

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

Effective as of October 1, 2017; Issued February 28, 2018

**Table of Contents**

**California-Specific Reporting Requirements Appendix .....CA-3**

- Introduction .....CA-3**
- Definitions .....CA-3**
- Variations from the Core Reporting Requirements Document .....CA-5**
- Reporting on HRAs and ICPs Completed Prior To First Effective Enrollment Date .....CA-6**
- Guidance on HRAs and ICPs for Members with a Break in Coverage .CA-7**
- Quality Withhold Measures .....CA-9**
- Reporting on Disenrolled and Retro-disenrolled Members.....CA-9**
- Hybrid Sampling .....CA-10**
- Value Sets.....CA-11**
- California’s Implementation, Ongoing, and Continuous Reporting Periods.....CA-12**
- Data Submission.....CA-12**
- Resubmission of Data .....CA-13**
- Section CAI. Care Coordination .....CA-14**
- Section CAII. Enrollee Protections .....CA-32**
- Section CAIII. Organizational Structure and Staffing .....CA-37**
- Section CAIV. Utilization .....CA-39**

## California-Specific Reporting Requirements Appendix

### **Introduction**

The measures in this appendix are required reporting for all MMPs in the Cal MediConnect 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 Model: Core Reporting Requirements, which can be found at the following web address:

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

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

The core and state-specific measures supplement existing Part C and Part D reporting requirements, as well as measures that MMPs report via other vehicles or venues, such as HEDIS<sup>®1</sup> 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 (CA1.9 and 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 HelpDesk at [CAHelpDesk@norc.org](mailto: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.

**Calendar Year:** All annual measures are reported on a calendar year basis. For MMPs with a first effective enrollment date of April 1, 2014, data for annual CY

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<sup>1</sup> HEDIS<sup>®</sup> is a registered trademark of the National Committee for Quality Assurance (NCQA).

2014 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 CY 2014 measures will be reported for the time period beginning July 1, 2014 and ending December 31, 2014. For MMPs with a first effective enrollment date of July 1, 2015, data for annual CY 2015 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 Core Reporting Requirements for more information). 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***

MMPs may complete Health Risk Assessments (HRAs) prior to individuals' effective date of enrollment, provided that the MMP meets the requirements as articulated in the National MMP Enrollment and Disenrollment Guidance. Note that for individuals who are passively enrolled, the MMP may reach out to complete an HRA no sooner than 20 days before the individual's effective date of the passive enrollment.

For purposes of reporting data on initial HRAs (Core 2.1 and Core 2.2), MMPs should report any HRAs completed prior to the first effective enrollment date as if they were completed on the first effective enrollment date. For example, if a member's first effective enrollment date was June 1 and the HRA for that member was completed on May 25, the MMP should report the HRA as if it 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. 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 June 1 would reach their 90th day (3 full months) on August 31. Therefore, these members would be reported in the data submission for the Quarter 3 reporting period, even if their HRA was marked as complete on the first effective enrollment date (i.e., June 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 measures Core 3.2, CA1.5, and CA1.6) as if it was completed on the first effective enrollment date. For example, if a member's first effective enrollment date was June 1 and the ICP for that member was completed on May 27, the MMP should report the ICP as if it were completed on June 1.

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

#### Health Risk Assessments

To determine if a Health Risk Assessment (HRA) should be conducted for a member that re-enrolled in the same or a different MMP, the MMP should determine if the member previously received an HRA from any MMP in the Cal MediConnect Demonstration. If the member received an HRA from the same MMP within one year of his/her most recent enrollment date, or from a different MMP within 6 months of changing MMPs, then the MMP is not necessarily required to conduct a new HRA, until there is a change in the enrollee's condition. 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. 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 within one year of his/her most recent date of enrollment into the same MMP or an HRA was not completed for the member within the previous 6 months by a different MMP for those members who changed MMPs, the MMP is required to conduct a HRA for the member within the timeframe prescribed by the contract and relevant Duals Plan Letter (DPL). 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 completed 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 Core 3.2, CA1.5, and CA1.6 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 complete 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, state-specific quality withhold measures are marked with the following symbol for Demonstration Year 1: (i) and the following symbol for Demonstration Years 2 through 5: (ii). For more information about the state-specific quality withhold measures for Demonstration Year 1, refer to the Quality Withhold Technical Notes (DY 1): California-Specific Measures at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPQualityWithholdMethodologyandTechnicalNotes.html>. Additional information on the withhold methodology and benchmarks for Demonstration Years 2 through 5 will be provided at a later time.

