

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

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

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Illinois-Specific Reporting Requirements Appendix

Introduction

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

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

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

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

MMPs should contact the IL Help Desk at ILHelpDesk@norc.org with any questions about the Illinois state-specific appendix or the data submission process.

Definitions

Calendar Year: All annual measures are reported on a calendar year basis. For example, Calendar Year (CY) 2015 will represent January 1, 2015 through December 31, 2015.

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.

Implementation Period: The period of time starting with the first effective enrollment date, March 1, 2014 through December 31, 2014.

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

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.

Primary Care Provider (PCP): Nurse practitioners, physician assistants or physicians who are board certified or eligible for certification in one of the following specialties: family practice, internal medicine, general practice, obstetrics/gynecology, or geriatrics.

Variation from the Core Document

Core Measures 2.1, 2.2, and 2.3

For the following measures, the specifications for reporting will differ from the core requirement. Guidance for reporting Health Risk Screenings and Health Risk Assessments is provided below:

- Core Measure 2.1 - Members with an assessment completed within 90 days of enrollment.
 - For this measure, MMPs should report data on the number of members with a Health Risk Screening (HRS) completed within 90 days of enrollment. However, as outlined in section 2.6.1.1 of the three-way contract, if the MMP completed a Health Risk Assessment (HRA) in place of a HRS for any members, the MMP should include those members when it reports on the number of members who had an assessment completed within 90 days of enrollment (Core 2.1 Element D). If a MMP completed both an HRS and an HRA for a given member, that member should only be counted once when reporting Core 2.1.
- Core Measure 2.2 – Members with an assessment completed.
 - For this measure, MMPs should report data on the number of members with a Health Risk Screening (HRS) completed. However, as outlined in section 2.6.1.1 of the three-way contract, if the MMP completed a Health Risk Assessment (HRA) in place of an HRS for any members, the MMP should include those members when it reports on the number of members who had an assessment completed within the reporting period (Core 2.2 Element A) and the number of members enrolled for 90 days or longer who had an assessment completed (Core 2.2 Element C). If the MMP completed both an HRS and an HRA for a given member, that member should only be counted once when reporting Core 2.2.

- Core Measure 2.3 – Members with an annual reassessment.
 - For members classified as no or low risk, the MMP can conduct the annual reassessment using the Health Risk Screening (HRS) tool. However, as indicated in section 2.6.1.1 of the three-way contract, the MMP has the option to administer a Health Risk Assessment (HRA) in place of the HRS.
 - For members classified as moderate- or high-risk, the MMP must conduct the annual reassessment using the HRA tool.
 - When reporting Core 2.3, the MMP should include all annual reassessments completed, regardless if the annual reassessment was conducted using the HRA or HRS tool (i.e., include all no and low-risk members with an annual HRA/HRS and all moderate- and high-risk members with an annual HRA). If the MMP completed both an annual HRS and an annual HRA for a given member, only one annual reassessment should be counted for that member when reporting Core 2.3.

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). Illinois MMPs should use Determination of Need (DON) scores, supplemented by claims or enrollment data, to categorize members as nursing home certifiable. Individuals with DON scores of 29 or higher, as stated on the service plan shared with the MMP, can be considered nursing home certifiable.

In addition, MMPs should use other sources of data to confirm this information. Specifically:

- The daily 834 file distributed to MMPs by the state identifies waiver members by a two-digit waiver code (see below) and nursing home residents by a 12-digit code indicating the specific facility where the member resides. All waiver members can be categorized as nursing home certifiable provided they meet all other criteria for the measure elements. Nursing home residents may be considered nursing home certifiable if they meet all other criteria for the measure elements and have resided in the nursing facility for no more than 100 days.
- Claims data or rate cells to identify individuals using nursing home services or waiver services.

- The Department of Rehabilitative Services (DORS) or Department of Aging's systems, which identify whether the member is on a waiver as well as the date the member became eligible for a waiver.

