MEDICARE-MEDICAID CAPITATED FINANCIAL ALIGNMENT MODEL REPORTING REQUIREMENTS: NEW YORK FIDA-SPECIFIC REPORTING REQUIREMENTS

Effective as of October 1, 2016; Issued April 13, 2017

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New York FIDA-Specific Reporting Requirements Appendix

Introduction

The measures in this appendix are required reporting for all plans participating in the New York Fully Integrated Duals Advantage (FIDA) Demonstration. CMS and the State of New York 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:

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

FIDA Plans should refer to the core document for additional details regarding 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 FIDA Plans 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.

FIDA Plans should contact the NY Help Desk at NYHelpDesk@norc.org with any questions about the New York state-specific appendix or the data submission process.

Definitions

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

Calendar Year: All annual measures are reported on a calendar year basis. For example, Calendar Year 2015 (CY1) will represent January 1, 2015 through December 31, 2015.

Community-based Long Term Services and Supports (LTSS): A range of medical, habilitation, rehabilitation, home care, or social services a person needs over months or years in order to improve or maintain function or health which are

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

provided in the person's home or community-based setting such as assisted-living facilities. These home and community-based services are designed to meet an individual's needs as an alternative to long-term nursing facility care and to enable a person to live as independently as possible. 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.

Facility-based Long-Term Services and Supports (LTSS): Facility-based LTSS are a range of medical, social, or rehabilitation services a person needs over months or years in order to improve or maintain function or health which are provided in a long-term care facility, such as a nursing facility (not including assisted living residences).

Implementation Period: The initial months of the demonstration during which FIDA plans will report to CMS and the State on a more intensive reporting schedule. The Implementation Period starts on the first effective enrollment date and continues until the end of the first 2015 calendar year quarter after the end of passive enrollment (January 1, 2015 – September 30, 2015).

Long stay: A long stay is an episode with cumulative days in facility greater than or equal to 101 days.

New to service: Eligible individuals who are not already receiving Facility-based or Community-based LTSS.

Primary Care Provider (PCP): Primary care physicians licensed by the State of New York and board certified in family practice, internal medicine, general practice, obstetrics/gynecology, or geriatrics, State licensed physician assistants, or a physician extender who is a registered nurse practitioner or advanced practice nurse or advanced practice nurse group practice within an acceptable specialty as required under State regulation.

Variations from the Core Document

Core 9.2

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

Core 9.2 focuses on "nursing home certifiable" members, defined as "members living in the community, but requiring an institutional level of care" (see the Core Reporting Requirements for more information). All Participants with a level of care (LOC) score of 5 or greater in the Uniform Assessment System for New York (UAS-NY) Community Health Assessment should be reported as nursing home certifiable. FIDA Plans must confirm that such Participants are living in the community and not in long-term nursing facility stay.

Quality Withhold Measures

CMS and the State of New York will establish a set of quality withhold measures, and FIDA Plans 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 and 3: ([ii]). For more information about the state-specific quality withhold measures for Demonstration Year 1, refer to the Quality Withhold Technical Notes (DY 1): New York-Specific Measures at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html. Additional information on the withhold methodology and benchmarks for Demonstration Years 2 and 3 will be provided at a later time.

In addition to the quality withhold measures identified in this appendix and the Core Reporting Requirements, the following measure from the Core Reporting Requirements will be a DY 2 and 3 state-specific quality withhold measure for plans participating in the FIDA Demonstration:

- Core Measure 9.2 – Nursing Facility Diversion

FIDA Plans will be required to report this measure according to the specifications in the Core Reporting Requirements.

Reporting on Disenrolled and Retro-disenrolled Participants

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

Due to retro-disenrollment of Participants, there may be instances where there is a lag between a Participant's effective disenrollment date and the date on which the FIDA Plan is informed about that disenrollment. This time lag might create occasional data inaccuracies if a FIDA Plan includes Participants in reports who had in fact disenrolled before the start of the reporting period. If FIDA Plans are aware at the time of reporting that a Participant 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 FIDA Plans may exclude that Participant from reporting. Please note that FIDA Plans are ***not*** required to re-submit corrected data should they be informed of a retro-disenrollment subsequent to a reporting deadline. FIDA Plans should act upon their best and most current knowledge at the time of reporting regarding each Participant's enrollment status.

Reporting on Assessments and PCSPs Completed Prior To First Effective Enrollment Date

For FIDA Plans that have requested and obtained CMS approval to do so, assessments may be completed up to 20 days prior to the individual's coverage effective date for individuals who are passively enrolled. Early assessment outreach for opt-in Participants is permitted for all participating FIDA Plans.

For purposes of reporting data on assessments (Core 2.1 and Core 2.2), FIDA Plans should report any assessments completed prior to the first effective enrollment date as if they were completed on the first effective enrollment date. For example, if a Participant's first effective enrollment date was June 1 and the assessment for that Participant was completed on May 25, the FIDA Plan should report the assessment as if it were completed on June 1.

FIDA Plans should refer to the Core reporting requirements for detailed specifications for reporting Core 2.1 and Core 2.2. For example, Core 2.1 should only include Participants whose 90th day of enrollment occurred during the reporting period. Participants enrolled into the FIDA Plan on January 1, 2015 would reach their 90th day (three full months) on March 31, 2015. Therefore, these Participants would be reported in the data submission for the March monthly reporting period, even if their assessment was marked as complete on the first effective enrollment date (i.e., January 1).

FIDA Plans must comply with the IDT Policy regarding completion of Person-Centered Service Plans (PCSPs) within 90 days of enrollment. In the event that a PCSP is also finalized prior to the first effective enrollment date, FIDA Plans should report completion of the PCSP (for measures NY2.1 and NY2.2) as if it were completed on the first effective enrollment date. For example, if a Participant's first effective enrollment date was June 1 and the PCSP for that Participant was completed on May 27, the FIDA Plan should report the PCSP as if it were completed on June 1.

Guidance on Assessments and PCSPs for Participants with a Break in Coverage

<u>Assessments</u>

If a FIDA Plan already completed an assessment for a Participant that was previously enrolled, the FIDA Plan is not necessarily required to conduct a new assessment if the Participant rejoins the same FIDA Plan within six months of his/her most recent assessment. Instead, the FIDA Plan 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 Participant's condition since the assessment was conducted; and

2. Ask the Participant (or his/her authorized representative) if there has been a change in the Participant's health status or needs since the assessment was conducted.

