MEDICARE-MEDICAID
CAPITATED FINANCIAL ALIGNMENT MODEL
REPORTING REQUIREMENTS

Effective as of January 1, 2017; Issued December 16, 2016

Table of Contents

Introduction

The Medicare-Medicaid Financial Alignment Initiative is designed to test innovative models to better align Medicare and Medicaid financing and the services provided to Medicare-Medicaid enrollees.

The purpose of this document is to provide Medicare-Medicaid Plans (MMPs) with the reporting requirements for the capitated financial alignment model. It provides technical specifications to help assure a common understanding of the data to be reported by MMPs, to assist MMPs in preparing and submitting datasets, to ensure a high level of accuracy in the data reported to the Centers for Medicare & Medicaid Services (CMS) and the states, and to reduce the need for MMPs to correct and resubmit data.

The reporting requirements document is divided into three sections. The first section consists of all Medicare Part C reporting requirements the MMPs are responsible for submitting via the Health Plan Management System (HPMS). The second section consists of all Medicare Part D reporting requirements the MMPs are responsible for submitting via HPMS. The requirements are consistent with the Medicare Parts C and D plan reporting requirements. These unmodified Part C and Part D measures, as described in the first two sections, will continue to be reported using existing processes and specifications. Accordingly, MMPs are required to report these measures upon Office of Management and Budget (OMB) approval, and must comply with the Part C and Part D data validation requirements.

The third section consists of the MMP-specific core reporting requirements for the capitated financial alignment model, which include some modified Part C and D measures. Specifications for these demonstration measures indicate their reporting frequency and due dates.

Measures should be reported at the contract level, unless otherwise indicated.

Definitions

The following terms are used throughout the document:

Medicare-Medicaid Plan (MMP): An MMP is a managed care plan that has entered into a three-way contract with CMS and the state in which the plan will operate. Note: some demonstrations might use different terms to refer to their plans, such as One Care plans in Massachusetts.

State: The state with which the MMP has contracted.

Health Plan Management System (HPMS): The CMS centralized information system used by MMPs to submit Part C, Part D, and MMP-specific core measure data.

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.

Passive Enrollment and Stopping Enrollment

Under the capitated financial alignment model, demonstrations may allow for passive enrollment. During passive enrollment, MMPs must demonstrate adequate performance across a range of measures to remain eligible to receive passive enrollment of beneficiaries. Failure to adequately meet any single measure or set of measures may result in CMS and the state ceasing enrollment. CMS and each state, through the Contract Management Team (CMT), will have the option to discontinue passive enrollment for MMPs for various reasons, including for MMPs failing to completely and accurately report measures or to adequately meet performance standards.

Quality Withhold Measures

CMS and each state will establish a set of quality withhold measures, and MMPs will be required to meet established thresholds. Throughout this document, CMS core 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]). MMPs may have state-specific exceptions to the quality withhold measures outlined in this document. Exceptions, and definitions of Demonstration Years, are noted in the state-specific quality withhold appendices. Additional information on the withhold methodology can be found at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html.

Reporting on Disenrolled and Retro-disenrolled Members

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

Due to retro-disenrollment of members, there may be instances where there is a lag between a member's effective disenrollment date and the date on which the MMP is informed about that disenrollment. This time lag might create occasional data inaccuracies if an MMP includes members in reports who had in fact disenrolled before the start of the reporting period. If MMPs are aware at the time of reporting that a

member has been retro-disenrolled with a disenrollment effective date prior to the reporting period (and therefore was not enrolled during the reporting period in question), then MMPs may exclude that member from reporting. Please note that MMPs are *not* required to re-submit corrected data should they be informed of a retro-disenrollment subsequent to a reporting deadline. MMPs should act upon their best and most current knowledge at the time of reporting regarding each member's enrollment status.

Data Submission

All MMPs will submit core measure data in accordance with the guidance in these reporting requirements. Submission requirements vary by measure, but most core measures are reported through HPMS.

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

Resubmission of MMP-Specific Core Measure Data to HPMS

MMPs must comply with the following steps to resubmit data for MMP-specific core measures after an established due date:

1. Email the applicable NORC HelpDesk to request resubmission.
    - Specify in the email which measures need resubmission;
    - Specify for which reporting period(s) the resubmission is needed; and
    - Provide a brief explanation for why the data need to be resubmitted.

    After review of the request, the NORC HelpDesk will notify the MMP that the resubmission can be completed.

2. Resubmit data through HPMS.

3. Notify the NORC HelpDesk again after resubmission has been completed.

Please note, requests for resubmission after an established due date may result in compliance action from CMS.

Medicare Part C Reporting Requirements

Part C Section V. Grievances

Reporting section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
5. Grievances	05 – MMP	1/Year Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31 (2/5/2018 reporting will include each quarter)	First Monday of February in following year

The data elements to be reported under this reporting section are:

A. Number of Grievances - Total Grievances
B. Number of grievances in which timely notification was given – Total Grievances
C. Number of Grievances – Number of Expedited Grievances
D. Number of grievances in which timely notification was given – Number of Expedited Grievances
E. Number of grievances – Dismissed Grievances
F. Number of Grievances - Enrollment/Disenrollment Grievances
G. Number of grievances in which timely notification was given – Enrollment/Disenrollment Grievances
H. Number of Grievances - Plan Benefit Grievances
I. Number of grievances in which timely notification was given – Plan Benefit Grievances
J. Number of Grievances - Pharmacy Access Grievances
K. Number of grievances in which timely notification was given – Pharmacy Access Grievances
L. Number of Grievances - Marketing Grievances
M. Number of grievances in which timely notification was given – Marketing Grievances
N. Number of Grievances - Customer Service Grievances
O. Number of grievances in which timely notification was given – Customer Service Grievances
P. Number of Grievances – Organization / Determination and Redetermination Process Grievances

Q. Number of grievances in which timely notification was given – Organization / Determination and Redetermination Process Grievances
R. Number of Grievances - Quality of Care Grievances
S. Number of grievances in which timely notification was given – Quality of Care Grievances
T. Number of Grievances - Grievances related to "CMS Issues"
U. Number of grievances in which timely notification was given – Grievances related to "CMS Issues"
V. Number of Grievances - Other Grievances
W. Number of grievances in which timely notification was given – Other Grievances

* Timely notification of grievances means the member was notified according to the following timelines:

- For standard grievances: no later than 30 calendar days after receipt of grievance.
- For standard grievances with an extension taken: no later than 44 calendar days after receipt of grievance.
- For expedited grievances: no later than 24 hours after receipt of grievance.

Notes

This reporting section requires upload into HPMS.

In cases where a purported representative files a grievance on behalf of a beneficiary without an Appointment of Representative (AOR) form, the timeliness calculation ("clock") starts upon receipt of the AOR form. This is a contrast to grievances filed by a beneficiary, in which cases the clock starts upon receipt of the grievance.

For an explanation of Medicare Part C Grievance Procedures, refer to CMS Regulations and Guidance: 42 CFR Part 422, Subpart M, and Chapter 13 of the Medicare Managed Care Manual and the CMS website: Medicare Managed Care Appeals & Grievances. For an explanation of grievance procedures for MMPs, refer to the Demonstration-specific three-way contracts.

CMS requires plans to use one of 22 categories described in this section to report grievances to CMS (Elements A-W). For purposes of Reporting Section 5:

- A grievance is defined in Chapter 13 of the Medicare Managed Care Manual as "Any complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. An enrollee or their representative may make the complaint or dispute, either orally or in writing, to a Medicare health plan, provider, or facility. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration, or invoked

an extension to an organization determination or reconsideration time frame. In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care."

- For Part C reporting, grievances are defined as those grievances completed (i.e., plan has notified enrollee of its decision) during the reporting period, regardless of when the request was received; and include grievances filed by the enrollee or his or her representative.

The category, "Grievances Related to CMS Issues" involves grievances that primarily involve complaints concerning CMS' policies, processes, or operations; the grievance is not directed against the health plan or providers. The new grievance category is meant to identify those grievances that are due to CMS issues, and are related to issues outside of the Plan's direct control. This same type of categorization is used in the Complaint Tracking Module (CTM) and allows CMS to exclude those grievances that are outside of the Plan's direct control, from the total number of grievances filed against the contract.

Reporting Inclusions:

Report:

- Only those grievances processed in accordance with the grievance procedures outlined in 42 CFR Part 422, Subpart M (i.e., Part C grievances). Please note that MMP grievances are also included for reporting under these technical specifications.

- Report grievances involving multiple issues under each applicable category.

- Report grievances if the member is ineligible on the date of the call to the plan but was eligible previously.

- *Dismissals: CMS expects that dismissed grievances represent a very small percentage of total Part C grievances a plan receives. However, this element has been added to provide plans with a means to report grievances that are received but not processed by the plan because they do not meet the requirements for a valid grievance. Generally, a dismissal would occur when the procedure requirements for a valid grievance are not met and the plan is unable to cure the defect. For example, a grievance is received from a purported representative of the enrollee, but a properly executed appointment of representative form has not been filed and there is no other documentation to show that the individual is legally authorized to act on the enrollee's behalf and the plan is unable to obtain the required documentation in a reasonable amount

of time and therefore, dismisses the grievance. See guidance set forth in section 10.4.1 of Chapter 13.

Reporting Exclusions:

Do not report:

- Enrollee complaints only made through the CMS Complaints Tracking Module (CTM). CTM complaints are addressed through a process that is separate and distinct from the plan's procedures for handling enrollee grievances. Therefore, plans should not report their CTM records to CMS as their grievance logs.

- Withdrawn grievances.

- Enrollee grievances processed in accordance with the grievance procedures described under 42 C.F.R., Part 423, Subpart M (i.e., Part D grievances).

Additional Guidance

- Plans should validate that the total number of grievances is equal to the sum of the total number of grievances for each category excluding expedited grievances.

- Plans should validate that the total number of timely notifications is equal to the sum of the total number of timely notifications for each category excluding expedited grievances.

- In cases where an extension is requested after the required decision making timeframe has elapsed, the plan is to report the decision as non-timely. For example: Plan receives grievance on 1/1/2016 at 04:00pm. An extension is requested at 1/31/2016 04:05pm. Plan completes investigation and provides notification on 2/5/2016 04:00pm (35 calendar days after receipt). This grievance is not considered timely for reporting as the decision was rendered more than 30 calendar days after receipt.

- If an enrollee files a grievance and then files a subsequent grievance on the same issue *prior to* the organization's decision or deadline for decision notification (whichever is earlier), then the issue is counted as one grievance.

- If an enrollee files a grievance and then files a subsequent grievance on the same issue *after* the organization's decision or deadline for decision notification (whichever is earlier), then the issue is counted as a separate grievance.

- If the enrollee files a grievance with a previous contract, but enrolls in a new contract before the grievance is resolved, the previous contract is still responsible for investigating, resolving and reporting the grievance.

- *For MA-PD contracts:* Include only grievances that apply to the Part C benefit. (If a clear distinction cannot be made for an MA-PD, cases are reported as Part C grievances.)

For additional details concerning Reporting Section 5 reporting requirements, see the Part C Reporting Module and Appendix 1: FAQs: Reporting Sections 5 & 6.

