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

Effective as of January 1, 2014, issued, November 10, 2014

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Massachusetts-Specific Reporting Requirements

Introduction

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

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

MMPs should refer to the core document for additional details regarding Demonstration-wide definitions, reporting phases and timelines, and sampling methodology except as otherwise specified in this document.

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

Definitions

Calendar Year: All annual measures are reported on a calendar year basis. Calendar year 2014 (CY1) will begin on January 1, 2014 and end on December 31, 2014.

Implementation Period: The period of time starting with the first effective passive enrollment date until the end of the second wave of passive enrollment. Massachusetts will have a minimum of two waves of passive enrollment.

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.

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

Primary Care Provider: 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

For the following measures, the specifications for One Care MMP reporting will differ from the core requirement:

- Core Measure 2.1 – Members with an assessment completed within 90 days of enrollment.
    - Data Submission: MMPs will submit data collected for this measure through the MassHealth-developed Monthly Enrollment and Assessment Progress Tracking tool, not HPMS. This measure will be reported monthly for the duration of the demonstration according to the reporting schedule for MassHealth's Monthly Enrollment and Assessment Tracking tool.
- Core Measure 2.2 – Members with an assessment completed.
    - Data Submission: MMPs will submit data collected for this measure through the MassHealth-developed Monthly Enrollment and Assessment Progress Tracking tool, not HPMS.
- Core Measure 5.3 – Establishment of a consumer advisory board.
    - Definition: Initially, as the holding of a board meeting that includes Consumers within 90 days of the first Effective Enrollment Date for the Demonstration; and on an ongoing basis, as the holding of a board meeting that includes consumers at least quarterly.
    - Reporting: During the implementation period, MMPs must submit within 150 days of the first demonstration passive enrollment effective date the meeting minutes for the first board meeting that includes consumers and that is held within 90 days of the first effective enrollment date. During the ongoing reporting period, MMPs must annually submit meeting minutes for board meetings that include consumers and that are held at least quarterly. For the first year, MMPs are required to report both the first meeting minutes during the implementation reporting phase, and subsequent meeting minutes as part of annual reporting for the ongoing reporting phase.

Quality Withhold Measures

The following measure from The Medicare-Medicaid Capitated Financial Alignment: Core Reporting Requirements will be a Quality Withhold Measure for demonstration years 2 and 3 for MMPs participating in the Massachusetts One Care Demonstration:

- Core Measure 6.1 - Screening for Clinical Depression and Follow-up Plan. (modified from NQF #0418)

State-specific quality withhold measures for demonstration years 2 and 3 will be released in future updates.

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.

CMS understands that 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 you 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.

Massachusetts Implementation, Ongoing, and Continuous Reporting Periods

Demonstration Year 1			
Phase		**Dates**	**Explanation**
Continuous Reporting	Implementation Period	1-1-14 through 6-30-14	From January 1st through June 30th, 2014
	Ongoing Period	1-1-14 through 12-31-14	From January 1st through December 31st, 2014.
Demonstration Year 2			
Continuous Reporting	Ongoing Period	1-1-15 through 12-31-15	From January 1st through the end of the second demonstration year.
Demonstration Year 3			
Continuous Reporting	Ongoing Period	1-1-16 through 12-31-16	From January 1st through the end of the third demonstration year.

Data Submission

Beginning November 1, 2014, all MMPs will submit data through the web-based Financial Alignment Initiative (FAI) Data Collection System. 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 plan. This information will be used to log in to the FAI system and complete the data submission.)

Section MAI. Care Coordination

MA1.1 Members with care plans within 90 days of enrollment.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
MA1. Care Coordination	Monthly, beginning after 90 days	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
MA1. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members enrolled whose 90th day of enrollment occurred within the reporting period.	Total number of members enrolled whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric
B.	Total number of members who are documented as unwilling to complete a care plan within 90 days of enrollment.	Of the total reported in A, the number of members who are documented as unwilling to complete a care plan within 90 days of enrollment.	Field type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of members the MMP was unable to locate, following three documented attempts within 90 days of enrollment.	Of the total reported in A, the number of members the MMP was unable to locate, following three documented attempts within 90 days of enrollment.	Field type: Numeric Note: Is a subset of A.
D.	Total number of members with a care plan completed within 90 days of enrollment.	Of the total reported in A, the number of members with a care plan completed within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A.

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

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

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

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

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

- Members who refused to have a care plan completed within 90 days of enrollment.
- Members who were unable to be located to have a care plan completed within 90 days of enrollment.
- Members who had a care plan completed within 90 days of enrollment.
- Members that were willing to participate and who could be located who had a care plan 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 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).

