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

Effective as of January 1, 2015, Issued August 24, 2015

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California-Specific Reporting Requirements Appendix

Introduction

The measures within this appendix are required reporting for all MMPs in the California Capitated Demonstration. CMS reserves the right to update the measures in this appendix for subsequent demonstration years. These state-specific measures directly supplement the Medicare-Medicaid Capitated Financial Alignment: Core Reporting Requirements, which can be found at the following web address:

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

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

The core and state-specific measures supplement existing Part C and Part D reporting requirements, as well as measures that MMPs report via other vehicles or venues, such as HEDIS®[1] and HOS. CMS and the states 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.

For the measures contained within the California state-specific appendix, MMPs will be required to submit data at the contract level. However, there are some measures (CA1.8 – CA1.10; CA4.2) that will be reported at the county level. Additional information regarding the Data Submission process is provided on page CA-12.

MMPs should contact the CA Help Desk at CAHelpDesk@norc.org with any questions about the California state-specific appendix or the data submission process.

Definitions

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

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

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

Case Management, Information and Payrolling System II (CMIPS II): A system that tracks case information and processes payments for the California Department of Social Services In-Home Supportive Services Program, enabling nearly 400,000 qualified aged, blind, and disabled individuals in California to remain in their own homes and avoid institutionalization.

In-Home Supportive Services (IHSS): Pursuant to Article 7 of the California Welfare and Institutions Code (WIC) (commencing with Section 12300) of Chapter 3, and WIC Sections 14132.95, 14132.952, and 14132.956, IHSS is a California program that provides in-home care for people who cannot safely remain in their own homes without assistance. To qualify for IHSS, an Enrollee must be aged, blind, or disabled and, in most cases, have income below the level to qualify for the Supplemental Security Income/State Supplementary Program. IHSS includes the Community First Choice Option (CFCO), Personal Care Services Program (PCSP), and IHSS-Plus Option (IPO).

Implementation Period: The period of time starting with the first effective enrollment date until the end of the first full quarter following the third wave of passive enrollment (therefore, all plans would have an implementation period of at least 6 months). For MMPs adding a county in 2015, the implementation period continues for a full quarter following the first effective date of enrollment.

For example, for an MMP that began both opt-in and passive enrollment on April 1, 2014, the implementation period would start on April 1, 2014 and end on September 30, 2014. For an MMP that began opt-in enrollment on April 1, 2014 and began passive enrollment on May 1, 2014, the implementation period would start on April 1, 2014 and end on December 31, 2014. For an MMP that began opt-in enrollment on April 1, 2014 and began passive enrollment on July 1, 2014, the implementation period would start on April 1, 2014 and end on December 31, 2014. For an MMP that began both opt-in and passive enrollment on July 1, 2014, the implementation period would start on July 1, 2014 and end on December 31, 2014. For an MMP beginning both opt-in and passive enrollment on January 1, 2015, the implementation period would start on January 1, 2015 and end on June 30, 2015. For an MMP beginning opt-in enrollment on July 1, 2015 and beginning passive enrollment on August 1, 2015, the implementation

period would start on July 1, 2015 and end on December 31, 2015. For any MMP that begins passive enrollment in a new county in 2015, the implementation period for that MMP would extend for a full quarter following the first wave of passive enrollment for that county.

For MMPs with less than 3 waves of passive enrollment, the implementation period will end September 30, 2014.

Individualized Care Plan (ICP or Care Plan): The plan of care developed by an Enrollee and/or an Enrollee's Interdisciplinary Care Team or health plan.

Long Term Services and Supports (LTSS): A wide variety of services and supports that help people with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in the California Welfare and Institutions Code (WIC) Section 14186.1, Medi-Cal covered LTSS includes all of the following:

1) In-Home Supportive Services (IHSS) provided pursuant to Article 7 of California WIC (commencing with Section 12300) of Chapter 3, and WIC Sections 14132.95, 14132.952, and 14132.956;
2) Community-Based Adult Services (CBAS);
3) Multipurpose Senior Services Program (MSSP) services; and
4) Skilled nursing facility services and subacute care services.

Primary Care Provider (PCP): A person responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining the continuity of patient care. A PCP may be a physician or non-physician medical practitioner.

Unmet Need: Documented unmet need is a recipient's total hours for Non-Protective Supervision In-Home Supportive Services (IHSS) that are in excess of the statutory maximum.

Variations from the Core Reporting Requirements Document

Core Measure 9.2 – Nursing Facility (NF) Diversion

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.

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 2015

Core Reporting Requirements, pages 75-76). Please reference Title 22, CCR Division 3, sections 51173.1, 51120, 51124, 51124.5, 51125.6, 51334 and 51335 of the CA Code of Regulations for additional information and definitions as it relates to this measure.

The Medicaid 834 eligibility file provided to MMPs by the state on a daily and monthly basis contains variables indicating an individual's status with regard to meeting the NF LOC. The relevant variables are as follows:

- Variable 3.8. Institutional Indicator (Y): Identifies actual institutional placement (i.e., anyone residing in a SNF for 90 or more consecutive days).
- Variable 3.7. CCI Exclusion Indicator (M, N): Indicates that a member lives in the community and meets the NF LOC for CBAS and MSSP only.
- Eligibility status code 2K, Loop 2300 REF 01 under 'CE' (Note: Status code 2K could be found in any of the following fields - SPEC1-AID, SPEC2-AID, SPEC3-AID): Indicates that a member lives in the community and meets the NF LOC for IHSS only.

In addition to these variables in the 834 file, MMPs should use claims data to ensure the member qualifies as nursing home certifiable, (i.e., is living in the community or has resided in a NF for fewer than 100 days). This may include individuals who have resided in a NF for 90 – 99 days and have thus triggered the long-term care (LTC) indicator, but still fall below the 100 day threshold for the purposes of Core 9.2.

It is possible that some individuals who have never been assessed for LTSS (e.g., community well or individuals stratified as HCBS low) will indeed be nursing home certifiable and this status will be unknown to the MMP. This is a limitation of this measure. Provided that MMPs comply with the requirements for assessment and care planning under the Demonstration, no further action by the MMP to identify these individuals is necessary.

Reporting on HRAs and ICPs Completed Prior To First Effective Enrollment Date

For MMPs that have requested and obtained CMS approval to do so, Health Risk Assessments (HRAs) may be completed up to 20 days prior to the individual's coverage effective date for individuals who are passively enrolled. Early HRA outreach for opt-in members is permitted for all participating MMPs.

For purposes of reporting data on HRAs (Core 2.1, Core 2.2, CA1.1, CA1.2, CA1.3, and CA1.4), 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 was completed on June 1.

MMPs should refer to the Core reporting requirements for detailed specifications for reporting Core 2.1 and Core 2.2 and to the state-specific reporting requirements for specifications on reporting CA1.1, CA1.2, CA1.3, and CA1.4. For example, Core 2.1 should only include members whose 90th day of enrollment occurred during the reporting period. Members enrolled into the MMP on January 1, 2015, would reach their 90th day (3 full months) on March 31, 2015. Therefore, these members would be reported in the data submission for the March monthly reporting period, even if their HRA was marked as complete on the first effective enrollment date (i.e., January 1).

MMPs must comply with contractually specified timelines regarding completion of Individualized Care Plans (ICPs) following the HRA. In the event that an ICP is also finalized prior to the first effective enrollment date, MMPs should report completion of the ICP for CA1.1, CA1.2, CA1.3, and CA1.4 as if the HRA were completed on the member's first effective enrollment date. For example, using an effective enrollment date of June 1, if the HRA is completed on May 25 and the ICP is completed on May 27 (a difference of 2 days), the MMP should report the HRA as if it were completed on June 1 and the ICP as if it were completed on June 3 (again, a difference of 2 days). If the HRA is completed prior to the effective date of coverage, but the ICP is not, the MMP should still report the ICP as if the HRA was completed on the first effective enrollment date. For example, using an effective enrollment date of June 1, if the HRA is completed on May 25 and the ICP is completed on June 24 (a difference of 30 days), the MMP should report the HRA as if it was completed on June 1 and the ICP as if it was completed on July 1 (again, a difference of 30 days).

Guidance on HRAs and ICPs for Members with a Break in Coverage

Health Risk Assessments

If an MMP already completed a Health Risk Assessment (HRA) for a member that 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 his/her 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 his/her authorized representative) 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 his/her authorized representative) 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 contract. If there are no changes, the MMP is not required to conduct a new HRA unless requested by the member (or his/her authorized representative). Please note, if the MMP prefers to conduct HRAs on all re-enrollees regardless of status, it may continue to do so.