Part C Section VI. Organization Determinations/Reconsiderations

Reporting section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
6. Organization Determinations/ Reconsiderations	05 – MMP	1/Year Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31 (2/26/2018 reporting will include each quarter)	Last Monday of February in following year

Data elements for this reporting section are contained in Table 1. There are five new data elements:

- Case Level (Organization Determination or Reconsideration)
- Was the case processed under the expedited timeframe? (Y/N)
- Case Type (Service or Payment)
- Status of treating provider (Contract or Non-Contract)
- Additional Information (optional)

Table 1: Data Elements for Organization Determinations/Reconsiderations Reporting Section

Element Number	Data Elements for Organization Determinations/Reconsiderations
6.1	Total Number of Organization Determinations Made in Reporting Time Period Above
6.2	Of the Total Number of Organization Determinations in 6.1, Number Processed Timely
6.3	Number of Organization Determinations – Fully Favorable (Services)
6.4	Number of Organization Determinations – Fully Favorable (Claims)
6.5	Number of Organization Determinations – Partially Favorable (Services)
6.6	Number of Organization Determinations – Partially Favorable (Claims)
6.7	Number of Organization Determinations – Adverse (Services)
6.8	Number of Organization Determinations – Adverse (Claims)
6.9	Number of Requests for Organization Determinations - Withdrawn
6.10	Number of Requests for Organization Determinations - Dismissals
6.11	Total number of Reconsiderations Made in Reporting Time Period Above
6.12	Of the Total Number of Reconsiderations in 6.10, Number Processed Timely
6.13	Number of Reconsiderations – Fully Favorable (Services)

Element Number	Data Elements for Organization Determinations/Reconsiderations
6.14	Number of Reconsiderations – Fully Favorable (Claims)
6.15	Number of Reconsiderations – Partially Favorable (Services)
6.16	Number of Reconsiderations – Partially Favorable (Claims)
6.17	Number of Reconsiderations – Adverse (Services)
6.18	Number of Reconsiderations – Adverse (Claims)
6.19	Number of Requests for Reconsiderations - Withdrawn
6.20	Number of Requests for Reconsiderations - Dismissals
6.21	Total number of reopened (revised) decisions, for any reason, in Time Period Above
	For each case that was reopened, the following information will be uploaded in a data file:
6.22	Contract Number
6.23	Plan ID
6.24	Case ID
6.25	Case level (Organization Determination or Reconsideration)
6.26	Date of original disposition
6.27	Original disposition (Fully Favorable; Partially Favorable or Adverse)
6.28	Was the case processed under the expedited timeframe? (Y/N)
6.29	Case type (Service or Claim)
6.30	Status of treating provider (Contract, Non-contract)
6.31	Date case was reopened
6.32	Reason(s) for reopening (Clerical Error, Other Error, New and Material Evidence, Fraud or Similar Fault, or Other)
6.33	Additional Information (Optional)
6.34	Date of reopening disposition (revised decision)*
6.35	Reopening disposition (Fully Favorable; Partially Favorable, Adverse, or Pending)

*The date of disposition is the date the required written notice of revised decision was sent per 405.982.

Notes

This reporting section requires a file upload.

For an explanation of Part C organization determination, reconsideration, and reopenings procedures, refer to CMS regulations and guidance: 42 CFR Part 422, Subpart M, and Chapter 13 of the Medicare Managed Care Manual, and the CMS website: Medicare Managed Care Appeals & Grievances. For an explanation of organization determination and reconsideration procedures for MMPs, refer to the Demonstration-specific three-way contracts.

All plan types listed in the table at the beginning of this section are required to report: organization determinations, reconsiderations, and reopenings as described in this

guidance, regardless of whether the request was filed by an enrollee, the enrollee's representative, a physician or a non-contract provider who signed a Waiver of Liability.

In cases where a purported representative files an appeal on behalf of a beneficiary without an Appointment of Representative (AOR) form, the timeliness calculation ("clock") starts upon receipt of the AOR form. This is a contrast to appeals filed by a beneficiary, in which case the clock starts upon receipt of the appeal.

For instances when the organization approves an initial request for an item or service (e.g., physical therapy services) and the organization approves a separate additional request to extend or continue coverage of the same item or service, include the decision to extend or continue coverage of the same item or service as another, separate, fully favorable organization determination.

Plans are to report encounter data, whereby an encounter took place under a capitation arrangement, as an organization determination. That is, we want plans to report capitated providers' encounters in lieu of actual claims data. All encounter data should be reported as timely submissions.

If the plan receives an Organization Determination or Reconsideration Request and issues a timely decision, however, the request is withdrawn, the plan would report the timely decision as well as the withdrawn request.

If the plan receives an Organization Determination or Reconsideration Request and the request is withdrawn prior to a decision being issued, the plan would report the withdrawal only.

CMS requires plans to report organization determinations and reconsiderations requests submitted to the plan. For purposes of Reporting Section 6:

- An **organization determination** is a plan's response to a request for coverage (payment or provision) of an item or service – including auto-adjudicated claims, service authorizations which include prior-authorization (authorization that is issued prior to the services being rendered), current authorization (authorization that is issued at the time the service is being rendered), and post-authorization (authorization that is issued after the services have already been provided), and requests to continue previously authorized ongoing courses of treatment. It includes requests from both contract and non-contract providers.

- **Reconsideration** is a plan's review of an adverse or partially favorable organization determination.

- A **Fully Favorable** decision means an item or service was covered in whole.

- A **Partially Favorable** decision means an item or service was partially covered. For example, if a claim has multiple line items, some of which were paid and

some of which were denied, it would be considered partially favorable. Also, if a pre-service request for 10 therapy services was processed, but only 5 were authorized, this would be considered partially favorable.

- An **Adverse** decision means an item or service was denied in whole.

- A **withdrawn** organization determination or reconsideration is one that is, upon request, removed from the plan's review process. This category excludes appeals that are dismissed.

- A **dismissal** is an action taken by a Medicare health plan when an organization determination request or reconsideration request lacks required information or otherwise does not meet CMS requirements to be considered a valid request. For example, an individual requests a reconsideration on behalf of an enrollee, but a properly executed appointment of representative form has not been filed and there is no other documentation to show that the individual is legally authorized to act on the enrollee's behalf per guidance set forth in section 10.4.1 of Chapter 13. The plan must follow Chapter guidance in addition to guidance provided in the September 10, 2013 HPMS memo regarding Part C Reconsideration Dismissal Procedures prior to issuing the dismissal.

If a provider (e.g., a physician) declines to provide a service an enrollee has requested or offers alternative service, the provider is making a treatment decision, not an organization determination on behalf of the plan. In this situation, if the enrollee disagrees with the provider's decision, and still wishes to obtain coverage of the service or item, the enrollee must contact the Medicare health plan to request an organization determination or the provider may request the organization determination on the enrollee's behalf.

Reporting Inclusion

Organization Determinations:

- All fully favorable payment (claims) and service-related organization determinations for contract and non-contract providers/suppliers.

- All partially favorable payment (claims) and service-related organization determination for contract and non-contract providers/suppliers.

- All adverse payment (claims) and service-related organization determinations for contract and non-contract providers/suppliers.

Reconsiderations:

- All fully favorable payment (claims) and service-related reconsideration determinations for contract and non-contract providers/suppliers.

- All partially favorable payment (claims) and service-related reconsideration determinations for contract and non-contract providers/suppliers.

- All adverse payment (claims) and service-related reconsideration determinations for contract and non-contract providers/suppliers.

Reopenings:

- All Fully Favorable, Partially Favorable, Adverse or Pending Reopenings of Organization Determinations and Reconsiderations, as described in the preceding sections.

Report:

- **Completed organization determinations and reconsiderations** (i.e., plan has notified enrollee of its pre-service decision or adjudicated a claim) during the reporting period, regardless of when the request was received. Plans are to report organization determination or reconsideration where a substantive decision has been made, as described in this section and processed in accordance with the organization determination and reconsideration procedures described under 42 C.F.R. Part 422, Subpart M and Chapter 13 of the Medicare Managed Care Manual.

- All Part B drug claims processed and paid by the plan's PBM are reported as organization determinations or reconsiderations.

- **Claims with multiple line items** at the "summary level."

- A **request for payment** as a separate and distinct organization determination, even if a pre-service request for that same item or service was also processed.

- A denial of a Medicare request for coverage (payment or provision) of an item or service as either partially favorable or adverse, regardless of whether Medicaid payment or provision ultimately is provided, in whole or in part, for that item or service.

- Report denials based on exhaustion of Medicare benefits.

- In cases where an **extension** is requested after the required decision making timeframe has elapsed, the plan is to report the decision as non-timely. For example: Plan receives standard pre-service reconsideration request on 1/1/2016 at 04:00pm. An extension is requested at 1/31/2016 04:05pm. Plan completes reconsideration and provides notification on 2/5/2016 04:00pm (35

calendar days after receipt). This reconsideration is not considered timely for reporting as the decision was rendered more than 30 calendar days after receipt.

- Dismissals

Do not report:

- Independent Review Entity (IRE) decisions.
- Reopenings requested or completed by the IRE, Administrative Law Judge (ALJ), and Appeals Council.
- Concurrent reviews during hospitalization.
- Concurrent review of Skilled Nursing Facility (SNF), Home Health Agency (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) care.
- Duplicate payment requests concerning the same service or item.
- Payment requests returned to a provider/supplier in which a substantive decision (fully favorable, partially favorable or adverse) has not been made– e.g., payment requests or forms are incomplete, invalid or do not meet the requirements for a Medicare claim (e.g., due to a clerical error).
- A Quality Improvement Organization (QIO) review of an individual's request to continue Medicare-covered services (e.g., a SNF stay) and any related claims/requests to pay for continued coverage based on such QIO decision.
- Enrollee complaints only made through the CMS Complaints Tracking Module (CTM).

NOTE: For purposes of this current reporting effort, plans are not required to distinguish between standard and expedited organization determinations or standard and expedited reconsiderations.

For additional details concerning the Reporting Section 6 reporting requirements, see Appendix 1: FAQs: Reporting Sections 5 & 6.

Reopenings (Organization Determinations and Redeterminations)

1. A **reopening** is a remedial action taken to change a final determination or decision even though the determination or decision may have been correct at the time it was made based on the evidence of record.
2. Refer to 42 CFR §422.616 and Chapter 13, section 130 of the Medicare Managed Care Manual for additional information and CMS requirements related to reopenings.

3. All reopened coverage determinations and redeterminations should be included.
4. For cases that are in a reopening status across multiple reporting periods, contracts should report those cases in each applicable reporting period. For example, if a plan reopened an organization determination on 3/15/2017 and sent the notice of the revised decision on 4/22/2017, that case should be reported as "pending" in the Q1 data file and then as resolved in Q2 (either Fully Favorable, Partially Favorable or Adverse).
5. If the IRE fully or partially overturns the plan's determination, the case is not and must not be reported as a reopening.

Part C Section XV. Rewards and Incentives Programs

Reporting section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
15. Rewards and Incentives Programs	05 – MMP	1/Year Contract	1/1-12/31	Last Monday of February in following year

The data collection method is partially a data entry and an upload. A plan user needs to select "Yes" or "No" for data element 15.1 on the edit page. If the plan user selected "No", no upload is necessary. If the plan user select "Yes", then the user will be required to upload additional information in accordance with the file record layout.

In 2015, CMS added a new regulation at 42 CFR §422.134 that permits MA organizations to offer one or more Rewards and Incentives Program(s) to currently enrolled enrollees. Plans have a choice in whether or not they offer a Rewards and Incentives Program(s), but if they do, they must comply with the regulatory requirements set forth at §422.134. CMS needs to collect Rewards and Incentives Program data in order to track which MA organizations are offering such programs and how those programs are structured. This will inform future policy development and allow CMS to determine whether programs being offered adhere to CMS standards and have proper beneficiary protections in place.

Data Elements:

15.1 Do you have a Rewards and Incentives Program(s)? (“0” = “No”; “1” = “Yes”)

If yes, please list each individual Rewards and Incentives Program you offer and provide information on the following:

15.2 What health related services and/or activities are included in the program? Text

15.3 What reward(s) may enrollees earn for participation? Text

15.4 How do you calculate the value of the reward? Text

15.5 How do you track enrollee participation in the program? Text

15.6 How many enrollees are currently enrolled in the program? Enter _ _ _ _ _ _ _

15.7 How many rewards have been awarded so far? Enter _ _ _ _

Part C Section XVII. Payments to Providers

Reporting section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
17. Payments to Providers	05 – MMP*	1/Year Contract	1/1-12/31	Last Monday of February in following year

* MMPs should report for all alternative payment models (APMs), not just Medicare APMs.

This reporting section requires a file upload.

In order to maintain consistency with HHS goals of increasing the proportion of Medicare payments made based on quality and value, HHS developed the four categories of value based payment: fee-for-service with no link to quality (category 1); fee-for-service with a link to quality (category 2); alternative payment models built on fee-for-service architecture (category 3); and population-based payment (category 4). CMS will collect data from MA organizations about the proportion of their payments made to contracted providers based on these four categories in order to understand the extent and use of alternate payment models in the MA industry. Descriptions of the four categories are as follows:

- Category one includes a fee-for-service with no link to quality arrangement to include all arrangements where payments are based on volume of services and not linked to quality of efficiency.