The FIDA Plan must document any risk stratification, claims data review, or other analyses that are performed to detect any changes in the Participant's condition. The FIDA Plan must also document its outreach attempts and the discussion(s) with the Participant (or his/her authorized representative) to determine if there was a change in the Participant's health status or needs.

If a change is identified, the FIDA Plan must conduct a new assessment within the timeframe prescribed by the contract. If there are no changes, the FIDA Plan is not required to conduct a new assessment unless requested by the Participant (or his/her authorized representative). Please note, if the FIDA Plan prefers to conduct assessments on all re-enrollees regardless of status, it may continue to do so.

Once the FIDA Plan has conducted a new assessment as needed or confirmed that the prior assessment is still accurate, the FIDA Plan can mark the assessment as complete for the Participant's current enrollment. The FIDA Plan would then report that completion according to the specifications for Core 2.1 and Core 2.2. When reporting these measures, the FIDA Plan should count the number of enrollment days from the Participant's most recent enrollment effective date, and should report the assessment based on the date the prior assessment was either confirmed to be accurate or a new assessment was completed.

If the FIDA Plan is unable to reach a re-enrolled Participant to determine if there was a change in health status, then the FIDA Plan may report that Participant as unable to be reached so long as the FIDA Plan made the requisite number of outreach attempts. If a re-enrolled Participant refuses to discuss his/her health status with the FIDA Plan, then the FIDA Plan may report that Participant as unwilling to participate in the assessment.

If the FIDA Plan did not complete an assessment for the re-enrolled Participant during his/her prior enrollment period, or if it has been more than six months since the Participant's assessment was completed, the FIDA Plan is required to conduct an assessment for the Participant within the timeframe prescribed by the contract. The FIDA Plan must make the requisite number of attempts to reach the Participant (at minimum) after their most recent enrollment effective date, even if the FIDA Plan reported that the Participant was unable to be reached during his/her prior enrollment. Similarly, Participants that refused the assessment during their prior enrollment must be asked again to participate (i.e., the FIDA Plan may not carry over a refusal from one enrollment period to the next).

<u>Person-Centered Service Plans (PCSP)</u>

If the FIDA Plan conducts a new assessment for the re-enrolled Participant, the Interdisciplinary Team (IDT) must revise the PCSP accordingly within the timeframe prescribed by the contract. Once the PCSP is revised, the FIDA Plan may mark the

PCSP as complete for the Participant's current enrollment. If the FIDA Plan determines that the prior assessment is still accurate and therefore the IDT does not need to update the previously completed PCSP, the FIDA Plan may mark the PCSP as complete for the current enrollment at the same time that the assessment is marked complete. The FIDA Plan would then follow the applicable state-specific measure specifications for reporting the completion. Please note, for purposes of reporting, the PCSP for the re-enrolled Participant should be classified as an *initial* PCSP.

If the IDT did not complete a PCSP for the re-enrolled Participant during his/her prior enrollment period, or if it has been more than six months since the Participant's PCSP was completed, the IDT is required to complete a PCSP for the Participant within the timeframe prescribed by the contract. The IDT must also follow the above guidance regarding reaching out to Participants that previously refused to participate or were not reached.

Reassessments and PCSP updates

The FIDA Plan must follow contract requirements regarding the completion of reassessments at least every six months, and the IDT should update the PCSP as necessary following the reassessment. If the FIDA Plan determined that an assessment from a Participant's prior enrollment was accurate and marked that assessment as complete for the Participant's current enrollment, the FIDA Plan should count from the date that the assessment was completed in the prior enrollment period to determine the due date for the reassessment and PCSP update. For example, when reporting Core 2.3, the FIDA Plan should count 365 days from the date when the assessment was actually completed, even if that date was during the Participant's prior enrollment period.

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

New York State's Implementation, Ongoing, and Continuous Reporting Periods

Phase		Dates	Explanation
Demonstration Year 1			
Continuous Reporting	Implementation Period	1-1-15 through 9-30-15	From the first effective enrollment date through the end of the first full quarter after the end of passive enrollment.
	Ongoing Period	1-1-15 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 1st through the end of the second demonstration year.
Demonstration Year 3			
Continuous Reporting	Ongoing Period	1-1-17 through 12-31-17	From January 1st through the end of the third demonstration year.

Data Submission

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

(Note: Prior to the first use of the system, all FIDA Plans 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).

All FIDA Plans 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

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

1. Email the NY HelpDesk (NYHelpDesk@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 NY HelpDesk will notify the FIDA Plan once the FAI Data Collection System and/or HPMS has been re-opened.

3. Resubmit data through the applicable reporting system.

4. Notify the NY 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 NYI. Assessment

NY1.1 Participants who enrolled through opt-in enrollment with an initial assessment completed within 30 days of enrollment. – ***Suspended***

NY1.2 Participants who are passively enrolled with an initial assessment completed within 60 days of enrollment. – ***Suspended***

NY1.3 Improvement and stability in Activities of Daily Living (ADL) functioning between the previous assessment and most recent assessment.[ii]

Please note: No FIDA Plan reporting is required for this measure; however, FIDA Plans must assist NYSDOH with data collection and analysis as needed.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
NY1. Assessment	Annually	Contract	Calendar Year	N/A

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

- Guidance will be forthcoming on the established threshold for this measure.

B. 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 percent of Participants in the FIDA Plan who remained stable or improved in ADL functioning between the previous assessment and most recent assessment.

Section NYII. Care Coordination

NY2.1 Participants with Person-Centered Service Plans (PCSPs) completed within 90 days of enrollment and PCSPs updated within 30 days of a reassessment.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
NY2. Care Coordination	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the second month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
NY2. 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 Participants enrolled whose 90th day of enrollment occurred within the reporting period.	Total number of Participants enrolled whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric
B.	Total number of Participants who are documented as unwilling to participate in the initial PCSP within 90 days of enrollment.	Of the total reported in A, the number of Participants who are documented as unwilling to participate in the initial PCSP 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 Participants the FIDA Plan was unable to reach, following no fewer than three documented attempts within 90 days of enrollment.	Of the total reported in A, the number of Participants the FIDA Plan was unable to reach, following no fewer than three documented attempts within 90 days of enrollment.	Field type: Numeric Note: Is a subset of A.
D.	The number of Participants with an initial PCSP completed within 90 days of enrollment.	Of the total reported in A, the number of Participants with an initial PCSP completed within 90 days of enrollment.	Field type: Numeric Note: Is a subset of A.
E.	Total number of reassessments completed during the reporting period.	Total number of reassessments completed during the reporting period for Participants who were continuously enrolled for 30 days following the completion of the reassessment.	Field Type: Numeric
F.	Total number of reassessments completed for which the Participant was documented as unwilling to participate in the revised PCSP within 30 days after the completion of the reassessment.	Of the total reported in E, the number of reassessments for which the Participant was documented as unwilling to participate in the revised PCSP within 30 days after the completion of the reassessment.	Field Type: Numeric Note: Is a subset of E.
G.	Total number of reassessments completed for which the Participant was unable to be reached, following no fewer than three documented attempts within 30 days after the completion of the reassessment.	Of the total reported in E, the number of reassessments for which the Participant was unable to be reached, following no fewer than three documented attempts within 30 days of the completion of the reassessment.	Field Type: Numeric Note: Is a subset of E.

