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

Issued February 28, 2023

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TEXAS-SPECIFIC REPORTING REQUIREMENTS APPENDIX

Introduction

The measures in this appendix are required reporting for all MMPs in the Texas Dual Eligible Integrated Care Demonstration Project (the "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

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

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

MMPs should contact the TX HelpDesk at TXHelpDesk@norc.org with any questions about the Texas 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 MMPs reported to CMS and the state on a more intensive reporting schedule. The Implementation Period started with the first effective enrollment date and continued for seven months (March 1, 2015 – September 30, 2015).

Long Term Services and Supports (LTSS): Services to meet an individual's health or personal care needs over an extended period of time and may include nursing, assistance with activities of daily living (such as bathing, toileting, dressing, and eating),

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

meal preparation, relief for caregivers, home modifications and repairs, transportation, adaptive aids, services at licensed facilities, and nutrition services such as home-delivered meals or meals at senior centers. LTSS are provided predominantly in homes and communities, but also in facility-based settings such as nursing facilities.

Primary Care Provider: A Provider who has agreed with the MMP to provide a Medical Home to Enrollees and who is responsible for providing initial and primary care to Enrollees, maintaining the continuity of care, and initiating referral for services.

Service Coordination: A specialized care management service that is performed by a Service Coordinator that includes but is not limited to: 1) identification of needs, including physical and behavioral health services, and LTSS, 2) development of and necessary updates to an Integrated Plan of Care to address those identified needs; 3) assistance to ensure timely and a coordinated access to an array of Providers and Covered Services; 4) attention to addressing unique, person-centered needs of Enrollees; 5) coordination of Covered Services with Non-Capitated Services, as necessary and appropriate; and 6) includes, for Enrollees who have been determined STAR+PLUS Home and Community-Based Services (HCBS) eligible, the development of an ISP with the Enrollee, family members, and Provider(s), as well as authorization of HCBS services.

Variations from the Core Reporting Requirements Document

Core 2.1 and Core 2.2

Under certain circumstances, Texas MMPs are permitted to count assessments previously completed by the MMP's affiliated STAR+PLUS and/or Medicare Advantage D-SNP product. As a result, there are some caveats to the reporting of the core measures that pertain to assessments (i.e., Core 2.1 and Core 2.2).

Only those assessments completed by a MMP's own sister product may be counted toward MMP requirements. In addition, the MMP must determine, through contact with the member or other means as appropriate, if the member has experienced any of the triggering events listed in Section 2.6.2.8.2 of the three-way contract. If so, the MMP should conduct a new assessment and report that completion according to the specifications for Core 2.1 and Core 2.2.

In the absence of a triggering event as described in Section 2.6.2.8.2 of the three-way contract, MMPs are not required to complete an additional assessment for members who have previously received a comprehensive assessment in the MMP's sister product within the prior nine months. As such, for former STAR+PLUS and/or D-SNP members with a comprehensive assessment completed within nine months of their initial effective enrollment date in the MMP, MMPs are to report those assessments under Core 2.1 and Core 2.2 as having been completed as of the member's first effective enrollment date in the MMP. For example, if a member's first effective enrollment date was March 1, 2023 and the assessment for that member was previously completed on August 20, 2022, the MMP should report the assessment as if it were completed on March 1, 2023.

For Level 2 members who received a non-comprehensive assessment from the MMP's sister product within nine months of their initial effective enrollment date in the MMP, and who have not had a triggering event as described in Section 2.6.2.8.2 of the three-

way contract, MMPs are required to ask the additional required assessment questions within 90 days of the member's effective enrollment date in the MMP. MMPs are to report such assessments as completed as of the date on which the missing questions were asked and documented. Alternatively, the MMP may opt to complete a new assessment for the low-risk member using its new comprehensive tool (with the required questions added) within 90 days of the member's enrollment in the MMP. MMPs would report the completion of the new comprehensive assessment under Core 2.1 and Core 2.2 according to the actual date of completion.

Level 1 members who received a non-comprehensive assessment while enrolled in an MMP's sister product must have a new, comprehensive assessment within 90 days of enrollment. MMPs should report these new comprehensive assessments under Core 2.1 and Core 2.2 according to the actual date of completion.

MMPs should refer to the Core Reporting Requirements for detailed specifications for reporting Core 2.1 and Core 2.2. For example, Core 2.1 should only include members whose 90th day of enrollment occurred during the reporting period and who were still enrolled as of the last day of the reporting period. Members enrolled into the MMP on March 1 would reach their 90th day (which is equivalent to three full months) on May 31. Therefore, these members would be reported in the data submission for the Quarter 2 reporting period, even if their assessment was marked as complete on the first effective enrollment date (i.e., March 1).

Core 2.3

For Core 2.3, members with an annual reassessment, MMPs should determine whether members are eligible for an annual reassessment using the actual date the initial assessment was completed, even if that date occurred when the member was enrolled in the MMP's sister product.