- Category two includes fee-for-service with a link to quality to include all arrangements where at least a portion of payments vary based on the quality or efficiency of health care delivery including hospital value-based purchasing and physician value-based modifiers.

- Category three includes alternative payment models built on fee-for-service architecture to include all arrangements where some payment is linked to the effective management of a population or an episode of care. Payments are still triggered by delivery of services, but there are opportunities for shared savings or 2-sided risk.

- Category four includes population-based payment arrangements to include some payment is not directly triggered by service delivery so volume is not linked to payment. Under these arrangements, clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., greater than a year).

For detailed information regarding these categories, please refer to the Alternative Payment Model (APM) Framework at https://hcp-lan.org/workproducts/apm-whitepaper.pdf

Based on internal review, we propose to add four data elements (shown in table below) in order to more accurately categorize existing MA payment arrangements. Categories 2, 3 and 4 of value based payment are inherently linked to quality as defined in the HHS developed Alternative Payment Model (APM) Definitional Framework. However, CMS recognizes that some providers are paid based on pure risk based or pure capitation models with no link to quality (e.g. 3N and 4N in the APM definitional framework), which are not specified under the current reporting data elements. The addition of the four proposed elements would allow more accurate reporting about the full spectrum and prevalence of alternative payment models in Medicare Advantage.

Collecting these data will help to inform us as we determine how broadly MA organizations are using alternative payment arrangements.

Data Elements (at the contract level):

Element Number	Data Elements for Payments to Provider
17.1	Total Medicare Advantage payment made to contracted providers.
17.2	Total Medicare Advantage payment made on a fee-for-service basis with no link to quality (category 1).
17.3	Total Medicare Advantage payment made on a fee-for-service basis with a link to quality (category 2).
17.4a	Total Medicare Advantage payment made using alternative payment models built on fee-for-service architecture (category 3).
17.4b	Total Risk-based payments not linked to quality (e.g. 3N in APM definitional framework).
17.5a	Total Medicare Advantage payment made using population-based payment (category 4).
17.5b	Total capitation payment not linked to quality (e.g. 4N in the APM definitional framework).
17.6	Total number of Medicare Advantage contracted providers.
17.7	Total Medicare Advantage contracted providers paid on a fee-for-service basis with no link to quality (category 1).
17.8	Total Medicare Advantage contracted providers paid on a fee-for-service basis with a link to quality (category 2).
17.9a	Total Medicare Advantage contracted providers paid based on alternative payment models built on a fee-for-service architecture (category 3).

Element Number	Data Elements for Payments to Provider
17.9b	Total Medicare Advantage contracted providers paid based on risk-based payments not linked to quality (e.g. 3N in the APM definitional framework).
17.10a	Total Medicare Advantage contracted providers paid based on population based payment (category 4).
17.10b	Total Medicare Advantage contracted providers paid based on capitation with no link to quality (e.g. category 4N in the APM definitional framework).

Part C Appendix 1: FAQs: Reporting Sections 5 & 6:

Grievances, Organization Determinations, & Reconsiderations

	PLAN INQUIRIES	CMS RESPONSES
1.	Should plans report informal complaints as Grievances under the Part C reporting requirements? For example: During the course of a home visit, a member expresses dissatisfaction regarding a particular issue. The member does not contact the plan directly to file a complaint, but the plan representative determines the member is not happy and logs the issue for Quality Improvement tracking.	Plans are to report any grievances filed directly with the plan and processed in accordance with the plan grievance procedures outlined under 42 CFR Part 422, Subpart M. Plans are not to report complaints made to providers, such as the complaint in the example provided, that are not filed with the plan.
2.	Should plans report **all** Dual Eligible member grievances to CMS?	No. Plans are only to report Dual Eligible member grievances processed in accordance with the plan grievance procedures outlined under 42 CFR Part 422, Subpart M. For example, grievances filed under the state Medicaid process but not filed under the plan's Subpart M grievance process, should not be reported.
3.	Is a plan to report a grievance, organization determination or reconsideration to CMS when the plan makes the final decision or when the request is received?	Plans are to report grievances, organization determinations and reconsiderations that were completed (i.e., plan has notified enrollee of its decision or provided or paid for a service, if applicable) during the reporting period, regardless of when the request was received.
4.	Are plans to report only those organization determinations defined under 42 C.F.R. 422.566?	CMS requires plans to report requests for payment and services, as described in the Part C Technical Specifications, Reporting section 6. Plans are to report requests for payment and services consistent with CMS regulations at 42 C.F.R. Part 422, Subpart M as "organization determinations." For example, plans are to include adjudicated claims in the reportable data for Organization Determinations.

	PLAN INQUIRIES	CMS RESPONSES
5.	We are seeking information on how we should report pre-service requests and claims requests for this category. Do you want fully favorable, partially favorable, and adverse for both pre-service requests and claims requests?	Yes. Plans are to report fully favorable, partially favorable, and adverse pre-service and claims requests (organization determinations and reconsiderations), as described in this guidance.
6.	If we have a prior authorization request and a claim for the same service - is that considered a duplicate or should we report both?	Plans are to report **both** a prior authorization request and a claim for the same service; this is not considered a duplicate.
7.	Is a request for a predetermination to be counted as an organization determination? Does it matter who requests the predetermination – contracted provider, non-contracted provider or member? If so, should they also be counted as partially and fully unfavorable?	Organization determinations include a request for a pre-service ("predetermination") decision submitted to the plan, regardless of who makes the pre-service request – e.g., a contracted provider, non-contracted provider or member. Plans are to report partially favorable, adverse and fully favorable pre-service organization determinations, as described in this guidance.
8.	Should plans report determinations made by delegated entities or only decisions that are made directly by the plan – e.g., should plans report decisions made by contracted radiology or dental groups?	Yes. Plans are to report decisions made by delegated entities – such as an external, contracted entity responsible for organization determinations (e.g., claims processing and pre-service decisions) or reconsiderations.
9.	The Tech Specs advise plans to exclude certain duplicate/edits when reporting on the claim denial requirement. Is the intent to exclude duplicates or is it to exclude "billing" errors or both? For example, if a claim is denied because the provider didn't submit the claim with the required modifier, should that be excluded from the count?	Plans should exclude duplicate claim submissions (e.g., a request for payment concerning the same service) and claims returned to a provider/supplier due to error (e.g., claim submissions or forms that are incomplete, invalid or do not meet the requirements for a Medicare claim).
10.	Do we have to include lab claims for this reporting section? Do we need to report the ones which involve no pre-service as well as the ones that involve pre-service?	Yes. Plans are to report lab claims. Even in the absence of a pre-service request, a request for payment (claim) is a reportable organization determination.

	PLAN INQUIRIES	CMS RESPONSES
11.	Enrollee is hospitalized for heart surgery, no prior authorization is required and the claim is paid timely in accordance with full benefit coverage. Our reading of the Medicare Managed Care Manual reveals that the organization is only required to notify the enrollee of Partially Favorable or Adverse decisions. There is no requirement to notify enrollees of Fully Favorable decisions. Is this an organization determination?	Prior authorization is not required to consider a decision an organization determination. A submitted claim is a request for an organization determination. All paid claims are reportable (fully favorable) organization determinations. Timeframe and notification requirements for Fully Favorable determinations are described under 42 C.F.R 422.568(b) and (c). Written notice is required for Partially Favorable, and Adverse determinations.
12.	Enrollee obtains a rhinoplasty for purely cosmetic reasons, which is a clear exclusion on the policy. Enrollee and provider both know this is likely not covered but they submit the claim. Claim is denied as an exclusion/ non-covered service. Neither the enrollee nor the provider pursues it any further. Is this an organization determination?	The plan is to report this denial as an organization determination. A request for payment (claim) is a reportable organization determination.
13.	Enrollee is out of area and in need of urgent care. Provider is out of area / network. The enrollee calls plan and requests a coverage determination for this service. Health Plan approves use of out of area services. Claim is submitted and paid in full. Is this counted as one event (i.e., pre-authorization and claim not counted as two events)?	In this example, both the pre-service decision and claim are counted as two, separate fully favorable organization determinations. A claim submitted for payment is an organization determination request. Claims paid in full are reportable (fully favorable) organization determinations.

	PLAN INQUIRIES	CMS RESPONSES
14.	When an organization determination is extended into the future does that extension count in the reporting of org determinations (e.g. on-going approval for services approved in the initial decision)?	Yes. Plans generally are to count an initial request for an organization determination (request for an ongoing course of treatment) as separate from any additional requests to extend the coverage. For example, plans are to count an initial approved request for physical therapy services as one organization determination. If the plan, later, approves a subsequent request to continue the ongoing services, the plan should count the decision to extend physical therapy services as another, separate organization determination.
15.	Our interpretation is that the term "contracted provider" means "contracted with the health plan" not "contracted with Medicare."	Yes. For purposes of Part C Reporting Section 6 reporting requirements, "contracted provider" means "contracted with the health plan" not "contracted" (or participating) with Medicare."
16.	When we make an adverse determination that is sent to the QIO for review and later our adverse determination is overturned, should we count and report the initial Adverse determination that goes to the QIO? We understand that QIO determinations are excluded from our reporting.	Yes. Regardless of whether a QIO overturns an Adverse organization determination, plans are to report the initial adverse or partially favorable organization determination.
17.	Should cases forwarded to the Part C IRE be counted once in the reporting section, i.e., as the Partially Favorable or adverse decision prior to sending to the IRE?	When a plan upholds its adverse or partially favorable organization determination at the reconsideration level, the plan generally must report both the adverse or partially favorable organization determination and reconsideration. Exceptions: Plans are not to report: 1.) Dismissed cases, or 2.) QIO determinations concerning an inpatient hospital, skilled nursing facility, home health and comprehensive outpatient rehabilitation facility services terminations.

	PLAN INQUIRIES	CMS RESPONSES
18.	Should supplemental benefit data be excluded from the Part C Reporting?	As described in this guidance, a plan's response to a request for coverage (payment or provision) of an item or service is a reportable organization determination. Thus, requests for coverage of a supplemental benefit (e.g., a non-Medicare covered item/service) are reportable under this effort.

Medicare Part D Reporting Requirements

Part D Section II. Retail, Home Infusion, and Long-Term Care Pharmacy Access

As outlined in §423.120, Part D sponsors are required to maintain a pharmacy network sufficient for ensuring access to Medicare beneficiaries residing in their service areas. Part D sponsors must ensure that they provide convenient access to retail pharmacies, as provided in §423.120(a)(1); adequate access to home infusion (HI) pharmacies, as provided in §423.120(a)(4); and convenient access to long-term care (LTC) pharmacies, as provided in §423.120(a)(5). After their initial pharmacy access submissions are approved at the time of application, Part D sponsors are responsible for notifying CMS of any substantive changes in their pharmacy network that may impact their ability to maintain a Part D pharmacy network that meets our requirements, as described in section 50 of Chapter 5 of the Prescription Drug Benefit Manual.

Part D sponsors will be required to submit certain data elements on an annual basis that will allow CMS to evaluate Part D sponsors' continued compliance with pharmacy access requirements. For purposes of evaluating compliance with the retail pharmacy access standards, Part D sponsors should use the CMS reference file that provides counts of Medicare beneficiaries by State, region, and ZIP code. This reference file is provided by CMS for the Part D applications and will be posted on the Prescription Drug Contracting, Application Guidance section of CMS' website in January (http://www.cms.hhs.gov/PrescriptionDrugCovContra/04_RxContracting_ApplicationGuidance.asp#TopOfPage). Note that this file contains total Medicare beneficiary counts, not plan enrollee counts, and that the total Medicare beneficiary count is the appropriate number to use for purposes of ensuring compliance with the standards for convenient access to retail pharmacies as provided in §423.120(a)(1), and adequate access to home infusion pharmacies as provided in §423.120(a)(4).

For purposes of evaluating compliance with the LTC and home infusion pharmacy access standards, CMS will use data elements submitted by Part D Sponsors, as well as information from CMS reference files containing counts of nursing home beds and Medicare beneficiaries by State, region, and ZIP code, as detailed in sections 50.4 and 50.5.1 of Chapter 5 of the Prescription Drug Benefit Manual.