The two-digit waiver codes used to indicate members' waiver enrollments are as follows:

Department of Aging		Traumatic Brain Injury		AIDS	
A0	Aging	B0	TBI	C0	AIDS
AT	**Aging Pre-Transition	BT	**TBI Pre-Transition	VT	**AIDS Pre-Transition
AY	**Aging Transition Year	BY	**TBI Transition Year	VY	**AIDS Transition Year
AW	**Aging Withdrawal	BW	**TBI Withdrawal	VW	**AIDS Withdrawal
Tech. Dependent Children		Department of Mental Health		Department of Rehabilitation	
G0	TDC Hospital Residing Care	MT	**MH Pre-Transition	H0	Physically Disabled
G1	TDC SNF/PED Care	MY	**MH Transition Year	HT	**DORS Pre-Transition
G4	TDC Hospital Negotiated Rate	MW	**MH Withdrawal	HY	**DORS Transition Year
G5	TDC SNF/PED Care Negotiated Rate			HW	**DORS Withdrawal
Developmentally Disabled		Department of Health and Family Services		Children with Complex Needs	
D0	DD Adult	DB	Death Date Presumed	BK	Children with Complex Behavioral Needs
D1	DD Children In home support	DC	Death Date Certified	CK	Children with Complex Medical Needs
D2	DD Children Residential	CB	Colbert Consent Decree		
DT	**DD Children Pre-Transition	WM	Williams Consent Decree		
DY	**DD Transition Year	FO	Supportive Living Facility resident		
DW	**DD Withdrawal				

**All Pre-Transition, Transition and Withdrawal codes are part of DHFS 'Money Follows the Person' Program.

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). Note that additional DY 2-5 state-specific quality withhold measures are reported separately through HEDIS[®].² For more information about the state-specific quality withhold measures, refer to the Quality Withhold Technical Notes (DY 1): Illinois-Specific Measures and the Quality Withhold Technical Notes (DY 2-5): Illinois-Specific Measures at <https://www.cms.gov/Medicare-Medicaid->

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

[Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPQualityWithOldMethodologyandTechnicalNotes.html](#).

Reporting on Disenrolled and Retro-disenrolled Members

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

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

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

MMPs may complete Health Risk Screenings (HRSs) and/or 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 HRS and/or HRA no sooner than 20 days before the individual's effective date of the passive enrollment.

For purposes of reporting data on HRS/HRA completions (Core 2.1, Core 2.2, and state-specific measure IL2.2), MMPs should report any HRS/HRA completed prior to the first effective enrollment date as if it was completed on the first effective enrollment date. For example, if a member's first effective enrollment date was November 1 and the HRS/HRA for that member was completed on October 25, the MMP should report the HRS/HRA as if it were completed on November 1.

MMPs should refer to the Core reporting requirements for detailed specifications for reporting Core 2.1 and Core 2.2, and to this document for specifications on reporting IL2.2. 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 November 1 would reach their 90th day (i.e., three full months) on January

31. Therefore, these members would be reported in the data submission for the Quarter 1 reporting period, even if their HRS/HRA was marked as complete on the first effective enrollment date (i.e., November 1).

Note that this document also contains additional guidance regarding reporting HRS/HRA completions under Core 2.1 and Core 2.2 (see above in the “Variation from the Core Document” section). For these Core measures, MMPs should report on the number of members with a HRS completed. However, as outlined in section 2.6.1.1 of the three-way contract, if the MMP completes a HRA in place of a HRS for any members, the MMP should include those members in the counts for Core 2.1 and Core 2.2. If a MMP completed both an HRS and an HRA for a given member, that member should only be counted once when reporting.

MMPs must also comply with contractually specified timelines regarding the completion of care plans. In the event that a care plan is also finalized prior to the first effective enrollment date, MMPs should report completion of the care plan (for measures Core 3.2 and IL3.2) as if it was completed on the first effective enrollment date. For example, if a member’s first effective enrollment date was November 1 and the care plan for that member was completed on October 27, the MMP should report the care plan as if it were completed on November 1.

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

Screenings and Assessments

If a MMP already completed a Health Risk Screening (HRS) or Health Risk Assessment (HRA) for a member that was previously enrolled, the MMP is not necessarily required to conduct a new HRS or HRA if the member rejoins the same MMP within 90 days of his/her most recent HRS or HRA. Instead, the MMP can:

1. Perform any risk stratification, claims data review, or other analyses as required by the three-way contract to detect any changes in the member’s condition since the HRS or 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 HRS or 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 HRS or HRA within the timeframe prescribed by the contract. For members that are stratified as no or low risk, the MMP must conduct an HRS (unless the MMP opts to conduct an HRA in

place of an HRS, as permitted by the contract). For members that are stratified as moderate- or high-risk, the MMP must conduct an HRA.

