# MEDICARE-MEDICAID CAPITATED FINANCIAL ALIGNMENT MODEL REPORTING REQUIREMENTS: TEXAS-SPECIFIC REPORTING REQUIREMENTS

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

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# Texas-Specific Reporting Requirements Appendix

## *Introduction*

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

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

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

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

MMPs should contact the TX Help Desk at TXHelpDesk@norc.org with any questions about the Texas 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. Calendar year 2015 (CY1) will be an abbreviated year, with data reported for the time period beginning March 1, 2015 and ending December 31, 2015. Calendar year 2016 (CY2) will represent January 1, 2016 through December 31, 2016.

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

Implementation Period: The period of time starting with the first effective enrollment date, March 1, 2015, until September 30, 2015.

Long Term Services and Supports (LTSS): Services to meet an individual's health or personal care needs over an extended period of time and may include nursing, assistance with bathing, toileting, dressing, eating, meal preparation, relief for caregivers, home modifications and repairs, transportation, adaptive aids, services at licensed facilities, and nutrition services such as home-delivered meals or meals at senior centers. LTSS are provided predominantly in homes and communities, but also in facility-based settings such as nursing facilities.

Primary Care Provider: A Provider who has agreed with the STAR+PLUS MMP to provide a Medical Home to Enrollees and who is responsible for providing initial and primary care to Enrollees, maintaining the continuity of care, and initiating referral for services.

Service Coordination: A specialized Care Management service that is performed by a Service Coordinator that includes but is not limited to: 1) identification of needs, including physical and behavioral health services, and LTSS, 2) development of and necessary updates to a Plan of Care to address those identified needs; 3) assistance to ensure timely and a coordinated access to an array of Providers and Covered Services; 4) attention to addressing unique, person-centered needs of Enrollees; 5) coordination of Covered Services with Non-Capitated Services, as necessary and appropriate; and 6) includes, for Enrollees who have been determined STAR+PLUS HCBS eligible, the development of an ISP with the Enrollee, family members, and Provider(s), as well as authorization of HCBS services.

### *Variation from the Core Document*

Core 2.1 and Core 2.2

Under certain circumstances, Texas MMPs are permitted to count assessments previously completed by the MMP's affiliated STAR+PLUS and/or Medicare Advantage D-SNP product. As a result, there are some caveats to the reporting of the core measures that pertain to assessments (i.e., Core 2.1 and Core 2.2).

Only those assessments completed by a MMP's own sister product may be counted toward MMP requirements. In addition, the MMP must determine, through contact with the member or other means as appropriate, if the member has experienced any of the triggering events listed in Section 2.6.2.8.2 of the contract. If so, the MMP should conduct a new assessment and report that completion according to the specifications for Core 2.1 and Core 2.2.

In the absence of a triggering event as described in Section 2.6.2.8.2 of the contract, MMPs are not required to complete an additional assessment for

members who have previously received a comprehensive assessment in the MMP's sister product within the prior nine months. As such, for formerly STAR+PLUS and/or D-SNP members with a comprehensive assessment completed within nine months of their initial effective enrollment date in the MMP, MMPs are to report those assessments under Core 2.1 and Core 2.2 as having been completed as of the member's first effective enrollment date in the MMP. For example, if a member's first effective enrollment date was March 1, 2015 and the assessment for that member was previously completed on August 20, 2014, the MMP should report the assessment as if it were completed on March 1, 2015.

For Level 2 members who received a non-comprehensive assessment from the MMP's sister product within nine months of their initial effective enrollment date in the MMP, and who have not had a triggering event as described in Section 2.6.2.8.2 of the contract, MMPs are required to ask the additional required assessment questions within 90 days of the member's effective enrollment date in the MMP. MMPs are to report such assessments as completed as of the date on which the missing questions were asked and documented. Alternatively, the MMP may opt to complete a new assessment for the low-risk member using its new comprehensive tool (with the required questions added) within 90 days of the member's enrollment in the MMP. MMPs would report the completion of the new comprehensive assessment under Core 2.1 and Core 2.2 according to the actual date of completion.

Level 1 members who received a non-comprehensive assessment while enrolled in an MMP's sister product must have a new, comprehensive assessment within 90 days of enrollment. MMPs should report these new comprehensive assessments under Core 2.1 and Core 2.2 according to the actual date of completion.

MMPs should refer to the Core reporting requirements for detailed specifications for reporting Core 2.1 and Core 2.2. For example, Core 2.1 should only include members whose 90th day of enrollment occurred during the reporting period and who were still enrolled as of the last day of the reporting period. Members enrolled into the MMP on March 1, 2015 would reach their 90th day (which is equivalent to three full months) on May 31, 2015. Therefore, these members would be reported in the data submission for the May monthly reporting period, even if their assessment was marked as complete on the first effective enrollment date (i.e. March 1).

Core 2.3

For Core 2.3, members with an annual reassessment, MMPs should determine whether members are eligible for an annual reassessment using the actual date the initial assessment was completed, even if that date occurred when the member was enrolled in the MMP's sister product.

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). TX STAR+PLUS MMPs should use risk group assignments, supplemented by claims or enrollment data, to categorize members as "nursing home certifiable." Members in the following risk groups should be included:

- Dually-eligible, STAR+PLUS Waiver
- Dually-eligible, Nursing Facility, for individuals residing in the nursing home no more than 100 days

In addition, MMPs may have members who, for a short period, may be in HCBS but not yet assigned to the appropriate risk group. MMPs should use information available in internal data systems wherever possible to identify whether these individuals should be included in reporting for Core 9.2.

### *Reporting on Assessments and Plans of Care Completed Prior To First Effective Enrollment Date*

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

For purposes of reporting data on HRAs (Core 2.1 and Core 2.2), MMPs should report any HRAs completed prior to the first effective enrollment date as if they were completed on the first effective enrollment date. For example, if a member's first effective enrollment date was June 1 and the HRA for that member was completed on May 25, the MMP should report the HRA as if it were completed on June 1. As noted in the prior section, MMPs should refer to the Core reporting requirements for detailed specifications for reporting Core 2.1 and Core 2.2.

MMPs must comply with contractually specified timelines regarding completion of Plans of Care within 90 days of enrollment. In the event that a Plan of Care is also finalized prior to the first effective enrollment date, MMPs should report completion of the Plan of Care (for measures TX1.1, TX1.2, and TX1.4) as if it were completed on the first effective enrollment date. For example, if a member's first effective enrollment date was June 1 and the Plan of Care for that member was completed on May 27, the MMP should report the Plan of Care as if it were completed on June 1.

***Guidance on Assessments and Plans of Care for Members with a Break in Coverage***

Health Risk Assessments

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

1. Perform any risk stratification, claims data review, or other analyses as required by the three-way contract to detect any changes in the member's condition since the HRA was conducted; and

2. Ask the member (or his/her authorized representative) and service coordinator if there has been a change in the member's health status or needs since the HRA was conducted.

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

If a change is identified, the MMP must conduct a new HRA within the timeframe prescribed by the contract. If there are no changes, the MMP is not required to conduct a new HRA unless requested by the member (or his/her authorized representative). Please note, if the MMP prefers to conduct HRAs on all re-enrollees regardless of status, it may continue to do so. The MMP must inform the member of his/her right to request a new HRA at any time.

Once the MMP has conducted a new HRA as needed or confirmed that the prior HRA is still accurate, the MMP can mark the HRA as complete for the member's current enrollment. The MMP would then report that completion according to the specifications for Core 2.1 and Core 2.2. When reporting these core measures, the MMP should count the 90 days from the member's most recent enrollment effective date, and should report the HRA based on the date the prior HRA was either confirmed to be accurate or a new HRA was completed.

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

If the MMP did not complete an HRA for the re-enrolled member during his/her prior enrollment period, or if it has been more than one year since the member's HRA was completed, the MMP is required to conduct a HRA for the member within the timeframe prescribed by the contract. The MMP must make the

requisite number of attempts to reach the member (at minimum) after his/her most recent enrollment effective date, even if the MMP reported that the member was unable to be reached during his/her prior enrollment. Similarly, members that refused the HRA during their prior enrollment must be asked again to participate (i.e., the MMP may not carry over a refusal from one enrollment period to the next).

Plans of Care

If the MMP conducts a new HRA for the re-enrolled member, the MMP must revise the Plan of Care accordingly in collaboration with the member or authorized representative within the timeframe prescribed by the contract. Once the Plan of Care is revised, the MMP may mark the Plan of Care as complete for the member's current enrollment. If the MMP determines that the prior HRA is still accurate and therefore no updates are required to the previously completed Plan of Care, the MMP may mark the Plan of Care as complete for the current enrollment at the same time that the HRA is marked complete. The MMP would then follow the applicable state-specific measure specifications for reporting the completion. Please note, for purposes of reporting, the Plan of Care for the re-enrolled member should be classified as an *initial* Plan of Care.

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

Annual Reassessments and Plan of Care Updates

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

### *Quality Withhold Measures*

CMS and the state will establish a set of quality withhold measures, and MMPs will be required to meet established thresholds. Throughout this document, state-specific quality withhold measures are marked with the following symbol for Demonstration Year 1: (ⁱ) and the following symbol for Demonstration Years 2

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): Texas-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.