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 (and all applicable state-specific measures). When reporting these measures, the MMP should count the number of enrollment 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.

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 his/her 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 his/her 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 a HRA for the member within the timeframe prescribed by the contract. The MMP must make the requisite number of attempts to reach the member (at minimum) after his/her most recent enrollment effective date, even if the MMP reported that the member was unable to be reached during his/her prior enrollment. Similarly, members that 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).

Individualized Care Plans

If the MMP conducts a new HRA for the re-enrolled member, the MMP must revise the Individualized Care Plan (ICP) accordingly within the timeframe prescribed by the contract. Once the ICP is revised, the MMP may mark the ICP 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 developed ICP, the MMP may mark the ICP as complete for the current enrollment at the same time that the HRA is marked complete. The MMP would then follow the applicable state-specific measure specifications for

reporting the completion. Please note, for purposes of reporting, the ICP for the re-enrolled member should be classified as an *initial* ICP.

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

Annual Reassessments and ICP Updates

The MMP must follow contract requirements regarding the completion of annual reassessments and updates to ICPs. If the MMP determined that a HRA/ICP from a member's prior enrollment was accurate and marked that HRA/ICP as complete for the member's current enrollment, the MMP should count continuously from the date that the HRA/ICP was completed in the prior enrollment period to determine the due date for the annual reassessment and ICP 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.

Quality Withhold Measures

CMS and the state will establish a set of quality withhold measures, and MMPs will be required to meet established thresholds. Throughout this document, these measures are marked with the following symbol: (ⁱ). This document contains only Demonstration Year 1 (DY1) quality withhold measures. CMS will update the quality withhold measures for subsequent demonstration years closer to the start of Demonstration Year 2 (DY2). For more information, refer to the Quality Withhold Technical Notes (DY 1): California Specific Measures at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html.

Reporting on Disenrolled and Retro-disenrolled Members

Unless otherwise indicated in the reporting requirements, MMPs should report on all members enrolled in the demonstration who meet the definition of the data elements, regardless of whether that member was subsequently disenrolled from the MMP. Measure-specific guidance on how to report on disenrolled members is provided under the Notes section of each 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 to identify the numerator. In these instances, the sample size should be 411, plus additional records 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).

Step 2: Determine the final sample size. The final sample size will be 411 plus 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 final sample size.

Step 3: If the eligible population exceeds the final sample size as determined in Step 2, proceed to Step 5. If the eligible population is less than or equal to the final sample size as determined in Step 2, proceed to Step 4.

Step 4: 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:

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

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 5: 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, and 2018 and from Z to A in 2015, 2017, and 2019).
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 6: 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:

- 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 4, for instances in which the eligible population was less than or equal to the number derived from Step 2.

Step 7: 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 8: Select every *Kth* record thereafter until the selection of the sample size is completed.

California's Implementation, Ongoing, and Continuous Reporting Periods

Demonstration Year 1			
Phase		**Dates**	**Explanation**
Continuous Reporting	Implementation Period	Varies	The period of time starting with the first effective enrollment date until the end of the first full quarter following the third wave of passive enrollment. For MMPs adding a county in 2015, the implementation period continues for a full quarter following the first effective date enrollment.
	Ongoing Period	Varies	From the first effective enrollment date through the end of the first full calendar year of the demonstration.
Demonstration Year 2			
Continuous Reporting	Ongoing Period	1-1-16 through 12-31-16	From January 1st through the end of the second full calendar year of the demonstration.
Demonstration Year 3			
Continuous Reporting	Ongoing Period	1-1-17 through 12-31-17	From January 1st through the end of the third full calendar year of the demonstration.

Data Submission

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

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

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

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

Resubmission of Data to the FAI Data Collection System or HPMS

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

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

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

2. Resubmit data through the applicable reporting system.

3. Notify the CA 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 CAI. Care Coordination

CA1.1 High risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the *timely* Health Risk Assessment (HRA).

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA1. Care Coordination	Monthly, beginning after 90 days	Contract	Current Month Ex: 1/1 – 1/31	By the end of the first month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
CA1. 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 high risk members whose 90th day of enrollment occurred within the reporting period.	Total number of high risk members whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric
B.	Total number of high risk members who were documented as unwilling to complete a HRA within 45 days of enrollment.	Of the total reported in A, the number of high risk members who were documented as unwilling to complete a HRA within 45 days of enrollment.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of high risk members the MMP was unable to reach, following three documented attempts, within 45 days of enrollment.	Of the total reported in A, the number of high risk members the MMP was unable to reach, following three documented attempts, within 45 days of enrollment.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of high risk members with a HRA completed within 45 days of enrollment.	Of the total reported in A, the number of high risk members with a HRA completed within 45 days of enrollment.	Field Type: Numeric Note: Is a subset of A.
E.	Total number of high risk members who were documented as unwilling to complete an ICP within 30 working days after the completion of the HRA.	Of the total reported in D, the number of high risk members who were documented as unwilling to complete an ICP within 30 working days after the completion of the HRA.	Field Type: Numeric Note: Is a subset of D.
F.	Total number of high risk members the MMP was unable to reach, following three documented attempts, within 30 working days after the completion of the HRA.	Of the total reported in D, the number of high risk members the MMP was unable to reach, following three documented attempts, within 30 working days after the completion of the HRA.	Field Type: Numeric Note: Is a subset of D.
G.	Total number of high risk members with an ICP completed within 30 working days after the completion of the HRA.	Of the total reported in D, the number of high risk members with an ICP completed within 30 working days after the completion of the HRA.	Field Type: Numeric Note: Is a subset of D.

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

- CMS and the state will perform an outlier analysis.

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

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

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

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of high risk members who:

- Refused to have a HRA completed within 45 days of enrollment.
- Were unable to be reached to have a HRA completed within 45 days of enrollment.
- Had a HRA completed within 45 days of enrollment.
- Were willing to participate and could be reached who had a HRA completed within 45 days of enrollment.

In addition, CMS and the state will evaluate the percentage of high risk members who had a HRA completed within 45 days or enrollment who:

- Refused to have an ICP completed within 30 working days after the completion of the HRA.
- Were unable to be reached to have an ICP completed within 30 working days after the completion of the HRA.
- Had an ICP completed within 30 working days after the completion of the HRA.
- Were willing to participate and could be reached who had an ICP completed within 30 working days after the completion of the HRA.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members whose 90th day of enrollment occurred within the reporting period regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period). For the purposes of reporting Element A, 90 days of enrollment will be equivalent to three full calendar months.

- MMPs should refer to the CA three-way contract for specific requirements pertaining to ICPs and HRAs.
- Risk level should be determined using an approved health risk stratification mechanism or algorithm to identify new enrollees with high risk or more complex health care needs. The health risk stratification shall be conducted in accordance with the guidance provided in the most recent DHCS Duals Plan Letter (DPL).
- MMPs should use the member's *initial* risk level categorization for purposes for reporting this measure. For example, if a member is initially deemed high risk, then is subsequently deemed low risk, that member should be considered high risk and the MMP should follow the requirements for completing the HRA for a high risk member.
- High risk members are members who are at increased risk for having an adverse health outcome or worsening of his or her health status if he or she does not receive initial contact within 45 calendar days after their effective enrollment date. Members without any claims history should be considered high risk at the time of enrollment (and for purposes of reporting this measure). If subsequent information becomes available deeming a member low risk, the members should still be considered high risk for this measure (i.e., use the member's initial risk categorization).
- For all members the HRA must be completed before an ICP can be completed. However, the HRA and ICP can be completed during a single meeting with the member.
- Timely HRAs are defined as completed within 45 calendar days for high risk members and within 90 calendar days for lower risk members as described in Section 2.8.2 of the CA three-way contract.
- For data element B, MMPs should report the number of members who were unwilling to participate in the HRA if a member (or his or her authorized representative):
    - Affirmatively declines to participate in the HRA. Member communicates this refusal by phone, mail, fax, or in person.
    - Expresses willingness to complete the HRA but asks for it to be conducted after 45 days (despite being offered a reasonable opportunity to complete the HRA within 45 days). Discussions with the member must be documented by the MMP.
    - Expresses willingness to complete the HRA, but reschedules or is a no-show and then is subsequently non-responsive. Attempts to contact the member must be documented by the MMP.
    - Initially agrees to complete the HRA, but then declines to answer a majority of the questions in the HRA.