Core 9.2

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

Core 9.2 focuses on "nursing home certifiable" members, defined as "members living in the community, but requiring an institutional level of care" (see the Core Reporting Requirements for more information). MMPs should use risk group assignments, supplemented by claims or enrollment data, to categorize members as "nursing home certifiable." Members in the following risk groups should be included:

- Dually-eligible, STAR+PLUS Home and Community-Based Services program
- Dually-eligible, Nursing Facility, for individuals residing in the nursing home no more than 100 days

In addition, MMPs may have members who, for a short period, may be in HCBS but not yet assigned to the appropriate risk group. MMPs should use information available in internal data systems wherever possible to identify whether these individuals should be included in reporting for Core 9.2.

Quality Withhold Measures

CMS and the state established a set of quality withhold measures, and MMPs are 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 8 ([ii]). Note that an additional state-specific quality withhold measure for DY 2 through 6 is collected separately through CAHPS®, and additional state-specific quality withhold measures for DY 7 and 8 are reported separately through the Core Reporting Requirements and HEDIS.[2] For more information about the state-specific quality withhold measures, refer to the Quality Withhold Technical Notes (DY 1): Texas-Specific Measures and the Quality Withhold Technical Notes (DY 2-8): Texas-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 Integrated Plans of Care Completed Prior to First Effective Enrollment Date

MMPs may complete Health Risk Assessments (HRAs) 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 HRA no sooner than 20 days before the individual's effective date of the passive enrollment.

For purposes of reporting data on HRAs (Core 2.1 and Core 2.2), MMPs should report any HRAs 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 HRA for that member was completed on May 25, the MMP should report the HRA as if it were completed on June 1. As noted in the prior section, MMPs should refer to the Core Reporting Requirements for detailed specifications for reporting Core 2.1 and Core 2.2.

MMPs must comply with the contractually-specified timeline for completion of Integrated Plans of Care (IPCs) within 90 days of enrollment. In the event that an IPC is also finalized prior to the first effective enrollment date, MMPs should report completion of the IPC (for measures Core 3.2, TX1.2, and TX1.4) 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 IPC for that member was completed on May 27, the MMP should report the IPC as if it were completed on June 1.

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[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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

<u>Health Risk Assessments</u>

If a MMP already completed an HRA for a member who was previously enrolled, the MMP is not necessarily required to conduct a new HRA if the member rejoins the same MMP within one year of their most recent HRA. Instead, the MMP can:

1. Perform any risk stratification, claims data review, or other analyses as required by the three-way contract to detect any changes in the member's condition since the HRA was conducted; and

2. Ask the member (or their authorized representative) and service coordinator if there has been a change in the member's health status or needs since the HRA was conducted.

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

If a change is identified, the MMP must conduct a new HRA within the timeframe prescribed by the three-way contract. If there are no changes, the MMP is not required to conduct a new HRA unless requested by the member (or their authorized representative). Please note, if the MMP prefers to conduct HRAs on all re-enrollees regardless of status, it may continue to do so. <u>The MMP must inform the member of their right to request a new HRA at any time.</u>

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

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

If the MMP did not complete an HRA for the re-enrolled member during their prior enrollment period, or if it has been more than one year since the member's HRA was completed, the MMP is required to conduct an HRA for the member within the timeframe prescribed by the three-way contract. The MMP must make the requisite number of attempts to reach the member (at minimum) after their most recent enrollment effective date, even if the MMP reported that the member was unable to be reached during their prior enrollment. Similarly, members who refused the HRA during

their prior enrollment must be asked again to participate (i.e., the MMP may not carry over a refusal from one enrollment period to the next).

Integrated Plans of Care

If the MMP conducts a new HRA for the re-enrolled member, the MMP must revise the IPC accordingly in collaboration with the member or authorized representative within the timeframe prescribed by the three-way contract. Once the IPC is revised, the MMP may mark the IPC as complete for the member's current enrollment. If the MMP determines that the prior HRA is still accurate and therefore no updates are required to the previously completed IPC, the MMP may mark the IPC as complete for the current enrollment at the same time that the HRA is marked complete. The MMP would then follow the Core 3.2, TX1.2, and TX1.4 measure specifications for reporting the completion. Please note, for purposes of reporting, the IPC for the re-enrolled member should be classified as an *initial* IPC.

If the MMP did not complete an IPC for the re-enrolled member during their prior enrollment period, or if it has been more than one year since the member's IPC was completed, the MMP is required to complete an IPC for the member within the timeframe prescribed by the three-way contract. The MMP must also follow the above guidance regarding reaching out to members who previously refused to participate or were not reached.

Annual Reassessments and Integrated Plan of Care Updates

The MMP must follow the three-way contract requirements regarding the completion of annual reassessments and updates to the IPC. If the MMP determined that an HRA/IPC from a member's prior enrollment was accurate and marked that HRA/IPC as complete for the member's current enrollment, the MMP should count continuously from the date that the HRA/IPC was completed in the prior enrollment period to determine the due date for the annual reassessment and IPC update. For example, when reporting Core 2.3, the MMP should count 365 days from the date when the HRA 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 Texas state-specific measures, MMPs should include all members who meet the criteria for inclusion in the measure regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.