- The 90th day of enrollment should be based on each member's effective date of enrollment. For the 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 refer to the Massachusetts MOU and three-way contract for specific requirements pertaining to care plans.
- Failed attempts to contact a member to complete a care plan must be documented and CMS and the state may validate this number.

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

MA1.2 Members with documented discussions of care goals.[i]

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
MA1. 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**
MA1. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

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

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

- Percentage achieved by highest scoring ICO minus 10 points. Note: For withhold purposes, the measure is calculated as follows:
  - Denominator: Total members with a care plan developed (Data Element A) summed over four quarters.
  - Numerator: Total members with at least one documented discussion of care goals (Data Element B) summed over four quarters.
  - By summing the denominators and numerators before calculating the rate, the final calculation is adjusted for volume.

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 who had a care plan developed in the reporting period who had at least one documented discussion of care goals in the care plan.
- CMS and the state will evaluate the percentage of members who had a care plan developed 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.
- MMPs should include all members who meet the criteria outlined in 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).
- Development of the original care plan can be counted as a discussion of care goals if goals are clearly documented in the care plan.
- Documented discussions of care goals will be recorded in a member's electronic health record (EHR).

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

MA1.3 Members with LTSS needs who have an IL-LTSS Coordinator.[i]

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
MA1. Care Coordination	Monthly, beginning after 90 days	Contract	Current Month Ex: 1/1 – 1/31	According to the MassHealth reporting schedule for MassHealth's Monthly Enrollment and Assessment Tracking tool

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. Cell references under "Allowable Values" correspond to the MassHealth Monthly Enrollment and Assessment Tracking Tool.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members enrolled whose 90th day of enrollment occurred within the reporting period.	Total number of members enrolled whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric Corresponds to cell B28.

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of members identified with LTSS needs within 90 days of enrollment.	Of the total reported in A, the number of members identified with LTSS needs within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A. Corresponds to cell A25.
C.	Total number of members with LTSS needs who refused an IL-LTSS coordinator within 90 days of enrollment.	Of the total reported in B, the number of members with LTSS needs who refused an IL-LTSS coordinator within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of B. Corresponds to cell B25.
D.	Total number of members with LTSS needs who have a referral to an IL-LTSS coordinator within 90 days of enrollment.	Of the total reported in B, the number of members with LTSS needs who have a referral to an IL-LTSS coordinator within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of B. Corresponds to cell C25.
E.	Total number of members with LTSS needs that are in the C3 and F1 rating categories.	Of the total reported in B, the number of members with LTSS needs that are in the C3 and F1 rating categories.	Field Type: Numeric Note: Is a subset of B. Corresponds to cell D25.
F.	Total number of members with LTSS needs who are in the C3 and F1 rating categories who refused an IL-LTSS coordinator within 90 days of enrollment.	Of the total reported in E, the number of members with LTSS needs who are in the C3 and F1 rating categories who refused an IL-LTSS coordinator within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of E. Corresponds to cell E25.
G.	Total number of members with LTSS needs who are in the C3 and F1 rating categories who have a referral to an IL-LTSS coordinator within 90 days of enrollment.	Of the total reported in E, the number of members with LTSS needs who are in the C3 and F1 rating categories who have a referral to an IL-LTSS coordinator within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of E. Corresponds to cell F25.

Element Letter	Element Name	Definition	Allowable Values
H.	Total number of members with LTSS needs who are in the C3 and F1 rating categories who have met with an IL-LTSS coordinator within 90 days of enrollment.	Of the total reported in E, the number of members with LTSS needs who are in the C3 and F1 rating categories who have met with an IL-LTSS coordinator within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of E. Corresponds to cell H25.

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.

- Percentage achieved by highest scoring ICO minus 10 points. Note: For withhold purposes, the measure is calculated as follows:
  - Denominator: Members with LTSS needs (Date Element B) minus members who refuse a coordinator (Data Element C) summed over four quarters.
  - Numerator: Subset of the denominator who have a referral to an IL-LTSS coordinator within 90 days of enrollment (Data Element D) summed over four quarters.
  - By summing the denominators and numerators before calculating the rate, the final calculation is adjusted for volume.