Submission of supporting documentation with the data elements below is not required; however, CMS reserves the right to request appropriate documentation to support a Part D sponsor's submitted pharmacy networks. CMS evaluation of compliance with pharmacy access standards will be conducted based on point-in-time information about pharmacy networks submitted by Part D sponsors once per year.

Reporting timeline for Section 1 only:

	Period 1
Reporting Period	January 1 - March 31
Data due to CMS/HPMS	First Monday of May

Data files to be uploaded through the HPMS at the Contract level, following templates provided in HPMS.

1. **Network Pharmacy data files, as of the last day of the reporting period specified above:**
   A. A list of contracted network retail pharmacies, including preferred/non-preferred status as applicable to network design;
   B. A list of contracted Home Infusion pharmacies, and
   C. A list of contracted Long-term Care pharmacies.

Please note that contracts will be required to submit pharmacy data using only the NPI number.

Part D Section III. Medication Therapy Management Programs

The requirements stipulating that Part D sponsors provide Medication Therapy Management (MTM) programs are described in Title I, Part 423, Subpart D, § 423.153. For monitoring purposes, Part D sponsors will be responsible for reporting several data elements related to their MTM program. Data will be uploaded in a data file.

Reporting timeline:

	YTD
Reporting Period	January 1 - December 31
Data due to CMS/HPMS	Last Monday of February

Sponsors are required to target beneficiaries for the MTM program who meet specific criteria as specified by CMS in § 423.153(d). Some sponsors also offer enrollment in the MTM program to other members who do not meet the specific CMS targeting criteria.

The following information will be collected for each beneficiary identified as being eligible for the Part D MTM program, whether based on CMS' specifications or other plan-specific targeting criteria within the reporting period. Regardless of this designation, the corresponding MTM services delivered to each beneficiary (such as targeted medication review or comprehensive medication review) must meet CMS definitions. The reported beneficiaries must receive MTM services that meet or exceed CMS' MTM program requirements.

A. Contract Number.
B. HICN or RRB Number.
C. Beneficiary first name.
D. Beneficiary middle initial.
E. Beneficiary last name.
F. Beneficiary date of birth.
G. Met the specified targeting criteria per CMS – Part D requirements. (Y (yes) or N (no)).
H. Beneficiary identified as cognitively impaired at time of comprehensive medication review (CMR) offer or delivery of CMR. (Y (yes), N (no), or U (unknown)).
I. Date of MTM program enrollment.
J. Date met the specified targeting criteria per CMS – Part D requirements. Required if met the specified targeting criteria per CMS – Part D requirements. (May be same as Date of MTM program enrollment)
K. Date of MTM program opt-out.
L. Reason participant opted-out of MTM program (Death; Disenrollment from Plan; Request by beneficiary; or Other). Required if Date of MTM program opt-out is applicable.
M. Offered annual CMR. (Y (yes) or N (no)). Required if met the specified targeting criteria per CMS – Part D requirements.

N. If offered, date of (initial) offer.
O. Received annual CMR with written summary in CMS standardized format. (Y (yes) or N (no)). Required if offered annual CMR.
P. Number of CMRs received with written summary in CMS standardized format. Required if received annual CMR.
Q. Date(s) of CMR(s) with written summary in CMS standardized format. (If more than 1 CMR is received, up to 2 dates will be allowed.) Required if received annual CMR.
R. Method of delivery for the annual CMR. (Face-to-face; Telephone; Telehealth consultation; or Other). (If more than 1 CMR is received, report the method of delivery for the initial CMR). Required if received annual CMR.
S. Qualified Provider who performed the initial CMR. (Physician; Registered Nurse; Licensed Practical Nurse; Nurse Practitioner; Physician's Assistant; Local Pharmacist; LTC Consultant Pharmacist; Plan Sponsor Pharmacist; Plan Benefit Manager (PBM) Pharmacist; MTM Vendor Local Pharmacist; MTM Vendor In-house Pharmacist; Hospital Pharmacist; Pharmacist – Other; Supervised Pharmacy Intern; or Other). Required if received annual CMR.
T. Recipient of CMR. (Beneficiary, Beneficiary's prescriber; Caregiver; or Other authorized individual). Required if received annual CMR.
U. Number of targeted medication reviews. Required if met the specified targeting criteria per CMS – Part D requirements.
V. Number of drug therapy problem recommendations made to beneficiary's prescriber(s) as a result of MTM services. (For reporting purposes, a recommendation is defined as a suggestion to take a specific course of action related to the beneficiary's drug therapy. If the same recommendation is made to multiple prescribers or repeated on multiple dates, then that recommendation should only be counted and reported once. Examples include, **but are not limited to**: Needs additional therapy; Unnecessary drug therapy; Dosage too high; Dosage too low; More effective drug available; Adverse drug reaction; or Medication Non-compliance/Non-adherence).
W. Number of drug therapy problem resolutions resulting from recommendations made to beneficiary's prescriber(s) as a result of MTM recommendations. (For reporting purposes, a resolution is defined as a change or variation from the beneficiary's previous drug therapy. Examples include, **but are not limited to**: Initiate drug; Change drug (such as product in different therapeutic class, dose, dosage form, quantity, or interval); Discontinue or substitute drug (such as discontinue drug, generic substitution, therapeutic substitution, or formulary substitution); Medication compliance/adherence).

Part D Section IV. Grievances

According to MMA statute, all Part D sponsors must provide meaningful procedures for hearing and resolving grievances between an enrollee and the sponsor, including an entity or individual through which the sponsor provides benefits. A grievance is any complaint or dispute, other than a coverage determination, or appeal about any aspect of the operations, activities, or behavior of a Part D organization, regardless of whether remedial action is requested. Part D sponsors are required to notify enrollees of their decision no later than 30 days after receiving their grievance based on the enrollee's health condition. An extension up to 14 days is allowed if it is requested by the enrollee, or if the Part D Sponsor needs additional information and documents that this extension is in the interest of the enrollee. An expedited grievance that involves refusal by a Part D sponsor to process an enrollee's request for an expedited coverage determination or redetermination requires a response from the Part D sponsor within 24 hours.

When categorizing grievances into core categories, Sponsors may report based on their investigations subsequent to the enrollees' filing of the grievances.

Sponsors should:

- Report data based on the date the grievance decision was made.
- Track multiple grievances by a single complainant and report as separate grievances.

Sponsors should not:

- Report requests for coverage determinations, including exceptions, or redeterminations inappropriately as grievances.
- Limit grievance reporting to include only CTM data.
- Report general inquiries or questions that do not include a complaint as grievances.
- Exclude any grievances filed by beneficiaries or their appointed representatives from this reporting section.

Sponsors will report quarterly data on an annual basis.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Reporting Period	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	First Monday of February (reporting for all quarters due on this date)			

Data to be reported at the Contract level:

	Number of grievances	Number of grievances in which timely notification was given
Total Grievances		
Number of Expedited Grievances		
Dismissed Grievances		N/A
Grievance Category		
Enrollment/Disenrollment Grievances		
Plan Benefit Grievances		
Pharmacy Access Grievances		
Marketing Grievances		
Customer Service Grievances		
Coverage Determination and Redetermination Process Grievances		
Quality of Care Grievances		
Grievances related to “CMS Issues”		
Other		

Part D Section V. Improving Drug Utilization Review Controls

In the section entitled, "Improving Drug Utilization Review Controls in Part D" of the Final 2013 Call Letter issued on April 2, 2012 and in supplemental guidance, September 6, 2012, CMS described how Medicare Part D sponsors can comply with drug utilization management (DUM) requirements of 42 C.F.R §423.153 et seq. to prevent overutilization of opioids. As described in the 2017 Call Letter issued on April 4, 2016, we expect sponsors to implement either a soft and/or hard formulary-level cumulative opioid morphine equivalent dose (MED) edit at point of sale (POS), while excluding beneficiaries with known exceptions from the edit.

We expect sponsors' Pharmacy and Therapeutics (P&T) committees to develop the specifications for their formulary-level cumulative MED POS edit(s) based on the observed opioid overutilization in their Part D plans, and the reasonableness of the numbers of targeted beneficiaries for plan oversight. We recommend that a soft opioid edit threshold be set at levels no lower than 90 mg MED, and a hard opioid edit threshold be set no lower than 200 mg MED. We also expect sponsors to apply specifications to minimize false positives by accounting for known exceptions, such as hospice care, certain cancer diagnoses, reasonable overlapping dispensing dates for prescription refills or new prescription orders for continuing fills, and high-dose opioid usage previously determined to be medically necessary such as through case management or the coverage determination and appeals process. If sponsors decide to include a provider count criterion in the soft or hard edit specifications, we recommend a prescriber threshold set no lower than two prescribers. Sponsors may also include a pharmacy count criterion. We do not recommend a consecutive high-MED days criterion because it would not prevent beneficiaries from reaching high opioid doses (meaning averaging the MED may be preferred).

Part D sponsors will report cumulative YTD data each quarter to CMS on the beneficiaries who triggered either a soft and/or hard formulary-level cumulative opioid MED POS edits(s) as implemented by the sponsor. All data elements must be uploaded to HPMS at the Plan level. These elements will enable CMS to monitor sponsors' implementation of the cumulative opioid MED POS edits as well as the impact and outcome of the edits aggregated at both the claim and unique beneficiary levels (i.e., based on count of unique health insurance claim numbers, or HICNs).

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Reporting Period	January 1 - March 31	January 1 - June 30	January 1 - September 30	January 1 - December 31
Data due to CMS/HPMS	Last Monday of February (reporting for all quarters due on this date)			

A. Did the plan have a soft formulary-level cumulative opioid MED edit at POS in place during the time period above? (Y (yes) or N (no)).
B. If yes to element A, the cumulative MED threshold used.
C. If yes to element A, the provider count criterion used, if applicable.
D. If yes to element A, the pharmacy count criterion used, if applicable.
E. If yes to element A, the number of claims rejected due to the soft formulary-level cumulative opioid MED edit at POS.
F. If yes to element A, the number of unique beneficiaries with at least one claim rejected due to the soft formulary-level cumulative opioid MED edit at POS.
G. Of the total reported in element E, the number of soft edit claim rejections overridden by the pharmacist at the pharmacy.
H. Of the total reported in element F, the number of beneficiaries with at least one soft edit claim rejection overridden by the pharmacist at the pharmacy.
I. Did the plan have a hard formulary-level cumulative opioid MED edit at POS in place during the time period above? (Y (yes) or N (no)).
J. If yes to element I, the cumulative MED threshold used.
K. If yes to element I, the provider count criterion used, if applicable.
L. If yes to element I, the pharmacy count criterion used, if applicable.
M. If yes to element I, the number of claims rejected due to the hard formulary-level cumulative opioid MED edit at POS.
N. If yes to element I, the number of unique beneficiaries with at least one claim rejected due to the hard formulary-level cumulative opioid MED edit at POS.
O. Of the total reported in element N, the number of unique beneficiaries with at least one hard edit claim rejection that also had a coverage determination request for an opioid drug subject to the hard opioid MED edit.
P. Of the total reported in element N, the number of unique beneficiaries with at least one rejected claim that also had a claim successfully processed (paid) for an opioid drug subject to the hard opioid MED edit such as, but not limited to, through a favorable coverage determination or process.

Part D Section VI. Coverage Determinations and Redeterminations

Title I, Part 423, Subpart M describes Part D sponsors' requirements for coverage determinations (including formulary and tier exceptions, and exceptions to established drug utilization management programs) and redeterminations, including timeframes for standard and expedited requests. Part B vs. Part D coverage determinations and redeterminations should be included in this reporting. Sponsors should report data based on the date the coverage determination or redetermination decision is made. A sponsor's complete decision includes making the determination, appropriately notifying the enrollee of the determination, and authorizing coverage or sending payment, where applicable.

Coverage decisions (both coverage determinations and redeterminations) may result in a partially favorable decision.

- Example of a fully favorable decision: Non-formulary exception request approved for drug and quantity prescribed.
- Example of a partially favorable decision: Non-formulary exception request approved for drug, but full quantity prescribed not approved.

Sponsors should also include reopened coverage determination and redetermination data in this reporting, based on the date the revised decision is made. A reopening is any revision to a binding determination for any reason that is not processed as an appeal, including but not limited to clerical errors and new and material evidence not available or known at the time of the determination. A reopening may or may not change the disposition of the case.