- For data element C, MMPs should report the number of members the MMP was unable to reach after three attempts to contact the member. MMPs should refer to the CA three-way contract or state guidance for any specific requirements pertaining to the method of outreach to members. MMPs must document each attempt to reach the member, including the method of the attempt (i.e., phone, mail, or email), as CMS and the state may validate this number.
  There may be instances when the MMP has a high degree of confidence that a member's contact information is correct, yet that member is not responsive to the MMP's outreach efforts. So long as the MMP follows the guidance regarding outreach attempts, these members may be included in the count for this data element.
- There may be certain circumstances that make it impossible or inappropriate to complete a HRA within 45 days of enrollment. For example, a member may be medically unable to respond and have no authorized representative to do so on their behalf, or a member may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for a HRA. However, MMPs should not include such members in the counts for data elements B and C.
- If a member's HRA was started but not completed within 45 days of enrollment, then the assessment should not be considered completed and, therefore, would not be counted in data elements B, C, or D. However, this member would be included in data element A.
- For data element E, MMPs should report the number of members who were unwilling to participate in the development of the ICP if a member (or his or her authorized representative):
    1. Affirmatively declines to participate in the ICP. Member communicates this refusal by phone, mail, fax, or in person.
    2. Expresses willingness to complete the ICP but asks for it to be conducted after 30 working days following the completion of the HRA (despite being offered a reasonable opportunity to complete the ICP within 30 working days). Discussions with the member must be documented by the MMP.
    3. Expresses willingness to complete the ICP, but reschedules or is a no-show and then is subsequently non-responsive. Attempts to contact the member must be documented by the MMP.
    4. Initially agrees to complete the ICP, but then declines to answer a majority of the questions in the ICP.
- For data element F, MMPs should report the number of members the MMP was unable to reach after three attempts to contact the member. MMPs should refer to the CA three-way contract or state

guidance for any specific requirements pertaining to the method of outreach to members. MMPs must document each attempt to reach the member, including the method of the attempt (i.e., phone, mail, or email), as CMS and the state may validate this number. There may be instances when the MMP has a high degree of confidence that a member's contact information is correct, yet that member is not responsive to the MMPs outreach efforts. So long as the MMP follows the guidance regarding outreach attempts, these members may be included in the count for this data element.

- There may be certain circumstances that make it impossible or inappropriate to complete an ICP within 30 working days of the HRA. 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. However, MMPs should not include such members in the counts for data elements E and F.
- The initial HRA must be completed within the reporting period, but the ICP may not be in the same reporting period. For example, if the initial HRA is completed less than 30 working days before the end of the reporting period (e.g., March 15), look up to 30 working days past the end of the reporting period to identify if an ICP was completed.
- If an ICP was started but not completed within 30 working days of the initial HRA, then the ICP should not be considered completed and, therefore, would not be counted in data elements E, F, or G. However, this member would be included in data element D if the initial HRA was completed within the reporting period (and met all criteria to be included in data element A).

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

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

CA1.2 High risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the Health Risk Assessment (HRA).

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA1. Care Coordination	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the third month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
CA1. 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 third 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 high risk members with a HRA completed during the reporting period.	Total number of high risk members with a HRA completed during the reporting period and who were continuously enrolled for 30 working days following the completion of the HRA.	Field Type: Numeric
B.	Total number of high risk members who were documented as unwilling to complete an ICP within 30 working days after the completion of the HRA.	Of the total reported in A, the number of high risk members who were documented as unwilling to complete an ICP within 30 working days after the completion of the HRA.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of high risk members the MMP was unable to reach, following three documented attempts, within 30 working days after the completion of the HRA.	Of the total reported in A, the number of high risk members the MMP was unable to reach, following three documented attempts, within 30 working days after the completion of the HRA.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of high risk members with an ICP completed within 30 working days after the completion of the HRA.	Of the total reported in A, the number of high risk members with an ICP completed within 30 working days after the completion of the HRA.	Field Type: Numeric Note: Is a subset of A.

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

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

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

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

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of high risk members who completed a HRA during the reporting period who:

- Refused to have an ICP completed within 30 working days after the completion of the HRA.
- Were unable to be reached to have an ICP completed within 30 working days after the completion of the HRA.
- Had an ICP completed within 30 working days after the completion of the HRA.
- Were willing to participate and could be reached who had an ICP completed within 30 working days after the completion of the HRA.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members with an HRA completed during the reporting period regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- Members need to be continuously enrolled for 30 working days from the date of HRA completion with no gaps in enrollment to be included in this measure.
- The HRA must be completed within the reporting period, but the ICP may not be in the same reporting period. For example, if the HRA is completed less than 30 working days before the end of the reporting period (e.g., March 15), look up to 30 working days past the end of the reporting period to identify whether an ICP was completed.
- Unlike CA1.1, the HRA reported in data element A may or may not have been completed within the required time frame (i.e., within 45 days of a member's effective enrollment date). MMPs should include all members who meet the criteria outlined in data element A, regardless of whether their HRA was completed before or after the member's 45th day of enrollment.
- MMPs should refer to the CA three-way contract for specific requirements pertaining to ICPs and HRAs.
- Risk level should be determined using an approved health risk stratification mechanism or algorithm to identify new enrollees with high risk or more complex health care needs. The health risk stratification shall be conducted in accordance with the most recent DHCS DPL.
- MMPs should use the member's *initial* risk level categorization for purposes for reporting this measure. For example, if a member is initially deemed high risk, then is subsequently deemed low risk, that member should be considered high risk and the MMP should follow the requirements for completing the HRA for a high risk member.
- High risk members are members who are at increased risk for having an adverse health outcome or worsening of his or her health status if he or she does not receive initial contact within 45 calendar days after their effective enrollment date. Members without any claims history should be considered high risk at the time of enrollment (and for purposes of reporting this measure). If subsequent information becomes available deeming a member low

risk, the members should still be considered high risk for this measure (i.e., use the member's initial risk categorization).

- For all members the HRA must be completed before an ICP can be completed. However, the HRA and ICP can be completed during a single meeting with the member.
- For data element B, MMPs should report the number of members who were unwilling to participate in the development of the ICP within 30 working days after the completion of the HRA if a member (or his or her authorized representative):
    1. Affirmatively declines to participate in the ICP. Member communicates this refusal by phone, mail, fax, or in person.
    2. Expresses willingness to complete the ICP but asks for it to be conducted after 30 working days following the completion of the assessment (despite being offered a reasonable opportunity to complete the ICP within 30 working days). Discussions with the member must be documented by the MMP.
    3. Expresses willingness to complete the ICP, but reschedules or is a no-show and then is subsequently non-responsive. Attempts to contact the member must be documented by the MMP.
    4. Initially agrees to complete the ICP, but then declines to answer a majority of the questions in the ICP.
- For data element C, MMPs should report the number of members the MMP was unable to reach after three attempts to contact the member. MMPs should refer to the CA three-way contract or state guidance for any specific requirements pertaining to the method of outreach to members. MMPs must document each attempt to reach the member, including the method of the attempt (i.e., phone, mail, or email), as CMS and the state may validate this number. There may be instances when the MMP has a high degree of confidence that a member's contact information is correct, yet that member is not responsive to the MMPs outreach efforts. So long as the MMP follows the guidance regarding outreach attempts, these members may be included in the count for this data element.
- There may be certain circumstances that make it impossible or inappropriate to complete an ICP within 30 working days of the health risk 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. However, MMPs should <u>not</u> include such members in the counts for data elements B and C.

- If an ICP was started but not completed within 30 working days of the initial HRA, then the ICP should not be considered completed and, therefore, would not be counted in data elements B, C, or D. However, this member would be included in data element A if the initial HRA was completed within the reporting period and they were continuously enrolled for 30 working days following the completion of the health risk assessment.

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 accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

CA1.3 Low risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the *timely* Health Risk Assessment (HRA).

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA1. Care Coordination	Monthly, beginning after 135 days	Contract	Current Month Ex: 1/1 – 1/31	By the end of the first FULL month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
CA1. 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 low risk members whose 135th day of enrollment occurred within the reporting period.	Total number of low risk members whose 135th day of enrollment occurred within the reporting period.	Field Type: Numeric
B.	Total number of low risk members who were documented as unwilling to complete a HRA within 90 days of enrollment.	Of the total reported in A, the number of low risk members who were documented as unwilling to complete a HRA within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of low risk members the MMP was unable to reach, following three documented attempts, within 90 days of enrollment.	Of the total reported in A, the number of low risk members the MMP was unable to reach, following three documented attempts, within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of low risk members with a HRA completed within 90 days of enrollment.	Of the total reported in A, the number of low risk members with a HRA completed within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A.
E.	Total number of low risk members who were documented as unwilling to complete an ICP within 30 working days after the completion of the HRA.	Of the total reported in D, the number of low risk members who were documented as unwilling to complete an ICP within 30 working days after the completion of the HRA.	Field Type: Numeric Note: Is a subset of D.