Reporting on Disenrolled and Retro-disenrolled Members

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

Due to retro-disenrollment of members, there may be instances where there is a lag between a member's effective disenrollment date and the date on which the MMP is

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

Hybrid Sampling

Some Demonstration-specific measures may allow medical record/supplemental documentation review (i.e., manual abstraction of data) to identify the numerator. In these instances, the sample size should be 411, plus additional records should be oversampled to allow for substitution. Sampling should be systematic to ensure that all individuals eligible for a measure have an equal chance of inclusion.

MMPs should complete the following steps for each measure that requires medical record review:

Step 1: Determine the eligible population. Create a list of eligible members, including full name, date of birth, and event (if applicable) using claim header level information.

Step 2: Determine the final sample size. The final sample size will be 411 unless the eligible population is less than 411. If the eligible population is less than 411, follow Step 5 to determine the final sample size.

Step 3: Determine the oversample which should include an adequate number of additional records to make substitutions. Oversample only enough to guarantee that the targeted sample size of 411 is met. The following oversampling rates are acceptable: 5 percent, 10 percent, 15 percent, or 20 percent. If oversampling, round up to the next whole number when determining the oversample.

Step 4: If the eligible population exceeds the final sample size as determined in Step 2, proceed to Step 6. If the eligible population is less than or equal to the final sample size as determined in Step 2, proceed to Step 5.

Step 5: If the eligible population is less than or equal to the final sample size as determined in Step 2, the sample size can be reduced from 411 cases to a reduced final sample size by using the following formula:

$$Reduced\ Final\ Sample\ Size = \frac{Original\ Final\ Sample\ Size}{1 + \left(\frac{Original\ Final\ Sample\ Size}{Eligible\ Population}\right)}$$

Where the *Original Final Sample Size* is the number derived from Step 2, and the *Eligible Population* is the number derived from Step 1.

Step 6: Sort the list of eligible members in alphabetical order by last name, first name, date of birth, and event (if applicable). Sort this list by last name from A to Z during even reporting periods and from Z to A in odd reporting periods (i.e., name will be sorted from A to Z in 2014, 2016, 2018, 2020, 2022, and 2024 and from Z to A in 2015, 2017, 2019, 2021, 2023, and 2025).

Note: Sort order applies to all components. For example, for reporting period 2014, the last name, first name, date of birth, and events will be ascending.

Step 7: Calculate *N*, which will determine which member will start your sample. Round down to the nearest whole number.

$$N = \frac{\text{Eligible Population}}{\text{Final Sample Size}}$$

Where the *Eligible Population* is the number derived from Step 1. The *Final Sample Size* is either of the following:

- The number derived from Step 2, for instances in which the eligible population exceeds the final sample size as determined in Step 2.
  OR
- The number derived in Step 5, for instances in which the eligible population was less than or equal to the number derived from Step 2.

Step 8: Randomly select starting point, *K*, by choosing a number between one and *N* using a table of random numbers or a computer-generated random number.

Step 9: Select every *Kth* record thereafter until the selection of the sample size is completed.

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 Texas-Specific Value Sets Workbook includes all value sets and codes needed to report certain measures included in the Texas-Specific Reporting Requirements and is intended to be used in conjunction with the measure specifications outlined in this document. The Texas-Specific Value Sets Workbook can be found on the CMS website at the following address: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html

Texas's Implementation, Ongoing, and Continuous Reporting Periods

Phase		Dates	Explanation
Demonstration Year 1.a			
Continuous Reporting	Implementation Period	3-1-15 through 9-30-15	From the first effective enrollment date through September 30, 2015.
	Ongoing Period	3-1-15 through 12-31-15	From the first effective enrollment date through December 31, 2015.
Demonstration Year 1.b			
Continuous Reporting	Ongoing Period	1-1-16 through 12-31-16	From January 1, 2016 through the end of the first demonstration year.
Demonstration Year 2			
Continuous Reporting	Ongoing Period	1-1-17 through 12-31-17	From January 1, 2017 through the end of the second demonstration year.
Demonstration Year 3			
Continuous Reporting	Ongoing Period	1-1-18 through 12-31-18	From January 1, 2018 through the end of the third demonstration year.
Demonstration Year 4			
Continuous Reporting	Ongoing Period	1-1-19 through 12-31-19	From January 1, 2019 through the end of the fourth demonstration year.
Demonstration Year 5			
Continuous Reporting	Ongoing Period	1-1-20 through 12-31-20	From January 1, 2020 through the end of the fifth demonstration year.
Demonstration Year 6			
Continuous Reporting	Ongoing Period	1-1-21 through 12-31-21	From January 1, 2021 through the end of the sixth demonstration year.
Demonstration Year 7			
Continuous Reporting	Ongoing Period	1-1-22 through 12-31-22	From January 1, 2022 through the end of the seventh demonstration year.

Phase		Dates	Explanation
Demonstration Year 8			
Continuous Reporting	Ongoing Period	1-1-23 through 12-31-23	From January 1, 2023 through the end of the eighth demonstration year.