## ***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:

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

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  $K$ th record thereafter until the selection of the sample size is completed.

### **Value Sets**

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

**California's Implementation, Ongoing, and Continuous Reporting Periods**

Phase		Dates	Explanation
<b>Demonstration Year 1</b>			
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.
<b>Demonstration Year 2</b>			
Continuous Reporting	Ongoing Period	1-1-16 through 12-31-16	From January 1, 2016 through the end of the second full calendar year of the demonstration.
<b>Demonstration Year 3</b>			
Continuous Reporting	Ongoing Period	1-1-17 through 12-31-17	From January 1, 2017 through the end of the third full calendar year of the demonstration.
<b>Demonstration Year 4</b>			
Continuous Reporting	Ongoing Period	1-1-18 through 12-31-18	From January 1, 2018 through the end of the fourth full calendar year of the demonstration.
<b>Demonstration Year 5</b>			
Continuous Reporting	Ongoing Period	1-1-19 through 12-31-19	From January 1, 2019 through the end of the fifth full calendar year of the demonstration.

**Data Submission**

All MMPs will submit state-specific measure data through the web-based Financial Alignment Initiative Data Collection System (FAI DCS) (unless otherwise specified in the measure description). All data submissions must be submitted to this site by 5:00p.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 DCS and complete the data submission.)

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

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

### ***Resubmission of Data***

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

1. Email the CA HelpDesk ([CAHelpDesk@norc.org](mailto: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 DCS 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 initial Health Risk Assessment (HRA). – **Retired**

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

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

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

CA1.5 Members with an ICP completed.

<b>IMPLEMENTATION</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
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
<b>ONGOING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Periods</b>	<b>Due Date</b>
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
B.	Total number of high-risk members who had an initial Individualized Care Plan (ICP) completed.	Of the total reported in A, the number of high-risk members who had an initial 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 90 days or longer as of the end of the reporting period.	Total number of low-risk members enrolled for 90 days or longer as of the end of the reporting period.	Field Type: Numeric
D.	Total number of low-risk members who had an initial ICP completed.	Of the total reported in C, the number of low-risk members who had an initial ICP completed as of the end of the reporting period.	Field Type: Numeric Note: Is a subset of C.

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

- CMS and the state will perform an outlier analysis.
- As data are received from 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 initial ICP completed as of the end of the reporting period.
- Low-risk members enrolled for 90 days or longer who had an initial 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 data elements A and C, 90 days of enrollment will be equivalent to three full calendar months.
- The effective date of enrollment is the first date of the member's coverage through the MMP.
- 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 of reporting this measure.
- MMPs should refer to the California three-way contract for specific requirements pertaining to ICPs.
- The completed initial 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. Only members who participated in the development of the ICP should be included in these data elements.
- 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.<sup>i, ii</sup>

<b>CONTINUOUS REPORTING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
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.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of members with an initial Individualized Care Plan (ICP) completed.	Total number of members with an initial ICP completed 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.

- Guidance will be forthcoming on the established benchmark for this measure for DY 2 through 5.

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 completed 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 data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless

of whether they are currently enrolled or disenrolled as of the last day of the reporting period).

- For reporting, the MMPs may elect to sample since this measure may require 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 CA-10 to CA-11 of this document.
- 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 completed for the first time during the reporting period (i.e., the member did not previously have an ICP completed prior to the start of the reporting period). There can be no more than one initial ICP completed per member. Only ICPs that included participation from the member (or his/her authorized representative) in the completion of the ICP should be reported.
- The MMP should only count members in data element C when the discussion of care goals with the member (or his/her authorized representative) is clearly documented in the member's initial ICP.
- Data element D should include all existing ICPs that were revised during the reporting period. MMPs should refer to the California three-way contract for specific requirements pertaining to updating the ICP. Only ICPs that included participation from the member (or his/her authorized representative) in the revision to the ICP should be reported.
- MMPs should only include ICPs in data element F when a new or previously documented care goal is discussed with the member (or his/her authorized representative) 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, then 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 that received care coordination with the primary mental health provider.<sup>ii</sup>