Element Letter	Element Name	Definition	Allowable Values
F.	Total number of low risk members the MMP was unable to reach, following three documented attempts, within 30 working days after the completion of the HRA.	Of the total reported in D, the number of low risk members the MMP was unable to reach, following three documented attempts, within 30 working days after the completion of the HRA.	Field Type: Numeric Note: Is a subset of D.
G.	Total number of low risk members with an ICP completed within 30 working days after the completion of the HRA.	Of the total reported in D, the number of low risk members with an ICP completed within 30 working days after the completion of the HRA.	Field Type: Numeric Note: Is a subset of D.

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

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

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

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

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of low risk members who:

- Refused to have a HRA completed within 90 days of enrollment.
- Were unable to be reached to have a HRA completed within 90 days of enrollment.
- Had a HRA completed within 90 days of enrollment.
- Were willing to participate and could be reached who had a HRA completed within 90 days of enrollment.

In addition, CMS and the state will evaluate the percentage of low risk members who had a HRA completed within 90 days of enrollment who:

- Refused to have an ICP completed within 30 working days after the completion of the HRA.
- Were unable to be reached to have an ICP completed within 30 working days after the completion of the HRA.
- Had an ICP completed within 30 working days after the completion of the HRA.
- Were willing to participate and who could be reached who had an ICP completed within 30 working days after the completion of the HRA.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members whose 135th day of enrollment occurred within the reporting period regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- MMPs should refer to the CA three-way contract for specific requirements pertaining to ICPs and HRAs.
- Risk level should be determined using an approved health risk stratification mechanism or algorithm. The health risk stratification shall be conducted in accordance with the most recent DHCS DPL.
- MMPs should use the members *initial* risk level categorization for purposes for reporting this measure. For example, if a member is initially deemed low risk, then is subsequently deemed high risk, that member should be considered low risk and the MMP should follow the requirements for completing the HRA for a low risk member.
- Low risk members are those members who do not meet the minimum requirements of a high risk member. If subsequent information becomes available deeming a member high risk, the members should still be considered low risk for this measure (i.e., use the member's initial risk categorization).
- For all members the HRA must be completed before an ICP can be completed. However, the HRA and ICP can be completed during a single meeting with the member.
- Timely HRAs are defined as completed within 45 calendar days for high risk members and within 90 calendar days for lower risk members as described in Section 2.8.2 of the CA three-way contract.

- For data element B, MMPs should report the number of members who were unwilling to participate in the HRA if a member (or his or her authorized representative):
    - Affirmatively declines to participate in the HRA. Member communicates this refusal by phone, mail, fax, or in person.
    - Expresses willingness to complete the HRA but asks for it to be conducted after 90 days (despite being offered a reasonable opportunity to complete the HRA within 90 days). Discussions with the member must be documented by the MMP.
    - Expresses willingness to complete the HRA, but reschedules or is a no-show and then is subsequently non-responsive. Attempts to contact the member must be documented by the MMP.
    - Initially agrees to complete the HRA, but then declines to answer a majority of the questions in the HRA.
- For data element C, MMPs should report the number of members the MMP was unable to reach after three attempts to contact the member. MMPs should refer to the CA three-way contract or state guidance for any specific requirements pertaining to the method of outreach to members. MMPs must document each attempt to reach the member, including the method of the attempt (i.e., phone, mail, or email), as CMS and the state may validate this number. There may be instances when the MMP has a high degree of confidence that a member's contact information is correct, yet that member is not responsive to the MMP's outreach efforts. So long as the MMP follows the guidance regarding outreach attempts, these members may be included in the count for this data element.
- There may be certain circumstances that make it impossible or inappropriate to complete a HRA within 90 days of enrollment. For example, a member may be medically unable to respond and have no authorized representative to do so on their behalf, or a member may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for assessment HRA. However, MMPs should <u>not</u> include such members in the counts for data elements B and C.
- If a member's HRA was started but not completed within 90 days of enrollment, then the HRA should not be considered completed and, therefore, would <u>not</u> be counted in data elements B, C, or D. However, this member would be included in data element A.
- For data element E, MMPs should report the number of members who were unwilling to participate in the development of the ICP if a member (or his or her authorized representative):
    1. Affirmatively declines to participate in the ICP. Member communicates this refusal by phone, mail, fax, or in person.

2. Expresses willingness to complete the ICP but asks for it to be conducted after 30 working days following the completion of the assessment (despite being offered a reasonable opportunity to complete the ICP within 30 working days). Discussions with the member must be documented by the MMP.
3. Expresses willingness to complete the ICP, but reschedules or is a no-show and then is subsequently non-responsive. Attempts to contact the member must be documented by the MMP.
4. Initially agrees to complete the ICP, but then declines to answer a majority of the questions in the ICP.

- For data element F, MMPs should report the number of members the MMP was unable to reach after three attempts to contact the member. MMPs should refer to the CA three-way contract or state guidance for any specific requirements pertaining to the method of outreach to members. MMPs must document each attempt to reach the member, including the method of the attempt (i.e., phone, mail, or email), as CMS and the state may validate this number. There may be instances when the MMP has a high degree of confidence that a member's contact information is correct, yet that member is not responsive to the MMPs outreach efforts. So long as the MMP follows the guidance regarding outreach attempts, these members may be included in the count for this data element.
- There may be certain circumstances that make it impossible or inappropriate to complete an ICP within 30 working days of the 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. However, MMPs should <u>not</u> include such members in the counts for data elements E and F.
- The initial assessment must be completed within the reporting period, but the ICP may not be in the same reporting period. For example, if the initial assessment is completed less than 30 working days before the end of the reporting period (e.g., March 15), look up to 30 working days past the end of the reporting period to identify if an ICP was completed.
- If an ICP was started but not completed within 30 working days of the initial HRA, then the ICP should not be considered completed and, therefore, would <u>not</u> be counted in data elements E, F, or G. However, this member would be included in data element D if the initial assessment was completed within the reporting period.

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 accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

CA1.4 Low risk members with an Individualized Care Plan (ICP) within 30 working days after the completion of the Health Risk Assessment (HRA).

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA1. Care Coordination	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the third month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
CA1. 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 third 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 low risk members with a HRA completed during the reporting period.	Total number of low risk members with a HRA completed during the reporting period and who were continuously enrolled for 30 working days following the completion of the HRA.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of low risk members who were documented as unwilling to complete an ICP within 30 working days after the completion of the HRA.	Of the total reported in A, the number of low risk members who were documented as unwilling to complete an ICP within 30 working days after the completion of the HRA.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of low risk members the MMP was unable to reach, following three documented attempts, within 30 working days after the completion of the HRA.	Of the total reported in A, the number of low risk members the MMP was unable to reach, following three documented attempts, within 30 working days after the completion of the HRA.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of low risk members with an ICP completed within 30 working days after the completion of the HRA.	Of the total reported in A, the number of low risk members with an ICP completed within 30 working days after the completion of the HRA.	Field Type: Numeric Note: Is a subset of A.

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

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

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

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

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of low risk members who completed a HRA during the reporting period who:

- Refused to have an ICP completed within 30 working days after the completion of the HRA.
- Were unable to be reached to have an ICP completed within 30 working days after the completion of the HRA.
- Had an ICP completed within 30 working days after the completion of the HRA.
- Were willing to participate and could be reached who had an ICP completed within 30 working days after the completion of the HRA.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members with an HRA completed within the reporting period regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- Members need to be continuously enrolled for 30 working days from the date of HRA completion with no gaps in enrollment to be included in this measure.
- The HRA must be completed within the reporting period, but the ICP may not be in the same reporting period. For example, if the HRA is completed less than 30 working days before the end of the reporting period (e.g., March 15), look up to 30 working days past the end of the reporting period to identify if an ICP was completed. Unlike CA1.3, the HRA reported in data element A may or may not have been completed within the required time frame (i.e., within 90 days of a member's effective enrollment date). MMPs should include all members who meet the criteria outlined in data element A, regardless of whether their HRA was completed before or after the members 90th day of enrollment.
- MMPs should refer to the CA three-way contract for specific requirements pertaining to ICPs and HRAs.
- Risk level should be determined using an approved health risk stratification mechanism or algorithm. The health risk stratification shall be conducted in accordance with the most recent DHCS DPL. MMPs should use the member's *initial* risk level categorization for purposes for reporting this measure. For example, if a member is initially deemed low risk, then is subsequently deemed high risk, that member should be considered low risk and the MMP should follow the requirements for completing the HRA for a low risk member.
- Low risk members are those members who do not meet the minimum requirements of a high risk member. If subsequent

information becomes available deeming a member high risk, the members should still be considered low risk for this measure.