### *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 MMPs. Measure-specific guidance on how to report on disenrolled members is provided under the Notes section of each state-specific measure.

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

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

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

| Phase | | Dates | Explanation |
|---|---|---|---|
| **Demonstration Year 1.a** | | | |
| Continuous Reporting | Implementation Period | 3-1-15 through 9-30-15 | From the first effective enrollment date through September 30, 2015. |
| | Ongoing Period | 3-1-15 through 12-31-15 | From the first effective enrollment date through the end of the first demonstration year. |
| **Demonstration Year 1.b** | | | |
| Continuous Reporting | Ongoing Period | 1-1-16 through 12-31-16 | From the first effective enrollment date through the end of the first demonstration year. |
| **Demonstration Year 2** | | | |
| Continuous Reporting | Ongoing Period | 1-1-17 through 12-31-17 | From January 1st through the end of the second demonstration year. |
| **Demonstration Year 3** | | | |
| Continuous Reporting | Ongoing Period | 1-1-18 through 12-31-18 | From January 1st through the end of the third demonstration year. |

***Data Submission***

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

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

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

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

### *Resubmission of Data*

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

1. Email the TX HelpDesk (TXHelpDesk@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 TX HelpDesk will notify the MMP once the FAI Data Collection System and/or HPMS has been re-opened.
3. Resubmit data through the applicable reporting system.
4. Notify the TX 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 TXI. Care Coordination

TX1.1 Members with Plans of Care within 90 days of enrollment.

| IMPLEMENTATION | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Period** | **Due Date** |
| TX1. Care Coordination | Monthly, beginning after 90 days | Contract | Current Month<br>Ex:<br>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** |
| TX1. Care Coordination | Quarterly | Contract | Current Calendar Quarter<br>Ex:<br>1/1-3/31<br>4/1-6/30<br>7/1-9/30<br>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 were documented as unwilling to complete a Plan of Care within 90 days of enrollment. | Of the total reported in A, the number of members who were documented as unwilling to complete a Plan of Care within 90 days of enrollment. | Field type: Numeric<br><br>Note: Is a subset of A. |

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| C. | Total number of members the MMP was unable to reach, following five documented attempts within 90 days of enrollment. | Of the total reported in A, the number of members the MMP was unable to reach, following five documented attempts within 90 days of enrollment. | Field type: Numeric<br><br>Note: Is a subset of A. |
| D. | Total number of members with a Plan of Care completed within 90 days of enrollment. | Of the total reported in A, the number of members with a Plan of Care completed within 90 days of enrollment. | Field Type: Numeric<br><br>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 or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee 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 whose 90th day of enrollment occurred within the reporting period:

- Who refused to have a Plan of Care completed within 90 days of enrollment.
- Who were unable to be reached to have a Plan of Care completed within 90 days of enrollment.
- Who had a Plan of Care completed within 90 days of enrollment.
- Who were willing to participate and who could be reached who had a Plan of Care 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 Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in data element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The 90th day of enrollment should be based on each member's effective enrollment date. For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months.
- The effective enrollment date is the first date of the member's coverage through the MMP.
- Members reported in data elements B, C, and D must also be reported in data element A since these data elements are subsets of data element A. Additionally, data elements B, C, and D should be mutually exclusive (e.g. a member reported in element B or C should not also be reported in element D). If a member could meet the criteria for multiple data elements (B, C, or D) use the following guidance to ensure the member is included in only one of those three elements:
    - If a member initially refused a Plan of Care or could not be reached after five outreach attempts, but then subsequently completes a Plan of Care within 90 days of enrollment, the member should be classified in data element D.
    - If a member was not reached after five outreach attempts, but then subsequently is reached and refuses to complete the Plan of Care within 90 days of enrollment, the member should be classified in data element B.
- For data element B, MMPs should report the number of members who were unwilling to participate in the development of the Plan of Care if the member (or his or her authorized representative):
    - Affirmatively declines to participate in the Plan of Care. Member communicates this refusal by phone, mail, fax, or in person.
    - Expresses willingness to complete the Plan of Care but asks for it to be conducted after 90 days (despite being offered a reasonable opportunity to complete the Plan of Care within 90 days). Discussions with the member must be documented by the MMP.
    - Expresses willingness to complete the Plan of Care, but reschedules or is a no-show and then is subsequently non-responsive. Attempts to contact the member must be documented by the MMP.

    - Initially agrees to complete the Plan of Care, but then declines to answer a majority of the questions in the Plan of Care.
- For data element C, MMPs should report the number of members the MMP was unable to reach after five attempts to contact the member. MMPs should refer to the TX three-way contract or state guidance for any specific requirements pertaining to the method of outreach to members. MMPs must document each attempt to reach the member, including the method of the attempt (i.e., phone, mail, or email), as CMS and the state may validate this number. There may be instances when the MMP has a high degree of confidence that a member's contact information is correct, yet that member is not responsive to the MMP's outreach efforts. So long as the MMP follows the guidance regarding outreach attempts, these members may be included in the count for this data element.
- There may be certain circumstances that make it impossible or inappropriate to complete a Plan of Care within 90 days of the enrollment. For example, a member may become medically unable to respond and have no authorized representative to do so on their behalf, or a member may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for a Plan of Care. However, MMPs should not include such members in the counts for data elements B and C.
- If a Plan of Care was started but not completed within 90 days of enrollment, then the Plan of Care should not be considered completed and, therefore, would not be counted in data elements B, C, or D. However, this member would be included in data element A if the member's 90th day of enrollment occurred within the reporting period.
- Completion of a Plan of Care requires the participation of the member. A Plan of Care is a person-centered care plan that is developed by the STAR+PLUS MMP Service Coordinator with the member, his/her family and caregiver supports, as appropriate, and providers. As such, a member must be able to be reached in order to complete the Plan of Care and members who had a Plan of Care completed by the MMP without the member's participation should not be included in the count for data element D. MMPs should refer to the Texas three-way contract for additional requirements pertaining to a Plan of Care.

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.

TX1.2 Members with Plans of Care completed.

| IMPLEMENTATION | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Period** | **Due Date** |
| TX1. Care Coordination | Monthly, beginning after 90 days | Contract | Current Month<br>Ex:<br>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** |
| TX1. Care Coordination | Quarterly | Contract | Current Calendar Quarter<br>Ex:<br>1/1-3/31<br>4/1-6/30<br>7/1-9/30<br>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 for 90 days or longer as of the last day of the reporting period. | Total number of members enrolled for 90 days or longer as of the last day of the reporting period and who were currently enrolled as of the last day of the reporting period. | Field Type: Numeric |
| B. | Total number of members who had a Plan of Care completed as of the end of the reporting period. | Of the total reported in A, the number of members who had a Plan of Care completed as of the end of the reporting period. | Field type: Numeric<br><br>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 or its designee will perform an outlier analysis.

- As data are received from MMPs over time, CMS and the state or its designee 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 members enrolled for 90 days or longer as of the last day of the reporting period who had a Plan of Care completed as of the end of the reporting period.

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

- MMPs should include all Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- The 90th day of enrollment should be based on each member's effective enrollment date. For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months.
- The effective enrollment date is the first date of the member's coverage through the MMP.
- The Plans of Care reported in data element B could have been completed at any time prior to the end of the reporting period, not necessarily during the reporting period.
- Completion of a Plan of Care requires the participation of the member. A Plan of Care is a person-centered care plan that is developed by the STAR+PLUS MMP Service Coordinator with the member, his/her family and caregiver supports, as appropriate, and providers. As such, a member must be able to be reached in order to complete the Plan of Care and members who had a Plan of Care completed by the MMP without the member's participation should not be included in the count for data element B. MMPs should refer to the Texas three-way contract for additional requirements pertaining to a Plan of Care.

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.

TX1.3 Members with first follow-up visit within 30 days of hospital discharge.

| CONTINUOUS REPORTING | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Periods** | **Due Date** |
| TX1. Care Coordination | Quarterly | Contract | Current Calendar Quarter<br>Ex:<br>1/1-3/31<br>4/1-6/30<br>7/1-9/30<br>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<br><br>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 or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

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

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

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

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

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

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

- MMPs should include all hospital discharges for Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all hospital discharges for members who meet the criteria outlined in data 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.
- 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.
- This measure will be due four months following the last day of the reporting period; therefore, MMPs will have sufficient time to collect and report data for discharges with a follow-up visit that occurred during the first month of the subsequent reporting period.
- The member needs to be enrolled from the date of the hospital discharge through 30 days after the hospital discharge, with no gaps in enrollment, to be included in this measure.
- A follow-up visit is defined as an ambulatory care follow-up visit to assess the member's health following a hospitalization. Codes to identify follow-up visits are provided in the Ambulatory Visits value set and Other Ambulatory Visits value set. MMPs should report ambulatory care follow-up visits based on all visits identified, including denied and pended claims, and including encounter data as necessary in cases where follow-up care is included as part of a bundled payment covering the services delivered during the inpatient stay. MMPs should use all information available, including encounter data supplied by providers, to ensure complete and accurate reporting.
- To identify all 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 end of 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 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.