Data Submission

All MMPs 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

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

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

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

Resubmission of Data

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

1. Email the TX HelpDesk (TXHelpDesk@norc.org) to request resubmission.
   a. Specify in the email which measure(s) needs 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 TX HelpDesk will notify the MMP once the FAI DCS and/or HPMS has been re-opened.
3. Resubmit data through the applicable reporting system.
4. Notify the TX 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 TXI. Care Coordination

TX1.1   Members with an Integrated Plan of Care within 90 days of enrollment. – ***Retired***

TX1.2   Members with an Integrated Plan of Care (IPC) completed.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX1. Care Coordination	Monthly, beginning after 90 days	Contract	Current Month Ex: 1/1-1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
TX1. 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 last day of the reporting period.	Total number of members enrolled for 90 days or longer as of the last day of the reporting period and who were currently enrolled as of the last day of the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of members who had an initial IPC completed as of the end of the reporting period.	Of the total reported in A, the number of members who had an initial IPC 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 or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

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

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

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

- CMS and the state will evaluate the percentage of members enrolled for 90 days or longer as of the last day of the reporting period who had an initial IPC completed as of the end of the reporting period.
  - Percentage = (B / A) * 100

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

Definition

- An IPC is a person-centered care plan that is developed by the MMP Service Coordinator with the member, the member's family and caregiver supports, as appropriate, and providers.

Data Element A

- MMPs should only include those members who are currently enrolled as of the last day of the reporting period, including deceased members who were enrolled through the end of the reporting period. The last day of the reporting period is the anchor date, or the date on which all reported members must be enrolled in the MMP.
- The 90th day of enrollment should be based on each member's most recent effective enrollment date in the MMP. Members must be continuously enrolled from the most recent effective enrollment date through 90 days of enrollment (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

- The initial IPCs 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.
- MMPs should only report completed IPCs in data element B when the member or the member's authorized representative was involved in the development of the IPC.

General Guidance

- MMPs should refer to the three-way contract for additional requirements pertaining to an IPC.

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

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

TX1.3   Members with first follow-up visit within 30 days of hospital discharge.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX1. 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
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 or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

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

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

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

   o Rate = (A / Total Member Months) * 10,000

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

Data Element A

- MMPs should include all 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, MMPs 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).

- o Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay value set) on the claim.
  - o 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:
  - o An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1 (a direct transfer).
  - o 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.
  - o 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.
- MMPs 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. MMPs should use all information available, including encounter data supplied by providers, to ensure complete and accurate reporting.

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

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

TX1.4   Members whose Integrated Plan of Care (IPC) is updated annually before the expiration date.[i, ii]

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX1. Care Coordination	Annually	Contract	Calendar Year, beginning CY2	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members eligible for an IPC annual update.	Total number of members eligible for an IPC annual update during the reporting period.	Field Type: Numeric
B.	Total number of members whose IPC was updated annually before the expiration date.	Of the total reported in A, the number of members whose IPC was updated annually before the expiration date during the reporting period.	Field Type: Numeric Note: Is a subset of A.

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

- The quality withhold benchmark is 91% for DY 2 through 6 and 95% for DY 7 and 8. For more information, refer to the Quality Withhold Technical Notes (DY 2-8): Texas-Specific Measures.

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

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

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

- CMS and the state will evaluate the percentage of members eligible for an IPC annual update during the reporting period whose IPC was updated annually before the expiration date during the reporting period.
  - 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 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.

- For data element A, MMPs should include all members who were enrolled as of the last day of the current reporting period and who had an initial or updated IPC completed in the previous reporting period. The IPC completed in the previous reporting period must have been developed with involvement from the member or the member's authorized representative.
- To be eligible for an IPC update, a member must be enrolled for 90 days prior to the expiration date of the most recent IPC completion date in the previous reporting period.
    - For example, if a member had their IPC updated twice during CY 2022 (the previous reporting period) – first on May 15, 2022 and again on October 15, 2022 – the member must be enrolled continuously in the MMP for at least 90 days prior to October 14, 2023, or enrolled at least July, August, September and October 2023.

Data Element B

- For data element B, MMPs should include members reported in data element A whose IPC update occurred during the current reporting period and that update was completed within 365 days of their most recent IPC completion date in the previous reporting period.
    - For example, if a member had their IPC updated twice during CY 2022 (the previous reporting period) – first on May 15, 2022 and again on October 15, 2022 – count 365 days continuously from October 15, 2022 to determine if an IPC update occurred within 365 days.
        - In this example, if the member's IPC was updated on September 15, 2023, they would be included in data element B for CY 2023 reporting.
        - Conversely, if the member's IPC was not updated until November 15, 2023, they would not be included in data element B for CY 2022 reporting.
- MMPs should only report members in data element B when the member or the member's authorized representative was involved in the update to the IPC.
- Please note that data element B may include a limited number of members with a break in enrollment for whom the updated IPC in the current reporting period has also been marked as an "initial" IPC for the purposes of reporting measures Core 3.2 and TX1.2.
    - For example, if a member had an IPC update on October 15, 2022, subsequently disenrolled from the MMP on October 31, 2022, reenrolled on July 1, 2023, had their IPC updated on September 20, 2023, and remained enrolled through December 31, 2023, this member's IPC would be reported in multiple measures.
        - The member would be reported as having an initial IPC completed within 90 days for the purposes of Core 3.2 (Q3 2023 reporting), as having an initial IPC completed for the purposes of TX1.2 (Q3 2023 reporting), and as having an IPC update annually before the expiration date for TX1.4 (CY 2023).