- For all members the HRA must be completed before an ICP can be completed. However, the HRA and ICP can be completed during a single meeting with the member.
- For data element B, MMPs should report the number of members who were unwilling to participate in the development of the ICP within 30 working days after the completion of the HRA if a member (or his or her authorized representative):
    1. Affirmatively declines to participate in the ICP. Member communicates this refusal by phone, mail, fax, or in person.
    2. Expresses willingness to complete the ICP but asks for it to be conducted after 30 working days following the completion of the assessment (despite being offered a reasonable opportunity to complete the ICP within 30 working days). Discussions with the member must be documented by the MMP.
    3. Expresses willingness to complete the ICP, but reschedules or is a no-show and then is subsequently non-responsive. Attempts to contact the member must be documented by the MMP.
    4. Initially agrees to complete the ICP, but then declines to answer a majority of the questions in the ICP.
- For data element C, MMPs should report the number of members the MMP was unable to reach after three attempts to contact the member. MMPs should refer to the CA three-way contract or state guidance for any specific requirements pertaining to the method of outreach to members. MMPs must document each attempt to reach the member, including the method of the attempt (i.e., phone, mail, or email), as CMS and the state may validate this number. There may be instances when the MMP has a high degree of confidence that a member's contact information is correct, yet that member is not responsive to the MMPs outreach efforts. So long as the MMP follows the guidance regarding outreach attempts, these members may be included in the count for this data element.
- There may be certain circumstances that make it impossible or inappropriate to complete an ICP within 30 working days of the HRA. 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. However, MMPs should <u>not</u> include such members in the counts for data elements B and C.
- If an ICP was started but not completed within 30 working days of the initial HRA, then the ICP should not be considered completed

and, therefore, would not be counted in data elements B, C, or D. However, this member would be included in data element A if the initial assessment was completed within the reporting period.

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 accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

CA1.5 Members with an ICP completed.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA1. Care Coordination	Monthly, beginning after 90 days	Contract	Current Month Ex: 1/1 – 1/31	By the end of the first month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
CA1. 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, including examples, methods for calculations, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of high risk members enrolled for 90 days or longer as of the end of the reporting period.	Total number of high risk members enrolled for 90 days or longer as of the end of the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of high risk members who had an ICP completed.	Of the total reported in A, the number of high risk members who had an ICP completed as of the end of the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of low risk members enrolled for 135 days or longer as of the end of the reporting period.	Total number of low risk members enrolled for 135 days or longer as of the end of the reporting period.	Field Type: Numeric Note: This data element should not be reported until after 135 days of Implementation.
D.	Total number of low risk members who had an ICP completed.	Of the total reported in C, the number of low risk members who had an ICP completed as of the end of the reporting period.	Field Type: Numeric Note: Is a subset of C. Note: This data element should not be reported until after 135 days of Implementation.

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

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

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

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

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

- High risk members enrolled for 90 days or longer who had an ICP completed as of the end of the reporting period.

- Low risk members enrolled for 135 days or longer who had an ICP completed as of the end of the reporting period.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- For the purposes of reporting Element A, 90 days of enrollment will be equivalent to three full calendar months.
- The 135th day of enrollment should be based on each member's effective enrollment date.
- The effective date of enrollment is the first date of the member's coverage through the MMP.
- MMPs should refer to the CA three-way contract for specific requirements pertaining to ICPs.
- The ICPs reported in data elements B and D could have been completed at any point from the member's first day of enrollment through the end of the reporting period.
- The first monthly report for the first reporting period is due at the end of the first month after the 90th day. For example, for MMPs beginning the demonstration on April 1, 2014, the 90th day will occur on June 30, 2014. Therefore, the first report reflecting the reporting period of June 1, 2014 to June 31, 2014 will be due July 31, 2014 and monthly thereafter for the remainder of the Implementation period.
- The first monthly report for data elements C and D is due at the end of the first FULL month after the 135th day. For example, for MMPs beginning the demonstration on April 1, 2014, the 135th day will occur on August 14, 2014. Therefore, the first report reflecting the reporting period of August 1, 2014 to August 31, 2014 will be due September 30, 2014 and monthly thereafter for the remainder of the Implementation period.
- High risk members are members who are at increased risk for having an adverse health outcome or worsening of his or her health status if he or she does not receive initial contact within 45 calendar days after their effective enrollment date.
- Low risk members are members who do not meet the minimum requirements of a high risk member.

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

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

CA1.6 Members with documented discussions of care goals.[i]

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA1. Care Coordination	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 members with an initial Individualized Care Plan (ICP) developed.	Total number of members with an initial ICP developed during the reporting period.	Field Type: Numeric
B.	Total number of members sampled that met the inclusion criteria.	Of the total reported in A, the number of members sampled that met inclusion criteria.	Field type: Numeric Note: Is a subset of A.
C.	Total number of members with at least one documented discussion of care goals in the initial ICP.	Of the total reported in B, the number of members with at least one documented discussion of care goals in the initial ICP.	Field Type: Numeric Note: Is a subset of B.
D.	Total number of existing ICPs revised.	Total number of existing ICPs revised during the reporting period.	Field Type: Numeric
E.	Total number of revised ICPs sampled that met inclusion criteria.	Of the total reported in D, the number of revised ICPs sampled that met inclusion criteria.	Field Type: Numeric Note: Is a subset of D.

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

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

- The quality withhold benchmark is set as the percentage achieved by the highest scoring MMP minus 10 percentage points. For more information, refer to the Quality Withhold Technical Notes (DY 1): California-Specific Measures.

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

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

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

- Members with an initial ICP developed during the reporting period who had evidence of creation of at least one care goal documented in the initial ICP.
- Existing ICPs revised during the reporting period that had at least one documented discussion of new or existing care goals.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. A subset of all members that are eligible will be included in the sample. Medicaid-only members should not be included.

- MMPs should include all members who meet the criteria outlined in 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).
- For reporting, the MMPs may elect to sample since this measure requires documentation review to identify data elements C and F. Sampling should be systematic to ensure all eligible individuals have an equal chance of inclusion. The sample size should be 411, plus oversample to allow for substitution. For further instructions on selecting the sample size, please see pages 35-36 of the Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements on CMS' Web site: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans
- If an MMP does not elect to sample, data element B should be equal to data element A.
- If an MMP does not elect to sample, data element E should be equal to data element D.
- Data element A should include all members with ICPs that were created for the first time during the reporting period (i.e., the member did not previously have an ICP developed prior to the start of the reporting period). There can be no more than one initial ICP per member.
- The MMP should only count members in data element C when the discussion of care goals with the member is clearly documented in the member's ICP.
- Data element D should include all existing ICPs that were revised during the reporting period. MMPs should refer to the CA three-way contract for specific requirements pertaining to updating the ICP.
- MMPs should only include ICPs in data element F when a new or previously documented care goal is discussed with the member and is clearly documented in the member's revised ICP. If the initial ICP 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 ICP, then that ICP should not be reported in data element F.
- If a member has an initial ICP completed during the reporting period, and has their ICP revised during the same reporting period, the member's initial ICP should be reported in data element A and the member's revised ICP should be reported in data element D.
- If a member's ICP is revised multiple times during the same reporting period, each revision should be reported in data element D. For example, if a member's ICP is revised twice during the same reporting period, two ICPs should be counted in data element D.

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 accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

CA1.7 Members receiving Medi-Cal specialty mental health services receiving coordinated care plans as indicated by having an Individualized Care Plan (ICP) with the primary mental health provider.[i]

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA1. 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 members receiving Medi-Cal specialty mental health services.	Total number of members who have been continuously enrolled in the same Cal MediConnect MMP for at least five months during the reporting period and who have received Medi-Cal specialty mental health services for three or more consecutive months.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of members that have ICPs that indicate evidence of coordinated care planning with the primary mental health provider.	Of the total reported in A, the number of members who have ICPs that indicate evidence of coordinated care planning with the primary mental health provider.	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 set as the percentage achieved by the highest scoring MMP minus 10 percentage points. For more information, refer to the Quality Withhold Technical Notes (DY 1): California-Specific Measures.

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

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

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

- CMS and the state will evaluate the percentage of members receiving Medi-Cal specialty mental health services for three or more consecutive months who have care plans that indicate evidence of coordinated care planning with the primary mental health provider.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in 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).