Sponsors will report quarterly data on an annual basis at the Contract level. All data elements to be entered into the HPMS at the Contract level, except reopenings data in element B to be uploaded in a data file.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Reporting Period	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	Last Monday of February (reporting for all quarters due on this date)			

1. Rejected Pharmacy Transactions

A. The total number pharmacy transactions.
B. The number of pharmacy transactions rejected due to non-formulary status.
C. The number of pharmacy transactions rejected due to prior authorization (PA) requirements.
D. The number of pharmacy transactions rejected due step therapy requirements.

E. The number of pharmacy transactions rejected due to quantity limits based on CMS approved formulary. Safety edits and rejections due to early refills should be excluded.
F. Did the plan have high cost edits for non-compounds? If yes, what is the cost threshold used? N/A, if no.
G. The number of pharmacy transaction claims rejected due to high cost edits for non-compounds.

2. Coverage Determinations (including exceptions)

A. Total Number of Coverage Determinations	
Timeliness - All Coverage Determinations	
B. The number processed timely.	
C. The number not processed timely and auto-forwarded to the IRE.	
D. The number not processed timely but not auto-forwarded to the IRE.	
Disposition – All Coverage Determinations	
E. The total number of fully favorable decisions.	
F. The total number of partially favorable decisions.	
G. The total number of adverse decisions.	
H. The total number withdrawn.	
I. The total number dismissed.	
Disposition – Utilization Management Exceptions	
J. The number of utilization management exceptions.	
K. The number of fully favorable decisions.	
L. The number of partially favorable decisions.	
M. The number of adverse decisions.	
N. The number withdrawn.	
O. The number dismissed.	
Disposition – Formulary Exceptions	
P. The number of formulary exceptions.	
Q. The number of fully favorable decisions.	
R. The number of partially favorable decisions.	
S. The number of adverse decisions.	
T. The number withdrawn.	
U. The number dismissed.	
Disposition – Tiering Exceptions	
V. The number of tiering exceptions.	
W. The number of fully favorable decisions.	

X. The number of partially favorable decisions.	
Y. The number of adverse decisions.	
Z. The number withdrawn.	
AA. The number dismissed.	

3. Redeterminations

A. Total Number of Redeterminations	
Timeliness	
B. The number processed timely.	
C. The number not processed timely and auto-forwarded to the IRE.	
D. The number not processed timely but not auto-forwarded to the IRE.	
Disposition	
E. The number of fully favorable decisions.	
F. The number of partially favorable decisions.	
G. The number of adverse decisions.	
H. The number withdrawn.	
I. The number dismissed.	

4. Reopenings

A. The total number of reopened (revised) decisions, for any reason, in the time period above.
B. For each case that was reopened, the following information will be uploaded in a data file:
   1. Contract Number;
   2. Plan ID;
   3. Case ID;
   4. Case level (Coverage Determination or Redetermination);
   5. Date of original disposition;
   6. Original disposition (Fully Favorable; Partially Favorable or Adverse);
   7. Was case processed under expedited timeframe (Y/N);
   8. Case type (Pre-service; Payment)
   9. Date case was reopened;
   10. Reason(s) for reopening (Clerical Error, Other Error, New and Material Evidence, Fraud or Similar Fault, or Other).
   11. Date of reopening disposition (revised decision);
   12. Reopening disposition (Fully Favorable; Partially Favorable, Adverse, or Pending).

MMP-Specific Core Reporting Requirements

Introduction

The core reporting requirements section consists of measures developed for all capitated financial alignment demonstrations, including some modified Part C and D measures. State-specific appendices capture the reporting requirements specific to each state's demonstration. The core and state-specific measures supplement existing Medicare Part C and Part D reporting requirements, as well as measures that MMPs report via other vehicles or venues, such as HEDIS®, HOS, CAHPS® and state Medicaid agencies.[1,2] In addition, CMS and the states will 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.

Value Sets

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

Reporting Phases

There are three distinct types of reporting phases for demonstration measures: "Implementation," "Ongoing," and "Continuous Reporting."

The Implementation phase corresponds with the initial months of the demonstration and will be further defined in the Introduction section of each state-specific appendix. Monitoring will be more intensive during this phase to allow CMS and the state to quickly become aware of any performance or access issues. MMPs will report measures on the Implementation reporting timeline only during the Implementation phase.

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

The Ongoing phase begins at the inception of the demonstration and continues for the life of the demonstration. MMPs will report measures on the Ongoing reporting timeline during the Ongoing phase. Note: Measures that have both an Implementation and Ongoing phase should be reported concurrently (e.g., Measure 2.1, Members with an assessment completed within 90 days of enrollment). MMPs will cease reporting on the Implementation reporting timeline once the Implementation phase is complete. Some measures do not include an Ongoing phase, meaning data are collected only during the Implementation phase.

Continuous Reporting measures will be reported at the same frequency for the duration of the demonstration. The first reporting period for these measures coincides with the first reporting period of the Ongoing and Implementation phases.

Reporting timelines are defined in terms of calendar days, not business days. If a reporting due date for any core measure falls on a weekend or a federal holiday, MMPs may submit data on the following business day. Table 1 and Table 2 below are examples of reporting timelines that will be found throughout this section. The introduction of each state-specific appendix provides tables describing each state's Implementation, Ongoing, and Continuous Reporting periods.

Table 1. Sample Implementation and Ongoing reporting timeline

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

Table 2. Sample Continuous Reporting timeline

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

Measure Specifications

Each measure specification includes information regarding the following subjects:

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

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

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

D. Analysis - how CMS will evaluate reported data, as well as how other data sources may be monitored.

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

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

Hybrid Sampling

Some demonstration-specific measures may require medical record/supplemental documentation review to identify the numerator. In these instances, the sample size should be 411, plus additional records to allow for substitution. Sampling should be systematic to ensure that all individuals eligible for a measure have an equal chance of inclusion.

MMPs should complete the following steps for each measure that requires medical record review:

Step 1: Determine the eligible population. Create a list of eligible members, including full name, date of birth, and event (if applicable).

Step 2: Determine the final sample size. The final sample size will be 411 plus an adequate number of additional records to make substitutions. Oversample only enough to guarantee that the targeted sample size of 411 is met. The following oversampling rates are acceptable: 5 percent, 10 percent, 15 percent, or 20 percent. If oversampling, round up to the next whole number when determining the final sample size.

Step 3: If the eligible population exceeds the final sample size as determined in Step 2, proceed to Step 5. If the eligible population is less than or equal to the final sample size as determined in Step 2, proceed to Step 4.

Step 4: If the eligible population is less than or equal to the final sample size as determined in Step 2, the sample size can be reduced from 411 cases to a reduced final sample size by using the following formula:

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

Where the *Original Final Sample Size* is the number derived from Step 2, and the *Eligible Population* is the number derived from Step 1.

Step 5: Sort the list of eligible members in alphabetical order by last name, first name, date of birth and event (if applicable). Sort this list by last name from A to Z during even reporting periods and from Z to A in odd reporting periods (i.e., name will be sorted from A to Z in 2014, 2016, and 2018 and from Z to A in 2015, 2017, and 2019.

Note: Sort order applies to all components. For example, for reporting period 2014, the last name, first name, date of birth, and events will be ascending.

Step 6: Calculate *N*, which will determine which member will start your sample. Round down to the nearest whole number.

$$N = \frac{\text{Eligible Population}}{\text{Final Sample Size}}$$

Where the *Eligible Population* is the number derived from Step 1. The *Final Sample Size* is either:

- The number derived from Step 2, for instances in which the eligible population exceeds the final sample size as determined in Step 2.
  OR
- The number derived in Step 4, for instances in which the eligible population was less than or equal to the number derived from Step 2.

Step 7: Randomly select starting point, *k*, by choosing a number between one and N using a table of random numbers or a computer-generated random number.

Step 8: Select every *kth* record thereafter until the selection of the sample size is completed.

Section I. Access

1.1 Claims (excluding pharmacy point of sale [POS]) denied during the first 90 days of enrollment with the MMP, by reason for denial. – ***Suspended for 2017***

1.2 Pharmacy point-of-sale (POS) claims denied during passive enrollment, by reason for denial.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
1. Access	Every 14 days during the first month of a wave of passive (subsequent submissions may be necessary for MMPs that meet or exceed the threshold)	Contract	14 days Ex: 12:00a.m. on January 1st through 11:59p.m. on January 14th and 12:00a.m. on January 15th through 11:59p.m. on January 28th.	5:00p.m. ET three days following the end of the reporting period Ex: Data is due by 5:00p.m. ET on January 17th for the reporting period that ends at 11:59p.m. ET on January 14th. Data is due by 5:00p.m. ET on January 31st for the reporting period that ends at 11:59p.m. ET on January 28th.

The list of pharmacy POS denied claims will be limited to claims denied for the following reasons: non-formulary, prior authorization, and step therapy. A template for providing these claims is located on the CMS Financial Alignment Initiative website:

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

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

- Required file format is Microsoft Excel file.
- The file name extension should be ".xlsx"
- File name= RX_(STATEABBREVIATION)_(CONTRACTID)_(REPORTING PERIOD)_(SUBMISSIONDATE).xlsx.

- Replace (STATEABBREVIATION) with the two-character state abbreviation (e.g., Massachusetts is MA), (CONTRACTID) with the contract ID, (REPORTINGPERIOD) with the month and year of the beginning of the reporting period in YYYYMM format (e.g., February 2014 would be 201402), and (SUBMISSIONDATE) with the year, month, and day of the submission in YYYYMMDD format (e.g., March 31, 2014 would be 20140331).
- The first worksheet in the template should be named "Rejected Claims."
- The second worksheet in the template should be named "Key Acronyms."
- The third worksheet in the template should be named "Addl Reject Codes_Pharmacy Msgs."

File Layout

Field Name	Field Description	Allowable Values
HICN	Health insurance claim number (HICN) refers to the number assigned by the Social Security Administration to an individual for the purpose of identifying him/her as a Medicare beneficiary. HICN will be shown in the beneficiary's insurance card and it is on the basis of this number that a beneficiary's Medicare claims are processed.	Field Type: Alpha-numeric
Member Enrollment Date	Identifies the date that each member enrolled. Enrollment eligibility begins on the 1st of the month. If a member has a gap in coverage, provide the most recent enrollment date.	Field Type: Date in MM/DD/YYYY format
Member Disenrollment Date	Identifies the date that each member disenrolled. Eligibility continues through the last day of the month that the member disenrolls.	Field Type: Date in MM/DD/YYYY format If a member is still enrolled during the reporting period, please insert 12/31/9999 to indicate the member is currently enrolled.
Cardholder ID	Insurance ID assigned to the cardholder or identification number used by the MMP. May be the same as HICN.	Field Type: Alpha-numeric
CCN	Claim Control Number (CCN). A claim control number is a unique number given to each claim.	Field Type: Alpha-numeric
CMS Contract ID	Designation assigned by CMS that identifies a specific sponsor.	Field Type: Alpha-numeric
Plan Name	Plan Name	Field Type: Text

Field Name	Field Description	Allowable Values
NDC 11 (no hyphens)	National Drug Code Drug products are identified and reported using a unique, three-segment number, called the National Drug Code (NDC), which serves as a universal product identifier for drugs. FDA publishes the listed NDC numbers and the information submitted as part of the listing information in the NDC.	Field Type: Numeric Note: 11-digit NDC code with no hyphens
Date of Service	Identifies date the prescription was filled. This date may be outside the reporting period as long as the associated Date of Rejection is after the Date of Service.	Field Type: Date in MM/DD/YYYY Format
Date of Rejection	Identifies the date the claim was rejected. The Date of Rejection must occur during the reporting period.	Field Type: Date in MM/DD/YYYY Format
Claim Quantity	Quantity dispensed expressed in metric decimal units.	Field Type: Numeric Allowable Values: >0
Claim Days Supply	Estimated number of days the prescription will last.	Field Type: Numeric Allowable Values: >0; < 999
Compound Code	Code indicating whether or not the prescription is a compound.	Field Type: Numeric Allowable Values: 0 = not specified 1 = not a compound 2 = compound
Rejection Category (1=NF, 2=PA, 3=ST)	Rejection Category: Use category 1 if the rejection is for Non-Formulary drug. Use category 2 if the rejection is for Prior Authorization. Use category 3 if the rejection is for Step Therapy.	Field Type: Numeric Allowable Values: 1=Non-Formulary 2=Prior Authorization 3=Step Therapy
Reject Code 1	Reject code used in MMP's claim adjudication system.	Field Type: Alpha-numeric
Pharmacy Message 1	Reject Message used in MMP's claim adjudication system.	Field Type: Text
Reject Code 2	Reject code used in MMP's claim adjudication system.	Field Type: Alpha-numeric
Pharmacy Message 2	Reject Message used in MMP's claim adjudication system.	Field Type: Text
Reject Code 3	Reject code used in MMP's claim adjudication system.	Field Type: Alpha-numeric
Pharmacy Message 3	Reject Message used in MMP's claim adjudication system.	Field Type: Text

Field Name	Field Description	Allowable Values
MMP must provide all reject codes and messaging, not limited to the number of fields in the "Rejected Claims" template. Please insert columns in the "Add'l Reject Codes_Pharmacy Msgs" template as necessary.	Provide any additional reject codes and messaging.	