TX1.4 Members whose Plan of Care is updated annually before the expiration date.[i, ii]

| CONTINUOUS REPORTING | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Period** | **Due Date** |
| TX1. Care Coordination | Annually | Contract | Calendar Year, beginning 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 members eligible for a Plan of Care annual update. | Total number of members eligible for a Plan of Care annual update during the reporting period. | Field Type: Numeric |
| B. | Total number of members whose Plan of Care was updated annually before the expiration date. | Of the total reported in A, the number of members whose Plan of Care was updated annually before the expiration date during the reporting period. | Field Type: Numeric<br><br>Note: Is a subset of A. |

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

- The quality withhold benchmark for DY 1.b is 86%. For withhold purposes, the measure is calculated as follows:
  - Denominator: Total number of members eligible for a Plan of Care annual update (data element A).
  - Numerator: Total number of members from data element A whose Plan of Care was updated annually before the expiration date (data element B).
- For more information, refer to the Quality Withhold Technical Notes (DY 1): Texas-Specific Measures. Separate guidance will be forthcoming on the established benchmark for this measure for DY 2 and 3.

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

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data 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 eligible for a Plan of Care annual update during the reporting period whose Plan of Care was updated annually before the expiration date during the reporting period.

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

- MMPs should include all Medicare-Medicaid members 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 those members who are currently enrolled as of the last day of the reporting period. The last day of the reporting period is the anchor date, or the date on which all reported members must be enrolled in the MMP.
- For data element A, MMPs should include all members who were enrolled as of the last day of the current reporting period and who had an initial or updated Plan of Care completed in the previous reporting period. To be eligible for a Plan of Care update, a member must be enrolled for 90 days prior to the expiration date of the most recent Plan of Care completion date in the previous reporting period. For example, if a member had his or her Plan of Care updated twice during CY 2015 (the previous reporting period) – first on May 15, 2015 and again on October 15, 2015 – the member must be enrolled continuously in the MMP for at least 90 days prior to October 14, 2016, or enrolled at least July, August, September and October 2016.
- For data element B, MMPs should include members reported in data element A whose Plan of Care update occurred during the current reporting period and that update was completed within 365 days of their most recent Plan of Care completion date in the previous reporting period. For example, if a member had his or her Plan of Care updated twice during CY 2015 (the previous reporting period) – first on May 15, 2015 and again on October 15, 2015 – count 365 days continuously from October 15, 2015 to determine if a Plan of Care update occurred within 365 days. In this example, if the member's Plan of Care was updated on September 15, 2016, he or she would be included in data element B for CY 2016 reporting. Conversely, if the member's Plan of Care was not

updated until November 15, 2016, he or she would not be included in data element B for CY 2016 reporting.

- Please note that data element B may include a limited number of members with a break in enrollment for whom the updated Plan of Care in the current reporting period has also been marked as an "initial" Plan of Care for the purposes of reporting measures TX1.1 and TX1.2. For example, if a member had a Plan of Care update on October 15, 2015, subsequently disenrolled from the MMP on October 31, 2015, reenrolled on September 1, 2016, had his or her Plan of Care updated on September 20, 2016, and remained enrolled December 31, 2016, this member's Plan of Care would be reported in multiple measures. The member would be reported as having an initial Plan of Care completed within 90 days for the purposes of TX1.1 (Q4 2016 reporting), as having a Plan of Care completed for the purposes of TX1.2 (Q4 2016 reporting), and as having a Plan of Care update annually before the expiration date for TX1.4 (CY 2016). For members with a break in enrollment for whom the 90 days following reenrollment do not overlap with the expiration date of the most recent Plan of Care update in the previous reporting period, initial Plans of Care should be completed according to the Texas three-way contract requirements and reported distinctly from the annual Plan of Care update reported in this measure. Members who meet the inclusion criteria for this measure who do not have an annual Plan of Care update completed within 365 days of the most recent Plan of Care update in the previous reporting period should not be included in data element B.
- This measure will not be reported until Calendar Year 2 (e.g., CY 2016 will be Calendar Year 2 for all MMPs whose demonstration effective enrollment date began in CY 2015).

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 TXII. Enrollee Protections

TX2.1 The number of critical incident and abuse reports for members receiving LTSS.

| IMPLEMENTATION | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Period** | **Due Date** |
| TX2. Enrollee Protections | Monthly | Contract | Current Month<br>Ex:<br>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** |
| TX2. Enrollee Protections | Quarterly | Contract | Current Calendar Quarter<br>Ex:<br>1/1-3/31<br>4/1-6/30<br>7/1-9/30<br>10/1-12/31 | By the end of the second month following the last day of the reporting period |

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

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

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

- CMS and the state or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee 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 Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in data element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- MMPs should refer to the STAR+PLUS handbook for guidance on how to identify members classified as receiving LTSS.
- 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.
- For data elements A and B, MMPs should include all new critical incident and abuse cases that are reported during the reporting period, regardless if the case status is open or closed as of the last day of the reporting period.
- Critical incident and abuse reports could be reported by the MMP or any provider, and are not limited to only those providers defined as LTSS providers.
- Critical Event or Incident means an event or incident that may harm, or create the potential for harm, to an individual. Critical Events or Incidents include:
    - Abuse, neglect, or exploitation;
    - The unauthorized use of restraint, seclusion, or restrictive interventions;
    - Serious injuries that require medical intervention or result in hospitalization;
    - Criminal victimization;
    - Unexplained death;
    - Medication errors; and
    - Other events or incidents that involve harm or risk of harm to a member.

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 TXIII. Organizational Structure and Staffing

TX3.1 Service coordinator training for supporting self-direction.

| CONTINUOUS REPORTING | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Period** | **Due Date** |
| TX3. Organizational Structure and Staffing | Annually | Contract | Calendar Year | By the end of the second month following the last day of the reporting period |

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

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| A. | Total number of newly hired service coordinators (or those newly assigned to the MMP) who have been employed by the MMP for at least six months. | Total number of newly hired service coordinators (or those newly assigned to the MMP) who have been employed by the MMP for at least six months during the reporting period. | Field Type: Numeric |
| B. | Total number of newly hired service coordinators that have undergone State-based training for supporting self-direction under the demonstration. | Of the total reported in A, the number of newly hired service coordinators that received State-based training for supporting self-direction under the demonstration. | Field Type: Numeric<br><br>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 or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

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

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

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

- CMS and the state will evaluate the percentage of newly hired service coordinators who have been employed by the MMP for at least six months that received 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 Texas three-way contract for specific requirements pertaining to a service coordinator.
- MMPs should refer to the Texas three-way contract for specific requirements pertaining to training for supporting self-direction. Additional guidance and training materials will be provided by HHSC.
- A service coordinator includes all full-time and part-time staff.
- If a service coordinator was not currently with the MMP at the end of the reporting period, but was with the MMP for at least six months during the reporting period, they should be included in this measure. All service coordinators newly hired and beginning employment with the MMP during the reporting period, or newly assigned during the reporting period to the MMP from another role, should be reported in data element A.

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

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

## Section TXIV. Performance and Quality Improvement

TX4.1 Diabetes short-term complications admission rate. (PQI #01)

| CONTINUOUS REPORTING | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Period** | **Due Date** |
| TX4. Performance and Quality Improvement | Annually | Contract | Calendar Year | By the end of the fourth month following the last day of the reporting period |

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

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| A. | Total number of member months for members age 21 and older. | Total number of member months during the reporting period for members age 21 and older. | Field Type: Numeric |
| B. | Total number of discharges for members age 21 years and older with a principal ICD-10-CM diagnosis code for diabetes short-term complications. | Of the total reported in A, the number of discharges for members age 21 years and older with a principal ICD-10-CM diagnosis code for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma). | 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 or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

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

- Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable.
- All data elements should be positive values.

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

- CMS and the state will evaluate the number of admissions (discharges) for members age 21 years and older with a principal ICD-10-CM diagnosis code for diabetes short-term complications per 100,000 member months.

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

- MMPs should include all Medicare-Medicaid 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 data element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all member months for members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The numerator for this measure is based on inpatient discharges, not members.
- 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 MMP on January 1, Ms. X contributes one member month in January.
- MMPs should reference the AHRQ PQI Technical Specifications for additional information on reporting this measure: http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx
- Codes to identify diabetes short-term complications are provided in the Diabetes Short-Term Complications value set.
- Cases to 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
    - With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing).
- See the Admission Codes for Transfers value set.

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

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established

by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

TX4.2 Diabetes long-term complications admission rate. (PQI #03)

| CONTINUOUS REPORTING | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Period** | **Due Date** |
| TX4. Performance and Quality Improvement | Annually | Contract | Calendar Year | By the end of the fourth month following the last day of the reporting period |

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

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| A. | Total number of member months for members age 21 and older. | Total number of months during the reporting period for members age 21 and older. | Field Type: Numeric |
| B. | Total number of discharges for members age 21 years and older with a principal ICD-10-CM diagnosis code for diabetes with long-term complications. | Of the total reported in A, the number of discharges for members age 21 years and older with a principal ICD-10-CM diagnosis code for diabetes with long-term complications (renal, eye, neurological, circulatory, or complications not otherwise specified). | 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 or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

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

- Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable.
- All data elements should be positive values.