- Evidence of coordinated care planning will be defined in the CA three-way contract to mean that the member's ICP includes all of the following:
    1. The name and contact information of the primary county or county-contracted mental health provider,
    2. Attestation[2] that the county mental health provider and the primary care provider have reviewed and approved the care plan, and
    3. Record of at least one case review meeting that included the county mental health provider and includes date of meeting, names of participants, and evidence of creation or adjustment of care goals, as described in the MMPs models of care reviewed and approved by NCQA.
- Attestations that the county mental health provider and primary care provider have reviewed and approved the care plan should occur during the reporting period.

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 accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

CA1.8 Unmet Need in IHSS.

Please note: No MMP reporting is required for this measure; CMS and the state will receive data from California Department of Social Services (CDSS). MMPs are required to assist CDSS with the process, and more detail will be provided.

Subsequent to establishing the methodology for this measure, this appendix will be updated to include the measure specifications.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA1. Care Coordination	Annually	County	Calendar Year	CMS and state will receive data from CDSS

[2] Plans may determine the most feasible method of attestation, such as but not necessarily limited to an electronic signature, an attached paper signature or a checked box. Regardless of the method of attestation, DHCS requires that MMPs document that the attestation was received.

CA1.9 IHSS social worker contact with member

Please note: No MMP reporting is required for this measure; CMS and the state will receive data from CDSS. MMPs are required to assist CDSS with the process, and more detail will be provided.

Subsequent to establishing the methodology for this measure, this appendix will be updated to include the measure specifications.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA1. Care Coordination	Annually	County	Calendar Year	CMS and state will receive data from CDSS

CA1.10 Satisfaction with IHSS social worker, home workers, personal care.

Please note: No MMP reporting is required for this measure; CMS and the state will receive data from CDSS. MMPs are required to assist CDSS with the process, and more detail will be provided.

Subsequent to establishing the methodology for this measure, this appendix will be updated to include the measure specifications.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA1. Care Coordination	Annually	County	Calendar Year	CMS and state will receive data from CDSS

CA1.11 Members with first follow-up visit within 30 days after hospital discharge.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
CA1. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the fourth month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of hospital discharges.	Total number of hospital discharges during the reporting period.	Field Type: Numeric
B.	Total number of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days after discharge from the hospital.	Of the total reported in A, the number of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days after discharge from the hospital.	Field Type: Numeric Note: Is a subset of A.

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

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

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

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

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

- CMS and the state will evaluate the percentage of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days after discharge from the hospital.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all hospital discharges for members who meet the criteria outlined in Element A and who were continuously enrolled from the date of the hospital discharge through 30 days

after the hospital discharge, regardless of whether they are disenrolled as of the end of the reporting period.

- The date of discharge must occur within the reporting period, but the follow-up visit may or may not occur in the same reporting period. For example, if a discharge occurs during the last month of the reporting period, look to the first month of the following reporting period to identify the follow-up visit.
- The member needs to be enrolled from the date of the hospital discharge through 30 days after the hospital discharge, with no gaps in enrollment to be included in this measure.
- A follow-up visit is defined as an ambulatory care follow-up visit to assess the member's health following a hospitalization. Codes to identify follow-up visits are provided in Table CA-1.
- Codes to identify inpatient discharges are provided in Table CA-2.
- Exclude discharges in which the patient was readmitted within 30 days after discharge to an acute or non-acute facility.
- Exclude discharges due to death. Codes to identify patients who have expired are provided in Table CA-3.

Table CA-1: Codes to Identify Ambulatory Health Services

Description	CPT	HCPCS	ICD-9-CM Diagnosis	UB Revenue
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245			051x, 0520-0523, 0526-0529, 0982, 0983
Home services	99341-99345, 99347-99350			
Nursing facility care	99304-99310, 99315, 99316, 99318			0524, 0525
Domiciliary, rest home or custodial care services	99324-99328, 99334-99337			
Preventive medicine	99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429	G0344, G0402, G0438, G0439		
Ophthalmology and optometry	92002, 92004, 92012, 92014			
General medical examination			V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	

Table CA-2: Codes to Identify Inpatient Discharges		
Principal ICD-9-CM Diagnosis		**MS-DRG**
001-289, 317-999, V01-V29, V40-V90	***OR***	001-013, 020-042, 052-103, 113-117, 121-125, 129-139, 146-159, 163-168, 175-208, 215-264, 280-316, 326-358, 368-395, 405-425, 432-446, 453-517, 533-566, 573-585, 592-607, 614-630, 637-645, 652-675, 682-700, 707-718, 722-730, 734-750, 754-761, 765-770, 774-782, 789-795, 799-804, 808-816, 820-830, 834-849, 853-858, 862-872, 901-909, 913-923, 927-929, 933-935, 939-941, 947-951, 955-959, 963-965, 969-970, 974-977, 981-989, 998, 999

WITH

UB Type of Bill	***OR***	Any acute inpatient facility code
11x, 12x, 41x, 84x		

Table CA-3: Codes to Identify Patients who Expired
Discharge Status Code
20

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

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

CA1.12 Members who have a care coordinator and have at least one care team contact during the reporting period.[i]

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA1. Care Coordination	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 members who have/had a care coordinator.	Total number of members who have/had a care coordinator during the reporting period.	Field Type: Numeric
B.	Total number of members who had at least one care coordinator or other care team contact.	Of the total reported in A, the number of members who had at least one care coordinator or other care team contact.	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 set as the percentage achieved by the highest scoring MMP minus 10 percentage points. For more information, refer to the Quality Withhold Technical Notes (DY 1): California-Specific Measures.

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

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

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

- CMS and the state will evaluate the percentage of members with a care coordinator who had at least one care coordinator or other care team contact during the reporting period.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in 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 contact can be from the care coordinator or another member of the care team, depending on the member's needs.
- MMPs should include only successful care coordinator or other care team contacts in data element B.
- MMPs should refer to the CA three-way contract for specific requirements pertaining to the care team.
- To be included in this measure, the member needs to be continuously enrolled for six months during the reporting period, with no gaps in enrollment.

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 accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

Section CAII. Enrollee Protections

CA2.1The number of critical incident and abuse reports for members receiving LTSS.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA2. 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**
CA2. 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 IHSS.	Total number of members receiving IHSS during the reporting period.	Field Type: Numeric
B.	Total number of members receiving CBAS services.	Total number of members receiving CBAS services during the reporting period.	Field Type: Numeric
C.	Total number of members receiving MSSP services.	Total number of members receiving MSSP services during the reporting period.	Field Type: Numeric
D.	Total number of members receiving nursing facility (NF) services.	Total number of members receiving NF services during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
E.	Total number of critical incident and abuse reports among members receiving IHSS.	Of the total reported in A, the number of critical incident and abuse reports during the reporting period.	Field Type: Numeric
F.	Total number of critical incident and abuse reports among members receiving CBAS.	Of the total reported in B, the number of critical incident and abuse reports during the reporting period.	Field Type: Numeric
G.	Total number of critical incident and abuse reports among members receiving MSSP services.	Of the total reported in C, the number of critical incident and abuse reports during the reporting period.	Field Type: Numeric
H.	Total number of critical incident and abuse reports among members receiving NF services.	Of the total reported in D, 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 MMPs over time, CMS and the state will apply threshold checks.

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

- All data elements should be positive values.

D. Analysis - how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the number of critical incident and abuse reports per 100 members receiving:

- IHSS during the reporting period.
- CBAS services during the reporting period.
- MSSP services during the reporting period.
- NF services during the reporting period.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Elements A, B, C, and D 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).
- For quarterly reporting, if a member is enrolled at any point in time during the reporting period and received one of the specified categories of services, he/she should be included in this measure.
- For data elements E through H, 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 new critical incident and abuse reports during the reporting period should be counted.
- 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.
- Abuse refers to:

  1. Willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish;
  2. Knowing, reckless, or intentional acts or failures to act which cause injury or death to an individual or which places that individual at risk of injury or death;
  3. Rape or sexual assault;
  4. Corporal punishment or striking of an individual;
  5. Unauthorized use or the use of excessive force in the placement of bodily restraints on an individual; and
  6. Use of bodily or chemical restraints on an individual which is not in compliance with federal or state laws and administrative regulations.

- Community Based Adult Services (CBAS) is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to eligible Medi-Cal beneficiaries, aged 18 years and older, blind, or disabled.
- Multi-Purpose Senior Services Program (MSSP) is a California-specific program, the 1915(c) Home and Community-Based services waiver that provides HCBS to Medi-Cal eligible individuals

who are 65 years or older with disabilities as an alternative to nursing facility placement.