- For members with a break in enrollment who are reenrolled with the MMP for less than 90 days prior to the expiration date of the most recent IPC update in the previous reporting period, initial IPCs should be completed according to the three-way contract requirements and reported distinctly from the annual IPC update reported in this measure.

Data Element B Exclusion

- Members who meet the inclusion criteria for this measure who do not have an annual IPC update completed within 365 days of the most recent IPC update in the previous reporting period should not be included in data element B.

General Guidance

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

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

- MMPs will submit data collected for this measure 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 TXII. Enrollee Protections

TX2.1   The number of critical incident and abuse reports for members receiving LTSS.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX2. 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**
TX2. 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 or its designee will perform an outlier analysis.

- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

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

- N/A.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will 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 = (Sum of B for prior four reporting periods / 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.

Definition

- Critical incident or abuse means an event or incident that may harm, or create the potential for harm, to an individual. Critical incidents or abuse include:
  - Abuse, neglect, or exploitation as defined in 40 Tex. Admin. Code Chapter 711;
  - The unauthorized use of restraint, seclusion, or restrictive interventions;
  - Serious injuries that require medical intervention or result in hospitalization;
  - Criminal victimization;
  - Unexplained death;
  - Medication errors; and
  - Other events or incidents that involve harm or risk of harm to a member.

Data Element A

- MMPs 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).
- MMPs should refer to the STAR+PLUS handbook for guidance on how to identify members classified as receiving LTSS.

Data Element B

- For data element B, MMPs 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 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 MMPs will submit data collected to CMS and the state.

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

Section TXIII. Organizational Structure and Staffing

TX3.1   Service coordinator training for supporting self-direction.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX3. Organizational Structure and Staffing	Annually	Contract	Calendar Year	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of newly hired full-time and part-time service coordinators (or those newly assigned to the MMP) who have been employed by the MMP for at least six months.	Total number of newly hired full-time and part-time service coordinators (or those newly assigned to the MMP) who have been employed by the MMP for at least six months during the reporting period.	Field Type: Numeric
B.	Total number of newly hired service coordinators who received State-based training for supporting self-direction under the demonstration.	Of the total reported in A, the number of newly hired service coordinators who received State-based training for supporting self-direction under the demonstration.	Field Type: Numeric Note: Is a subset of A.

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

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

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

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

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

- CMS and the state will evaluate the percentage of newly hired full-time and part-time service coordinators who have been employed by the MMP for at least six months who received State-based training for supporting self-direction.
  - Percentage = (B / A) * 100

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

Data Element A

- All service coordinators newly hired and beginning employment with the MMP during the reporting period, or newly assigned during the reporting period to the MMP from another role, should be reported in data element A.
- If a service coordinator was not currently with the MMP at the end of the reporting period but was with the MMP for at least six months at any point during the reporting period, they should be included in this measure.

General Guidance

- MMPs should refer to the three-way contract for specific requirements pertaining to a service coordinator and to training for supporting self-direction. Additional guidance and training materials will be provided by HHSC.

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

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

Section TXIV. Performance and Quality Improvement

TX4.1 Diabetes short-term complications admission rate. (PQI #01) – ***Retired***

TX4.2 Diabetes long-term complications admission rate. (PQI #03) – ***Retired***

TX4.3 Chronic obstructive pulmonary disease (COPD) or asthma in older adults admission rate. (PQI #05) – ***Retired***

TX4.4 Hypertension admission rate. (PQI #07) – ***Retired***

TX4.5 Heart failure admission rate. (PQI #08) – ***Retired***

TX4.6 Dehydration admission rate. (PQI #10) – ***Retired***

TX4.7 Bacterial pneumonia admission rate. (PQI #11) – ***Retired***

TX4.8 Urinary tract infection admission rate. (PQI #12) – ***Retired***

TX4.9 Angina without procedure admission rate. (PQI #13) – ***Retired***

TX4.10 Uncontrolled diabetes admission rate. (PQI #14) – ***Retired***

TX4.11 Lower-extremity amputation among patients with diabetes admission rate. (PQI #16) – ***Retired***

TX4.12 Medication management for people with asthma. – ***Retired***

TX4.13 Cervical cancer screening.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX4. Performance and Quality Improvement	Annually	Contract	Calendar Year, beginning in CY2	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 women 24-64 years old.	Total number of women 24-64 years old, who were continuously enrolled in the MMP during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric
B.	Total number of women sampled that met inclusion criteria.	Of the total reported in A, the number of women sampled that met inclusion criteria.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of women who were appropriately screened for cervical cancer.	Of the total reported in B, the number of women who were appropriately screened for cervical cancer.	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 or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

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

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

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

- CMS and the state will evaluate the percentage of women 24-64 years old who were appropriately screened for cervical cancer.
  - Percentage = (C / B) * 100

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

<u>Data Element A</u>

- The member must be enrolled during the current reporting period with 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 1-month gap in coverage (i.e., a member whose coverage lapses for two months [60 days] is not considered continuously enrolled).