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

- CMS and the state will evaluate the number of admissions (discharges) for members age 21 years and older with a principal ICD-10-CM diagnosis code for diabetes with long-term complications per 100,000 member months.

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

- MMPs should include all Medicare-Medicaid 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 data element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all member months for members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The numerator for this measure is based on inpatient discharges, not members.
- 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 MMP on January 1, Ms. X contributes one member month in January.
- MMPs should reference the AHRQ PQI Technical Specifications for additional information on reporting this measure: http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx
- Codes to identify diabetes with long-term complications are provided in the Diabetes Long-Term Complications value set.
- Exclude cases:
    - Transfer from a hospital (different facility)
    - Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
    - Transfer from another health care facility
    - With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing).
- See the Admission Codes for Transfers value set.

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

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

TX4.3 Chronic obstructive pulmonary disease (COPD) or asthma in older adults admission rate. (PQI #05)

| CONTINUOUS REPORTING | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Period** | **Due Date** |
| TX4. Performance and Quality Improvement | Annually | Contract | Calendar Year | By the end of the fourth month following the last day of the reporting period |

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

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| A. | Total number of 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 discharges for members age 40 years and older with either a principal ICD-10-CM diagnosis code for COPD (excluding acute bronchitis); or a principal ICD-10-CM diagnosis code for asthma. | Of the total reported in A, the number of discharges for members age 40 years and older with either a principal ICD-10-CM diagnosis code for COPD (excluding acute bronchitis); or a principal ICD-10-CM diagnosis code for asthma. | 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 or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

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

- Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable.
- All data elements should be positive values.

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

- CMS and the state will evaluate the number of admissions (discharges) for members age 40 years and older with either a principal ICD-10-CM diagnosis code for COPD (excluding acute bronchitis); or a principal ICD-10-CM diagnosis code for asthma per 100,000 member months.

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

- MMPs should include all Medicare-Medicaid 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 data element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all member months for members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The numerator for this measure is based on inpatient discharges, not members.
- 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 MMP 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 eight months to the 40 and older age group category.
- MMPs should reference the AHRQ PQI Technical Specifications for additional information on reporting this measure: http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx

- To identify data element B, MMPs should include discharges for members age 40 years and older with either:
    - A principal ICD-10-CM diagnosis for COPD (excluding acute bronchitis) (COPD [Excluding Acute Bronchitis] value set); or
    - A principal ICD-10-CM diagnosis for asthma (Asthma value set)
- Exclude cases:
    - With any listed ICD-10-CM diagnosis codes for cystic fibrosis and anomalies of the respiratory system (Cystic Fibrosis and Anomalies of Respiratory System value set)
    - Transfer from a hospital (different facility)
    - Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
    - Transfer from another health care facility
    - With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing).
- See the Admission Codes for Transfers value set.

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

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

TX4.4 Hypertension admission rate. (PQI #07)

| CONTINUOUS REPORTING | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Period** | **Due Date** |
| TX4. Performance and Quality Improvement | Annually | Contract | Calendar Year | By the end of the fourth month following the last day of the reporting period |

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

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| A. | Total number of member months for members age 21 and older. | Total number of member months during the reporting period for members age 21 and older. | Field Type: Numeric |
| B. | Total number of discharges for members age 21 years and older with a principal ICD-10-CM diagnosis code for hypertension. | Of the total reported in A, the number of discharges for members age 21 years and older with a principal ICD-10-CM diagnosis code for hypertension. | 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 or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

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

- Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable.
- All data elements should be positive values.

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

- CMS and the state will evaluate the number of admissions (discharges) for members age 21 years and older with a principal ICD-10-CM diagnosis code for hypertension per 100,000 member months.

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

- MMPs should include all Medicare-Medicaid 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 data element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all member months for members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The numerator for this measure is based on inpatient discharges, not members.

- Member months refers to the number of months each Medicare-Medicaid 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 MMP on January 1, Ms. X contributes one member month in January.
- MMPs should reference the AHRQ PQI Technical Specifications for additional information on reporting this measure: http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx
- Codes to identify hypertension are provided in the Hypertension value set.
- Exclude cases:
    - With any listed ICD-10-PCS procedure codes for cardiac procedure (Cardiac Procedure value set)
    - With any listed ICD-10-CM diagnosis codes for Stage I-IV kidney disease (Kidney Disease value set), only if accompanied by any listed ICD-10-PCS procedure codes for dialysis access (Dialysis Access value set)
    - Transfer from a hospital (different facility)
    - Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
    - Transfer from another health care facility
    - With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing).
- See the Admission Codes for Transfers value set.

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

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

TX4.5 Heart failure admission rate. (PQI #08)

| CONTINUOUS REPORTING | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Period** | **Due Date** |
| TX4. Performance and Quality Improvement | Annually | Contract | Calendar Year | By the end of the fourth month following the last day of the reporting period |

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

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| A. | Total number of member months for members age 21 and older. | Total number of member months during the reporting period for members age 21 and older. | Field Type: Numeric |
| B. | Total number of discharges for members age 21 years and older with a principal ICD-10-CM diagnosis code for heart failure. | Of the total reported in A, the number of discharges for members age 21 years and older with a principal ICD-10-CM diagnosis code for heart failure. | 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 or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

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

- Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable.
- All data elements should be positive values.

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

- CMS and the state will evaluate the number of admissions (discharges) for members age 21 years and older with a principal

ICD-10-CM diagnosis code for heart failure per 100,000 member months.

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

- MMPs should include all Medicare-Medicaid 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 data element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all member months for members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The numerator for this measure is based on inpatient discharges, not members.
- 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 MMP on January 1, Ms. X contributes one member month in January.
- MMPs should reference the AHRQ PQI Technical Specifications for additional information on reporting this measure: http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx
- Codes to identify heart failure are provided in the Heart Failure value set.
- Exclude cases:
    - With any listed ICD-10-PCS procedure codes for cardiac procedure (Cardiac Procedure value set)
    - Transfer from a hospital (different facility)
    - Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
    - Transfer from another health care facility
    - With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing).
- See the Admission Codes for Transfers value set.

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

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

TX4.6 Dehydration admission rate. (PQI #10)

| CONTINUOUS REPORTING | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Period** | **Due Date** |
| TX4. Performance and Quality Improvement | Annually | Contract | Calendar Year | By the end of the fourth month following the last day of the reporting period |

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

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| A. | Total number of member months for members age 21 and older. | Total number of member months during the reporting period for members age 21 and older. | Field Type: Numeric |
| B. | Total number of discharges for members age 21 years and older with either a principal ICD-10-CM diagnosis code for dehydration; or any secondary ICD-10-CM diagnosis code for dehydration and a principal ICD-10-CM diagnosis code for hyperosmolality and/or hypernatremia, gastroenteritis, or acute kidney injury. | Of the total reported in A, the number of discharges for members age 21 years and older with either a principal ICD-10-CM diagnosis code for dehydration; or any secondary ICD-10-CM diagnosis code for dehydration and a principal ICD-10-CM diagnosis code for hyperosmolality and/or hypernatremia, gastroenteritis, or acute kidney injury. | 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 or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

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

- Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable.
- All data elements should be positive values.

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

- CMS and the state will evaluate the number of admissions (discharges) for members age 21 years and older with either a principal ICD-10-CM diagnosis code for dehydration; or any secondary ICD-10-CM diagnosis code for dehydration and a principal ICD-10-CM diagnosis code for hyperosmolality and/or hypernatremia, gastroenteritis, or acute kidney injury per 100,000 member months.

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

- MMPs should include all Medicare-Medicaid 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 data element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all member months for members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The numerator for this measure is based on inpatient discharges, not members.
- 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 MMP on January 1, Ms. X contributes one member month in January.
- MMPs should reference the AHRQ PQI Technical Specifications for additional information on reporting this measure: http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx
- To identify data element B, MMPs should include discharges for members age 21 years and older with either:
    - A principal ICD-10-CM diagnosis code for dehydration (Dehydration value set); or
    - Any secondary ICD-10-CM diagnosis code for dehydration and a principal ICD-10-CM diagnosis code for hyperosmolality and/or hypernatremia

(Hyperosmolality/Hypernatremia value set), gastroenteritis (Gastroenteritis value set), or acute kidney injury (Acute Kidney Injury value set)

- Exclude cases:
  - With any listed ICD-10-CM diagnosis codes for chronic renal failure (Chronic Renal Failure value set)
  - Transfer from a hospital (different facility)
  - Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
  - Transfer from another health care facility
  - With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing).
- See the Admission Codes for Transfers value set.

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

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

TX4.7 Bacterial pneumonia admission rate. (PQI #11)

| CONTINUOUS REPORTING | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Period** | **Due Date** |
| TX4. Performance and Quality Improvement | Annually | Contract | Calendar Year | By the end of the fourth month following the last day of the reporting period |

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

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| A. | Total number of member months for members age 21 and older. | Total number of member months during the reporting period for members age 21 and older. | Field Type: Numeric |

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| B. | Total number of discharges for members age 21 years and older with a principal ICD-10-CM diagnosis code for bacterial pneumonia. | Of the total reported in A, the number of discharges for members age 21 years and older with a principal ICD-10-CM diagnosis code for bacterial pneumonia. | 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 or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

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

- Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable.
- All data elements should be positive values.