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 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 during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of members for whom the MMP was unable to reach the member's county mental health provider/county clinic, following at least three documented outreach attempts, for the purpose of care coordination of the member's mental health needs.	Of the total reported in A, the number of members for whom the MMP was unable to reach the member's county mental health provider/county clinic, following at least three documented outreach attempts, for the purpose of care coordination of the member's mental health needs during the reporting period.	Field Type: Numeric  Note: Is a subset of A.
C.	Total number of members for whom the MMP successfully contacted the member's county mental health provider/county clinic for the purpose of care coordination of the member's mental health needs.	Of the total reported in A, the number of members for whom the MMP successfully contacted the member's county mental health provider/county clinic for the purpose of care coordination of the member's mental health needs during the reporting period.	Field Type: Numeric  Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of members the MMP was unable to reach, following at least three documented outreach attempts, for the purpose of care coordination of the member's mental health needs.	Of the total reported in A, the number of members the MMP was unable to reach, following at least three documented outreach attempts, for the purpose of care coordination of the member's mental health needs during the reporting period.	Field Type: Numeric Note: Is a subset of A.
E.	Total number of members the MMP successfully contacted for the purpose of care coordination of the member's mental health needs.	Of the total reported in A, the number of members the MMP successfully contacted for the purpose of care coordination of the member's mental health needs during the reporting period.	Field Type: Numeric Note: Is a subset of A.

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

- Guidance will be forthcoming on the established benchmark for this measure for DY 3.

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, D, and E are less than or equal to data element A.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of members who have been continuously enrolled in the same MMP for at least five months during the reporting period who have received Medi-Cal specialty mental health services for three or more consecutive months during the reporting period:

- For whom the MMP successfully contacted the member's county mental health provider/county clinic for the purpose of care coordination of the member's mental health needs during the reporting period.
- For whom the member's county mental health provider/county clinic could be reached and who the MMP was able to successfully contact for the purpose of care coordination of the member's mental health needs during the reporting period (i.e., data element A minus data element B will serve as the denominator).
- Who the MMP successfully contacted for the purpose of care coordination of the member's mental health needs during the reporting period.
- Who could be reached and who the MMP was able to successfully contact for the purpose of care coordination of the member's mental health needs during the reporting period (i.e., data element A minus data element D will serve as the denominator).

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 data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- Medi-Cal specialty mental health services are financed and administered by county agencies under the provisions of the 1915(b) SMHS waiver. For more information, including a list of specialty mental health services, refer to the Coordinated Care Initiative and Behavioral Health Services Fact Sheet available at: <http://www.calduals.org/wp-content/uploads/2013/03/FAQ-BH.pdf>
- To identify members who have received Medi-Cal specialty mental health services for three or more consecutive months during the reporting period, MMPs should refer to information provided by the county agencies and/or claims data provided by the State.
- For information about care coordination expectations, MMPs should refer to the California three-way contract, which delineates care coordination requirements in several sections. The contract also highlights the California Welfare and Institutions (WIC) Code for the definition and administration of care coordination (see WIC Sections 14182.17(d)(4) and 14186(b)). MMPs are encouraged to reference the contract and the WIC code for guidance on care coordination for all members, including members receiving Medi-Cal specialty mental health services.

- For data element B, the MMP should only report those members for whom the MMP was unable to reach the member's county mental health provider/county clinic following at least three documented outreach attempts for the purpose of care coordination of the member's mental health needs during the reporting period. Documentation of outreach attempts must include:
  - The name of the member's county mental health provider/county clinic;
  - The name of the person the MMP attempted to contact at the member's county mental health provider/county clinic;
  - The time and date of the outreach attempt;
  - The method of the outreach attempt (e.g., phone, email, fax, in-person, etc.);
  - The outcome of the outreach attempt.
- For data element C, successful contact occurs when the MMP and county provider discuss diagnoses (including medical, behavioral, and social needs), review treatment plans, and/or coordinate mental health services provided by the county provider with any of the services (e.g., medical, LTSS, etc.) provided by the MMP. This exchange of information may be conducted via phone, secure email, fax, or in person. If the county provider is reached, but is not able to discuss the member's case at that time (e.g., due to lack of signed release), then the contact is not considered successful, but may be counted as an outreach attempt.
- Data elements B and C are mutually exclusive (i.e., the same member should not be counted in both data elements B and C). If the member's county mental health provider/county clinic was not reached after three outreach attempts, but then subsequently is successfully contacted during the reporting period for the purpose of care coordination of the member's mental health needs, then the member should be counted in data element C.
- For data element D, the MMP should only report those members the MMP was unable to reach following at least three outreach attempts to contact the member for the purpose of care coordination of the member's mental health needs during the reporting period. Documentation of outreach attempts must include:
  - The time and date of the outreach attempt;
  - The method of the outreach attempt (e.g., phone, email, fax, in-person, etc.);
  - The outcome of the outreach attempt.
- For data element E, successful contact occurs when the MMP and member discuss the member's mental health needs and services, and how those services may be coordinated with other services (e.g., medical, LTSS, etc.) provided by the MMP. This discussion may be conducted via phone, secure email, fax, or in person.