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 elements C, D, and E are less than or equal to data element B.
- 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 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 LTSS needs identified within 90 days of enrollment. (B/A)
- Who refused an IL-LTSS coordinator within 90 days of enrollment. (C/B)
- Who have a referral to an IL-LTSS coordinator within 90 days of enrollment. (D/B)
- With LTSS needs identified who are in the C3 and F1 rating categories. (E/B)
- Who are in the C3 and F1 rating categories who refused an IL-LTSS coordinator within 90 days of enrollment. (F/E)

- Who are in the C3 and F1 rating categories who have a referral to an IL-LTSS coordinator within 90 days of enrollment. (G/E)
- Who are in the C3 and F1 rating categories who have met with an IL-LTSS coordinator within 90 days of enrollment. (H/E)

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Element A, regardless 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).
- The 90th day of enrollment should be based on each member's effective date of enrollment. For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months.
- MMPs should refer to the Massachusetts MOU and three-way contract for specific requirements pertaining to an IL-LTSS coordinator.
- LTSC refers to long term services and supports coordinator.
- CBO refers to Community Based Organization.
- F1 refers to facility-based care individuals identified as having a long-term facility stay of more than 90 days.
- C3 refers to community tier 3 high community need. Individuals who have a daily skilled need; two or more activities of daily living (ADL). Limitations and three days of skilled nursing need; and individuals with four or more ADL limitations.
- Identified LTSS members refers to members who were identified during the reporting period as having LTSS needs.
- Meeting with Coordinator refers to a face-to-face meeting with an IL-LTSS coordinator.
- Refuse refers to anyone who refuses an IL-LTSS coordinator.
- The effective date of enrollment is the first date of the member's coverage through the MMP.
- Element A: See cell B28 ("Total Enrollment") on the Monthly Enrollment and Assessment Progress Tracking tool.
- Element B: See cell A25 ("Total LTSS need identified") on the Monthly Enrollment and Assessment Progress Tracking tool.
- Element C: See cell B25 ("Total refused LTSC referrals") on the Monthly Enrollment and Assessment Progress Tracking tool.
- Element D: See cell C25 ("Total LTSC referrals made to CBOs" on the Monthly Enrollment and Assessment Progress Tracking tool.
- Element E: See cell D25 ("C3/F1 LTSS needs identified") on the Monthly Enrollment and Assessment Progress Tracking tool.
- Element F: See cell E25 ("C3/F1 refused LTSC referrals") on the Monthly Enrollment and Assessment Progress Tracking tool.

- Element G: See cell F25 (“C3/F1 LTSC referrals made to CBOs”) on the Monthly Enrollment and Assessment Progress Tracking tool.
- Element H: See cell H25 (“C3/F1 initial encounters by LTSCs”) on the Monthly Enrollment and Assessment Progress Tracking tool.

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 to MassHealth using MassHealth’s Monthly Enrollment and Assessment Tracking tool.

Section MAII. Enrollee Protections

MA2.1 The number of critical incident and abuse reports for members receiving LTSS.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
MA2. 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**
MA2. 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 members 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.

- 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 1,000 members receiving LTSS.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Element A, regardless 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).
- 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 MAIII. Organizational Structure and Staffing

MA3.1 Care coordinator training for supporting self-direction under the demonstration.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
MA3. 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 new care coordinators.	Total number of new care coordinators in the MMP during the reporting period.	Field Type: Numeric
B.	Total number of new care coordinators that have undergone state-based training for supporting self-direction under the demonstration.	Of the total reported in A, the number of new care coordinators that have undergone state-based training for supporting self-direction under the demonstration.	Field Type: Numeric Note: Is a subset of A.

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

- CMS and the state 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 new 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 the Massachusetts MOU and three-way contract for specific requirements pertaining to a care coordinator.
- MMPs should refer to the Massachusetts MOU and three-way contract for specific requirements pertaining to training for supporting self-direction.

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 MAIV. Performance and Quality Improvement

MA4.1 Mental Health Recovery Measure (MHRM©).

Note: The results of this measure will be obtained from a survey that the state will administer. MMPs will not be required to report for this measure.

MA4.2 Screening and brief counseling for unhealthy alcohol use.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
MA4. Performance and Quality Improvement	Annually	Contract	Two years	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 who had at least one visit during the two-year reporting period.	Total number of members who were enrolled as of December 31 of the prior year as well as December 31 of the current reporting period who had at least one visit or telephonic contact during the two-year reporting period.	Field Type: Numeric
B.	Total number of members who were screened for unhealthy alcohol use at least once during the two-year reporting period using a standardized screening tool.	Of the total reported in A, the number of members who were screened for unhealthy alcohol use at least once during the two-year reporting period using a standardized screening tool (e.g., AUDIT, CAGE, or AUDIT-C).	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of members who were positively identified as an unhealthy alcohol user during the two-year reporting period.	Of the total reported in B, the number of members who were positively identified as an unhealthy alcohol user based on the results of the standardized screening tool during the two-year reporting period.	Field Type: Numeric Note: Is a subset of B.
D.	Total number of members who received an appropriate intervention during the two-year reporting period.	Of the total reported in C, the number of members who received an appropriate intervention (brief counseling or referral) during the two-year 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 C is less than or equal to data element B.
- 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 were screened for unhealthy alcohol use at least once during the two-year reporting period using a standardized screening tool.
- Members identified as an unhealthy alcohol user who received an appropriate intervention (brief counseling or referral) during the two-year reporting period.