Element Letter	Element Name	Definition	Allowable Values
H.	Total number of reassessments for which a revised PCSP was completed within 30 days after the reassessment.	Of the total reported in E, the number of reassessments for which a revised PCSP was completed within 30 days after the reassessment.	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 FIDA Plans over time, CMS and the State will apply threshold checks.

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

- Confirm those data elements listed above as subsets of other elements.
- FIDA Plans should validate that data elements B, C, and D are less than or equal to data element A.
- FIDA Plans 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 Participants who:

- Were unable to be reached to have an initial PCSP completed within 90 days of enrollment.
- Refused to have an initial PCSP completed within 90 days of enrollment.
- Had an initial PCSP completed within 90 days of enrollment.
- Were willing to participate, who could be reached, and who had an initial PCSP completed within 90 days of enrollment.

CMS and the State will also evaluate the percentage of reassessments completed for which:

- Participants were unable to be reached to have a revised PCSP completed within 30 days of the completion of the reassessment.
- Participants refused to have a revised PCSP completed within 30 days after the completion of the reassessment.
- A revised PCSP was completed within 30 days after the completion of the reassessment.
- Participants were willing to participate, could be reached, and for whom a revised PCSP was completed within 30 days after the completion of the reassessment.

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

- FIDA Plans should include all Participants regardless of whether the Participant was enrolled through passive enrollment or opt-in enrollment. Medicaid-only Participants should not be included.
- FIDA Plans should include all Participants who meet the criteria outlined in data elements A and E, regardless of whether they are slated for disenrollment as of the end of the reporting period (i.e., include all Participants whose 90th day of coverage after enrollment or whose 30th day of coverage following the completion of a reassessment falls within the reporting period even if that day is his/her last effective day of coverage).
    - If a Participant is enrolled for fewer than 90 days, he/she should not be included in data element A.
    - Participants need to be continuously enrolled for 30 days from the date of reassessment completion to be included in data element E.
- FIDA Plans should refer to NY's IDT Policy and the three-way contract for specific requirements pertaining to PCSPs and reassessments.
- Participants reported in data elements B, C, and D (regarding completion of the initial PCSP) or reassessments reported in F, G, and H (regarding completion of the revised PCSP following a reassessment) must also be reported in data elements A (for the initial PCSP) or E (for the revised PCSP), respectively, since these data elements are each subsets of data elements A and E. Additionally, subset data elements should be mutually exclusive (e.g., a Participant reported in element B or C should not also be reported in element D). This is true for data elements B, C, and D for the initial PCSP completion and data elements F, G, and H for the revised PCSP completion. If a Participant or reassessment could meet the criteria for multiple data elements, use the following guidance to ensure the Participant or reassessment is included in only one of those three elements:
    - If a Participant initially refused to participate in the PCSP or could not be reached after three outreach attempts, but then subsequently has an initial or revised PCSP completed within the specified timeframe, the Participant should be classified in data element D (for an initial PCSP) or the reassessment for that Participant should be classified in data element H (for a revised PCSP).
    - If a Participant was not reached after three outreach attempts, but then subsequently is reached and refuses to participate in the PCSP within the specified timeframe, the Participant should be classified in data element B (initial PCSP) or the reassessment for that Participant should be classified in data element F (revised PCSP).

- For data elements B and F, FIDA Plans should report the number of Participants who were unwilling (data element B), or reassessments for which Participants were unwilling (data element F), to participate in the initial or revised PCSP if a Participant (or his or her authorized representative):
    - Affirmatively declines to participate in the PCSP. Participant communicates this refusal by phone, mail, fax, or in person.
    - Expresses willingness to complete the PCSP but asks for it to be conducted after the indicated timeframe (despite being offered a reasonable opportunity to complete the PCSP within that timeframe). Discussions with the Participant must be documented by the FIDA Plan.
    - Expresses willingness to complete the PCSP, but reschedules or is a no-show and then is subsequently non-responsive. Attempts to contact the Participant must be documented by the FIDA Plan.
    - Initially agrees to complete the PCSP, but then declines to participate in the PCSP.
- For data elements C and G, FIDA Plans should report the number of Participants the FIDA Plan was unable to reach (data element C), or reassessments for which the FIDA Plan was unable to reach the Participant (data element G), after three attempts to contact the Participant. FIDA Plans should refer to the NY three-way contract or state guidance for any specific requirements pertaining to the method of outreach to Participants. FIDA Plans must document each attempt to reach the Participant, 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 FIDA Plan has a high degree of confidence that a Participant's contact information is correct, yet that Participant is not responsive to the FIDA Plan's outreach efforts. So long as the FIDA Plan follows the guidance regarding outreach attempts, these Participants may be included in the count for this data element.
- There may be certain circumstances that make it impossible or inappropriate to complete a PCSP within the specified timeframes. For example, a Participant may become medically unable to respond and have no authorized representative to do so on their behalf, or a Participant may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for a PCSP. However, FIDA plans should not include such Participants in the counts for data elements B or C or reassessments in the counts for data elements F or G.
- The reassessment must be completed within the reporting period, but the PCSP may not be in the same reporting period. For example, if a reassessment is completed less than 30 days before the end of the reporting period (e.g., March 15), look up to 30 days past the end of the reporting period to identify whether a PCSP was completed.

- If a PCSP was started but not completed within the specified timeframes (within 90 days of enrollment or within 30 days of a reassessment), then the PCSP should not be considered completed and, therefore, would not be counted in data elements B, C, D, F, G, or H. However, this Participant would be included in data element A if he/she reached his/her 90th day of enrollment during the reporting period, or in data element E if a reassessment was completed within the reporting period.
- For data element E, exclude reassessments where the Participant has a trigger event that occurs within 30 days after completing the reassessment. These reassessments are excluded because the trigger event results in the need for the Participant to undergo another reassessment. Any subsequent reassessment should be reported in this measure in the reporting period in which it occurs.