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

Once the MMP has conducted a new HRS or HRA as needed or confirmed that the prior HRS or HRA is still accurate, the MMP can mark the HRS or HRA as complete for the member's current enrollment. The MMP would then report that completion according to the specifications and additional guidance for Core 2.1 and Core 2.2 (MMPs should refer to the guidance provided in the "Variation from the Core Document" section). If the re-enrolled member is stratified as moderate- or high-risk, the HRA completion would also be counted in measure IL2.2. When reporting these measures, the MMP should count the 90 days from the member's most recent enrollment effective date, and should report the HRS or HRA based on the date the prior HRS or HRA was either confirmed to be accurate or a new HRS or 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 HRS or HRA.

If the MMP did not complete an HRS or HRA for the re-enrolled member during his/her prior enrollment period, or if it has been more than 90 days since the member's HRS or HRA was completed, the MMP is required to conduct an HRS or HRA for the member within the timeframe prescribed by the contract. For members that are stratified as no or low risk, the MMP must conduct an HRS (unless the plan opts to conduct an HRA in place of an HRS as permitted by the contract). For members that are stratified as moderate- or high-risk, the MMP must conduct an HRA. 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 HRS or 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).

Care Plans

If the MMP conducts a new HRS or HRA for the re-enrolled member, the MMP must revise the care plan accordingly within the timeframe prescribed by the contract. Once the care plan is revised, the MMP may mark the care plan as complete for the member's current enrollment. If the MMP determines that the prior HRS or HRA is still accurate and, therefore, no updates are required to the previously completed

care plan, the MMP may mark the care plan as complete for the current enrollment at the same time that the HRS or HRA is marked complete. The MMP would then follow the Core 3.2 and IL3.2 measure specifications for reporting the completion. Please note, for purposes of reporting, the care plan for the re-enrolled member should be classified as an *initial* care plan.

If the MMP did not complete a care plan for the re-enrolled member during his/her prior enrollment period, or if it has been more than 90 days since the member's care plan was completed, the MMP is required to complete a care plan 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.

Reassessments and Care Plan Updates

As required by the contract, the MMP must analyze predictive modeling reports and other surveillance data of all members to identify risk level changes on a monthly basis. If risk levels change, the MMP must conduct reassessments as necessary and update the care plans and interventions. The MMP must also review care plans and interventions at least every 30 days for high-risk members and at least every 90 days for moderate-risk members. The MMP must conduct reassessments as necessary based on such reviews.

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

Guidance on Adopting Screenings and Assessments Completed Previously by an Affiliated Plan

When a member moves from an Integrated Care Program (ICP) plan or a Managed Long Term Services and Supports (MLTSS) plan to an affiliated MMAI MMP within 90 days of completing a Health Risk Screening (HRS) or Health Risk Assessment (HRA), the MMP is not necessarily required to conduct a new HRS/HRA. Instead, the MMP must contact the member (or his/her authorized representative) to ensure that the HRS/HRA is up to date and that there has been no change to the member's health status or needs in the prior 90 days. If the MMP confirms and documents that there have been no changes, then the MMP is not required to complete a new HRS/HRA. If there has been a change in the member's health status or needs since the initial HRS/HRA, regardless of when the ICP plan or MLTSS plan completed the

HRS/HRA, the MMP must attempt to conduct a new HRS and/or HRA (when applicable).

If it has been more than 90 days since the original HRS/HRA was completed while the member was enrolled in the ICP plan or MLTSS plan, the MMP must attempt to complete a new HRS and/or HRA (when applicable). The MMP is required to follow contractual requirements when conducting HRSs and HRAs.

Once the MMP has conducted a new HRS/HRA as needed or confirmed that the prior HRS/HRA is still accurate, the MMP can mark the HRS/HRA as complete for the member's current enrollment. The MMP would then report that completion according to the specifications and additional guidance for Core 2.1 and Core 2.2 (MMPs should refer to the guidance provided in the "Variation from the Core Document" section). If the re-enrolled member is stratified as moderate- or high-risk, the HRA completion would also be counted in measure IL2.2. When reporting these measures, the MMP should count the 90 days from the member's most recent enrollment effective date, and should report the HRS/HRA based on the date the prior HRS/HRA was either confirmed to be accurate or a new HRS/HRA was completed.

For Core 2.3, members with an annual reassessment, MMPs should determine whether members are eligible for an annual HRS/HRA using the actual date the initial HRS/HRA was completed, even if that date occurred when the member was enrolled in the ICP plan or MLTSS plan.