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

- MMPs should include all members aged 23 years and older as of the last day of the reporting period, regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should only include members who were enrolled as of December 31st of the current reporting period and December 31st of the prior year.
- For reporting Element A, visits may include telephonic visits.
- For reporting Elements B-D, the Centralized Enrollee Record (CER) may be used to determine screening status and screening outcome.
- Appropriate intervention includes documentation of a brief (15 minutes or less) or more extensive (15 minutes or more) intervention regarding alcohol use or a referral to a substance abuse program.
- The reporting period for this measure is two years, but reporting will occur on an annual basis. The first reporting period will consist of data from CY14 and CY15, with the first data submission due three months after the end of CY15. The second reporting period will consist of data from CY15 and CY16 with data submission due three months after the end of CY16.
- AUDIT (The Alcohol Use Disorders Identification Test), CAGE, AUDIT-C, or MDS-HC assessment question MDS7 are the standardized screening tools used for screening unhealthy alcohol use.

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

MA4.3 Tobacco use: screening and cessation.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
MA4. Performance and Quality Improvement	Annually	Contract	Two years	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 who had at least one visit during the two-year reporting period.	Total number of members who were enrolled as of December 31 of the prior year as well as December 31 of the current reporting period who had at least one visit or telephonic contact during the two-year reporting period.	Field Type: Numeric
B.	Total number of members who were screened for tobacco use at least once during the two-year reporting period.	Of the total reported in A, the number of members who were screened for tobacco use at least once during the two-year reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members who were positively identified as a tobacco user during the two-year reporting period.	Of the total reported in B, the number of members who were positively identified as a tobacco user based on results of the tobacco screening during the two-year reporting period.	Field Type: Numeric Note: Is a subset of B.
D.	Total number of members who received tobacco cessation counseling intervention during the two-year reporting period.	Of the total reported in C, the number of members who received tobacco cessation counseling intervention during the two-year 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 C is less than or equal to data element B.
- 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 were screened for tobacco use at least once during the two-year reporting period.
- Members identified as a tobacco user who received tobacco cessation counseling intervention during the two-year reporting period.

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

- MMPs should include all members aged 23 years and older as of the last day of the reporting period, regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should only include members who were enrolled as of December 31st of the current reporting period and December 31st of the prior year.
- For reporting Element A, visits may include telephonic visits.
- For reporting Elements B-D, the Centralized Enrollee Record (CER) may be used to determine screening status and screening outcome.
- Tobacco use includes any type of tobacco.
- Tobacco cessation counseling intervention includes counseling, pharmacotherapy counseling with pharmacotherapy, or referral to a smoking cessation program.
- Exclude members diagnosed with a terminal illness.
- The reporting period for this measure is two years, but reporting will occur on an annual basis. The first reporting period will consist of data from CY14 and CY15, with the first data submission due three months after the end of CY2. The second reporting period will consist of data from CY15 and CY16 with data submission due three months after the end of CY16.

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

MA4.4 Medication reconciliation post-discharge.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
MA4. Performance and Quality Improvement	Annually	Contract	Calendar Year	By the end of the sixth month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of inpatient discharges.	Total number of inpatient discharges that occurred during the reporting period.	Field Type: Numeric
B.	Total number of inpatient discharges sampled that met inclusion criteria.	Of the total reported in A, the number of inpatient discharges sampled that met inclusion criteria.	Field type: Numeric Note: Is a subset of A.
C.	Total number of inpatient discharges that resulted in a medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse within 30 days following the inpatient discharge.	Of the total reported in B, the number of inpatient discharges that resulted in a medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse within 30 days following the inpatient discharge.	Field Type: Numeric Note: Is a subset of B.

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

- CMS and the state will perform an outlier analysis.
- As data are received from 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 C is less than or equal to data element B.
- 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 inpatient discharges that resulted in a medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse within 30 days following the inpatient discharge during the reporting period.