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.

- An audit of a sample of claims will be performed. Claims not excluded from the analysis will be flagged as "potentially inappropriate." A sample of up to 30 potentially inappropriate claims will be selected for further review, including: protected class drugs and non-protected class drugs. If at least 15 protected and 15 non-protected class drugs are submitted, 15 protected and 15 non-protected class drugs will be sampled. If fewer than 15 claims are submitted in either drug class, additional claims from the opposing drug class will be selected, until a sample of 30 is reached (e.g., 13 protected and 17 non-protected drugs). If the plan submits fewer than 30 rejected claims, the sample will consist of all submitted rejected claims. MMPs will be required to review claims and address the following:
  - Was this claim was an appropriate Rejection (Y/N).
  - Patient setting (e.g., nursing facility, acute care hospital, etc.).
  - Patient DOB.
  - Provide a brief explanation as to why the claim was appropriate or inappropriate, related to one of the three rejection categories.
  - Was the claim paid (Y/N).
  - If the claim was paid, provide the date the claims was paid for the drug in question.

C. Edits and Validation checks - validation checks that should be performed by each MMP prior to data submission. Any claims that do not pass validation will be excluded from the analysis. These checks will include the following:

- The CMS Contract ID is formatted as 5 alpha-numeric characters.
- The CMS Contract ID matches the submitting Contract ID.
- The NDC consists of 11 numeric characters.
- The NDC is a valid NDC.
- The Date of Service is in the MM/DD/YYYY format.
- The Date of Rejection is in the MM/DD/YYYY format.
- The Date of Rejection is during the reporting period.
- The Date of Rejection is on or after the Date of Service.
- The Rejection Category is 1, 2, or 3.

- The Claim Quantity is greater than zero.
- The Claim Days Supply is greater than zero.
- The Claim Days Supply is between 1 and 3 numeric characters (1-999).

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 calculate an overall score once MMPs have reviewed and provided comments.
    - For all class drugs, the number of inappropriate denials (numerator) will be divided by the total number of potentially inappropriate claims sampled (denominator) to calculate an overall rate of inappropriate denials.
    - For protected class drugs, the number of inappropriate denials (numerator) will be divided by the total number of potentially inappropriate claims for protected class drugs sampled (denominator) to calculate an overall rate of inappropriate denials.
    - For non-protected class drugs, the number of inappropriate denials (numerator) will be divided by the total number of potentially inappropriate claims for non-protected class drugs sampled (denominator) to calculate an overall rate of inappropriate denials.

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

- Reporting timelines are defined in terms of calendar days, not business days. If a reporting due date for Core measure 1.2 falls on a weekend or holiday, MMPs may submit data on the following business day.
- This measure assesses only the following three denial types: non-formulary, prior authorization, and step therapy.
    - Non-formulary drugs are drugs that are not on an MMP's formulary.
    - Prior Authorization is defined as Approval that a member must get from the MMP before filling a prescription in order for the MMP to cover the prescription. The MMP may require prior authorization for certain drugs.
    - Step Therapy is a coverage rule used by some MMPs that requires a member to try one or more similar, lower cost drugs to treat their condition before the MMP will cover the prescribed drug.
- The reporting period for this measure will begin at the start of the passive enrollment period. Once reporting begins, members should be included regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- Passive enrollment periods may vary by state. MMPs should refer to their state's three-way contract for specific requirements.
- CMS reserves the right to extend the reporting frequency after the first two waves of passive enrollment, if necessary.

- MMPs should include all denied claims including adjusted and reprocessed claims, even if repeated claims are attempted on the same day.
- Date of Rejection must occur within the reporting period, but it is acceptable if the Date of Service is outside of the reporting period as long as the Date of Rejection is after the Date of Service.
- Denials ensuing from requests for early refills should be excluded.
- Subsequent 14 day submissions may be necessary for MMPs that meet or exceed the threshold or have an insufficient sample size. MMPs will receive a MMP-specific report indicating whether a MMP passed, failed, or had an insufficient sample size following the full 28 day period. Any MMP that failed or had an insufficient sample size must undergo another round and must submit data during the next wave of passive. For MMPs in states with monthly passive enrollment, the MMP must report the last 14 days of the next month of passive (e.g., for MMPs that start passive April 1, 2014, a subsequent submission will be May 15 – 28th). For MMPs with passive that is not month to month, the MMP must submit the first 14 days of the next wave of passive. MMPs that pass the first 28 day period will not need a subsequent round of review.

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 transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

Section II. Assessment

2.1 Members with an assessment completed within 90 days of enrollment.[i]

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
2. Assessment	Monthly during the implementation period, beginning after 90 days of implementation	Contract	Current Calendar Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period Ex: Demo implementation is January 1, 2017; 90 days after enrollment is March 31, 2017; first report is due by April 30, 2017; the next report would be due May 31, 2017
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
2. Assessment	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period.	Total number of members whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period.	Field type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of members who are documented as unwilling to participate in the assessment within 90 days of enrollment.	Of the total reported in A, the number of members who are documented as unwilling to participate in the assessment and who never had an assessment completed within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A. Unwillingness to participate must be clearly documented.
C.	Total number of members the MMP was unable to reach, following three outreach attempts, within 90 days of enrollment.	Of the total reported in A, the number of members the MMP was unable to reach, following three outreach attempts, to participate in the assessment and who never had an assessment completed within 90 days of enrollment.	Field type: Numeric Note: Is a subset of A. Three outreach attempts must be clearly documented.
D.	Total number of members with an assessment completed within 90 days of enrollment.	Of the total reported in A, the number of members with an assessment completed within 90 days of enrollment.	Field type: Numeric Note: Is a subset of A. Completed assessments must be clearly documented.

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.

- For Demonstration Year (DY) 1, the quality withhold benchmark is set at the highest scoring MMP minus ten percentage points. For more information, refer to the Medicare-Medicaid Capitated Financial Alignment Model CMS Core Quality Withhold Technical Notes for DY 1.

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

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data elements B, C, and D are less than or equal to data element A.
- MMPs should validate that members included in data element A were enrolled for at least 90 days and the 90th day of enrollment occurred within the reporting period.
- MMPs should validate that members included in data element A were enrolled as of the last day of the reporting period.

- MMPs should validate that members included in data element B were included in data element A.
- MMPs should validate that members included in data element C were included in data element A.
- MMPs should validate that members included in data element D were included in data element A.
- MMPs should validate that members reported in data element B were not reported in data elements C or D.
- MMPs should validate that members reported in data element C were not reported in data elements B or D.
- MMPs should validate that members reported in data element D were not reported in data elements B or C.
- MMPs should validate that members reported in data element B were clearly documented as unwilling to participate in the assessment within 90 days of enrollment.
- MMPs should validate that members reported in data element C had three outreach attempts clearly documented within 90 days of enrollment.
- MMPs should validate that members reported in data element D had a completed assessment clearly documented within 90 days of enrollment.
- 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 unwilling to participate in the assessment and who never had an assessment completed within 90 days of enrollment.
- Members the MMP was unable to reach, following three outreach attempts, to participate in the assessment and who never had an assessment completed within 90 days of enrollment.
- Members who had an assessment completed within 90 days of enrollment.
- Members that were willing to participate and who could be reached who had an assessment completed within 90 days of enrollment (i.e., data element A minus data elements B and C will serve as the denominator).

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should 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.
- The 90th day of enrollment should be based on each member’s effective date of Medicare-Medicaid enrollment. For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months. The 90th day of enrollment will always occur on the last day of

the third month following a member's effective enrollment date. When reporting quarterly results for Ongoing reporting periods, MMPs should report all members who reached their 90th day of enrollment at any point during the three months included in the quarter (e.g., members enrolled on May 1, June 1, and July 1 reached their 90th day of enrollment during the third quarter; therefore, these members should be included in Ongoing reporting for the third quarter).

- 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 the assessment or could not be reached after three outreach attempts, but then subsequently completes the assessment within 90 days of enrollment, the member should be classified in data element D.
    - If a member was not reached after three outreach attempts, but then subsequently is reached and refuses the assessment within 90 days of enrollment, the member should be classified in data element B.
- MMPs should only report members with an initial assessment for this measure. For reporting of members with an annual reassessment, refer to Core Measure 2.3.
- The assessment for this measure should be the comprehensive health risk assessment as applicable per state-specific guidance. The requirements pertaining to the assessment tool and how the tool should be administered (e.g., in-person, phone, etc.) may vary by state. The assessment tool should meet any state-specific criteria and include the appropriate domains as determined by the state. MMPs should refer to their state's three-way contract for specific requirements.
- Additional guidance is included in the state-specific reporting appendices. MMPs should refer to their state's reporting appendix for information on reporting assessments completed by the MMP prior to a member's effective enrollment date, reporting assessments for members with a break in coverage, and reporting assessments completed previously by the MMP's affiliated product. Note that the applicability of such guidance varies across states.
- For data element B, MMPs should report the number of members who were unwilling to participate in the assessment if a member (or his or her authorized representative):
    - Affirmatively declines to participate in the assessment, affirmatively declines care management activities overall, or refuses any contact with the MMP. Member communicates the declination or refusal by phone, mail, fax, or in person.

  - Expresses willingness to complete the assessment but asks for it to be conducted after 90 days (despite being offered a reasonable opportunity to complete the assessment within 90 days). Discussions with the member must be documented by the MMP.
  - Expresses willingness to complete the assessment, 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 assessment, but then declines to answer a majority of the questions in the assessment.
- For data element C, MMPs should report the number of members the MMP was unable to reach after three attempts to contact the member. MMPs should refer to the their state's 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 (e.g., phone, mail, or email), as CMS and the state may validate this number. If less than three outreach attempts are made to the member within 90 days of enrollment, the member should not be included in data element C.
- 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 data element C.
- There may be certain circumstances that make it impossible or inappropriate to complete an assessment within the required timeframes. For example, a member may be medically unable to respond and have no authorized representative to do so on their behalf, or a member may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for an assessment. However, MMPs should not include such members in the counts for data elements B or C.
- If a member's assessment is in progress, but is not completed within 90 days of enrollment, then the assessment should not be considered completed, and therefore, the member should not be counted in data element D.
- For additional guidance on identifying each data element, including examples and scenarios for correctly reporting members who may meet the criteria for multiple data elements, please reference the Core 2.1 FAQ document located on the CMS website: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

2.2 Members with an assessment completed.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
2. Assessment	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members with an assessment completed within the reporting period.	Total number of members with an assessment completed within the reporting period.	Field Type: Numeric
B.	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.	Field type: Numeric Note: This data element should not be reported until 90 days after implementation.
C.	Total number of members enrolled for 90 days or longer who had an assessment completed.	Of the total reported in B, the number of members enrolled for 90 days or longer who had an assessment completed.	Field type: Numeric Note: Is a subset of B. Note: This data element should not be reported until 90 days after implementation.