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 accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

CA2.2 Policies and procedures attached to the MOU with county behavioral health agency(ies) around assessments, referrals, coordinated care planning, and information sharing.[i]

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA2. Enrollee Protections	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.	Policies and procedures attached to the MOU with county behavioral health agency(ies) around assessments, referrals, coordinated care planning, and information sharing	Policies and procedures attached to the MOU with county behavioral health agency(ies) around assessments, referrals, coordinated care planning, and information sharing	Field Type: N/A Note: File will be emailed to the State; additional information will be forthcoming

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 100%. For more information, refer to the Quality Withhold Technical Notes (DY 1): California-Specific Measures.

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

- Confirm that the appropriate policies and procedures are submitted align with the MOU(s) with county behavioral health agency(ies).

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 verify that the policies and procedures contain, at a minimum, the roles and responsibilities of the MMP and the county behavioral health agency(ies) regarding assessments, referrals, coordinated care planning, and information sharing.

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

- These policies and procedures should be specific to each MMP/county behavioral health agency(ies) and reflect the appropriate roles and responsibilities of each organization.

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

- Data will be submitted directly to the state via email to: pmmp.monitoring@dhcs.ca.gov

Section CAIII. Organizational Structure and Staffing

CA3.1 MMPs with an established physical access compliance policy and identification of an individual who is responsible for physical access compliance.[i]

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA3. 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.	Physical Access Compliance Policy.	Physical Access Compliance Policy that describes the MMP's procedures for maintaining physical access compliance of its provider network (provider offices).	Field Type: N/A Note: File will be uploaded to FTP site as a separate attachment.
B.	Physical Access Compliance or Quality Officer.	Identification of MMP staff person responsible for physical access compliance of its provider network (provider offices).	Field Type: N/A Note: File will be uploaded to FTP site as a separate attachment.

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 100%. For more information, refer to the Quality Withhold Technical Notes (DY 1): California-Specific Measures.

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

- Confirm that all required information is included in each element as outlined below.

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 verify that each reported element follows the requirements outlined below.

- **Physical Access Compliance Policy (Element A)** – The Physical Access Compliance Policy should clearly describe the policies and procedures for maintaining compliance with the Americans with Disabilities Act (ADA) physical access requirements. The plan can either be part of the organization's overall compliance plan or a separate document that just describes ADA physical access compliance. The plan should include:
    1. Process for maintaining ADA physical access compliance
    2. Person and committee responsible for oversight
    3. Description of training for network provider staff
    4. Description of training for Interdisciplinary Care Team members
    5. Description of provider site assessment for compliance and frequency of assessment
    6. Description of steps taken in response to identification of issues
    7. Committee meeting minutes to validate oversight of the Physical Access Compliance Policy
    8. Annual assessment of the Physical Access Compliance Policy, including:
        1. Assessment of completion of planned activities and that the objectives of the plan were met
        2. Identification of issues or barriers that impacted meeting the objectives of the work plan
        3. Recommended interventions to overcome barriers and issues identified
        4. Overall effectiveness of the Physical Access Compliance Policy
- **Physical Access Compliance or Quality Officer (Element B)** – This document should identify the staff person responsible for ADA physical access compliance and also provide his/her job description.

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

- MMPs should refer to the California three-way contract for specific requirements pertaining to ADA physical access compliance.
- MMPs must continue to follow the process promulgated by DHCS for conducting assessments of ADA physical access compliance per the FSR/PAR DPL 14-005. This includes using the same

provider site assessment tool that is used for conducting the Medi-Cal Facility Site Reviews (FSR) and Physical-Accessibility Reviews (PAR).

- The Physical Access Compliance Officer or Quality Officer may be the same individual that serves as the MMP Compliance Officer.
- MMPs should refer to the following links for additional guidance on physical access for individuals with mobility disabilities: http://www.ada.gov/medcare_mobility_ta/medcare_ta.htm and http://www.adachecklist.org

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

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx
- For data submission, each data element above should be uploaded as a separate attachment.
- Required File Format is Microsoft Word File.
- The file name extension should be ".docx"
- File name= CA_(CONTRACTID)_(REPORTING PERIOD)_(SUBMISSIONDATE)_(ELEMENTNAME).docx
- Replace (CONTRACTID) with the contract ID, (REPORTINGPERIOD) with the year and month of the beginning of the reporting period in YYYYMM format (e.g., February 2014 would be 201402), (SUBMISSIONDATE) the year, month, and date of the submission in YYYYMMDD format (e.g., March 31, 2014 would be 20140331), and (ELEMENTNAME) with the element name listed below.
    1. For element letter "A", the (ELEMENTNAME) should be (POLICY).
    2. For element letter "B", the (ELEMENTNAME) should be (INDIVIDUAL).

CA3.2 Care coordinator training for supporting self-direction under the demonstration.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA3. 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 care coordinators who have been employed by the MMP for at least 30 days.	Total number of care coordinators who have been employed by the MMP for at least 30 days at any point during the reporting period.	Field Type: Numeric
B.	Total number of care coordinators that have undergone training for supporting self-direction under the demonstration within the reporting period.	Of the total reported in A, the number of care coordinators that have undergone training for supporting self-direction under the demonstration within the reporting period.	Field Type: Numeric Note: Is a subset of A.

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

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

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

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

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

- CMS and the state will evaluate the percentage of care coordinators who have undergone training for supporting self-direction within the reporting period.

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

- MMPs should refer to the CA three-way contract for specific requirements pertaining to care coordinators.

- MMPs should refer to the CA three-way contract for specific requirements pertaining to training for supporting self-direction.
- If a care coordinator was not currently with the MMP at the end of the reporting period, but was with the MMP for at least 30 days at any point during the reporting period, they should be included in this measure.
- All full-time and part-time staff are included in the count of total number of care coordinators.

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 accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

Section CAIV. Utilization

CA4.1 Reduction in emergency department (ED) use for seriously mentally ill and substance use disorder (SUD) members.

(Note: This will become a quality withhold for Demonstration Year 2 and Demonstration Year 3).

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA4. Utilization	Annually	Contract	Calendar Year, beginning in CY2	By the end of the fourth month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members enrolled for at least five months, with an indication of either serious mental illness or substance use disorders (SUD).	Total number of members continuously enrolled for at least five months during the reporting period, with an indication of either serious mental illness or SUD problems during the 12 months prior to the reporting period.	Field Type: Numeric
B.	Total number of member months.	Of the total reported in A, the number of member months during the reporting period.	Field Type: Numeric
C.	Total number of ED visits.	Of the total reported in A, the number of ED visits during the reporting period.	Field Type: Numeric

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

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

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

- Each member should have a member month value between 5 and 12. A value greater than 12 is not acceptable.
- All data elements should be positive values.

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

- CMS and the state will evaluate the number of ED visits for members with an indication of either serious mental illness or SUD problems during the 12 months prior to the reporting period per 1,000 member months.
- A 95 percent confidence interval will be set around the baseline utilization year, and future years will be compared against that 95 percent confidence interval to look for statistically significant changes:
    - Year 2 compared to baseline: Any statistically significant reduction.
    - Year 3 compared to baseline: A statistically significant reduction greater than in year 2.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in 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 diagnosed with serious mental illness *and/or* substance use disorders (SUD) should be included in this measure (i.e., members with both serious mental illness and SUD diagnoses should also be included).
- MMPs should exclude ED visits that resulted in a hospital admission or observation stay. Refer to Table CA-4 for codes to identify ED visits.
- Member months refers to the number of months each Medicare-Medicaid member was enrolled in the MMP in the year. Each member should have a member month value between 5 and 12. A value greater than 12 is not acceptable. Determine member months using the 15th of the month. This date must be used consistently from member to member, month to month, and from year to year. For example, if Ms. X is enrolled in the MMP as of January 15, Ms. X contributes one member month in January.

- A member with serious mental illness is defined as someone with the following:
    - Mental illness diagnosis in Medicare or Medicaid claims in the 12 months prior to the reporting period (Table CA-5).
- A member with SUD is defined as someone with ANY of the following:
    - SUD diagnosis in Medicare or Medicaid claims in the 12 months prior to the reporting period (Table CA-6).
    - SUD treatment or detox in Medicare of Medicaid claims in the 12 months prior to the reporting period (Table CA-7 and Table CA-8).