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

- MMPs should include all inpatient discharges for members aged 21 years and older[2], regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. A subset of all inpatient discharges for members that are eligible will be included in the sample.
- For reporting, the MMPs may elect to use a hybrid methodology and select a sample. Sampling should be systematic to ensure all eligible individuals have an equal chance of inclusion. The sample size should be 411, plus oversample to allow for substitution. For further instructions on selecting the sample size, please see pages 35-36 of the Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements on CMS' Web site: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html
- If an MMP does not elect to sample, data element B should be equal to data element A.
- The denominator for this measure is based on discharges, not members. If a member has more than one discharge, include all discharges on or between January 1 and December 1 of the reporting period.
- Members may not have any gaps in continuous enrollment and need to be continuously enrolled from the date of the inpatient discharge through 30 days after the inpatient discharge to be included in this measure.
- For data element A, discharges should only be included for members who met continuous enrollment criteria.
- Medication reconciliation is a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.
- If the discharge is followed by a readmission or direct transfer to an acute or nonacute facility within the 30-day follow-up period count only the

[2] The HEDIS eligible population for this measure is limited to individuals 66 years of age and older. The Massachusetts Demonstration population includes individuals ages 21 through 64 at the time of enrollment; therefore, this measure has been modified to apply to this population.

readmission discharge or the discharge from the facility to which the member was transferred.
- Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the reporting period.
- If a member remains in an acute or nonacute facility through December 1 of the reporting period, a discharge is not included in the measure for this member. However, the MMP must have a method for identifying the member's status for the remainder of the reporting period, and may not assume the member remained in the facility based only on the absence of a discharge before December 1.

Administrative Specifications
- If the MMP elects to only use administrative data, please refer to the HEDIS® Medication Reconciliation Value Set codes provided in Table MA-1 to identify numerator positive hits when using administrative data.

Hybrid Specifications
- If the MMP elects to use hybrid sampling, refer to the *Administrative Specifications* to identify positive numerator hits from administrative data.
- When reviewing a member's medical record, any of the following evidence should be documented in the medical record to meet criteria for this measure:
    - Notation that the medications prescribed or ordered upon discharge were reconciled with the current medications (in the outpatient record) by the appropriate practitioner type; or
    - A medication list in a discharge summary that is present in the outpatient chart and evidence of a reconciliation with the current medications conducted by an appropriate practitioner type (the MMP must be able to distinguish between the members discharge medications and the members current medications); or
    - Notation that no medications were prescribed or ordered upon discharge.
- Only documentation in the outpatient chart meets the intent of the measure, but an outpatient visit is not required.

Table MA-1: Codes to Identify Medication Reconciliation
CPT
99495, 99496, 1111F

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

MA4.5 Care for Adults

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
MA4. Performance and Quality Improvement	Annually	Contract	Calendar Year	By the end of the sixth month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total numbers of members continuously enrolled that were currently enrolled on the last day of the reporting period.	Total numbers of members continuously enrolled that were currently enrolled on the last day of the reporting period.	Field type: Numeric
B.	Total number of members sampled that met 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 who had both of the following completed on the same date of service during the reporting period: 1. At least one medication review conducted by a prescribing practitioner or clinical pharmacist. 2. The presence of a medication list in the medical record.	Of the total reported in B, the number of members who had both of the following completed on the same date of service during the reporting period: 1. At least one medication review conducted by a prescribing practitioner or clinical pharmacist. 2. The presence of a medication list in the medical record.	Field Type: Numeric Note: Is a subset of B.

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of members who had one functional status assessment completed during the reporting period.	Of the total reported in B, the number of members who had one functional status assessment completed during the reporting period.	Field Type: Numeric Note: Is a subset of B.
E.	Total number of members who had at least one pain screening or pain management plan completed during the reporting period.	Of the total reported in B, the number of members who had at least one pain screening or pain management plan completed during the reporting period.	Field Type: Numeric Note: Is a subset of B.

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

- CMS and the state will perform an outlier analysis.
- As data are received from 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 elements C, D, and E are less than or equal to data element B.
- 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 each of the following completed during the reporting period:

- Medication review.
- Functional status assessment.
- Pain assessment.

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

- MMPs should include all members aged 21 years and older[3], regardless of whether the member was enrolled through passive enrollment or opt-in

[3] The HEDIS eligible population for this measure is limited to individuals 66 years of age and older. The Massachusetts Demonstration population includes individuals ages 21 through 64 at the time of enrollment; therefore, this measure has been modified to apply to this population.

enrollment. A subset of all members that are eligible will be included in the sample. Medicaid-only members should not be included.