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

Illinois' Implementation, Ongoing, and Continuous Reporting Periods

Phase		Dates	Explanation
Demonstration Year 1			
Continuous Reporting	Implementation Period	3-1-14 through 12-31-14	From the first effective enrollment date through the end of tenth month of the demonstration.
	Ongoing Period	3-1-14 through 12-31-15	From the first effective enrollment date through the end of the first demonstration year.
Demonstration Year 2			
Continuous Reporting	Ongoing Period	1-1-16 through 12-31-16	From January 1, 2016 through the end of the second demonstration year.
Demonstration Year 3			
Continuous Reporting	Ongoing Period	1-1-17 through 12-31-17	From January 1, 2017 through the end of the third demonstration year.
Demonstration Year 4			
Continuous Reporting	Ongoing Period	1-1-18 through 12-31-18	From January 1, 2018 through the end of the fourth demonstration year.
Demonstration Year 5			
Continuous Reporting	Ongoing Period	1-1-19 through 12-31-19	From January 1, 2019 through the end of the fifth demonstration year.

Data Submission

All MMPs will submit state-specific measure data through the web-based Financial Alignment Initiative Data Collection System (FAI DCS) (unless otherwise specified in the measure description). All data submissions must be submitted to this site by 5:00p.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 IL HelpDesk (ILHelpDesk@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.
2. After review of the request, the IL HelpDesk will notify the MMP once the FAI DCS and/or HPMS has been re-opened.
3. Resubmit data through the applicable reporting system.
4. Notify the IL 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 ILI. Access

IL1.1 Adults access to preventive/ambulatory health services. (ICP AAP Measure) – **Retired**

Section ILII. Assessment

IL2.1 Behavioral health risk assessment and follow-up. (ICP IBHR Measure) – **Retired**

IL2.2 Moderate- and high-risk members with a health risk assessment completed within 90 days of enrollment.ⁱ

IMPLEMENTATION				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
IL2. Assessment	Monthly, beginning after 90 days	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	Reporting Frequency	Level	Reporting Periods	Due Date
IL2. Assessment	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of moderate-risk members enrolled whose 90th day of enrollment occurred within the reporting period.	Total number of moderate-risk members enrolled whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of moderate-risk members who are documented as unwilling to complete a health risk assessment (HRA) within 90 days of enrollment.	Of the total reported in A, the number of moderate-risk members who are documented as unwilling to complete a HRA within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of moderate-risk members the MMP was unable to reach, following five documented outreach attempts, to participate in the HRA within 60 days of enrollment.	Of the total reported in A, the number of moderate-risk members the MMP was unable to reach, following five documented outreach attempts, to participate in the HRA within 60 days of enrollment.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of moderate-risk members with a HRA completed within 90 days of enrollment.	Of the total reported in A, the number of moderate-risk members with a HRA completed within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A.
E.	Total number of high-risk members enrolled whose 90th day of enrollment occurred within the reporting period.	Total number of high-risk members enrolled whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric
F.	Total number of high-risk members who are documented as unwilling to complete a HRA within 90 days of enrollment.	Of the total reported in E, the number of high-risk members who are documented as unwilling to complete a HRA within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of E.

Element Letter	Element Name	Definition	Allowable Values
G.	Total number of high-risk members the MMP was unable to reach, following five documented outreach attempts, to participate in the HRA within 60 days of enrollment.	Of the total reported in E, the number of high-risk members the MMP was unable to reach, following five documented outreach attempts, to participate in the HRA within 60 days of enrollment.	Field Type: Numeric Note: Is a subset of E.
H.	Total number of high-risk members with a HRA completed within 90 days of enrollment.	Of the total reported in E, the number of high-risk members with a HRA completed within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of E.

- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will perform an outlier analysis.
 - As data are received from MMPs over time, CMS and the state will apply threshold checks.
- C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.
- Confirm those data elements listed above as subsets of other elements.
 - MMPs should validate that data elements B, C, and D are less than or equal to data element A.
 - MMPs should validate that data elements F, G, and H are 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:
- Moderate-risk members who were unable to be reached within 60 days to have a HRA.
 - Moderate-risk members who refused to have a HRA completed within 90 days of enrollment.
 - Moderate-risk members who had a HRA completed within 90 days of enrollment.
 - Moderate-risk members who were willing to participate and who could be reached who had a HRA completed within 90 days of enrollment.
 - High-risk members who were unable to be reached within 60 days to have a HRA.