- Data elements D and E are mutually exclusive (i.e., the same member should not be counted in both data elements D and E). If the member was not reached after three outreach attempts, but then subsequently is successfully contacted during the reporting period for the purpose of care coordination of the member's mental health needs, then the member should be counted in data element E.
- Data elements B and C are not mutually exclusive with data elements D and E. For example, if a member's county mental health provider/county clinic was not reached after three outreach attempts, but the member was successfully contacted during the reporting period for the purpose of care coordination of his/her mental health needs, then the member would be reported in both data elements B and E.
- The MMP does not have to conduct separate outreach to the member for the specific purpose of care coordination of the member's mental health needs (i.e., the MMP may discuss the member's mental health needs as part of its broader care coordination efforts, such as when conducting the health risk assessment or developing the care plan). If the MMP discusses the member's mental health needs when conducting the health risk assessment or developing the care plan (or as part of other care coordination efforts), the MMP must clearly document the outcome of the interaction with the member, following the instructions for documenting outreach attempts as noted above.
- The outreach attempts are meant to coordinate the mental health services being provided at the county with any of the services (e.g., medical, LTSS, etc.) that the MMP is providing.

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. – **Retired**

## 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. – **Retired**

## 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	Annually	Contract	Calendar Quarters Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the fourth month following the last day of the final quarterly reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of acute inpatient hospital discharges.	Total number of acute inpatient hospital discharges during the reporting period.	Field Type: Numeric

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

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

- CMS and the state will perform an outlier analysis.
- As data are received from 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 acute inpatient hospital discharges that resulted in an ambulatory care follow-up visit within 30 days after discharge from the inpatient hospital stay.

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

- MMPs should include all inpatient hospital discharges for members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all inpatient hospital discharges for members who meet the criteria outlined in data element A and who were continuously enrolled from the date of the inpatient hospital discharge through 30 days after the inpatient hospital discharge, regardless of whether they are disenrolled as of the end of the reporting period.
- The denominator for this measure is based on inpatient hospital discharges, not members.

- 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 inpatient hospital discharge through 30 days after the inpatient 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 the Ambulatory Visits value set and Other Ambulatory Visits value set. MMPs should report ambulatory care follow-up visits based on all visits identified, including denied and pended claims, and including encounter data as necessary in cases where follow-up care is included as part of a bundled payment covering the services delivered during the inpatient stay. MMPs should use all information available, including encounter data supplied by providers, to ensure complete and accurate reporting.
- To identify all acute inpatient hospital discharges during the reporting period (data element A):
  - Identify all acute and nonacute inpatient stays (Inpatient Stay value set).
  - Exclude nonacute inpatient stays (Nonacute Inpatient Stay value set)
  - Identify the discharge date for the stay. The date of discharge should be within the reporting period.

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

- MMPs should report discharges based on all inpatient stays identified, including denied and pended claims.
- If the discharge is followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period, count only the last discharge for reporting in data element A. To identify readmissions and direct transfers to an acute inpatient care setting:
  - Identify all acute and nonacute inpatient stays (Inpatient Stay value set)
  - Exclude nonacute inpatient stays (Nonacute Inpatient Stay value set)
  - Identify the admission date for the stay
- Exclude from data element A any discharges followed by readmission or direct transfer to a nonacute inpatient care setting

within the 30-day follow-up period. To identify readmissions and direct transfers to a nonacute inpatient care setting:

- Identify all acute and nonacute inpatient stays (Inpatient Stay value set)
- Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay value set) on the claim
- Identify the admission date for the stay

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

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

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.<sup>i, ii</sup>

<b>CONTINUOUS REPORTING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
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.
- Guidance will be forthcoming on the established benchmark for this measure for DY 2 through 5.
- 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 data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
  - The 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 California 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**

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

<b>IMPLEMENTATION</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
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
<b>ONGOING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Periods</b>	<b>Due Date</b>
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.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
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 data 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.