F. Data Submission – how FIDA Plans will submit data collected to CMS and the State.

- FIDA Plans 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.

NY2.2 Participants with documented discussions of care goals.[i]

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
NY2. 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**
NY2. 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 Participants with an initial PCSP completed.	Total number of Participants with an initial PCSP completed during the reporting period.	Field Type: Numeric
B.	Total number of Participants with at least one documented discussion of care goals in the initial PCSP.	Of the total reported in A, the number of Participants with at least one documented discussion of care goals in the initial PCSP.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of existing PCSPs revised.	Total number of existing PCSPs revised during the reporting period.	Field Type: Numeric
D.	Total number of revised PCSPs with at least one documented discussion of new or existing care goals.	Of the total reported in C, the number of revised PCSPs 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 FIDA Plan prior to data submission.

- Confirm those data elements above as subsets of other elements.
- FIDA Plans should validate that data element B is less than or equal to data element A.
- FIDA Plans 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:

- Participants with an initial PCSP completed in the reporting period who had at least one documented discussion of care goals in the initial PCSP.

- PCSPs 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.

- FIDA Plans should include all Participants regardless of whether the Participant was enrolled through passive enrollment or opt-in enrollment. Medicaid-only Participants should not be included.
- FIDA Plans should include all Participants 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 Participants regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- FIDA Plans should include all PCSPs that meet the criteria outlined in data element C, regardless of whether the Participants are disenrolled as of the end of the reporting period (i.e., include all PCSPs regardless of whether the Participants are currently enrolled or disenrolled as of the last day of the reporting period).
- Data element A should include all Participants whose PCSP was completed for the first time during the reporting period (i.e., the Participant did not previously have a PCSP completed prior to the start of the reporting period). There can be no more than one initial PCSP completed per Participant.
- FIDA Plans should only include Participants in data element B when the discussion of care goals is clearly documented in the Participant's initial PCSP.
- Data element C should include all existing PCSPs that were revised during the reporting period. FIDA Plans should refer to the three-way contract for specific requirements pertaining to updating the PCSP.
- FIDA Plans should only include PCSPs in data element D when a new or previously documented care goal is discussed and is clearly documented in the Participant's revised PCSP. If the initial PCSP clearly documented the discussion of care goals, but those existing care goals were not revised or discussed, or new care goals are not discussed and documented during the revision of the PCSP, then that PCSP should not be reported in data element D.
- If a Participant has an initial PCSP completed during the reporting period, and has their PCSP revised during the same reporting period, then the Participant should be reported in data element A and the Participant's revised PCSP should be reported in data element C.
- If a Participant's PCSP is revised multiple times during the same reporting period, each revision should be reported in data element C. For example, if a Participant's PCSP is revised twice during the same reporting period, two PCSPs should be counted in data element C.

F. Data Submission – how FIDA Plans will submit data collected to CMS and the State.

- FIDA Plans 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.

NY2.3 Participants with first follow-up visit within 30 days of hospital discharge.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
NY2. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the fourth month following the last day of the reporting period

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

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

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

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

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

- Confirm those data elements listed above as subsets of other elements.

- FIDA Plans should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

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

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

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

- FIDA Plans should include all Participants regardless of whether the Participant was enrolled through passive enrollment or opt-in enrollment. Medicaid-only Participants should not be included.
- FIDA Plans should include all hospital discharges for Participants who meet the criteria outlined in Element A and who were continuously enrolled from the date of the hospital discharge through 30 days after the hospital discharge, regardless if they are disenrolled as of the end of the reporting period (i.e., include all Participants regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The date of discharge must occur within the reporting period, but the follow-up visit may not be 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 Participant needs to be enrolled from the date of the hospital discharge through 30 days after the hospital discharge, with no gaps in enrollment.
- A follow-up visit is defined as an ambulatory care follow-up visit to assess the Participant'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. FIDA Plans should use all information available, including encounter data supplied by providers, to ensure complete and accurate reporting.
- To identify all inpatient discharges during the reporting period (data element A):
    - Identify all acute and non-acute inpatient stays (Inpatient Stay value set).
    - Identify the discharge date for the stay. The date of discharge should be within the reporting period.

  MMPs should report discharges based on all inpatient stays identified, including denied and pended claims.

- Exclude discharges in which the patient was transferred directly or readmitted to an acute or non-acute facility on the date of the discharge or within 30 days after discharge. These discharges are excluded because a re-hospitalization or transfer may prevent an outpatient follow-up visit from taking place. To identify readmissions to an acute or non-acute inpatient care setting:
    - Identify all acute and non-acute inpatient stays (Inpatient Stay value set)
    - Identify the admission date for the stay. The date of admission should be within the reporting period or 30 days after the reporting period.
    - Determine if the admission date for the stay occurred within 30 days of a previous inpatient discharge. If yes, exclude the initial discharge.

  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 FIDA Plans will submit data collected to CMS and the State.

- FIDA Plans 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 NYIII. Long Term Care Quality

NY3.1 Long Term Care Overall Balance.[i]

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
NY3. Long Term Care Quality	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 Participants continuously enrolled in the FIDA Plan for 6 months.	Total number of Participants continuously enrolled in the FIDA Plan for 6 months during the reporting period.	Field Type: Numeric
B.	Total number of Participants who did not reside in a nursing facility (NF) for a long stay at the time of enrollment.	Of the total reported in A, the number of Participants who did not reside in a NF for a long stay at the earliest point of their enrollment during the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of Participants who did not reside in a NF for a long stay.	Of the total reported in B, the number of Participants who did not reside in a NF for a long stay 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.
- A higher number of Participants who did not reside in a nursing facility for a long stay during the reporting period (data element C) is better.

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

- Confirm those data elements above as subsets of other elements.
- FIDA Plans should validate that data element B is less than or equal to data element A.
- FIDA Plans 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 Participants who did not reside in a nursing facility for a long stay at the earliest point of their enrollment during the reporting period who did not reside in a NF for a long stay during the reporting period.