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

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

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

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element 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 obtain enrollment data to evaluate the percentage of members:

- Who had an assessment completed within the reporting period.
- Enrolled for 90 days or longer as of the last day of the reporting period who had an assessment completed.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in data element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The 90th day of enrollment should be based on each member's effective date of enrollment. For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months.
- The effective date of enrollment is the first date of the member's coverage through the MMP.
- MMPs should only report members with an initial assessment for this measure. For reporting of members with an annual reassessment, refer to Core Measure 2.3.
- The assessment for this measure should be the comprehensive health risk assessment as applicable per state-specific guidance. The requirements pertaining to the assessment tool and how the tool should be administered (e.g., in-person, phone, etc.) may vary by state. The assessment tool should meet any state-specific criteria and include the appropriate domains as determined by the state. MMPs should refer to their state's three-way contract for specific requirements.
- Data element A will be reported after the first month following the beginning of the Implementation period, whereas data elements B and C will not be reported until after 90 days.
- The members reported in data element C could have had an assessment completed at any time, not necessarily during the reporting period.

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

2.3 Members with an annual reassessment.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
2. Assessment	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 enrolled as of the last day of the current reporting period.	Total number of members enrolled as of the last day of the current reporting period.	Field Type: Numeric
B.	Total number of members who had an assessment completed during the previous reporting period.	Of the total reported in A, the number of members who had an assessment completed during the previous reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members with a reassessment completed during the current reporting period.	Of the total reported in B, the number of members who had a reassessment completed during the current reporting period.	Field Type: Numeric Note: Is a subset of B.
D.	Total number of members with a reassessment completed within 365 days of the most recent assessment completed.	Of the total reported in C, the number of members with a reassessment completed during the current reporting period that occurred within 365 days of the most recent assessment completed during the previous reporting period.	Field Type: Numeric Note: Is a subset of C.

Element Letter	Element Name	Definition	Allowable Values
E.	Total number of members who did not have an assessment completed during the previous reporting period.	Of the total reported in A, the number of members enrolled for at least 90 days during the previous reporting period who did not have an assessment completed during the previous reporting period.	Field Type: Numeric Note: Is a subset of A.
F.	Total number of members with an assessment completed during the current reporting period.	Of the total reported in E, the number of members who had an assessment completed during the current reporting period.	Field Type: Numeric Note: Is a subset of E.

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

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

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

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

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

- Had an assessment completed during the previous reporting period who had a reassessment completed during the current reporting period.
- Had a reassessment completed during the current reporting period that was within 365 days of the most recent assessment completed during the previous reporting period.
- Were enrolled for at least 90 days during the previous reporting period who did not have an assessment completed during the previous reporting period but had an assessment completed during the current reporting period.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should only include members who are still enrolled as of the last day of the current reporting period.
- The assessment for this measure should be the comprehensive health risk assessment as applicable per state-specific guidance. The requirements pertaining to the assessment tool and how the tool should be administered (e.g., in-person, phone, etc.) may vary by state. The assessment tool should meet any state-specific criteria and include the appropriate domains as determined by the state. MMPs should refer to their state's three-way contract for specific requirements.
- For purposes of reporting this measure, 365 days will be equivalent to one full year. Additionally, 90 days of enrollment will be equivalent to three full calendar months.
- For reporting all data elements, MMPs should report unduplicated counts of members meeting the criteria for each element. Members with more than one assessment or reassessment completed during a reporting period should be reported only once in the relevant data elements.
- For reporting data element B, include all members who were enrolled as of the last day of the current reporting period who received an assessment (initial or reassessment) during the previous reporting period.
- For reporting data element C, include all members reported in data element B who had a reassessment completed at any time during the current reporting period.
- For reporting data element D, include all members reported in data element C who had a reassessment completed during the current reporting period that was completed within 365 days of the date of the member's most recent assessment (initial or reassessment) completed during the previous reporting period. For example, if a member was assessed twice during CY2016, first on May 15, 2016 and again on October 15, 2016, count 365 days continuously from October 15, 2016 to determine if a reassessment occurred within 365 days. In this example, if the member completes a reassessment on September 15, 2017, they would be included in data element D for CY2017 reporting. Conversely, if the member's reassessment was not completed until November 15, 2017, they would not be included in data element D for CY2017 reporting. In either case, the member would be captured in data element C.
- For members who disenroll and reenroll in the MMP, MMPs should count 365 days continuously from the member's most recent assessment date within the previous reporting period, even if that assessment was conducted during the member's prior enrollment period.
- For reporting data element E, include all members who were enrolled as of the last day of the current reporting period, who were enrolled for at

least 90 days during the previous reporting period who did not receive an assessment (initial or reassessment) during the previous reporting period.
    - For members who disenroll and reenroll in the MMP, MMPs should include members that had any continuous enrollment of 90 days or more in the previous year, even if that enrollment preceded a break in coverage by the MMP.
- For reporting data element F, include all members reported in data element E who had an assessment completed at any time during the current reporting period.
- This measure will not be reported until Calendar Year 2 (e.g., Calendar Year 2017 will be Calendar Year 2 for all MMPs whose demonstration effective enrollment date began in Calendar Year 2016).
- The term “current reporting period” in data elements A, C, D and F refers to the current calendar year. The term “previous reporting period” in elements B, D, and E refers to the prior calendar year.

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

Section III. Care Coordination

3.1 Members, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted within 24 hours of discharge to the facility or primary care provider or other health care professional designated for follow-up care. (modified from NQF #0648) – ***Suspended for 2017***

Section IV. Enrollee Protections

4.1 Part D appeals. – ***Suspended for 2017***; See Part D Reporting Requirements Section VI – Coverage Determinations and Redeterminations for required reporting.

4.2 Grievances and Appeals.

IMPLEMENTATION					
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**	**Data Elements**
4. Enrollee Protections	Monthly	Contract	Current Calendar Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period	A1-B2
ONGOING					
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**	**Data Elements**
4. Enrollee Protections	Annually	Contract	Calendar Quarters Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the final quarterly reporting period	A1-L3

Note: Plans should **report all non-Part D (i.e., Part C and Medicaid) grievances and appeals for data elements A-L**, in addition to reporting the already required Medicare Part C and D appeals and grievances as follows:

- Part D grievances are reported according to Part D reporting requirements (see Part D Section IV Grievances);
- Part D appeals are reported according to Part D reporting requirements (see Part D Section VI Coverage Determinations and Redeterminations);

- Part C grievances are also reported through Part C reporting requirements (see Part C Section V Grievances); and
- Part C appeals are also reported through Part C reporting requirements (see Part C Section VI Organization Determinations/Reconsiderations).

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.

Grievances

Element Letter	Element Name	Definition	Allowable Values
A1.	Inability to get an appointment with a primary care provider (PCP) – Total number of grievances.	The number of grievances related to an inability to get an appointment with a PCP.	Field Type: Numeric Is based on the date the decision was made.
A2.	Inability to get an appointment with a primary care provider (PCP) – Number of grievances for which the MMP provided timely notification of its decision.	The number of grievances related to an inability to get an appointment with a PCP that resulted in timely notification of decision.	Field Type: Numeric. Is a subset of A1. See Part C reporting requirements above for definition of timely grievance notification.
B1.	Inability to get an appointment with a specialist – Total number of grievances.	The number of grievances related to an inability to get an appointment with a specialist.	Field Type: Numeric Is based on the date the decision was made.
B2.	Inability to get an appointment with a specialist – Number of grievances for which the MMP provided timely notification of its decision.	The number of grievances related to an inability to get an appointment with a specialist that resulted in timely notification of decision.	Field Type: Numeric. Is a subset of B1. See Part C reporting requirements above for definition of timely grievance notification.
C1.	Excessive wait time to get an appointment with a PCP – Total number of grievances.	The number of grievances related to excessive wait time to get an appointment with a PCP.	Field Type: Numeric Is based on the date the decision was made.

Element Letter	Element Name	Definition	Allowable Values
C2.	Excessive wait time to get an appointment with a PCP – Number of grievances for which the MMP provided timely notification of its decision.	The number of grievances related to excessive wait time to get an appointment with a PCP that resulted in timely notification of decision.	Field Type: Numeric. Is a subset of C1. See Part C reporting requirements above for definition of timely grievance notification.
D1.	Excessive wait time to get an appointment with a specialist – Total number of grievances.	The number of grievances related to excessive wait time to get an appointment with a specialist.	Field Type: Numeric Is based on the date the decision was made.
D2.	Excessive wait time to get an appointment with a specialist – Number of grievances for which the MMP provided timely notification of its decision.	The number of grievances related to excessive wait time to get an appointment with a specialist that resulted in timely notification of decision.	Field Type: Numeric. Is a subset of D2. See Part C reporting requirements above for definition of timely grievance notification.
E1.	Other grievances related to areas not mentioned above – Total number of grievances.	The number of grievances related to other grievances related to areas not mentioned above.	Field Type: Numeric Is based on the date the decision was made.
E2.	Other grievances related to areas not mentioned above – Number of grievances for which the MMP provided timely notification of its decision.	The number of grievances related to other grievances related to areas not mentioned above that resulted in timely notification of decision.	Field Type: Numeric. Is a subset of E1. See Part C reporting requirements above for definition of timely grievance notification.

Appeals

Element Letter	Element Name	Definition	Allowable Values
F1.	Denial or limited authorization of specialty services – Fully Favorable.	The number of appeals related to denial or limited authorization of specialty services for which the MMP Coverage Decision or Reconsideration was fully favorable.	Field Type: Numeric The sum of data elements F1, F2, and F3 should equal the total number of appeals related to denial or limited authorization of specialty services.
F2.	Denial or limited authorization of specialty services – Partially Favorable.	The number of appeals related to denial or limited authorization of specialty services for which the MMP Coverage Decision or Reconsideration was partially favorable.	Field Type: Numeric
F3.	Denial or limited authorization of specialty services – Adverse.	The number of appeals related to denial or limited authorization of specialty services for which the MMP Coverage Decision or Reconsideration was adverse.	Field Type: Numeric
G1.	Denial or limited authorization of LTSS services – Fully Favorable.	The number of appeals related to denial or limited authorization of LTSS services (total) for which the MMP Coverage Decision or Reconsideration was fully favorable.	Field Type: Numeric The sum of data elements G1, G2, and G3 should equal the total number of appeals related to denial or limited authorization of LTSS services.
G2.	Denial or limited authorization of LTSS services – Partially Favorable.	The number of appeals related to denial or limited authorization of LTSS services (total) for which the MMP Coverage Decision or Reconsideration was partially favorable.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
G3.	Denial or limited authorization of LTSS services – Adverse.	The number of appeals related to denial or limited authorization of LTSS services (total) for which the MMP Coverage Decision or Reconsideration was adverse.	Field Type: Numeric
H1.	Denial or limited authorization of HCBS services – Fully Favorable.	The number of appeals related to denial or limited authorization of HCBS services for which the MMP Coverage Decision or Reconsideration was fully favorable.	Field Type: Numeric Note: Is a subset of G1. The sum of data elements H1, H2, and H3 should equal the total number of appeals related to denial or limited authorization of HCBS services.
H2.	Denial or limited authorization of HCBS services – Partially Favorable.	The number of appeals related to denial or limited authorization of HCBS services for which the MMP Coverage Decision or Reconsideration was partially favorable.	Field Type: Numeric Note: Is a subset of G2.
H3.	Denial or limited authorization of HCBS services – Adverse.	The number of appeals related to denial or limited authorization of HCBS services for which the MMP Coverage Decision or Reconsideration was adverse.	Field Type: Numeric Note: Is a subset of G3.
I1.	Denial or limited authorization of institutional services – Fully Favorable.	The number of appeals related to denial or limited authorization of institutional services for which the MMP Coverage Decision or Reconsideration was fully favorable.	Field Type: Numeric Note: Is a subset of G1. The sum of data elements I1, I2, and I3 should equal the total number of appeals related to denial or limited authorization of institutional services.

