only visit (i.e., a hospital visit that did not result in an inpatient admission).

General Guidance

- This measure was adapted from the PointRight Pro 30 measure. However, risk adjustment will not be required when reporting this measure. The RI MMP will report the actual rate only.

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

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

RI4.7 Members eligible for the Rhode to Home program who are transitioned from a nursing facility to the community.^{i,ii} – **Retired**

RI4.8 Member admissions to and discharges from residential settings involving out-of-plan services.ⁱ – **Retired**

RI4.9 Nursing facility residents with low-level care needs.^{i,ii} – **Retired**

RI4.10 Nursing facility residents who received an antipsychotic medication.ⁱⁱ – **Retired**