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

- FIDA Plans should include all Participants regardless of whether the Participant was enrolled through passive enrollment or opt-in enrollment. Medicaid-only Participants should not be included.
- FIDA Plans should include all Participants who meet the criteria for this measure, regardless if they are disenrolled as of the end of the reporting period.
- Determine the beginning of the Participant's FIDA Plan enrollment. For data element A, Participants must be continuously enrolled for at least six months during the reporting period, with no gaps in enrollment, to be included in this measure. Nursing facility long-stay status, for the purposes of reporting data elements B and C, must be determined using the first effective enrollment date of this continuous enrollment span.
- To establish a Participant's nursing facility long-stay status for data element B, use the Participant's nursing facility status from the earliest point of continuous enrollment during the current reporting period (either January 1 or the Participant's effective enrollment date if not enrolled on the first day of the reporting period). From the earliest point of the Participant's continuous FIDA enrollment, look up to 101 days into the previous reporting period to determine if the participant resided in a nursing facility prior to the start of continuous enrollment. A Participant is included in data element B if:
    - The Participant **did not reside in a nursing facility** as of the earliest point of continuous enrollment during the current reporting period OR
    - The Participant **resided in a nursing facility for less than 101 days** as of the first day of continuous enrollment during the current reporting period.
- To establish a Participant's nursing facility long stay status for data element C**,** evaluate the entire period in which the Participant was enrolled in the FIDA Plan and prior to enrollment in the FIDA Plan to

determine if the Participant resided in a nursing facility for more than 100 days. Sum the number of days a Participant resided in a nursing facility, if any, prior to the Participant's first day of continuous enrollment during the reporting period **and** the number of days a Participant resided in a nursing facility during his or her continuous enrollment during the reporting period. Participants who had a cumulative length of stay in a nursing facility of more than 100 days (i.e., long stay) are **not** reported in data element C.

- When determining a long stay:
    - If a Participant is discharged from the nursing facility to any other setting (another institution or the community) and is subsequently admitted to the same or a different nursing facility **within 30 days**, the discharge and subsequent admission does not disrupt the count of cumulative days. For example, if a Participant is discharged from the nursing facility to the hospital on day 93 and is subsequently admitted to the same or a different nursing facility 24 days later, this will be counted as the same long stay episode. The Participant's first day back in the nursing facility (i.e., the day the Participant is admitted to the nursing facility) will count as day 94 for that episode, not as day 1.
    - If a Participant is discharged from the nursing facility to any other setting (another institution or the community) and is subsequently admitted to the same or a different nursing facility **more than 30 days later**, the date of the subsequent admission is the start of a new episode in the nursing facility and will count as day 1 towards the Participant's cumulative days in a facility.
    - If a Participant is transferred from the nursing facility to another nursing facility, the transfer does not disrupt the count of cumulative days because the Participant remained in the nursing facility system. For example, if a Participant is transferred from one nursing facility to another on day 93 and remains in the new nursing facility for 24 days, this will be counted as the same long stay episode. The Participant would have 117 total days of cumulative nursing facility services.
- Codes to identify nursing facility services are provided in the Nursing Facility Services value set.
- Codes to identify a discharge or transfer are provided in the Discharges/Transfers value set.
- Nursing facility services are provided by Medicaid, Medicare, or other State agencies certified nursing homes and primarily provide the following types of services:
    1. Skilled nursing or medical care and related services;
    2. Rehabilitation needed due to injury, disability, or illness;
    3. Long term care – health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition;

4. Custodial care – non-medical care, such as help with daily activities like bathing and dressing.

F. Data Submission – how FIDA Plans will submit data collected to CMS and the State.

- FIDA Plans 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.

NY3.2 Community Reintegration.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
NY3. Long Term Care Quality	Annually	Contract	Calendar Year, beginning in CY2	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of Participants who resided in a nursing facility (NF) for a long stay during the previous reporting period.	Total number of Participants who resided in a NF for a long stay during the previous reporting period and who were continuously enrolled during the previous and current reporting period.	Field Type: Numeric
B.	Total number of Participants discharged to a community setting during the previous or current reporting period who did not return to the NF for a long stay.	Of the total reported in A, the number of Participants discharged to a community setting during the previous or current reporting period who did not return to the NF for a long stay during the current 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 FIDA Plans over time, CMS and the State will apply threshold checks.

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

- Confirm those data elements above as subsets of other elements.
- FIDA Plans 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 NF residents who resided in a NF for a long stay during the previous reporting period who were discharged to a community setting during the previous or current reporting period who did not return to the NF for a long stay during the current reporting period.

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

- FIDA Plan should include all Participants regardless of whether the Participant was enrolled through passive enrollment or opt-in enrollment. Medicaid-only Participants should not be included.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during the reporting period (i.e., January through December). To determine continuous enrollment for a Participant for whom enrollment is verified monthly, the Participant may not have more than a 1-month gap in coverage (i.e., a Participant whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
- A long stay is an episode with cumulative days in facility greater than or equal to 101 days.
- When determining a long stay:
    - If a Participant is discharged from the nursing facility to any other setting (another institution or the community) and is subsequently admitted to the same or a different nursing facility **within 30 days**, the discharge and subsequent admission does not disrupt the count of cumulative days. For example, if a Participant is discharged from the nursing facility to the hospital on day 93 and is subsequently admitted to the same or a different nursing facility 24 days later, this will be counted as the same long stay episode. The Participant's first day back in the nursing facility (i.e., the day the Participant is admitted to the nursing facility) will count as day 94 for that episode, not as day 1.
    - If a Participant is discharged from the nursing facility to any other setting (another institution or the community) and is

subsequently admitted to the same or a different nursing facility **more than 30 days later**, the date of the subsequent admission is the start of a new episode in the nursing facility and will count as day 1 towards the Participant's cumulative days in a facility.
    - If a Participant is transferred from the nursing facility to another nursing facility, the transfer does not disrupt the count of cumulative days because the Participant remained in the nursing home system. For example, if a Participant is transferred from one nursing facility to another on day 93 and remains in the new nursing facility for 24 days, this will be counted as the same long stay episode. The Participant would have 117 total days of cumulative nursing facility services.
- The discharge to community could have occurred during either the previous reporting period or the current reporting period.
- Codes to identify nursing facility services are provided in the Nursing Facility Services value set.
- Codes to identify a discharge or transfer are provided in the Discharges/Transfers value set.
- Codes to identify a discharge to a community setting are provided in the Discharges to the Community value set.
- A community based setting is defined as a private home, apartment, board and care, assisted living facility, or group home.
- This measure will not be reported until Calendar Year 2.