- Nursing facility services include any type of nursing facility care, including skilled and custodial services.
- It may be possible for a member to receive services from IHSS, CBAS, MSSP, and/or NF during the same quarterly reporting period. Certain services, such as NF services, cannot be received during the same month as IHSS, CBAS, and MSSP services, but they can be received during sequential months during the same quarterly reporting period. If a member receives services from more than one type of LTSS, they should be reported in all applicable data elements. For example, if a member received both IHSS and MSSP services during the same reporting period, he/she would be reported in data elements A and C. The MMP should report the critical incident/abuse report for the service during which the incident or abuse occurred. Using the example above, if the member had a reported critical incident while receiving MSSP services, the critical incident would be reported in data element G only. If the member received multiple services during the reporting period, the critical incident/abuse should only be reported once and MMPs should use their best judgment on which data element to report the critical incident/abuse.

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.<sup>i</sup>

<b>CONTINUOUS REPORTING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
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.
  - 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 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: [pmp.monitoring@dhcs.ca.gov](mailto:pmp.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.<sup>i</sup> – **Retired**

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 California three-way contract for specific requirements pertaining to care coordinators.
  - MMPs should refer to the California 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.<sup>ii</sup>

<b>CONTINUOUS REPORTING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
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.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
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.
- Guidance will be forthcoming on the established benchmark for this measure for DY 2 through 5.
- 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.

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 data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- Members 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 include all members with any diagnosis of serious mental illness *and/or* SUD, regardless of whether the diagnosis of mental illness *and/or* SUD is the primary diagnosis on the claim.
- MMPs should exclude ED visits (ED value set) or observation stays (Observation value set) that resulted in an inpatient stay (Inpatient Stay value set). An ED visit or observation stay results in an inpatient stay when the ED/observation date of service and the admission date for the inpatient stay are one calendar day apart or less.
- 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 (Mental Health Diagnosis value set). In the case where the member enrolled



for the first time within the reporting period (e.g., February 1, 2017 or later in 2017), MMPs can use Medicare or Medicaid claims in the 12 months prior to the member’s effective enrollment date to identify a mental illness diagnosis.

- 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 (AOD Abuse and Dependence value set). In the case where the member enrolled for the first time within the reporting period (e.g., February 1, 2017 or later in 2017), MMPs can use Medicare or Medicaid claims in the 12 months prior to the member’s effective enrollment date to identify a SUD diagnosis.

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.

<b>CONTINUOUS REPORTING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
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.

<b>CONTINUOUS REPORTING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
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.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
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.

Element Letter	Element Name	Definition	Allowable Values
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.	For the members 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.	For the members 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
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.	For the members 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

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
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 Note: Is a subset of G.
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 Note: Is a subset of G.
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.	For the members 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
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.	For the members 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

Element Letter	Element Name	Definition	Allowable Values
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.	For the members 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 45 days during the reporting period (i.e., January through December). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
- The date of transfer and the discharge back to any NF must occur within the same reporting period.
- 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.
- There are two ways for MMPs to identify members with diabetes: claim/encounter data and pharmacy data. The MMP must use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. Members may be identified as having diabetes during the current reporting period or the year prior to the current report period.
  - *Claim/encounter data.* Members who met any of the following criteria during the current reporting period or the

year prior to the current reporting period (count services that occur over both years):

- At least two visits of any combination of outpatient visits (Outpatient value set), observation visits (Observation value set), ED visits (ED value set), or nonacute inpatient encounters (Nonacute Inpatient value set) on different dates of service, with a diagnosis of diabetes (Diabetes value set). Visit type need not be the same for the two visits (e.g., one outpatient visit and one ED visit).
  - At least one acute inpatient encounter (Acute Inpatient value set) with a diagnosis of diabetes (Diabetes value set).
    - o *Pharmacy data.* Members who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the current reporting period or the year prior to the current reporting period (Diabetes Medications List).
- MMPs should identify members with a diagnosis of COPD using claims/encounter data. The member must have a least one diagnosis of COPD (COPD Diagnosis value set) during the reporting period to be captured in data elements C and I.
  - It is possible for a member to have multiple conditions (i.e., both diabetes and COPD). If a member has both a diabetes and a COPD diagnosis, then these members should be reported in all applicable data elements (i.e., data elements B, C, H, and I).
  - When determining members with a transfer from the NF and admission to an acute care hospital for any medical diagnosis (i.e., data elements D and J), include members with diabetes and COPD. In other words, members included in data elements D and J can have diabetes, COPD, and other medical diagnoses such as hypertension, asthma, heart failure, etc.
  - To identify a diabetes-related hospital admission, the member must have a primary diagnosis code listed in the Diabetes value set.
  - To identify a COPD-related hospital admission, the member must have a primary diagnosis code listed in the COPD Diagnosis value set.
  - 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.
  - 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.

### Identification of short and long stay residents

- 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 any 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.

#### 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>.