Table CA-4: Codes to Identify ED Visits

CPT Codes	UB Revenue Codes
99281-99285	045x, 0981

Table CA-5: Codes to Identify Mental Health Diagnosis

ICD-9-CM Diagnosis Codes
293-294, 294.8-302, 306-316

Table CA-6: Codes to Identify SUD Diagnosis

ICD-9-CM Diagnosis Codes
291-291.9, 303.00-303.02, 303.90-303.92, 304.00-304.02, 304.10-304.12, 304.20-304.22, 304.30-304.32, 304.40-304.42, 304.50-304.52, 304.60-304.62, 304.70-304.72, 304.80-304.82, 304.90-304.92, 305.00-305.02, 305.20-305.22, 305.30-305.32, 305.40-305.42, 305.50-305.52, 305.60-305.62, 305.70-305.72, 305.80-305.82, 305.90-305.92, 535.3, 571.1

Table CA-7: Codes to Identify Detoxification Visits

HCPCS	ICD-9-CM Procedure	UB Revenue
H0008-H0014	94.62, 94.65, 94.68	0116, 0126, 0136, 0146, 0156

Table CA-8: Codes to Identify SUD Procedures

ICD-9-CM Procedure Codes
94.61, 94.63, 94.64, 94.66, 94.67, 94.69

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 accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

CA4.2 In-Home Supportive Services (IHSS) utilization.

Please note: No MMP reporting is required for this measure; CMS and the state will receive data from California Department of Social Services (CDSS). MMPs are required to assist CDSS with the process, and more detail will be provided.

Subsequent to establishing the methodology for this measure, this appendix will be updated to include the measure specifications.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA4. Utilization	Annually	County	Calendar Year	CMS and state will receive data from CDSS

CA4.3 Readmissions of short- and long-stay nursing facility residents after hospitalization for diabetes, chronic obstructive pulmonary disease (COPD) or any medical diagnosis.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA4. Utilization	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of short-term stay nursing facility (NF) residents.	Total number of short-term stay NF residents during the reporting period.	Field Type: Numeric
B.	Total number of short-term stay NF residents with diabetes.	Of the total reported in A, the number of short-term stay NF residents with diabetes.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of short-term stay NF residents with chronic obstructive pulmonary disease (COPD).	Of the total reported in A, the number of short-term stay NF residents with COPD.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of transfers for short-term stay NF residents who were transferred from the NF and admitted to an acute care hospital for any medical diagnosis and who were subsequently discharged back to any NF.	Of the total reported in A, the number of transfers for short-term stay NF residents who were transferred from the NF and admitted to an acute care hospital for any medical diagnosis and who were subsequently discharged back to any NF during the reporting period.	Field Type: Numeric
E.	Total number of transfers for short-term stay NF residents with diabetes who were transferred from the NF and admitted to an acute care hospital for diabetes and who were subsequently discharged back to any NF.	Of the total reported in B, the number of transfers for short-term stay NF residents with diabetes who were transferred from the NF and admitted to an acute care hospital for diabetes and who were subsequently discharged back to any NF during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
F.	Total number of transfers for short-term stay NF residents with COPD who were transferred from the NF and admitted to an acute care hospital for COPD and who were subsequently discharged back to any NF.	Of the total reported in C, the number of transfers for short-term stay NF residents with COPD who were transferred from the NF and admitted to an acute care hospital for COPD and who were subsequently discharged back to any NF during the reporting period.	Field Type: Numeric
G.	Total number of long-term stay NF residents.	Total number of long-term stay NF residents during the reporting period.	Field Type: Numeric
H.	Total number of long-term stay NF residents with diabetes.	Of the total reported in G, the number of long-term stay NF residents with diabetes.	Field Type: Numeric
I.	Total number of long-term stay NF residents with COPD.	Of the total reported in G, the number of long-term NF residents with COPD.	Field Type: Numeric
J.	Total number of transfers for long-term stay NF residents who were transferred from the NF and admitted to an acute care hospital for any medical diagnosis and who were subsequently discharged back to any NF.	Of the total reported in G, the number of transfers for long-term stay NF residents who were transferred from the NF and admitted to an acute care hospital for any medical diagnosis and who were subsequently discharged back to any NF during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
K.	Total number of transfers for long-term stay NF residents with diabetes who were transferred from the NF and admitted to an acute care hospital for diabetes and who were subsequently discharged back to any NF.	Of the total reported in H, the number of transfers for long-term stay NF residents with diabetes who were transferred from the NF and admitted to an acute care hospital for diabetes and who were subsequently discharged back to any NF during the reporting period.	Field Type: Numeric
L.	Total number of transfers for long-term stay NF residents with COPD who were transferred from the NF and admitted to an acute care hospital for COPD and who were subsequently discharged back to any NF.	Of the total reported in I, the number of transfers for long-term stay NF residents with COPD who were transferred from the NF and admitted to an acute care hospital for COPD and who were subsequently discharged back to any NF during the reporting period.	Field Type: Numeric

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

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

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

- All data elements should be positive values.

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

Short-Term Stay Analysis

- CMS and the state will evaluate the number of transfers among short-term stay NF residents who were transferred from the NF and admitted to an acute care hospital for any medical diagnosis and

who were subsequently discharged back to any NF during the reporting period per 100 short-term stay NF residents.

- CMS and the state will evaluate the number of transfers among short-term stay NF residents with diabetes who were transferred from the NF and admitted to an acute care hospital for diabetes and who were subsequently discharged back to any NF during the reporting period per 100 short-term stay NF residents with diabetes.
- CMS and the state will evaluate the number of transfers among short-term stay NF residents with COPD who were transferred from the NF and admitted to an acute care hospital for COPD and who were subsequently discharged back to any NF during the reporting period per 100 short-term stay NF residents with COPD.

Long-Term Stay Analysis

- CMS and the state will evaluate the number of transfers among long-term stay NF residents who were transferred from the NF and admitted to an acute care hospital for any medical diagnosis and who were subsequently discharged back to any NF during the reporting period per 100 long-term stay NF residents.
- CMS and the state will evaluate the number of transfers among long-term stay NF residents with diabetes who were transferred from the NF and admitted to an acute care hospital for diabetes and who were subsequently discharged back to any NF during the reporting period per 100 long-term stay NF residents with diabetes.
- CMS and the state will evaluate the number of transfers among long-term stay NF residents with COPD who were transferred from the NF and admitted to an acute care hospital for COPD and who were subsequently discharged back to any NF during the reporting period per 100 long-term stay NF residents with COPD.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- The member must be continuously enrolled in the MMP for the entire reporting period, with no more than one gap in enrollment.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 30 days during each year of continuous enrollment (i.e., the reporting period). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
- A short-term stay resident is defined as having resided in the nursing facility for less than or equal to 100 cumulative days.

- A long-term stay resident is defined as having resided in the nursing facility for greater than 100 cumulative days.
- MMPs should determine long-term and short-term stay residents using the best information available. MMPs should use their plan experience and, whenever possible, integrate analysis of historical claims data to determine if the member's NF stay qualifies as short-term or long-term. For example, a member may reside in a NF at the time of enrollment (or the first day of the reporting period for reporting periods CY2 and CY3) and the MMP may use historical data to determine the number of days the member has resided in the NF at the time of enrollment (or on the first day of the reporting period).
- When determining a short or long stay, if a member is transferred from the nursing facility and then is readmitted to <u>any</u> nursing facility within 30 days (including day 30), 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 acute care hospital on day 193 and is subsequently readmitted to any 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 194 for that episode, not as day 1.
- When determining a short or long stay, if a member is transferred from the nursing 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 toward the members cumulative days in facility.
- The date of transfer must occur within the reporting period, but the discharge back to any NF may not occur in the same reporting period. For example, if a transfer occurs during the last month of the reporting period, look to the first month of the following reporting period to identify the discharge back to any NF.
- The member needs to be enrolled from the date of the transfer and admission to an acute care hospital through 30 days following the admission, with no gaps in enrollment to be included in this measure.
- It is possible for a member to have more than one transfer during the reporting period. MMPs should count all transfers that occur for each member during the reporting period.
- MMPs should include sub-acute care facilities and intermediate care facilities as part of NFs, as defined in Title 22 of the California Code of Regulations sections 51120, 51124, and 52224.5.
- If a member was transferred to a hospital but only had an ER visit or observation stay then returned to the nursing facility, then the transfer is not counted as an admission to the acute care hospital.

A member must be admitted to the hospital to be considered a numerator positive event.

- To identify a diabetes-related hospital admission, refer to the primary diagnosis codes listed in Table CA-9.
- To identify a COPD-related hospital admission, refer to the primary diagnosis codes listed in Table CA-10.

Table CA-9: Codes to Identify Diabetes

ICD-9-CM
250, 357.2, 362.0, 366.41, 648.0

Table CA-10: Codes to Identify Chronic Obstructive Pulmonary Disease

ICD-9-CM
491, 492, 493.2, 496

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 accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org