- High-risk members who refused to have a HRA completed within 90 days of enrollment.
 - High-risk members who had a HRA completed within 90 days of enrollment.
 - High-risk members who were willing to participate and who could be reached who had a HRA completed within 90 days of enrollment.
- 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 and data element E regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members whose 90th day of enrollment occurred during the reporting period regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
 - The 90th day of enrollment should be based on each member's effective date. For purposes of reporting this measure, 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.
 - MMPs should only report HRAs completed when reporting this measure, as opposed to Health Risk Screenings (HRS).
 - MMPs should refer to IL's three-way contract for specific requirements pertaining to a HRA.
 - Moderate-risk members are members identified as needing supportive Care Management services.
 - High-risk members are members identified as needing intensive Care Management services.
 - For data elements B and F, MMPs should report the number of members who were documented as unwilling to participate in the HRA if a member (or his or her authorized representative):
 - i. Affirmatively declines to participate in the HRA. Member communicates this refusal by phone, mail, fax, or in person. The declination must be documented by the MMP.
 - ii. Expresses willingness to complete the HRA but asks for it to be conducted after 90 days (despite being offered a reasonable opportunity to complete the HRA within 90 days). Discussions with the member must be documented by the MMP.
 - iii. Expresses willingness to complete the HRA, but reschedules or is a no-show and then is subsequently non-responsive. Attempts to contact the member must be documented by the MMP.

- iv. Initially agrees to complete the HRA, but then declines to answer a majority of the questions in the assessment. The declination must be documented by the MMP.
- For data elements C and G, MMPs should report the number of members the MMP was unable to reach after the requisite number of attempts to contact the member. MMPs should refer to the IL three-way contract or state guidance for any specific requirements pertaining to the method of outreach to members (e.g., outreach attempts must be on different days of the week and at different times during the day). MMPs must document each attempt to reach the member, including the method of the attempt (i.e., phone, mail, or email), as CMS and the state may validate this number. There may be instances when the MMP has a high degree of confidence that a member's contact information is correct, yet that member is not responsive to the MMP's outreach efforts. So long as the MMP follows the guidance regarding outreach attempts, these members may be included in the count for this data element.
- Members reported in data elements B, C, and D must also be reported in data element A, and members reported in data elements F, G, and H must also be reported in data element E since these data elements are subsets of data elements A and E, respectively. Additionally, data elements B, C, and D (moderate-risk members) and data elements F, G, and H (high-risk members) should be mutually exclusive (e.g., a member reported in data element B or C should not also be reported in data element D). If a member could meet the criteria for multiple data elements (e.g., B, C, or D for moderate-risk members) use the following guidance to ensure the member is included in only one of those three data elements:
 - i. If a member initially refused the HRA or could not be reached after five outreach attempts, but then subsequently completes the HRA within 90 days of enrollment, the member should be classified in data element D (moderate-risk members) or data element H (high-risk members).
 - ii. If a member was not reached after three outreach attempts, but then subsequently is reached and refuses the HRA within 90 days of enrollment, the member should be classified in data element B (moderate-risk members) or data element F (high-risk members).
- If a member initially could not be reached after five outreach attempts within 60 days of enrollment, but then subsequently completes the HRA within 90 days of enrollment, the member should be classified in data elements D or H, not data elements C or G.
- If a member initially could not be reached after five outreach attempts within 60 days of enrollment, but then subsequently is contacted and refuses to complete the HRA within 90 days of enrollment, the

member should be classified in data elements B or F, not data elements C or G.

- There may be certain circumstances that make it impossible or inappropriate to complete a HRA within 90 days of enrollment. For example, a member may be medically unable to respond and have no authorized representative to do so on their behalf, or a member may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for a HRA. However, MMPs should not include such members in the counts for data elements B, C, F, and G. However, this member would be included in data element A or E.
- If a member's HRA was started but not completed within 90 days of enrollment, then the HRA should not be considered completed and, therefore, would not be counted in data elements B, C, D, F, G, or H. However, this member would be included in data element A or E.

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

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

Section ILIII. Care Coordination

IL3.1 Members with care plans within 90 days of enrollment. – **Retired**

IL3.2 Members with documented discussions of care goals.ⁱ

IMPLEMENTATION				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
IL3. Care Coordination	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	Reporting Frequency	Level	Reporting Periods	Due Date
IL3. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1 – 3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

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

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

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

- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
 - CMS and the state will perform an outlier analysis.
 - As data are received from 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:
 - Members who had an initial care plan completed during the reporting period who had at least one documented discussion of care goals in the care plan.
 - Existing care plans 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. 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).