- For reporting, the MMPs may elect to use a hybrid methodology and select a sample. Sampling should be systematic to ensure all eligible individuals have an equal chance of inclusion. The sample size should be 411, plus oversample to allow for substitution. For further instructions on selecting the sample size, please see pages 35-36 of the Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements on CMS' Web site: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html
- If an MMP does not elect to sample, data element B should be equal to data element A.
- Members may not have more than one gap in continuous enrollment of up to 45 days during the reporting period.
- A medication list is a list of the member's medications in the medical record. The medication list may include medication names only or may include medication names, dosages and frequency, over-the-counter (OTC) medications and herbal or supplemental therapies.
- A medication review is a review of all a member's medications, including prescription medications, OTC medications, and herbal or supplemental therapies.
- A clinical pharmacist is a pharmacist with extensive education in the biomedical, pharmaceutical, sociobehavioral and clinical sciences. Clinical pharmacists are experts in the therapeutic use of medications and are a primary source of scientifically valid information and advice regarding the safe, appropriate and cost-effective use of medications. Most clinical pharmacists have a Doctor of Pharmacy (PharmD) degree and many have completed one or more years of post-graduate training (e.g., a general and/or specialty pharmacy residency). In some states, clinical pharmacists have prescriptive authority.
- A prescribing practitioner is a practitioner with prescribing privileges, including nurse practitioners, physician assistants and other non-MDs who have the authority to prescribe medications.

Administrative Specifications

Medication Review

- If the MMP elects to only use administrative data to identify members with a medication review completed (data element C), please refer to the HEDIS® Medication Review Value Set and Medication List Value Set codes provided in Table MA-2 to identify numerator positive hits when using administrative data. To be included in data element C, members must have had both completed on the same date of service during the reporting period.

Table MA-2: Codes to Identify Medication Review and Presence of Medication List
CPT
90862, 90863, 99605, 99606, 1160F

AND

CPT	OR	HCPCS
1159F		G8427

Functional Status Assessment

- If the MMP elects to only use administrative data to identify members with a functional status assessment completed (data element D), please refer to the HEDIS® Functional Status Assessment Value Set codes provided in Table MA-3 to identify numerator positive hits when using administrative data.

Table MA-3: Codes to Identify Functional Status Assessment
CPT
1170F

Pain Assessment

- If the MMP elects to only use administrative data to identify members with a pain assessment completed (data element E), please refer to the HEDIS® Pain Assessment Value Set codes provided in Table MA-4 to identify numerator positive hits when using administrative data.

Table MA-4: Codes to Identify Pain Assessment
CPT
1125F, 1126F

Hybrid Specifications

- If the MMP elects to use hybrid sampling, refer to the *Administrative Specifications* to identify positive numerator hits from administrative data.

Medication Review

- When reviewing a member's medical record, documentation must come from the same medical record and must include the following:
    - A medication list in the medical record, **and** evidence of a medication review by a prescribing practitioner or clinical pharmacist and the date when it was performed.
    - Notation that the member is not taking any medication and the date when it was noted.
- A review of side effects for a single medication at the time of prescription alone is not sufficient.

- An outpatient visit is not required to meet criteria.

Functional Status Assessment

- When reviewing a member's medical record, documentation must include evidence of a complete functional assessment and the date when it was performed.
- Notations for a complete functional status assessment must include one of the following:
    - Notation that Activities of Daily Living (ADL) were assessed (includes bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking).
    - Notation that Instrumental Activities of Daily Living (IADL) were assessed (includes shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances).
    - Result of assessment using a standardized functional status assessment tool, not limited to:
        1. SF-36®.
        2. Assessment of Living Skills and Resources (ALSAR).
        3. Barthel ADL Index Physical Self-Maintenance (ADLS) Scale.
        4. Bayer Activities of Daily Living (B-ADL) Scale.
        5. Barthel Index.
        6. Extended Activities of Daily Living (EADL) Scale.
        7. Independent Living Scale (ILS).
        8. Katz Index of Independence in Activities of Daily Living.
        9. Kenny Self-Care Evaluation.
        10. Klein-Bell Activities of Daily Living Scale.
        11. Kohlman Evaluation of Living Skills (KELS).
        12. Lawton & Brody's IADL scales.
    - Notation that at least three of the following four components were assessed:
        1. Cognitive status.
        2. Ambulation status.
        3. Sensory ability (including hearing, vision and speech).
        4. Other functional independence (e.g., exercise, ability to perform job).
- A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) does not meet criteria for a comprehensive functional status assessment. The components of the functional status assessment numerator may take place during separate visits within the reporting period.

Pain Assessment

- When reviewing a member's medical record, documentation in the medical record must include evidence of a pain assessment and the date when it was performed.
- Notations for a pain assessment must include one of the following:

- Documentation that the patient was assessed for pain (which may include positive or negative findings for pain).
- Result of assessment using a standardized pain assessment tool, not limited to:
    1. Numeric rating scales (verbal or written)
    2. Face, Legs, Activity, Cry, Consolability (FLACC) scale.
    3. Verbal descriptor scales (5–7 Word Scales, Present Pain Inventory).
    4. Pain Thermometer.
    5. Pictorial Pain Scales (Faces Pain Scale, Wong-Baker Pain Scale).
    6. Visual analogue scale.
    7. Brief Pain Inventory.
    8. Chronic Pain Grade.
    9. PROMIS Pain Intensity Scale.
    10. Pain Assessment in Advanced Dementia (PAINAD) Scale.