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

- CMS and the state will evaluate the number of admissions (discharges) for members age 21 years and older with a principal ICD-10-CM diagnosis code for bacterial pneumonia per 100,000 member months.

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

- MMPs should include all Medicare-Medicaid 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 data element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all member months for members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The numerator for this measure is based on inpatient discharges, not members.
- 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 MMP on January 1, Ms. X contributes one member month in January.

- MMPs should reference the AHRQ PQI Technical Specifications for additional information on reporting this measure: http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx
- Codes to identify bacterial pneumonia are provided in the Bacterial Pneumonia value set.
- Exclude cases:
    - With any listed ICD-10-CM diagnosis codes for sickle cell anemia or HB-S disease (Sickle Cell Anemia or HB-S Disease value set)
    - With any listed ICD-10-CM diagnosis codes or any listed ICD-10-PCS procedure codes for immunocompromised state (Immunocompromised State Diagnosis and Procedure value set)
    - Transfer from a hospital (different facility)
    - Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
    - Transfer from another health care facility
    - With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing).
- See the Admission Codes for Transfers value set.

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

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

TX4.8 Urinary tract infection admission rate. (PQI #12)

| CONTINUOUS REPORTING | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Period** | **Due Date** |
| TX4. Performance and Quality Improvement | Annually | Contract | Calendar Year | By the end of the fourth month following the last day of the reporting period |

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

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| A. | Total number of member months for members age 21 and older. | Total number of member months during the reporting period for members age 21 and older. | Field Type: Numeric |
| B. | Total number of discharges for members age 21 years and older with a principal ICD-10-CM diagnosis code for urinary tract infection. | Of the total reported in A, the number of discharges for members age 21 years and older with a principal ICD-10-CM diagnosis code for urinary tract infection. | 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 or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

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

- Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable.
- All data elements should be positive values.

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

- CMS and the state will evaluate the number of admissions (discharges) for members age 21 years and older with a principal ICD-10-CM diagnosis code for urinary tract infection per 100,000 member months.

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

- MMPs should include all Medicare-Medicaid 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 data element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all

member months for members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).

- The numerator for this measure is based on inpatient discharges, not members.
- 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 MMP on January 1, Ms. X contributes one member month in January.
- MMPs should reference the AHRQ PQI Technical Specifications for additional information on reporting this measure: http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx
- Codes to identify urinary tract infection are provided in the Urinary Tract Infection value set.
- Exclude cases:
    - With any listed ICD-10-CM diagnosis codes for kidney/urinary tract disorder (Kidney/Urinary Tract Disorder value set)
    - With any listed ICD-10-CM diagnosis codes or any listed ICD-10-PCS procedure codes for immunocompromised state (Immunocompromised State Diagnosis and Procedure value set)
    - Transfer from a hospital (different facility)
    - Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
    - Transfer from another health care facility
    - With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing).
- See the Admission Codes for Transfers value set.

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

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

TX4.9 Angina without procedure admission rate. (PQI #13) – ***Suspended***

TX4.10 Uncontrolled diabetes admission rate. (PQI #14)

| CONTINUOUS REPORTING | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Period** | **Due Date** |
| TX4. Performance and Quality Improvement | Annually | Contract | Calendar Year | By the end of the fourth month following the last day of the reporting period |

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

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| A. | Total number of member months for members age 21 and older. | Total number of member months during the reporting period for members age 21 and older. | Field Type: Numeric |
| B. | Total number of discharges for members age 21 years and older with a principal ICD-10-CM diagnosis code for uncontrolled diabetes without mention of a short-term or long-term complication. | Of the total reported in A, the number of discharges for members age 21 years and older with a principal ICD-10-CM diagnosis code for uncontrolled diabetes without mention of a short-term or long-term complication. | 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 or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

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

- Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable.
- All data elements should be positive values.

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

- CMS and the state will evaluate the number of admissions (discharges) for members age 21 years and older with a principal ICD-10-CM diagnosis code for uncontrolled diabetes without mention of a short-term or long-term complication per 100,000 member months.

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

- MMPs should include all Medicare-Medicaid 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 data element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all member months for members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The numerator for this measure is based on inpatient discharges, not members.
- 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 MMP on January 1, Ms. X contributes one member month in January.
- MMPs should reference the AHRQ PQI Technical Specifications for additional information on reporting this measure: http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx
- Codes to identify uncontrolled diabetes without mention of a short-term or long-term complication are provided in the Uncontrolled Diabetes value set.
- Exclude cases:
    - Transfer from a hospital (different facility)
    - Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
    - Transfer from another health care facility
    - With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing).
- See the Admission Codes for Transfers value set.

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

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established

by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

TX4.11 Lower-extremity amputation among patients with diabetes admission rate. (PQI #16)

| CONTINUOUS REPORTING | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Period** | **Due Date** |
| TX4. Performance and Quality Improvement | Annually | Contract | Calendar Year | By the end of the fourth month following the last day of the reporting period |

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

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| A. | Total number of member months for members age 21 and older. | Total number of member months during the reporting period for members age 21 and older. | Field Type: Numeric |
| B. | Total number of discharges for members age 21 years and older with any listed ICD-10-PCS procedure codes for lower-extremity amputation and any ICD-10-CM diagnosis codes for diabetes. | Of the total reported in A, the number of discharges for members age 21 years and older with any listed ICD-10-PCS procedure codes for lower-extremity amputation and any ICD-10-CM diagnosis codes for diabetes. | 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 or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

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

- Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable.
- All data elements should be positive values.

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

- CMS and the state will evaluate the number of admissions (discharges) for members age 21 years and older with any listed ICD-10-PCS procedure code for lower-extremity amputation and any ICD-10-CM diagnosis code for diabetes per 100,000 member months.

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

- MMPs should include all Medicare-Medicaid 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 data element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all member months for members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The numerator for this measure is based on inpatient discharges, not members.
- 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 MMP on January 1, Ms. X contributes one member month in January.
- MMPs should reference the AHRQ PQI Technical Specifications for additional information on reporting this measure: http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx
- Codes to identify lower-extremity amputation are provided in the Lower Extremity Amputation value set.
- Codes to identify diabetes are provided in the Diabetes value set.
- Exclude cases:
    - With any listed ICD-10-CM diagnosis codes for traumatic amputation of the lower extremity (Traumatic Amputation of Lower Extremity value set)
    - 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)

  - With missing gender (SEX=missing), age (AGE=missing), quarter (DQTR=missing), year (YEAR=missing), principal diagnosis (DX1=missing), or county (PSTCO=missing).
- See the Admission Codes for Transfers value set.

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

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

TX4.12 Medication management for people with asthma. – ***Suspended***

TX4.13 Cervical cancer screening.

| CONTINUOUS REPORTING | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Period** | **Due Date** |
| TX4. Performance and Quality Improvement | Annually | Contract | Calendar Year, beginning in CY2 | 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 women 24-64 years old. | Total number of women 24-64 years old, who were continuously enrolled during the reporting period, and who were enrolled on December 31 of the reporting period. | Field Type: Numeric |
| B. | Total number of women sampled that met inclusion criteria. | Of the total reported in A, the number of women sampled that met inclusion criteria. | Field Type: Numeric<br><br>Note: Is a subset of A. |

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| C. | Total number of women who were appropriately screened for cervical cancer. | Of the total reported in B, the number of women who were appropriately screened for cervical cancer. | Field Type: Numeric<br><br>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 or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee 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 women 24-64 years old who were appropriately screened for cervical cancer.

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

- MMPs should include all Medicare-Medicaid members ages 24-64 regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included. A subset of all members that are eligible will be included in the sample.
- The member must be enrolled during the current reporting period and the previous reporting period with no more than one gap in enrollment of up to 45 days during the reporting period (i.e., January through December). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
- Due to continuous enrollment criteria this measure will be reported beginning CY2.
- Members in hospice are excluded from the eligible population.

**Administrative Specifications**

- The MMP should refer to the HEDIS® Value sets listed in steps 1 and 2 to identify numerator positive hits when using administrative data.
    - **Step 1**: Identify women 24-64 years of age as of December 31 of the reporting period who had a cervical cytology (Cervical Cytology value set) during the reporting period or the two years prior to the reporting period.
    - **Step 2**: From the women who did not meet step 1 criteria, identify women 30-64 years of age as of December 31 of the reporting period who had cervical cytology (Cervical Cytology value set) and a human papillomavirus (HPV) test (HPV Tests value set) with service dates four or less days apart during the reporting period or the four years prior to the reporting period and who were 30 years or older on the date of both tests. For example, if the service date for cervical cytology was December 1 of the reporting period, then the HPV test must include a service date on or between November 27 and December 5 of the reporting period.
    - **Step 3**: Sum the events from steps 1 and 2 to obtain the rate.
- Exclude hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix (Absence of Cervix value set) any time during the member's history through December 31 of the reporting period. This is an optional exclusion.