F. Data Submission – how FIDA Plans will submit data collected to CMS and the State.

- FIDA Plans 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 NYIV. Enrollee Protections

NY4.1 The number of critical incident and abuse reports for Participants receiving LTSS.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
NY4. Enrollee Protections	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the second month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
NY4. Enrollee Protections	Quarterly	Contract	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 Participants receiving LTSS.	Total number of Participants 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 FIDA Plans over time, CMS and the State will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each FIDA Plan 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 Participants receiving LTSS.

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

- FIDA Plans should include all Participants regardless of whether the Participant was enrolled through passive enrollment or opt-in enrollment. Medicaid-only Participants should not be included.
- FIDA Plans should include all Participants 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 Participants regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- Since all Participants in the FIDA Plan receive LTSS, data element A should include all Participants enrolled in the FIDA Plan for any amount of time during the reporting period.
- For data element B, FIDA Plans 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 FIDA Plan or any provider, and are not limited to only those providers defined as LTSS providers.
- It is possible for Participants 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 Participant including, neglect, financial exploitation, and mandated reporting requirements called for under the Three-Way Contract, and under New York State and Federal requirements for reporting on incidents and residents of Nursing Facilities.
- Abuse refers to any of the following:
    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 FIDA Plans will submit data collected to CMS and the State.

- FIDA Plans 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 NYV. Utilization

NY5.1 Participants directing their own services through the consumer-directed personal assistance option.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
NY5. Utilization	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 Participants enrolled in the FIDA plan.	Total number of Participants continuously enrolled in the FIDA plan during the reporting period.	Field Type: Numeric
B.	Total number of Participants who were directing their own services through the consumer-directed personal assistance option.	Of the total reported in A, the number of Participants who were directing their own services through the consumer-directed personal assistance option 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 FIDA Plans over time, CMS and the State will apply threshold checks.

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

- Confirm those data elements above as subsets of other elements.
- FIDA Plans 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 Participants continuously enrolled in the FIDA Plan who were directing their own services through the consumer-directed personal assistance option during the reporting period.

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

- FIDA Plans should include all Participants regardless of whether the Participant was enrolled through passive enrollment or opt-in enrollment. Medicaid-only Participants should not be included.
- FIDA Plans should include all Participants 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 Participants regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during the reporting period (i.e., January through December). To determine continuous enrollment for a Participant for whom enrollment is verified monthly, the Participant may not have more than a 1-month gap in coverage (i.e., a Participant whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
- Consumer-directed personal assistance is a personal care program that empowers self-directing seniors and people with disabilities to recruit, hire, train, supervise and terminate their choice of personal assistant home care worker.

F. Data Submission – how FIDA Plans will submit data collected to CMS and the State.

- FIDA Plans 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 NYVI. Participant-Level File

The New York Office of Quality and Patient Safety (OQPS) will be evaluating measures using the Medicaid Encounter Data System (MEDS), the Uniform Assessment System (UAS-NY) and Participant-level data. The State will conduct ongoing research on Participants' personal experiences in FIDA and on potential relationship of these experiences with Participants' health outcomes.

The following table provides instructions on the submission of Participant-level data on a subset of measures FIDA Plans are reporting at the plan-level and a number of IDT-related performance measures. This table does not provide any additional measures; it only provides guidance on the subset of measures for which CMS/NYSDOH require Participant-level data. Please see the source of each measure for the technical specifications for each. In particular:

- Columns 17-48 provide instructions on reporting Participant level data on HEDIS measures.
- Columns 49-54 provide instructions on some of the NY-Specific measures defined elsewhere within this appendix.
- Columns 55-62 refer to MMP Specific Core Measures available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html
- Columns 63-359 provide instructions on reporting Participant level data on IDT activities. As noted for each element, some of the IDT requirements are specified within this appendix while others are specified within the final IDT policy. CMS and NYSDOH may establish thresholds and conduct outlier analysis based on this data.

Questions from FIDA Plans regarding these measures or the data submission process should be directed to NYSDOH.

NY6.1 Participant-Level File

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
NY6 Participant-Level Measures	Annually	Contract	Calendar Year	By the end of the sixth month following the last day of the reporting period

A. File Format definitions – details for each data element reported to CMS and the State.

Column Placement	Name	Direction	Allowed Values
Instructions for Participant Identification			
Column 1-8	MMIS ID	Enter the Plan's numeric eight-digit ID.	########
Column 9–16	Medicaid CIN	A Participant's client identification number. The field should be continuous without any spaces or hyphens. The field is alpha- numeric and should be treated as a text field. The CIN entered in this field should be for the CIN for the measurement period. For example, CINs for 2015 should be used.	**Dual eligible individuals only**
Instructions for Participant-level data on HEDIS Measures			
Column 17	Denominator for Antidepressant Medication Management (AMM)	Enter a '1' if the Participant is in the denominator of the Antidepressant Medication Management measures, '0' if the Participant is not in the denominator.	1 = Yes 0 = No
Column 18	Numerator for Antidepressant Medication Management – Effective Acute Phase Treatment (AMM)	Enter a '1' if the Participant is in the numerator of the Antidepressant Medication Management – Effective Acute Phase Treatment measure, '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 19	Numerator for Antidepressant Medication Management– Effective Continuation Phase Treatment (AMM)	Enter a '1' if the Participant is in the numerator of the Antidepressant Medication Management – Effective Continuation Phase Treatment measure, '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 20	Denominator for Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET): 18+ years	Enter: '1' if the Participant is in the denominator of the Initiation and Engagement of AOD Treatment, 18+ years measure '0' if the Participant is not in the denominator of this measure	1 = Yes 0 = No

Column Placement	Name	Direction	Allowed Values
Column 21	Numerator for Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET): Initiation of AOD Treatment—18+ years	Enter: '1' if the Participant is in the numerator of the Initiation and Engagement of AOD Treatment—Initiation of AOD Treatment, 18+ years measure '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 22	Numerator for Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET): Engagement of AOD Treatment—18+ years	Enter: '1' if the Participant is in the numerator of the Initiation and Engagement of AOD Treatment—Engagement of AOD Treatment, 18+ years measure '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 23-24	Denominator for Follow-Up After Hospitalization for Mental Illness (FUH)	Enter the number of times the Participant appears in the denominator of the Follow-Up After Hospitalization for Mental Illness; '0' if the Participant is not in the denominator.	00-98
Column 25-26	Numerator 1 for Follow-Up After Hospitalization for Mental Illness, 7 days after discharge (FUH)	Enter the number of times the Participant appears in numerator 1 of the Follow-Up After Hospitalization for Mental Illness, 7 days after discharge. '0' if the Participant is not in the numerator or the information is missing.	00-98
Column 27-28	Numerator 2 for Follow-Up After Hospitalization for Mental Illness, 30 days after discharge (FUH)	Enter the number of times the Participant appears in numerator 2 of the Follow-Up After Hospitalization for Mental Illness, 30 days after discharge. '0' if the Participant is not in the numerator or the information is missing.	00-98
Column 29-30	Denominator for Medication Reconciliation After Discharge from Inpatient Facility (MRP)	Enter the number of times the Participant appears in the denominator of the Medication Reconciliation After Discharge from Inpatient Facility	00-98