- Notation of a pain management plan alone does not meet criteria.
- Notation of a pain treatment plan alone does not meet criteria.
- Notation of screening for chest pain alone or documentation of chest pain alone does not meet criteria.

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 MAV. Systems

MA5.1 ICO Centralized Enrollee Record.[i]

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
MA5. Systems	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 Period**	**Due Date**
MA5. Systems	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 whose race data are collected and maintained in the ICO Centralized Enrollee Record.	Total number of members enrolled at the end of the reporting period whose race data are collected and maintained in the ICO Centralized Enrollee Record.	Field Type: Numeric
B.	Total number of members whose ethnicity data are collected and maintained in the ICO Centralized Enrollee Record.	Total number of members enrolled at the end of the reporting period whose ethnicity data are collected and maintained in the ICO Centralized Enrollee Record.	Field Type: Numeric
C.	Total number of members whose primary language data are collected and maintained in the ICO Centralized Enrollee Record.	Total number of members enrolled at the end of the reporting period whose primary language data are collected and maintained in the ICO Centralized Enrollee Record.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of members whose homelessness data are collected and maintained in the ICO Centralized Enrollee Record.	Total number of members enrolled at the end of the reporting period whose homelessness data are collected and maintained in the ICO Centralized Enrollee Record.	Field Type: Numeric
E.	Total number of members whose disability type data are collected and maintained in the ICO Centralized Enrollee Record.	Total number of members enrolled at the end of the reporting period whose disability type data are collected and maintained in the ICO Centralized Enrollee Record.	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.

- CY 2013: Timely reporting of all required data elements consistent with specifications.
- CY 2014: Percentage achieved by highest scoring ICO minus 10 points.
  Note: For withhold purposes, the measure is calculated as follows:
  - Denominator: Total number of members at the end of the reporting period times five (five is the number of required data elements).

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 obtain enrollment information and evaluate the percentage of members whose:

- Race data are collected and maintained in the ICO Centralized Enrollee Record.
- Ethnicity data are collected and maintained in the ICO Centralized Enrollee Record.
- Primary language data are collected and maintained in the ICO Centralized Enrollee Record.
- Homelessness data are collected and maintained in the ICO Centralized Enrollee Record.
- Disability type data are collected and maintained in the ICO Centralized Enrollee Record.

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 all data elements, please include the total number of members whose status is documented in the ICO Centralized Enrollee Record, regardless of the value.
    - For example, data element D captures the number of members whose homelessness data are collected and maintained in the ICO Centralized Enrollee Record. MMPs should report the total number of members who have this information documented, even if the member is not homeless. The number reported should not simply represent the number of documented homeless members.

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 MAVI. Utilization

MA6.1 Chronic obstructive pulmonary disease (COPD) or asthma in older adults admission rate.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
MA6. Utilization	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 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 member months for members age 40 and older.	Total number of member months during the reporting period for members age 40 and older.	Field Type: Numeric
B.	Total number of non-maternal discharges with an ICD-9-CM principal diagnosis code for COPD or asthma for members age 40 and older.	Total number of non-maternal discharges with an ICD-9-CM principal diagnosis code for COPD or asthma for members age 40 and older during the reporting period.	Field Type: Numeric Note: Select codes appearing in the primary diagnosis position must be accompanied by a secondary diagnosis of COPD.

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 discharges with a primary diagnosis of COPD or asthma per 100,000 member months for members age 40 and older.

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 member months for members who meet the criteria outlined in 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).
- MMPs should refer to pages 40-43 of the CMS Technical Specifications and Resource Manual for Federal Fiscal Year 2014 related to the Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Medicaid Adult Core Set) for further details on this measure: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-Adult-Core-Set-Manual.pdf
- To identify all non-maternal discharges with an ICD-9-CM principal diagnosis code for COPD, please refer to Table MA-5. Codes with an asterisk must be accompanied by a secondary diagnosis code of COPD. Please refer to Table MA-6 for diagnosis codes for Asthma.
- 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 1 and 12. A value greater than 12 is not acceptable. Determine member months using the 1st of the month. This date must be used consistent from member to member, month to month and from year to year. For example, if Ms. X is enrolled in the organization on January 1, Ms. X contributes one member month in January.
- For data element A, use the members' age on the specified day of each month to determine the age group to which member months will be contributed. For example, if an MMP tallies members on the 1st of each month and Ms. X turns 40 on April 3 and is enrolled for the entire year, then she contributes nine months to the 40 and older age group category.
- For data element B, age is based on the date of admission.
- MMPs should exclude:
  - Transfer from a hospital (different facility).
  - Transfer from a skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF).
  - Transfer from another health care facility.
  - MDC 14 (pregnancy, childbirth, and puerperium).