**Hybrid Specifications**

- MMPs may elect to use a hybrid methodology for this measure.
- The systematic sample drawn must include a subset of all eligible members whether the member was enrolled through passive enrollment or opt-in enrollment.
- 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.
- If the MMP does not elect to sample, data element B will be equal to data element A.
- The MMP should refer to the *Administrative Specifications* to identify positive numerator hits from administrative data.
- When reviewing a member's medical record, the following steps should be used to identify numerator compliance.
    - **Step 1**: Identify the number of women who were 24–64 years of age as of December 31 of the reporting period who had cervical cytology during the reporting period, or the two years prior to the reporting period. Documentation in the medical record must include both of the following:

  - A note indicating the date when the cervical cytology was performed.
  - The result or finding.
- Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that "no cervical cells were present"; this is not considered appropriate screening.
- Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.
- Lab results that indicate the sample contained "no endocervical cells" may be used if a valid result was reported for the test.

**Step 2**: From the women who did <u>not</u> meet step 1 criteria, identify the number of women who were 30–64 years of age as of December 31 of the reporting period who had cervical cytology and an HPV test on the same date of service during the reporting period or the four years prior to the reporting period *and* who were 30 years or older as of the date of testing. Documentation in the medical record must include both of the following:

  - A note indicating the date when the cervical cytology and the HPV test were performed. The cervical cytology and HPV test must be from the same data source.
  - The results or findings.
- Include only cytology and HPV "co-testing"; in co-testing, both cytology and HPV tests are performed (i.e., the samples are collected and both tests are ordered, regardless of the cytology result) on the same date of service. Do not include reflex testing. In addition, if the medical record indicates the HPV test was performed only after determining the cytology result, this is considered reflex testing and does not meet criteria for the measure.
- Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that "no cervical cells were present"; this is not considered appropriate screening.
- Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

- Lab results that indicate the sample contained "no endocervical cells" may be used if a valid result was reported for the test.

**Step 3**: Sum the events from Steps 1-2 to obtain the rate.

- Exclude the following (these are optional exclusions):
  - Evidence of a hysterectomy with no residual cervix, cervical agenesis, or acquired absence of cervix (Absence of Cervix value set) any time during the member's history through December 31 of the reporting period. Documentation of "complete," "total" or "radical" abdominal or vaginal hysterectomy meets the criteria for hysterectomy with no residual cervix.
  - The following also meet criteria:
    - Documentation of a "vaginal pap smear" in conjunction with documentation of "hysterectomy"
    - Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening

  Documentation of hysterectomy alone does not meet the criteria because it is not sufficient evidence that the cervix was removed.

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.

TX4.14 Avoidance of antibiotic treatment in adults with acute bronchitis.

| CONTINUOUS REPORTING | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Period** | **Due Date** |
| TX4. Performance and Quality Improvement | Annually | Contract | Calendar Year, beginning in CY2 | 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 21-64 years of age with a diagnosis of acute bronchitis. | Total number of members 21-64 years of age who were continuously enrolled one year prior to the Episode Date through seven days after the Episode Date with a diagnosis of acute bronchitis. | Field Type: Numeric |
| B. | Total number of members 21-64 years of age who were dispensed a prescription for antibiotic medication on or three days after the index episode start date (IESD). | Of the total reported in A, the number of members 21-64 years of age who were dispensed a prescription for antibiotic medication on or three days after the IESD. | Field Type: Numeric<br><br>Note: Is a subset of A. |
| C. | Total number of members 65 years of age and older with a diagnosis of acute bronchitis. | Total number of members 65 years of age and older who were continuously enrolled one year prior to the Episode Date through seven days after the Episode Date with a diagnosis of acute bronchitis. | Field Type: Numeric |
| D. | Total number of members 65 years of age and older who were dispensed a prescription for antibiotic medication on or three days after the IESD. | Of the total reported in C, the number of members 65 years of age and older who were dispensed a prescription for antibiotic medication on or three days after the IESD. | Field Type: Numeric<br><br>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 or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee will apply threshold checks.

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

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

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

NOTE: This measure is reported as an inverted rate [1-(numerator/eligible population)]. A higher rate indicates appropriate treatment of adults with acute bronchitis (i.e., the proportion for whom antibiotics were not prescribed).

CMS and the state will evaluate the percentage of:

- Members 21-64 years of age with a diagnosis of acute bronchitis who were not dispensed a prescription for antibiotic medication on or three days after the IESD.
- Members 65 years of age and older with a diagnosis of acute bronchitis who were not dispensed a prescription for antibiotic medication on or three days after the IESD.

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

- MMPs should include all Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- A member must be continuously enrolled for one year prior to the Episode Date through seven days after the Episode Date (373 total days).
- Due to continuous enrollment criteria this measure will be reported beginning CY2.
- No more than one gap in enrollment of up to 45 days is allowed during the 365 days (1 year) prior to the Episode Date. To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). No gaps in enrollment are allowed on the IESD through seven days after the IESD (defined below).
- The Intake Period is January 1-December 24 of the reporting period. The Intake Period captures eligible episodes of treatment.
- The Episode Date is the date of service for any outpatient or ED visit during the Intake Period with a diagnosis of acute bronchitis.

- The Index Episode Start Date (IESD) is the earliest Episode Date during the Intake Period that meets all of the following criteria:
    - A 30-day Negative Medication History prior to the Episode Date.
    - A 12-month Negative Comorbid Condition History prior to and including the Episode Date.
    - A Negative Competing Diagnosis during the 38-day period from 30 days prior to the Episode Date through seven days after the Episode Date.
    - The member was continuously enrolled one year prior to the Episode Date through seven days after the Episode Date.
- To qualify for Negative Medication History, the following criteria must be met:
    - A period of 30 days prior to the Episode Date, when the member had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug.
    - No prescriptions that were filled more than 30 days prior to the Episode Date and are active on the Episode Date.
- A prescription is considered active if the "days supply" indicated on the date when the member filled the prescription is the number of days or more between that date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the Intake Period.
- The Negative Comorbid Condition History is a period of 12 months prior to and including the Episode Date, when the member had no claims/encounters with any diagnosis for a comorbid condition.
- The Negative Competing Diagnosis is a period of 30 days prior to the Episode Date through seven days after the Episode Date (38 total days), when the member had no claims/encounters with any competing diagnosis.
- Follow the steps below to identify the eligible population. Members in hospice are excluded from the eligible population.

    **Step 1**: Identify all members who had an outpatient visit (Outpatient value set), an observation visit (Observation value set), or an ED visit (ED value set), during the Intake Period, with a diagnosis of acute bronchitis (Acute Bronchitis value set).
    Do not include ED visits or observation visits that result in an inpatient stay (Inpatient Stay value set). An ED visit or observation visit results in an inpatient stay with the ED/observation date of service and the admission date for the inpatient stay are one calendar day apart or less.

    **Step 2**: Determine all acute bronchitis Episode Dates. For each member identified in step one, determine all

outpatient, observation or ED visits with a diagnosis of acute bronchitis.

**Step 3**: Test for Negative Comorbid Condition History. Exclude Episode Dates when the member had a claim/encounter with any diagnosis for a comorbid condition during the 12 months prior to or on the Episode Date. A code from any of the following meets criteria for a comorbid condition:

- HIV value set
- HIV Type 2 value set
- Malignant Neoplasms value set
- Emphysema value set
- COPD value set
- Cystic Fibrosis value set
- Comorbid Conditions value set
- Disorders of the Immune System value set

**Step 4**: Test for Negative Medication History. Exclude Episode Dates where a new or refill prescription for an antibiotic medication (Table TX-1) was filled 30 days prior to the Episode Date or was active on the Episode Date.

i. MMPs should also reference the complete list of medications and NDC codes NCQA has posted to www.ncqa.org.

**Step 5**: Test for Negative Competing Diagnosis. Exclude Episode Dates where during the period 30 days prior to the Episode Date through seven days after the Episode Date (38 total days), the member had a claim/encounter with any competing diagnosis. A code from either of the following meets criteria for a competing diagnosis:

- Pharyngitis value set
- Competing Diagnosis value set

**Step 6**: Calculate continuous enrollment. The member must be continuously enrolled with no more than one gap in coverage from 365 days (one year) prior to the Episode Date through seven days after the Episode Date (373 total days).