<u>Data Element A Exclusion</u>

- Members who use hospice services or elect to use a hospice benefit at any time during the reporting period are excluded from the eligible population, regardless of when the service began. 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 members who received palliative care (Palliative Care Assessment value set; Palliative Care Encounter value set; Palliative Care Intervention value set) during the reporting period.

<u>Data Element B</u>

- MMPs may elect to use medical record or supplemental documentation to identify the numerator (i.e., hybrid sampling). For further instructions on hybrid sampling, please see pages TX-9 to TX-10 of this document.
- If an MMP does not elect to sample, data element B should be equal to data element A.

<u>Data Element C</u>

- When reporting this measure, services rendered before the current reporting period may be included in the numerator, whether or not they occurred during MMP-specific enrollment spells.

Administrative Specifications

- The number of women who were screened for cervical cancer. Either of the following meets criteria:
  - o Women 24-64 years of age as of December 31 of the reporting period who had cervical cytology (Cervical Cytology Lab Test value set; Cervical Cytology Result or Finding value set) during the reporting period or the two years prior to the reporting period.
  - o Women 30–64 years of age as of December 31 of the reporting period who had cervical high-risk human papillomavirus (hrHPV) testing (High Risk HPV Lab Test value set, High Risk HPV Test Result or Finding value set) during the reporting period or the four years prior to the reporting period **and** who were 30 years or older on the date of the test.

Note: Evidence of hrHPV testing within the last five years also captures patients who had co-testing; therefore, additional methods to identify co-testing are not necessary.

Hybrid Specifications

- When reviewing a member's medical record, appropriate screenings are defined by any of the following:
  - o Women 24–64 years of age as of December 31 of the reporting period who had cervical cytology during the reporting period or the two years prior to the reporting period.
    - ▪ Documentation in the medical record must include both of the following:
      - • A note indicating the date when the cervical cytology was performed.
      - • The result or finding.
    - ▪ Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that "no cervical cells were present"; this is not considered appropriate screening.
    - ▪ Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.
    - Note: Lab results that indicate the sample contained "no endocervical cells" may be used if a valid result was reported for the test.
  - o Women 30–64 years of age as of December 31 of the reporting period who had cervical high-risk human papillomavirus (hrHPV) testing during the reporting period or the four years prior to the reporting period **and** who were 30 years or older as of the date of testing.
    - ▪ Documentation in the medical record must include both of the following:
      - • A note indicating the date when the hrHPV test was performed. Generic documentation of "HPV test" can be counted as evidence of hrHPV test.
      - • The results or findings.
    - ▪ Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.
    - Note: Evidence of hrHPV testing within the last five years also captures patients who had co-testing.

Data Element C Exclusion

- Services rendered during the current reporting period but outside of MMP-specific enrollment spells should not be included.

Administrative Specifications (Optional)

- Exclude hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix (Absence of Cervix Diagnosis value set; Hysterectomy With No Residual Cervix value set) any time during the member's history through December 31 of the reporting period.

Hybrid Specifications (Optional)

- Evidence of a hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix any time during the member's history through December 31 of the reporting period. The following examples meet criteria for documentation of hysterectomy with no residual cervix:
  o Documentation of "complete," "total," or "radical" hysterectomy (abdominal, vaginal, or unspecified).
  o Documentation of "vaginal hysterectomy."
  o Documentation of a "vaginal pap smear" in conjunction with documentation of "hysterectomy."
  o Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening.
    ▪ Documentation of hysterectomy alone does not meet the criteria, because it is not sufficient evidence that the cervix was removed.

General Guidance

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

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

- MMPs will submit data collected for this measure 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

TX4.14   Avoidance of antibiotic treatment for acute bronchitis/bronchiolitis.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX4. Performance and Quality Improvement	Annually	Contract	Calendar Year, beginning in CY2	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 21-64 years of age with a diagnosis of acute bronchitis/bronchiolitis.	Total number of members 21-64 years of age who were continuously enrolled in the MMP 30 days prior to the Episode Date through three days after the Episode Date (34 days total) with a diagnosis of acute bronchitis/bronchiolitis.	Field Type: Numeric
B.	Total number of members 21-64 years of age who were dispensed a prescription for an antibiotic medication on or three days after the Episode Date.	Of the total reported in A, the number of members 21-64 years of age who were dispensed a prescription for an antibiotic medication on or three days after the Episode Date.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members 65 years of age and older with a diagnosis of acute bronchitis/bronchiolitis.	Total number of members 65 years of age and older who were continuously enrolled in the MMP 30 days prior to the Episode Date through three days after the Episode Date (34 days total) with a diagnosis of acute bronchitis/bronchiolitis.	Field Type: Numeric
D.	Total number of members 65 years of age and older who were dispensed a prescription for an antibiotic medication on or three days after the Episode Date.	Of the total reported in C, the number of members 65 years of age and older who were dispensed a prescription for an antibiotic medication on or three days after the Episode Date.	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 or its designee will perform an outlier analysis.

- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

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

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

NOTE: This measure is reported as an inverted rate [1-(numerator/eligible population)]. A higher rate indicates appropriate acute bronchitis/bronchiolitis treatment (i.e., the proportion for episodes that did *not* result in an antibiotic dispensing event).

CMS and the state will evaluate the percentage of:

- Members 21-64 years of age with a diagnosis of acute bronchitis/bronchiolitis who were not dispensed a prescription for an antibiotic medication on or three days after the Episode Date.
  - Percentage = $(1 - (B / A)) * 100$
- Members 65 years of age and older with a diagnosis of acute bronchitis/bronchiolitis who were not dispensed a prescription for an antibiotic medication on or three days after the Episode Date.
  - Percentage = $(1 - (D / C)) * 100$

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

Definitions

- The Intake Period is a 12-month window that begins on July 1 of the year prior to the reporting period and ends on June 30 of the reporting period. The Intake Period captures eligible episodes of treatment.
- The Episode Date is the date of service for any outpatient, telephone, observation or ED visit, e-visit or virtual check-in during the Intake Period with a diagnosis of acute bronchitis/bronchiolitis.
- To qualify for Negative Medication History, the following criteria must be met:
  - A period of 30 days prior to the Episode Date, when the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug.
  - No prescriptions that were filled more than 30 days prior to the Episode Date and are active on the Episode Date.

  A prescription is considered active if the "days supply" indicated on the date when the member filled the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the Intake Period.

- The <u>Negative Comorbid Condition History</u> is a period of 12 months prior to and including the Episode Date, when the member had no claims/encounters with any diagnosis for a comorbid condition.
- The <u>Negative Competing Diagnosis</u> is the Episode Date and three days following the Episode Date when the member had no claims/encounters with any competing diagnosis.

<u>Data Elements A and C</u>

- The member must be continuously enrolled for 30 days prior to the Episode Date through three days after the Episode Date (34 total days), with no gaps in enrollment during the continuous enrollment period.
- All claims (paid, suspended, pending, and denied) must be included when identifying the eligible population.
- Follow the steps below to identify the eligible population.
    - **Step 1**: Identify all members who had an outpatient visit (Outpatient value set), a telephone visit (Telephone Visits value set), an e-visit or virtual check-in (Online Assessments value set), an observation visit (Observation value set), or an ED visit (ED value set) during the Intake Period, with a diagnosis of acute bronchitis/bronchiolitis (Acute Bronchitis value set).
    - **Step 2**: Determine all acute bronchitis/bronchiolitis Episode Dates. For each member identified in step 1, determine all outpatient, telephone, observation or ED visits, e-visits and virtual check-ins with a diagnosis of acute bronchitis/bronchiolitis.
    Do not include visits that result in an inpatient stay (Inpatient Stay value set).
    - **Step 3**: Test for Negative Comorbid Condition History. Exclude Episode Dates when the member had a claim/encounter with any diagnosis for a comorbid condition during the 12 months prior to or on the Episode Date. A code from any of the following meets criteria for a comorbid condition:
        - HIV value set
        - HIV Type 2 value set
        - Malignant Neoplasms value set
        - Other Malignant Neoplasm of Skin value set
        - Emphysema value set
        - COPD value set
        - Comorbid Conditions value set
        - Disorders of the Immune System value set
    - **Step 4**: Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication (AAB Antibiotic Medications List) was filled 30 days prior to the Episode Date or was active on the Episode Date.
    - **Step 5**: Test for Negative Competing Diagnosis. Exclude Episode Dates where the member had a claim/encounter with a competing

diagnosis on or three days after the Episode Date. A code from either of the following meets criteria for a competing diagnosis:
- Pharyngitis value set
- Competing Diagnosis value set

- o **Step 6**: Calculate continuous enrollment. The member must be continuously enrolled without a gap in coverage from 30 days prior to the Episode Date through 3 days after the Episode Date (34 total days).
- o **Step 7**: De-duplicate eligible episodes. If a member has more than one eligible episode in a 31-day period, include only the first eligible episode.
  - For example, if a member has an eligible episode on January 1, include the January 1 visit and do not include eligible episodes that occur on or between January 2 and January 31; then, if applicable, include the next eligible episode that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period.

- Note: The denominator for this measure is based on episodes, not on members. All eligible episodes that were not excluded or de-duplicated remain in the denominator.

Data Element A Exclusion

- Members who use hospice services or elect to use a hospice benefit at any time during the reporting period are excluded from the eligible population, regardless of when services began. 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.

Data Elements B and D

- Identify members who were dispensed a prescription for an antibiotic medication (AAB Antibiotic Medications List) on or three days after the Episode Date.
- For data elements B and D, do not include denied claims.