Column Placement	Name	Direction	Allowed Values
Column 31-32	Numerator for Medication Reconciliation After Discharge from Inpatient Facility (MRP)	Enter the number of times the Participant appears in numerator of the Medication Reconciliation After Discharge from Inpatient Facility	00-98
Column 33	Denominator for the Care for Older Adults (COA)	Enter a '1' if the Participant is in the denominator of the Care for Older Adults measure, '0' if the Participant is not in the denominator.	1 = Yes 0 = No
Column 34	Numerator for Care for Older Adults – Medication Review (COA)	Enter a '1' if the Participant is in the numerator of the Care for Older Adults Medication Review measure, '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 35	Numerator for Care for Older Adults – Functional Status Assessment (COA)	Enter a '1' if the Participant is in the numerator of the Care for Older Adults Functional Status Assessment, '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 36	Numerator for Care for Older Adults – Pain Screening (COA)	Enter a '1' if the Participant is in the numerator of the Care for Older Adults Pain Screening, '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 37	Denominator for Comprehensive Diabetes Care (CDC)	Enter a '1' if the Participant is in the denominator of the CDC measures, '0' if the Participant is not in the denominator.	1 = Yes 0 = No
Column 38	Numerator for CDC – Eye Exam	Enter a '1' if the Participant is in the numerator of the CDC Eye Exam measure, '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 39	Numerator for CDC – Nephropathy Monitor	Enter a '1' if the Participant is in the numerator of the CDC Nephropathy Monitor measure, '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No

Column Placement	Name	Direction	Allowed Values
Column 40	Numerator for CDC – HbA1c Control (<8.0%)	Enter a '1' if the Participant is in the numerator of the CDC HbA1c Control (<8.0%) measure, '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 41	Denominator for Disease Modifying Anti-Rheumatic Drug Therapy (DMARD)	Enter a '1' if the Participant is in the denominator of the DMARD measure, '0' if the Participant is not in the denominator.	1 = Yes 0 = No
Column 42	Numerator for Disease Modifying Anti-Rheumatic Drug Therapy (DMARD)	Enter a '1' if the Participant is in the numerator of the DMARD measure, '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 43	Denominator for Controlling High Blood Pressure (CBP)	Enter a '1' if the Participant is in the denominator of the Controlling High Blood Pressure measure, '0' if the Participant is not in the denominator.	1 = Yes 0 = No
Column 44	Numerator for Controlling High Blood Pressure (CBP)	Enter a '1' if the Participant is in the numerator of the Controlling High Blood Pressure measure, '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 45	Denominator for Breast Cancer Screening (BCS)	Enter a '1' if the Participant is in the denominator of the Breast Cancer Screening measure, '0' if the Participant is not in the denominator.	1 = Yes 0 = No
Column 46	Numerator for Breast Cancer Screening (BCS)	Enter a '1' if the Participant is in the numerator of the Breast Cancer Screening measure, '0' if the participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 47	Denominator for Colorectal Cancer Screening (COL)	Enter a '1' if the Participant is in the denominator of the Colorectal Cancer Screening measure, '0' if the Participant is not in the denominator.	1 = Yes 0 = No
Column 48	Numerator for Colorectal Cancer Screening (COL)	Enter a '1' if the Participant is in the numerator of the Colorectal Cancer Screening measure, '0' if the Participant is not in the numerator of this measure.	1 = Yes 0 = No

Column Placement	Name	Direction	Allowed Values
Instructions for Participant Level Data on NY Specific Measures			
Column 49	Denominator for NY3.1 Long Term Care Overall Balance	Enter a '1' if the Participant is in the denominator of the NY3.1 Long Term Care Overall Balance measure, '0' if the Participant is not in the denominator.	1 = Yes 0 = No
Column 50	Numerator for NY3.1 Long Term Care Overall Balance	Enter a '1' if the Participant is in the numerator of the NY3.1 Long Term Care Overall Balance measure, '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 51	Denominator for the Participants directing their own services through the Consumer-Directed Personal Assistance Option	Enter a '1' if the Participant is in the denominator of the NY5.1 Consumer-Directed Personal Assistance Option measure above, '0' if the Participant is not in the denominator.	1 = Yes 0 = No
Column 52	Numerator for the Participants directing their own services through the Consumer-Directed Personal Assistance Option	Enter a '1' if the Participant is in the numerator of the NY5.1 Consumer-Directed Personal Assistance Option measure above, '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 53	Denominator for NY 3.2 Community Reintegration	Enter a '1' if the Participant is in the denominator of the NY 3.2 Community Reintegration measure above, '0' if the Participant is not in the denominator.	1 = Yes 0 = No
Column 54	Numerator for NY 3.2 Community Reintegration	Enter a '1' if the Participant is in the numerator of the NY 3.2 Community Reintegration measure above, '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Instructions for Participant Level Data on MMP-Specific Core Reporting Requirements			
Column 55	Denominator for Screening for MMP Core Measure 6.1 Clinical Depression and Follow-up Care	Enter a '1' if the Participant is in the denominator of the MMP Core Measure 6.1 Screening for Clinical Depression and Follow-up care, '0' if the Participant is not in the denominator. **Because measure is suspended at this time, fill with '0".**	1 = Yes 0 = No