- MMPs should include all care plans that meet the criteria outlined in data element C, regardless of whether the members are disenrolled as of the end of the reporting period (i.e., include all care plans regardless of whether the members are currently enrolled or disenrolled as of the last day of the reporting period).
- Data element A should include all members whose care plan was completed for the first time during the reporting period (i.e., the member did not previously have a care plan completed prior to the start of the reporting period). There can be no more than one initial care plan completed per member. Only care plans that included participation from the member (or his/her authorized representative) in the completion of the care plan should be reported.
- MMPs should only include members in data element B when the discussion of care goals with the member (or his/her authorized representative) is clearly documented in the member's initial care plan.
- Data element C should include all existing care plans that were revised during the reporting period. MMPs should refer to the IL three-way contract for specific requirements pertaining to updating the care plan. Only care plans that included participation from the member (or his/her authorized representative) in the revision to the care plan should be reported.
- MMPs should only include care plans in data element D 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 care plan. If the initial care plan clearly documented the discussions of care goals, but those existing care goals were not revised or discussed, or new care goals are not discussed and documented during the revision of the care plan, then that care plan should not be reported in data element D.
- If a member has an initial care plan completed during the reporting period, and has their care plan revised during the same reporting period, then the member's initial care plan should be reported in data element A and the member's revised care plan should be reported in data element C.
- If a member's care plan is revised multiple times during the same reporting period, each revision should be reported in data element C. For example, if a member's care plan is revised twice during the same reporting period, two care plans should be counted in data element C.

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

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

IL3.3 Ambulatory care follow-up with a provider within 14 days of emergency department (ED) visit. (ICP IAPE Measure) – **Retired**

IL3.4 Ambulatory care follow-up within 30 days of inpatient hospital discharge.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
IL3. Care Coordination	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

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

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

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

- CMS and the state 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 of the discharge from the inpatient hospital stay.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- The 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.
 - The 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, the 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 established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>.

IL3.5 Follow-up with a provider within 30 days after an initial behavioral health diagnosis. (ICP IFUP Measure) – **Retired**

IL3.6 Movement of members within service populations.ⁱⁱ

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
IL3. Care Coordination	Annually	Contract	Calendar Year	By the end of the sixth month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members enrolled as of the <u>first day</u> of the reporting period.	Total number of members enrolled as of the <u>first day</u> of the reporting period.	Field Type: Numeric
B.	Total number of members classified as being in long term care (LTC) as of the <u>first day</u> of the reporting period.	Of the total reported in A, the number of members classified as being in LTC as of the <u>first day</u> of the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members not classified as being in LTC as of the <u>first day</u> of the reporting period.	Of the total reported in A, the number of members not classified as being in LTC as of the <u>first day</u> of the reporting period.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of members enrolled as of the <u>last day</u> of the reporting period.	Total number of members enrolled as of the <u>last day</u> of the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
E.	Total number of members classified as being in LTC as of the <u>last day</u> of the reporting period.	Of the total reported in D, the number of members classified as being in LTC as of the <u>last day</u> of the reporting period.	Field Type: Numeric Note: Is a subset of D.
F.	Total number of members not classified as being in LTC as of the <u>last day</u> of the reporting period.	Of the total reported in D, the number of members not classified as being in LTC as of the <u>last day</u> of the reporting period.	Field Type: Numeric Note: Is a subset of D.

- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- The quality withhold benchmark for Demonstration Years 2 through 5 is timely and accurate reporting according to the measure specifications. For more information, refer to the Quality Withhold Technical Notes (DY 2-5): Illinois-Specific Measures.
- C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.
- Confirm those data elements listed above are subsets of other elements.
 - MMPs should validate that data elements B and C are less than or equal to data element A.
 - MMPs should validate that data elements E and F are less than or equal to data element D.
 - MMPs should validate that the sum of data elements B and C is equal to data element A.
 - MMPs should validate that the sum of data elements E and F is equal to data element D.
 - All data elements should be positive values.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the number and percentage of members who were:
- Classified as being in LTC as of the first day of the reporting period.
 - Classified as being in LTC as of the last day of the reporting period.
 - Not classified as being in LTC as of the first day of the reporting period.
 - Not classified as being in LTC as of the last day 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.
 - Members classified as being in LTC (i.e., data elements B and E) are members who resided in a nursing facility for more than 90 days.
 - Members not classified as being in LTC (i.e., data elements C and F) are members in the Community, HCBS Waiver members, and members who resided in a nursing facility for 90 days or less.
 - When determining a member's LTC status, if a member is transferred from the nursing facility to an acute care facility and then is readmitted to any nursing facility within 30 days, the transfer and subsequent readmission does not disrupt the count of cumulative days. For example, if a member is transferred from the nursing facility to the hospital on day 83 and is subsequently readmitted to any nursing facility 24 days later, this will be counted as the same 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 84 for that episode, not as day 1.
 - When determining a member's LTC status, 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 towards the member's cumulative days in facility.
 - To establish a member's nursing facility status as of the first day of the reporting period, look back up to 120 days into the previous reporting period to determine the length of the nursing facility stay.
 - i. Members who had a length of stay of more than 90 days in a nursing facility are considered in LTC and should be included data element B.
 - ii. Members who had a length of stay of 90 days or less in a nursing facility are not considered as being in LTC and should be included in data element C.
 - To establish a member's nursing facility status as of the last day of the reporting period, look up to 120 days prior to the last day of the reporting period to determine length of the nursing facility stay.
 - i. Members who had a length of stay of more than 90 days in a nursing facility are considered in LTC and should be included in data element E.
 - ii. Members who had a length of stay of 90 days or less in a nursing facility are not considered as being in LTC and should be included in data element F.
 - Members should be classified as in LTC or not in LTC in accordance with the most accurate data that the MMP has access to. This may be

claims data for waiver services or nursing facilities or a lack of these types of claims for Community members. It may also be the rate cell definitions provided in the IL three-way contract.

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

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

Section ILIV. Enrollee Protections

IL4.1 The number of critical incident and abuse reports for members receiving LTSS.

IMPLEMENTATION				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
IL4. Enrollee Protections	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	Reporting Frequency	Level	Reporting Periods	Due Date
IL4. Enrollee Protections	Quarterly	Contract	Current Calendar Quarter Ex: 1/1 – 3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members receiving LTSS.	Total number of members receiving LTSS during the reporting period.	Field Type: Numeric
B.	Total number of critical incident and abuse reports.	Of the total reported in A, the number of critical incident and abuse reports during the reporting period.	Field Type: Numeric

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

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

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

- MMPs should validate that data element B is less than or equal to data element A.
 - 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 total critical incident and abuse reports per 1,000 members receiving LTSS 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).
 - For data element B, MMPs should include all new critical incident and abuse cases that are reported during the reporting period, regardless if 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.
 - To identify members receiving LTSS, MMPs should refer to the daily eligibility file provided by the Illinois Department of Healthcare and Family Services. If a member is on an HCBS waiver, a two-digit waiver code is included on that file indicating which waiver the client is enrolled in. If a member is in a Long Term Care (LTC) facility, the name of the LTC facility and the 12-digit provider number for that facility is included on the daily file.
 - It is possible for members to have more than one critical incident and/or abuse report during the reporting period. All critical incident and abuse reports during the reporting period should be counted.
 - 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.

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

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

Section ILV. Organizational Structure and Staffing

IL5.1 Americans with Disabilities Act (ADA) compliance.ⁱ – **Retired**

IL5.2 Care coordinator training for supporting self-direction under the demonstration.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
IL5. Organizational Structure and Staffing	Annually	Contract	Calendar Year	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of newly hired care coordinators (or those newly assigned to the MMP) who have been employed by the MMP for at least 30 days.	Total number of newly hired care coordinators (or those newly assigned to the MMP) who have been employed by the MMP for at least 30 days during the reporting period.	Field Type: Numeric
B.	Total number of newly hired care coordinators (or those newly assigned to the MMP) that have undergone training for supporting self-direction under the demonstration within the past 12 months.	Of the total reported in A, the number of newly hired care coordinators (or those newly assigned to the MMP) that have undergone training for supporting self-direction under the demonstration within the past 12 months.	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 newly hired care coordinators that have undergone state-based training for supporting self-direction.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should refer to IL’s three-way contract for specific requirements pertaining to a care coordinator.
 - MMPs should refer to IL’s three-way contract, section 2.6.7, for more information on self-directed care.
 - The total number of newly hired care coordinators includes all full-time and part-time staff, who have been employed by (or newly assigned to) the MMP for at least 30 days.
- F. Data Submission – how MMPs will submit data collected to CMS and the state.
- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address:
<https://Financial-Alignment-Initiative.NORC.org>.