General Guidance

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

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

- MMPs will submit data collected for this measure 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

TX4.15   Use of appropriate medications for people with asthma. – **_Retired_**

TX4.16   Prenatal and postpartum care. – **_Retired_**

TX4.17   Ambulatory care-sensitive condition hospital admission. (PQI #90)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX4. 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 age 21 years and older.	Total number of members age 21 years and older enrolled in the MMP during the reporting period.	Field Type: Numeric
B.	Total number of hospital discharges for members age 21 years and older at the time of discharge with an admission for one of the following conditions: 1. Diabetes with short-term complications 2. Diabetes with long-term complications 3. Uncontrolled diabetes 4. Diabetes with lower-extremity amputation 5. Chronic obstructive pulmonary disease 6. Asthma 7. Hypertension 8. Heart failure 9. Community-acquired pneumonia 10. Urinary tract infection	Of the total reported in A, the number of hospital discharges for members age 21 years and older at the time of discharge with an admission for one of the following conditions: 1. Diabetes with short-term complications 2. Diabetes with long-term complications 3. Uncontrolled diabetes 4. Diabetes with lower-extremity amputation 5. Chronic obstructive pulmonary disease 6. Asthma 7. Hypertension 8. Heart failure 9. Community-acquired pneumonia 10. Urinary tract infection	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 or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

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

- N/A.

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

- CMS and the state will evaluate the number of ambulatory care-sensitive condition hospital admissions (discharges) for members age 21 years and older at the time of discharge per 100,000 members.
    - Rate = (B / A) * 100,000

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

Data Element A

- MMPs should include all members who meet the criteria outlined in data element A, regardless 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 B

- The PQI overall composite measure includes hospitalizations for one of the following conditions during the reporting period:
    - Diabetes Short-Term Complications (PQI #01)
    - Diabetes Long-Term Complications (PQI #03)
    - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults (PQI #05)
    - Hypertension (PQI #07)
    - Heart Failure (PQI #08)
    - Community-acquired Pneumonia (PQI #11)
    - Urinary Tract Infection (PQI #12)
    - Uncontrolled Diabetes (PQI #14)
    - Asthma in Younger Adults (PQI #15)
    - Lower-Extremity Amputation among Patients with Diabetes (PQI #16)
- The numerator for this measure is based on hospital discharges, not members.
- Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator.
- Further details on technical specifications for the individual PQI measures, including inclusion and exclusion criteria and codes, are located in the

Individual Measure Technical Specifications on the Agency for Healthcare Research and Quality (AHRQ) website at the following link: http://www.qualityindicators.ahrq.gov/Modules/pqi_resources.aspx. Further details on the AHRQ quality indicator software used to generate results are located at the following link: https://www.qualityindicators.ahrq.gov/Software/Default.aspx

  o When using the AHRQ quality indicator software to generate measure results, MMPs should report the Observed Rate.

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

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

Section TXV. Utilization

TX5.1   Members who went from community to hospital to nursing facility and remained in nursing facility.[i, ii]

Please note: No MMP reporting is required for this measure; however, MMPs must assist HHSC with data collection and analysis as needed.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
TX5. Utilization	Annually	Contract	Calendar Year	N/A

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

Element Letter	**Element Name**	**Definition**	**Allowable Values**
A.	Total number of members who were admitted to the hospital from the community and who remained in the hospital for 30 days or less.	Total number of members who were admitted to the hospital from the community and who remained in the hospital for 30 days or less during the reporting period.	Field Type: Numeric
B.	Total number of members who were discharged to a nursing facility (NF) and remained in the NF for at least 120 continuous days.	Of the total reported in A, the number of members who were discharged to a NF and remained in the NF for at least 120 continuous days.	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 or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

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

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

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

- CMS and the state will evaluate the percentage of members who were admitted to the hospital from the community, remained in the hospital for 30 days or less during the reporting period, and who were discharged to a NF and remained in the NF for at least 120 continuous days.
  - Percentage = (B / A) * 100

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

Definitions

- A nursing facility (NF) is a convalescent or nursing home or related institution licensed under Chapter 242, Health and Safety Code, that provides LTSS to Medicaid recipients.
- An admission is a stay in a NF longer than 120 continuous days.

Data Element A

- MMPs 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 member needs to be enrolled from the date of the hospital admission through 120 days following the hospital discharge, with no gaps in enrollment, to be included in this measure.

Data Element B

- The date of discharge must occur within the reporting period, but the amount of time spent in a NF may not be in the same reporting period.
  - For example, if the discharge occurs during the last four months of the reporting period, look to the first four months of the following reporting period to identify if a member remained in the NF for at least 120 continuous days.
- To determine members who were discharged to a NF and remained in the NF for at least 120 continuous days, the member must have no break in their stay in the NF.
  - For example, if a member is discharged to the NF and remains there for 80 days, then transferred back to the hospital, or some other facility, and then is readmitted back to the NF, the first day back in the NF would count as day one (and not day 81). A transfer or discharge from the NF before the member's 120th continuous day in the facility would disrupt the number of days the member remained in the NF.
  - However, if a member was discharged or transferred from the NF on day 122 of their NF stay, they would be counted in data element B.

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

- The data source for this measure is encounter data. HHSC will calculate the measure and provide it to CMS.