Column Placement	Name	Direction	Allowed Values
Column 56	Numerator for the MMP Core Measure 6.1 Screening for Clinical Depression and Follow-up Care	Enter a '1' if the Participant is in numerator 1 of the MMP Core Measure 6.1 Screening for Clinical Depression and Follow-up care, '0' if the Participant is not in the numerator or the information is missing. **Because measure is suspended at this time, fill with '0".**	1 = Yes 0 = No
Column 57	Denominator for MMP Core Measure 9.2 Nursing Facility Diversion	Enter a '1' if the Participant is in the denominator of the MMP Core Measure 9.2 Nursing Facility Diversion measure, '0' if the Participant is not in the denominator.	1 = Yes 0 = No
Column 58	Numerator for MMP Core Measure 9.2 Nursing Facility Diversion	Enter a '1' if the Participant is in the numerator of the MMP Core Measure 9.2 Nursing Facility Diversion measure, '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 59-60	Denominator for Care Transition Record Transmitted to Health Care Professional	Enter the number of times the Participant met the inclusion criteria for Element B of MMP Core Measure 3.1 Care Transition Record Transmitted to Health Care Professional measure, '00' if Participant does not.	00-98
Column 61-62	Numerator for Care Transition Record Transmitted to Health Care Professional	Enter the number of times the Participant the Participant met the inclusion criteria for Element C of the MMP Core Measure 3.1 Care Transition Record Transmitted to Health Care Professional measure, '00' if Participant is not in the numerator or the information is missing.	00-98
Instructions for Participant Level Data on IDT Requirements			
Column 63	Enrollment Type	Enter a '1' if the Participant is an opt-in enrollee, Enter a '0' if the Participant is a Passive enrollee.	1 = Voluntary 0 = Passive
Column 64	Did the Participant refuse to have his/her UAS-NY completed at least once in the reporting year?	Enter a '1' if the Participant refused to have his/her UAS-NY completed at least once in the reporting year, otherwise enter '0'.	1 = Yes 0 = No

Column Placement	Name	Direction	Allowed Values
Columns 65-160 (up to 12 dates for this measure)	Date(s) on which the Participant had a PCSP completed or updated	Enter the date(s) on which the Participant had their PCSP completed or updated as specified in the final IDT policy. Leave the cell blank if the Participant did not have a PSCP completed/updated or the information is missing.	MMDDYYYY
Column 161	Did the Participant refuse to have his/her PCSP completed at least once in the reporting year?	Enter a '1' if this Participant refused to have his/her PCSP completed at least once in the reporting year as specified in NY2.1 above and the final IDT policy, otherwise enter '0'.	1 = Yes 0 = No
Columns 162-257(e.g., column 162 for date 1, column 170 for date 2, etc.; up to 12 dates for this measure)	Date(s) on which the Participant had an IDT meeting within reporting year	Enter the date(s) on which the Participant had IDT meetings as specified in the final IDT policy. Leave the cell blank if the Participant did not have any IDT meetings or the information is missing.	MMDDYYYY
Column 258	Did the Participant refuse to have an IDT meeting at least once in the reporting year?	Enter a '1' if this Participant refused to have an IDT meeting as specified in the final IDT policy at least once in the reporting year, otherwise enter '0'.	1 = Yes 0 = No
Columns 259-354 (e.g., column 259 for date 1, column 267for date 2, etc.; up to 12 dates for this measure)	Date(s) on which the Participant Was Discharged From a Hospital Inpatient or Nursing Facility to the Community	Enter the date(s) on which the Participant was discharged from a hospital inpatient or nursing facility to the community as specified in the transition of care setting section of the final IDT policy. Leave the cell blank if the Participant was not discharged from a hospital inpatient or nursing facility to the community or the information is missing.	MMDDYYYY
Column 355	Did the Participant have Behavioral Health Specialist as a member of the IDT at least once in the reporting year?	Enter a '1' if the Participant had a Behavioral Health Specialist as a member of the IDT as specified in the final IDT policy, '0' if the Participant did not have a Behavioral Health Specialist as a member of the IDT.	1 = Yes 0 = No

Column Placement	Name	Direction	Allowed Values
Column 356	Did the Participant have an RN assessor as a member of the IDT at least once in the reporting year?	Enter a '1' if the Participant had the RN assessor as a member of the IDT as specified in the final IDT policy, '0' if the Participant did not have the RN Assessor as a member of the IDT.	1 = Yes 0 = No
Column 357	Did the Participant have a Participant Designee on the IDT at least once in the reporting year?	Enter a '1' if the Participant had a Participant Designee as a member of the IDT as specified in the final IDT policy, '0' if the Participant did not have a Participant Designee as a member of the IDT.	1 = Yes 0 = No
Column 358	Did the Participant have a home care aid or a designee with clinical experience from the home care agency on the IDT at least once in the reporting year?	Enter a '1' if the Participant had a home care aide or a designee with clinical experience from the home care agency as a member of the IDT as specified in the final IDT policy, '0' if the Participant did not have a home care aide or a designee with clinical experience from the home care agency as a member of the IDT.	1 = Yes 0 = No
Column 359	Did the Participant have a nursing facility representative on the IDT at least once in the reporting year?	Enter a '1' if the Participant had a nursing facility representative as a member of the IDT as specified in the final IDT policy, '0' if the Participant did not have a nursing facility representative as a member of the IDT.	1 = Yes 0 = No

A. Edits and Validation checks – validation checks that should be performed by each FIDA plan prior to data submission.

    - FIDA Plans should ensure that all data values are recorded in the prescribed format (see column "Allowed values").

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

    - NYSDOH will use the Participant-level data to conduct ongoing research on Participants' personal experiences in the FIDA program and on potential relationship of these experiences with Participants' health outcomes.

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

    - Overall format:

  - Prepare a fixed width text file in the following format.
  - Include one row for every Participant who was enrolled in the FIDA plan and who meets criteria for one or more of the specified FIDA measures for the measurement year.
  - Numeric values should be right justified and blank filled to the left of the value; text fields should be left-justified and blank filled to the right of the value.
  - The file should be named ParticipantFIDA.txt.
- The sum of the field should equal the numerator or denominator for the corresponding measure entered in the NYS submission tools for the plan-level reporting. Measures that are not applicable to the Participant should be zero-filled.
- The FIDA plan should use the continuous enrollment specifications applicable to each element as specified in HEDIS, elsewhere in this appendix, and/or the MMP-Specific Core Measures guidance.
- For the IDT performance measures, if a Participant had multiple enrollment periods within the same FIDA plan during the reporting period, include only dates for IDT formation, IDT meetings, and PCSPs, and safe discharge in the following manner:
  - If a Participant was passively enrolled, disenrolled, and then opted-back in to the same FIDA plan, include the dates for the period that relates to his/her passive enrollment.
  - If a Participant opted in to the FIDA plan, disenrolled, and then opted back in again in the same FIDA plan, include the dates for the latter period that relates to his/her second opt-in enrollment.

D. Data Submission – how FIDA Plans will submit data collected to CMS and the State.

- FIDA Plans will submit the files in the above specified format to Raina Josberger at NYSDOH via the Health Commerce System (HCS) Secure File Transfer 2.0.