Section ILVI. Performance and Quality Improvement

IL6.1 Adherence to antipsychotic medications for individuals with schizophrenia. (ICP SAA Measure) – **Retired**

IL6.2 Cervical cancer screening. (ICP CCS Measure) – **Retired**

IL6.3 Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications. (ICP SSD Measure) – **Retired**

IL6.4 Comprehensive diabetes care (administrative method). (ICP SCDC Measure) – **Retired**

IL6.5 Medication monitoring for patients with psychotic disorders. (ICP IMMP Measure) – **Retired**

IL6.6 Annual monitoring for patients on persistent medications. (ICP MPM Measure) – **Retired**

IL6.7 Use of high-risk medications in the elderly. (ICP SDAE Measure) – **Retired**

Section ILVII. Utilization

IL7.1 Coronary artery disease (CAD). (ICP ICAD Measure) – **Retired**

IL7.2 Heart Failure Admission Rate (PQI08). – **Retired**

IL7.3 Unduplicated members receiving HCBS and unduplicated members receiving nursing facility services.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
IL7. Utilization	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members.	Total number of members that were continuously enrolled for six months during the reporting period.	Field Type: Numeric
B.	Total number of eligible members receiving HCBS.	Of the total reported in A, the number of eligible members receiving HCBS during the reporting period who did not receive nursing facility services during the reporting period.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of eligible members receiving nursing facility services.	Of the total reported in A, the number of eligible members receiving nursing facility services during the reporting period who did not receive HCBS during the reporting period.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of eligible members receiving both HCBS and nursing facility services during the reporting period.	Of the total reported in A, the number of eligible members receiving both HCBS and nursing facility services 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.
- CMS and the state will perform an outlier analysis.
 - As data are received from MMPs over time, CMS and the state will apply threshold checks.
- C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.
- Confirm those data elements listed above as subsets of other elements.
 - MMPs should validate that data elements B, C, and D are less than or equal to data element A.
 - All data elements should be positive values.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will use enrollment data and will evaluate the following:
- The percentage of members receiving HCBS during the reporting period who did not receive nursing facility services during the reporting period.
 - The percentage of members receiving nursing facility services during the reporting period who did not receive HCBS during the reporting period.
 - The percentage of members receiving both HCBS and nursing facility 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 element A and who were continuously enrolled for 6 months during the reporting period, 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 data element A, members must be continuously enrolled for six months during the reporting period, with no gaps in enrollment, to be included in this measure.
 - Members receiving HCBS should only be counted for data element B (unduplicated). Members receiving nursing facility services should only be counted for data element C (unduplicated). Members receiving both HCBS and nursing facility services should only be counted for data element D (unduplicated). Data elements B, C and D are mutually exclusive.
 - Include members who were receiving HCBS or nursing facility services for any length of time during the reporting period.
 - HCBS refers to Home and Community Based Services.
 - Members are classified as in an HCBS waiver or nursing facility in accordance with the rate cell definitions provided in the IL three-way contract. For the purposes of this measure, all Waiver and Waiver Plus rate cell members would be classified as in an HCBS waiver. All members using nursing facility services, including either skilled or custodial services, would be classified as nursing facility users.
- F. Data Submission – how MMPs will submit data collected to CMS and the state.
- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address:
<https://Financial-Alignment-Initiative.NORC.org>.

IL7.4 Average length of receipt in HCBS.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
IL7. Utilization	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members receiving HCBS.	Total number of members receiving HCBS during the reporting period.	Field Type: Numeric
B.	Total number of days members were enrolled in HCBS.	Of the total reported in A, the number of days members were enrolled in HCBS 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 days members were enrolled in HCBS 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 if they are disenrolled as of the end of the

reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).

- HCBS refers to Home and Community Based Services.
- Members are classified as in an HCBS waiver or nursing facility in accordance with the rate cell definitions provided in the IL three-way contract. For the purposes of this measure, all Waiver and Waiver Plus rate cell members would be classified as in an HCBS waiver.

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

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

IL7.5 Long Term Care urinary tract infection admission rate and bacterial pneumonia admission rate. (ICP IUTI and IBPR Measures) – **Retired**

IL7.6 Long Term Care prevalence of hospital acquired pressure ulcers. (ICP IPPU Measure) – **Retired**

IL7.7 Inpatient hospital 30-day readmission rates. (ICP IIHR Measure) – **Retired**