- ICD-9-CM diagnosis codes for cystic fibrosis and anomalies of the respiratory system. Codes to identify cystic fibrosis and anomalies of the respiratory system are provided in Table MA-7.

Table MA-5: Codes to Identify Chronic Obstructive Pulmonary Disease
ICD-9-CM
4660*, 490*, 4910, 4911, 49120, 49121, 4918, 4919, 4920, 4828, 4940, 4941, 496

*Must be accompanied by a secondary diagnosis of COPD

Table MA-6: Codes to Identify Asthma
ICD-9-CM
49300, 49301, 49302, 49310, 49311, 49312, 49320, 49321, 49322, 49381, 49382, 49390, 49391, 49392

Table MA-7: Codes to Identify Cystic Fibrosis and Anomalies of the Respiratory System
ICD-9-CM
27700, 27701, 27702, 27703, 27709, 51661, 51662, 51663, 51664, 51669, 74721, 7483, 7484, 7485, 74860, 74861, 74869, 7488, 7489, 7503, 7593, 7707

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

MA6.2 Congestive heart failure (CHF) admission rate.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
MA6. Utilization	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 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 member months for members age 18 and older.	Total number of member months during the reporting period for members age 18 and older.	Field Type: Numeric
B.	Total number of non-maternal discharges with an ICD-9-CM principal diagnosis code for CHF.	Total number of non-maternal discharges with an ICD-9-CM principal diagnosis code for CHF 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 discharges with a primary diagnosis of CHF per 100,000 member months for members age 18 and older.

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

- MMPs should include all members aged 18 years and older[4], 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 member months for members who meet the criteria outlined in 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).
- MMPs should refer to pages 44-50 of the CMS Technical Specifications and Resource Manual for Federal Fiscal Year 2014 related to the Initial

[4] Massachusetts Demonstration population includes individuals ages 21 through 64 at the time of enrollment; therefore, all members will be 18 years and older.

Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Medicaid Adult Core Set) for further details on this measure: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-Adult-Core-Set-Manual.pdf

- To identify all non-maternal discharges with an ICD-9-CM principal diagnosis code for CHF, please refer to Table MA-8.
- 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 1 and 12. A value greater than 12 is not acceptable. Determine member months using the 1st of the month. This date must be used consistent from member to member, month to month and from year to year. For example, if Ms. X is enrolled in the organization on January 1, Ms. X contributes one member month in January.
- Age is based on date of admission.
- MMPs should exclude:
  - Transfer from a hospital (different facility).
  - Transfer from a skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF).
  - Transfer from another health care facility.
  - MDC 14 (pregnancy, childbirth, and puerperium).
  - ICD-9-CM procedure codes for cardiac procedure. Codes to identify cardiac procedure are provided in Table MA-9.

Table MA-8: Codes to Identify Congestive Heart Failure

ICD-9-CM
39891, 4280, 4281, 42820, 42821, 42822, 42823, 42830, 42831, 42832, 42833, 42840, 42841, 42842, 42843, 4289

Table MA-9: Codes to Identify Cardiac Procedure

ICD-9-CM
50, 51, 52, 53, 54, 56, 57, 66, 1751, 1752, 1755, 3500, 3501, 3502, 3503, 3504, 3505, 3506, 3507, 3508, 3509, 3510, 3511, 3512, 3513, 3514, 3520, 3521, 3522, 3523, 3524, 3525, 3526, 3527, 3528, 3531, 3532, 3533, 3534, 3535, 3539, 3541, 3542, 3550, 3551, 3552, 3553, 3582, 3583, 3584, 3591, 3592, 3593, 3594, 3595, 3596, 3597, 3598, 3599, 3601, 3602, 3603, 3604, 3605, 3606, 3607, 3609, 3610, 3611, 3612, 3613, 3614, 3615, 3616, 3617, 3619, 362, 363, 3631, 3632, 3633, 3634, 3639, 3691, 3699, 3731, 3732, 3733, 3734, 3735, 3736, 3737, 3741, 375, 3554, 3555, 3560, 3561, 3562, 3563, 3570, 3571, 3572, 3573, 3581, 3766, 0, 3770, 3771, 3772, 3773, 3774, 3775, 3776, 3777, 3778, 3779, 3780, 3781, 3751, 3752, 3753, 3754, 3755, 3760, 3761, 3762, 3763, 3764, 3765, 3782, 0, 3783, 3785, 3786, 3787, 3789, 3794, 3795, 3796, 3797, 3798, 3826

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