**Step 7**: Select the IESD. This measure examines the earliest eligible episode per member.

- For data elements B and D, do not include denied claims.

| Table TX-1: Antibiotic Medications | | | |
|---|---|---|---|
| **Description** | **Prescriptions** | | |
| Aminoglycosides | • Amikacin<br>• Gentamicin | • Kanamycin<br>• Streptomycin | • Tobramycin |
| Aminopenicillins | • Amoxicillin | • Ampicillin | |
| Antipseudomonal penicillins | • Piperacillin | | |
| Beta-lactamase inhibitors | • Amoxicillin-clavulanate<br>• Ampicillin-sulbactam | • Piperacillin-tazobactam<br>• Ticarcillin-clavulanate | |
| First-generation cephalosporins | • Cefadroxil | • Cefazolin | • Cephalexin |
| Fourth-generation cephalosporins | • Cefepime | | |
| Ketolides | • Telithromycin | | |
| Lincomycin derivatives | • Clindamycin | • Lincomycin | |
| Macrolides | • Azithromycin<br>• Clarithromycin | • Erythromycin<br>• Erythromycin ethylsuccinate | • Erythromycin lactobionate<br>• Erythromycin stearate |
| Miscellaneous antibiotics | • Aztreonam<br>• Chloramphenicol<br>• Dalfopristin-quinupristin | • Daptomycin<br>• Erythromycin-sulfisoxazole<br>• Linezolid | • Metronidazole<br>• Vancomycin |
| Natural penicillins | • Penicillin G benzathine-procaine<br>• Penicillin G potassium | • Penicillin G procaine<br>• Penicillin G sodium | • Penicillin V potassium<br>• Penicillin G benzathine |
| Penicillinase resistant penicillins | • Dicloxacillin | • Nafcillin | • Oxacillin |
| Quinolones | • Ciprofloxacin<br>• Gemifloxacin | • Levofloxacin<br>• Moxifloxacin | • Norfloxacin<br>• Ofloxacin |
| Rifamycin derivatives | • Rifampin | | |
| Second generation cephalosporin | • Cefaclor<br>• Cefprozil<br>• Cefuroxime | • Cefotetan<br>• Cefoxitin | |
| Sulfonamides | • Sulfamethoxazole-trimethoprim | • Sulfadiazine | |
| Tetracyclines | • Doxycycline | • Minocycline | • Tetracycline |
| Third generation cephalosporins | • Cefdinir<br>• Cefditoren<br>• Cefixime | • Cefotaxime<br>• Cefpodoxime<br>• Ceftazidime | • Ceftibuten<br>• Ceftriaxone |
| Urinary anti-infectives | • Fosfomycin<br>• Nitrofurantoin<br>• Nitrofurantoin macrocrystals | • Nitrofurantoin macrocrystals-monohydrate<br>• Trimethoprim | |

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.

TX4.15 Use of appropriate medications for people with asthma. – ***Suspended***

TX4.16 Prenatal and postpartum care.

| CONTINUOUS REPORTING | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Period** | **Due Date** |
| TX4. Performance and Quality Improvement | Annually | Contract | Calendar Year, beginning in CY2 | 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 live deliveries. | Total number of live deliveries for women who were continuously enrolled between 43 days prior to delivery and 56 days after delivery during the reporting period. | Field Type: Numeric |
| B. | Total number of deliveries sampled that met inclusion criteria. | Of the total reported in A, the number of deliveries sampled that met inclusion criteria. | Field Type: Numeric<br><br>Note: Is a subset of A. |

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| C. | Total number of deliveries that received a prenatal visit in the first trimester or within 42 days of enrollment. | Of the total reported in B, the number of deliveries that received a prenatal visit in the first trimester, on the enrollment date or within 42 days of enrollment in the MMP. | Field Type: Numeric<br><br>Note: Is a subset of B. |
| D. | Total number of deliveries that had a postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery. | Of the total reported in B, the number of deliveries that had a postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery. | Field Type: Numeric<br><br>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 or its designee will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state or its designee 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 and D 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 deliveries for women who were continuously enrolled between 43 days prior to delivery and 56 days after delivery during the reporting period that:

- Received a prenatal visit in the first trimester, on the enrollment start date or within 42 days of enrollment in the MMP.
- Had a postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery.

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

- MMPs should include all Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included. A subset of all members that are eligible will be included in the sample.
- A member must be continuously enrolled for 43 days prior to the delivery through 56 days after the delivery, with no gaps during the continuous enrollment period to be included in this measure.
- Include all events for those members who delivered a live birth on or between November 6 of the prior reporting period and November 5 of the current reporting period. Include women who delivered in any setting.
- Women who had two separate deliveries (different dates of service) between November 6 of the year prior to the reporting period and November 5 of the current reporting period should be counted twice. Women who had multiple live births during one pregnancy should be counted once in the measure.
- For data element C, the prenatal visit depends on the date of enrollment in the MMP and the gaps in enrollment during the pregnancy. Include only visits that occur while the member was enrolled.
- For data element D, the postpartum visit should be documented through either administrative data or medical record review.
- Follow the steps below to identify the eligible population, which is the denominator for both rates. Members in hospice are excluded from the eligible population.
    - **Step 1**: Identify deliveries. Identify all women with a delivery (Deliveries value set) on or between November 6 of the year prior to the reporting period and November 5 of the current reporting period.
    - **Step 2**: Exclude non-live births (Non-live Births value set)
    - **Step 3**: Identify continuous enrollment. Determine if enrollment was continuous between 43 days prior to delivery through 56 days after delivery, with no gaps.

**Administrative Specifications – Timeliness of Prenatal Care**

- Follow the steps below to identify the numerator:
    - **Step 1**: Determine enrollment status during the first trimester. For all women in the eligible population, identify those who were enrolled on or before 280 days prior to delivery (or estimated date of delivery [EDD]). For these women proceed to step 2.
        - For women not enrolled on or before 280 days prior to delivery or (EDD), who were therefore

pregnant at the time of enrollment, proceed to step 3.

**Step 2**: Determine continuous enrollment for the first trimester. Identify women from step 1 who were continuously enrolled during the first trimester (176-280 days prior to delivery [or EDD]), with no gaps in enrollment. For these women, determine numerator compliance using the decision rules for *Identifying Prenatal Care for Women Continuously Enrolled During the First Trimester* (see page TX-65).

- For women who were not continuously enrolled during the first trimester (e.g., had a gap between 176 and 280 days before delivery), proceed to step 3.

**Step 3**: Determine the start date of the last enrollment segment (i.e., the enrollment segment during the pregnancy with the start date that is closest to the delivery date).

- For women whose last enrollment started on or between 219 and 279 days before delivery, proceed to step 4.
- For women whose last enrollment started less than 219 days before delivery, proceed to step 5.

**Step 4**: Determine numerator compliance. If the last enrollment segment started on or between 219 and 279 days before delivery, determine numerator compliance using the instructions for *Identifying Prenatal Care for Women Not Continuously Enrolled During the First Trimester* (see page TX-67) and find a visit between the last enrollment start date and 176 days before delivery.

**Step 5**: Determine numerator compliance. If the last enrollment segment started less than 219 days before delivery (i.e., between 219 days before delivery and the day of delivery), determine numerator compliance using the instructions for *Identifying Prenatal Care for Women Not Continuously Enrolled During The First Trimester* (see page TX-67) and find a visit on the enrollment start date or within 42 days after enrollment.

**Identifying Prenatal Care for Women Continuously Enrolled During the First Trimester**

Decision Rule 1: Either of the following during the first trimester, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP meets criteria:

- A bundled service (Prenatal Bundled Services value set) where the MMP can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated).
- A visit for prenatal care (Stand Alone Prenatal Visits value set)

Decision Rule 2: Any of the following during the first trimester, where the practitioner type for the prenatal visit is an OB/GYN or other prenatal care practitioner, meet criteria:

- A prenatal visit (Prenatal Visits value set), with an obstetric panel (Obstetric Panel value set)
- A prenatal visit (Prenatal Visits value set) with an ultrasound (echocardiography) of the pregnant uterus (Prenatal Ultrasound value set).
- A prenatal visit (Prenatal Visits value set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis value set).
- A prenatal visit (Prenatal Visits value set) with all of the following:
  - Toxoplasma (Toxoplasma Antibody value set)
  - Rubella (Rubella Antibody value set)
  - Cytomegalovirus (Cytomegalovirus Antibody value set)
  - Herpes simplex (Herpes Simplex Antibody value set)
- A prenatal visit (Prenatal Visits value set) with rubella (Rubella Antibody value set) and ABO (ABO value set).
- A prenatal visit (Prenatal Visits value set) with rubella (Rubella Antibody value set) and Rh (Rh value set).
- A prenatal visit (Prenatal Visits value set) with rubella (Rubella Antibody value set) and ABO/Rh (ABO and Rh value set).

Decision Rule 3: Any of the following during the first trimester, where the practitioner type is a PCP, meet criteria:

- A prenatal visit (Prenatal Visits value set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis value set) and an obstetric panel (Obstetric Panel value set).

  - A prenatal visit (Prenatal Visits value set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis value set) and an ultrasound (echocardiography) of the pregnant uterus (Prenatal Ultrasound value set).
  - A prenatal visit (Prenatal Visits value set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis value set) and all of the following:
    - Toxoplasma (Toxoplasma Antibody value set)
    - Rubella (Rubella Antibody value set)
    - Cytomegalovirus (Cytomegalovirus Antibody value set)
    - Herpes simplex (Herpes Simplex Antibody value set)
  - A prenatal visit (Prenatal Visits value set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis value set) and rubella (Rubella Antibody value set) and ABO (ABO value set).
  - A prenatal visit (Prenatal Visits value set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis value set) and rubella (Rubella Antibody value set) and Rh (Rh value set).
  - A prenatal visit (Prenatal Visits value set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis value set) and rubella (Rubella Antibody value set) and ABO/Rh (ABO and Rh value set).
  - A prenatal visit (Prenatal Visits value set) with any internal MMP code for LMP or EDD with an obstetrical history.
  - A prenatal visit (Prenatal Visits value set) with any internal MMP code for LMP or EDD with risk assessment and counseling/education.
- For Decision Rule 3 criteria that require a prenatal visit code (Prenatal Visits value set) *and* a pregnancy-related diagnosis code (Pregnancy Diagnosis value set) the codes must be on the same claim.

**Identifying Prenatal Care for Women Not Continuously Enrolled During the First Trimester**

- Any of the following, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP, meet criteria:
  - A bundled service (Prenatal Bundled Services value set) where the MMP can identify the date when prenatal care was initiated (because bundled codes are used on the date

of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated).
    - A visit for prenatal care (Stand Alone Prenatal Visits value set).
    - A prenatal visit (Prenatal Visits value set) with an ultrasound (echocardiography) of the pregnant uterus (Prenatal Ultrasound value set).
    - A prenatal visit (Prenatal Visits value set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis value set).
- For criteria that require a prenatal visit code (Prenatal Visits value set) *and* a pregnancy-related diagnosis code (Pregnancy Diagnosis value set), the codes must be on the same claim.

**Administrative Specifications – Postpartum Care**

- A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery. Any of the following meet criteria:
    - A postpartum visit (Postpartum Visits value set).
    - Cervical Cytology (Cervical Cytology value set).
    - A bundled service (Postpartum Bundled Services value set) where the MMP can identify the date when the postpartum care was rendered (because bundled service codes are used on the date of the postpartum visit, these codes may be used only if the claim form indicates when postpartum care was rendered).
- The practitioner requirement only applies to the Hybrid Specification. The MMP is not required to identify practitioner type in administrative data.

**Hybrid Specifications – Timeliness of Prenatal Care**

- The systematic sample drawn must include a subset of all eligible members whether the member was enrolled through passive enrollment or opt-in enrollment.
- The MMP should refer to the *Administrative Specification* to identify positive numerator hits from administrative data.
- 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.
- If the MMP does not elect to sample, data element B will be equal to data element A.
- When reviewing a member's medical record, the record should include a prenatal care visit to an OB/GYN or other prenatal care practitioner or PCP. For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred, and evidence of one of the following:
    - A basic physical obstetrical examination that includes auscultation for fetal heart tone, *or* pelvic exam with

obstetric observations, *or* measurement of fundus height (standardized prenatal flow sheet must be used).
    - Evidence that a prenatal care procedure was performed, such as:
        - Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential white blood cell count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, red blood cell antibody screen, Rh and ABO blood typing), **or**
        - TORCH antibody panel alone, **or**
        - A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, **or**
        - Echography of a pregnant uterus.
    - Documentation of LMP or EDD in conjunction with *either* of the following.
        - Prenatal risk assessment and counseling/education.
        - Complete obstetrical history.
- For women whose last enrollment segment was after 219 days prior to delivery (i.e., between 219 days prior to delivery and the day of delivery) and women who had a gap during the first trimester, count documentation of a visit to an OB/GYN, family practitioner or other PCP with a principle diagnosis of pregnancy.

**Hybrid Specifications – Postpartum Care**

- The MMP should refer to the *Administrative Specification* to identify positive numerator hits from administrative data.
- The systematic sample drawn must include a subset of all eligible members whether the member was enrolled through passive enrollment or opt-in enrollment.
- 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.
- If the MMP does not elect to sample, data element B will be equal to data element A.
- When reviewing a member's medical record, the record should include a postpartum visit to an OB/GYN practitioner or midwife, family practitioner or other PCP on or between 21 and 56 days after delivery. Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and one of the following:
    - Pelvic exam.
    - Evaluation of weight, blood pressure, breasts and abdomen.
        - Notation of "breastfeeding" is acceptable for the "evaluation of breasts" component.

- Notation of postpartum care, including but not limited to:
  - Notation of “postpartum care”, “PP care”, “PP check”, “6-week check.”
  - A preprinted “Postpartum Care” form in which information was documented during the visit.

**Additional Notes:**

- For women continuously enrolled during the first trimester (176–280 days before delivery with no gaps), the MMP has sufficient opportunity to provide prenatal care in the first trimester. Any enrollment gaps in the second and third trimesters are incidental.
- Criteria for identifying prenatal care for women who were not continuously enrolled during the first trimester allow more flexibility than criteria for women who were continuously enrolled.
  - For women whose last enrollment segment started on or between 219 and 279 days before delivery, the MMP has sufficient opportunity to provide prenatal care by the end of the first trimester.
  - For women whose last enrollment segment started less than 219 days before delivery, the MMP has sufficient opportunity to provide prenatal care within 42 days after enrollment.
- Services that occur over multiple visits count toward this measure if all services are within the time frame established in the measure. Ultrasound and lab results alone are not considered a visit; they must be linked to an office visit with an appropriate practitioner in order to count for this measure.
- The MMP must use one date (date of delivery or EDD) to define the start and end of the first trimester. If multiple EDDs are documented, the MMP must define a method to determine which EDD to use, and use that date consistently. If the MMP elects to use EDD, and the EDD is not on or between November 6 of the year prior to the reporting period and November 5 of the current reporting period, the member is excluded as a valid data error and replaced by the next member of the oversample. The LMP may not be used to determine the first trimester.
- The MMP may use EDD to identify the first trimester for the Timeliness of Prenatal Care rate and use the date of delivery for the Postpartum Care rate.
- A Pap test alone does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate, but is acceptable for the Postpartum Care rate. A colposcopy alone is not numerator compliant for either rate.
- An OB/GYN includes:
  - Physicians certified as obstetricians or gynecologists by the American Medical Specialties Board of Obstetrics or Gynecology or the American Osteopathic Association; or, if

not certified, who successfully completed as accredited program of graduate medical or osteopathic education in obstetrics and gynecology.
    - Certified nurse midwives and nurse practitioners who deliver prenatal care services in a specialty setting (under the direction of an OB/GYN certified or accredited provider).
- A PCP is a primary care practitioner. A physician or nonphysician (e.g., nurse practitioner, physician assistant) who offers primary care medical services. Licensed practical nurses and registered nurses are not considered PCPs.
- The intent is that a visit is with a PCP or OB/GYN. Ancillary services (lab, ultrasound) may be delivered by an ancillary provider.
- The intent is to assess whether prenatal and preventive care was rendered on a routine, outpatient basis rather than assessing treatment for emergent events.

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 TXV. Utilization

TX5.1 Members who went from community to hospital to nursing facility and remained in nursing facility.[i, ii]

| CONTINUOUS REPORTING | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Period** | **Due Date** |
| TX5. Utilization | Annually | Contract | Calendar Year | N/A |

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 were admitted to the hospital from the community and who remained in the hospital for 30 days or less. | Total number of members who were admitted to the hospital from the community and who remained in the hospital for 30 days or less during the reporting period. | Field Type: Numeric |
| B. | Total number of members who were discharged to a nursing facility (NF) and remained in the NF for at least 120 continuous days. | Of the total reported in A, the number of members who were discharged to a NF and remained in the NF for at least 120 continuous days. | Field Type: Numeric<br><br>Note: Is a subset of A. |

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

- The quality withhold benchmark for DY 1 is 10% (lower is better). For withhold purposes, the measure is calculated as follows:
  - Denominator: Total number of members who were admitted to the hospital from the community and who remained in the hospital for 30 days or less (data element A).
  - Numerator: Total number of members from data element A who were discharged to a nursing facility and remained in the nursing facility for at least 120 continuous days (data element B).
- For more information, refer to the Quality Withhold Technical Notes (DY 1): Texas-Specific Measures. Separate guidance will be

forthcoming on the established benchmark for this measure for DY 2 and 3.

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

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data 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 were admitted to the hospital from the community, remained in the hospital for 30 days or less during the reporting period, and who were discharged to a NF and remained in the NF for at least 120 continuous days.

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

- MMPs should include all Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in data element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The date of discharge must occur within the reporting period, but the amount of time spent in a nursing facility may not be in the same reporting period. For example, if the discharge occurs during the last four months of the reporting period, look to the first four months of the following reporting period to identify if a member remained in the nursing facility for at least 120 continuous days.
- The member needs to be enrolled from the date of the hospital admission through 120 days following the hospital discharge, with no gaps in enrollment, to be included in this measure.
- Nursing facility: A convalescent or nursing home or related institution licensed under Chapter 242, Health and Safety Code, that provides long-term services and supports to Medicaid recipients.
- An admission is a stay in a nursing facility longer than 120 continuous days.
- To determine members who were discharged to a NF and remained in the NF for at least 120 continuous days (i.e., data element B), the member must have no break in their stay in the NF.

For example, if a member is discharged to the NF and remains there for 80 days, then transferred back to the hospital, or some other facility, and then is readmitted back to the NF, the first day back in the NF would count as day one (and not day 81). A transfer or discharge from the NF before the member's 120th continuous day in the facility would disrupt the number of days the member remained in the NF. However, if a member was discharged or transferred from the NF on day 122 of their NF stay, they would be counted in data element B.

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

- The data source for this measure is encounter data. HHSC will calculate the measure and provide it to CMS.