Element Letter	Element Name	Definition	Allowable Values
I2.	Denial or limited authorization of institutional services – Partially Favorable.	The number of appeals related to denial or limited authorization of institutional services for which the MMP Coverage Decision or Reconsideration was partially favorable.	Field Type: Numeric Note: Is a subset of G2.
I3.	Denial or limited authorization of institutional services – Adverse.	The number of appeals related to denial or limited authorization of institutional services for which the MMP Coverage Decision or Reconsideration was adverse.	Field Type: Numeric Note: Is a subset of G3.
J1.	Denial or limited authorization of mental health services – Fully Favorable.	The number of appeals related to denial or limited authorization of mental health services for which the MMP Coverage Decision or Reconsideration was fully favorable.	Field Type: Numeric The sum of data elements J1, J2, and J3 should equal the total number of appeals related to denial or limited authorization of mental health services.
J2.	Denial or limited authorization of mental health services – Partially Favorable.	The number of appeals related to denial or limited authorization of mental health services for which the MMP Coverage Decision or Reconsideration was partially favorable.	Field Type: Numeric
J3.	Denial or limited authorization of mental health services – Adverse.	The number of appeals related to denial or limited authorization of mental health services for which the MMP Coverage Decision or Reconsideration was adverse.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
K1.	Denial or limited authorization of substance use treatment services – Fully Favorable.	The number of appeals related to denial or limited authorization of substance use treatment services for which the MMP Coverage Decision or Reconsideration was fully favorable.	Field Type: Numeric The sum of data elements K1, K2, and K3 should equal the total number of appeals related to denial or limited authorization of substance use treatment services.
K2.	Denial or limited authorization of substance use treatment services – Partially Favorable.	The number of appeals related to denial or limited authorization of substance use treatment services for which the MMP Coverage Decision or Reconsideration was partially favorable.	Field Type: Numeric
K3.	Denial or limited authorization of substance use treatment services – Adverse.	The number of appeals related to denial or limited authorization of substance use treatment services for which the MMP Coverage Decision or Reconsideration was adverse.	Field Type: Numeric
L1.	Other appeals related to areas not mentioned above – Fully Favorable.	The number of appeals related to other areas not mentioned above (includes all Medicare and Medicaid demonstration related appeals) for which the MMP Coverage Decision or Reconsideration was fully favorable.	Field Type: Numeric The sum of data elements L1, L2, and L3 should equal the total number of appeals related to denial or limited authorization of services not mentioned above.

Element Letter	Element Name	Definition	Allowable Values
L2.	Other appeals related to areas not mentioned above – Partially Favorable.	The number of appeals related to other areas not mentioned above (includes all Medicare and Medicaid demonstration related appeals) for which the MMP Coverage Decision or Reconsideration was partially favorable.	Field Type: Numeric
L3.	Other appeals related to areas not mentioned above – Adverse.	The number of appeals related to other areas not mentioned above (includes all Medicare and Medicaid demonstration related appeals) for which the MMP Coverage Decision or Reconsideration was adverse.	Field Type: Numeric

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

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

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

- CMS and the state will evaluate denial or limited authorization rates per 1,000 enrollees and will trend rates from quarter to quarter and from previous year.
- All data elements should be positive values.

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

- CMS and the state will obtain enrollment information and will evaluate the following:
  - Number of grievances related to:
    1) Inability to get appointment with a PCP per 1,000 members.
    2) Inability to get appointment with a PCP that resulted in timely notification of decision per 1,000 members.

3) Inability to get an appointment with a specialist per 1,000 members.
4) Inability to get an appointment with a specialist that resulted in timely notification of decision per 1,000 members.
5) Excessive wait time to get an appointment with a PCP per 1,000 members.
6) Excessive wait time to get an appointment with a PCP that resulted in timely notification of decision per 1,000 members.
7) Excessive wait time to get an appointment with a specialist per 1,000 members.
8) Excessive wait time to get an appointment with a specialist that resulted in timely notification of decision per 1,000 members.
9) Other grievances related to areas not mentioned above per 1,000 members.
10) Other grievances related to areas not mentioned above that resulted in timely notification of decision per 1,000 members.

- Number of appeals related to denial or limited authorization of:
  1) Specialty services for which the MMP coverage decision or reconsideration was fully favorable per 1,000 members.
  2) Specialty services for which the MMP coverage decision or reconsideration was partially favorable per 1,000 members.
  3) Specialty services for which the MMP coverage decision or reconsideration was adverse per 1,000 members.
  4) LTSS services (total) for which the MMP coverage decision or reconsideration was fully favorable per 1,000 members.
  5) LTSS services (total) for which the MMP coverage decision or reconsideration was partially favorable per 1,000 members.
  6) LTSS services (total) for which the MMP coverage decision or reconsideration was adverse per 1,000 members.
  7) HCBS services for which the MMP coverage decision or reconsideration was fully favorable per 1,000 members.
  8) HCBS services for which the MMP coverage decision or reconsideration was partially favorable per 1,000 members.
  9) HCBS services for which the MMP coverage decision or reconsideration was adverse per 1,000 members.
  10) Institutional services for which the MMP coverage decision or reconsideration was fully favorable per 1,000 members.
  11) Institutional services for which the MMP coverage decision or reconsideration was partially favorable per 1,000 members.
  12) Institutional services for which the MMP coverage decision or reconsideration was adverse per 1,000 members.
  13) Mental health services for which the MMP coverage decision or reconsideration was fully favorable per 1,000 members.
  14) Mental health services for which the MMP coverage decision or reconsideration was partially favorable per 1,000 members.

15) Mental health services for which the MMP coverage decision or reconsideration was adverse per 1,000 members.
16) Substance use treatment services for which the MMP coverage decision or reconsideration was fully favorable per 1,000 members.
17) Substance use treatment services for which the MMP coverage decision or reconsideration was partially favorable per 1,000 members
18) Substance use treatment services for which the MMP coverage decision or reconsideration was adverse per 1,000 members

- Number of appeals related to areas not mentioned above for which the MMP coverage decision or reconsideration was fully favorable per 1,000 members.
- Number of appeals related to areas not mentioned above for which the MMP coverage decision or reconsideration was partially favorable per 1,000 members.
- Number of appeals related to areas not mentioned above for which the MMP coverage decision or reconsideration was adverse per 1,000 members.

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

- As noted above, MMPs should report all non-Part D (i.e., Part C and Medicaid) grievances and appeals under this measure.
- The date the decision was made should be used to assess which reporting period the appeal or grievance should be reported within.
- MMPs should refer to the explanatory notes in the Part C Reporting Requirements above for further reporting information, including inclusion and exclusion criteria, definitions of timeliness, and category assignments.
- One grievance involving multiple issues should be reported under each applicable category.
- If a member files a grievance and then files a subsequent grievance on the same issue prior to the organization's decision or deadline for decision notification (whichever is earlier), the issue is counted as one grievance.
- If a member files a grievance and then files a subsequent grievance on the same issue after the organization's decision or deadline for decision notification (whichever is earlier), the issue is counted as a separate grievance.
- There are no minimum enrollment criteria for this measure. All grievances and appeals should be reported regardless how long a member has been enrolled in the MMP or if they have disenrolled from the MMP.
- For reporting, MMPs should exclude grievances related to supplemental benefits as these are additional benefits provided by MMPs which are outside of reporting requirements.
- Specialty services are defined as any service or medical care provided or directed by a "specialist" (as opposed to a Primary Care Provider) that would not be a service offered by a Primary Care Provider or fitting into

another category above. Note: Specialty service providers should include occupational/physical/speech therapy, dental, vision, transportation, and durable medical equipment.

- Primary Care Provider (PCP) will be defined in the state-specific appendix.

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

Section V. Organizational Structure and Staffing

5.1 Care coordinator to member ratio.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
5. Organizational Structure and Staffing	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
5. 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 full time equivalent (FTE) care coordinators working on the Demonstration.	Total number of FTE care coordinators working on the Demonstration as of the last day of the reporting period.	Field Type: Numeric
B.	Total FTE care coordinators assigned to care management and conducting assessments.	Of the total reported in A, the number of FTE care coordinators assigned to care management and conducting assessments during the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of newly hired FTE care coordinators (or those newly assigned to the MMP).	Of the total reported in A, the number of newly hired FTE care coordinators (or those newly assigned to the MMP) during the reporting period.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of FTE care coordinators that left the MMP.	Total number of FTE care coordinators that left the MMP during the reporting period.	Field type: Numeric

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

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

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

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data elements B and C are less than or equal to data element A.
- All data elements should be positive integer 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 not adjusted for case mix, plus care coordination will vary for each demonstration and each MMP's care plan model structure. Therefore, this measure will be used solely to track care coordination investments and changes in each MMP's care coordinator to member ratio longitudinally.

CMS and the state will:

- Obtain enrollment data to evaluate the number of FTE care coordinators per enrollee.
- Evaluate the percentage of FTE care coordinators who were assigned to care management and conducting assessments.
- Evaluate the percentage of FTE care coordinators that left the MMP during the reporting period.

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

- Care coordinator will be defined in the state-specific appendix. Different terms may be used in different states.
- All part-time and full-time care coordinators will be counted, regardless of whether they are subcontracted or employed directly by the MMP.
- FTE is defined as full time equivalent. To calculate this, add up all of the care coordinators' work hours during the reporting period and divide this value by the number of normal working hours that occurred during the reporting period. In instances where care coordinators support multiple lines of business, include only the time associated with the

demonstration/MMP. For all data elements, FTE reported values should be rounded to the nearest positive integer.
- Data element D includes care coordinators who are assigned to a different role within the MMP.

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

5.2 Annual staffing worksheets. – ***Suspended for 2017***

5.3 Establishment of consumer advisory board or inclusion of consumers on a pre-existing governance board consistent with contractual requirements.[i]

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

MMPs will be required to submit information on each consumer advisory board and/or governance board during the annual reporting period. One template per meeting should be completed and submitted. A template for providing information is located on the CMS Financial Alignment Initiative website:

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

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.	Date.	Date each meeting occurred during the annual reporting period.	Field Type: N/A Note: Date in YYYYMMDD Format Note: MMPs should upload file to FTP site as a separate attachment.

Element Letter	Element Name	Definition	Allowable Values
B.	Name of board members invited.	Full names of all consumer advisory board/governance board members invited to the meeting.	Field Type: N/A Note: MMPs should upload file to FTP site as a separate attachment.
C.	Name of board members in attendance.	Full names of all consumer advisory board/governance board members in attendance either in-person or remotely.	Field Type: N/A Note: MMPs should upload file to FTP site as a separate attachment. Note: Is a subset of B.
D.	Name of board members invited who are actual beneficiaries or family caregivers.	Full names of board members invited who are actual beneficiaries or family caregivers. Professional advocates should not be included unless they are also members or caregivers for members of the MMP.	Field Type: N/A Note: MMPs should upload file to FTP site as a separate attachment. Note: Is a subset of B.
E.	Name of board members who are actual beneficiaries or family caregivers in attendance.	Full names of board members who are actual beneficiaries or family caregivers in attendance either in-person or remotely. Professional advocates should not be included unless they are also members or caregivers for members of the MMP.	Field Type: N/A Note: MMPs should upload file to FTP site as a separate attachment. Note: Is a subset of both C and D.
F.	Agenda.	Agenda for each meeting during the annual period.	Field Type: N/A Note: MMPs should upload file to FTP site as a separate attachment.
G.	Minutes.	Minutes for each meeting held during the annual reporting period.	Field Type: N/A Note: MMPs should upload file to FTP site as a separate attachment.

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.

- For Demonstration Year (DY) 1, the quality withhold benchmark is set at 100% compliance. For more information, refer to the Medicare-Medicaid Capitated Financial Alignment Model CMS Core Quality Withhold Technical Notes for DY 1.

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

- Meeting dates are within the performance period.
- MMPs should validate that the members reported in element C are a subset of the members reported in element B.
- MMPs should validate that the members reported in element D are a subset of the members reported in element B.
- MMPs should validate that the members reported in element E are a subset of the members reported in element D and also a subset of the members reported in element C.

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 analyze attendance and participation of MMP members in board meetings.

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

- MMPs should submit one template per meeting.
- For reporting data elements B, C, D, and E, MMPs should only include established consumer advisory board/governance board members.

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

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx
- Required File Format is Microsoft Word File.
- The file name extension should be ".docx"
- File name= (STATEABBREVIATION)_(CONTRACTID)_(REPORTING PERIOD)_(MEETINGDATE).docx.
- Replace (STATEABBREVIATION) with the two-character state abbreviation (e.g., Massachusetts is MA), (CONTRACTID) with the contract ID, (REPORTINGPERIOD) with the year and month of the beginning of the reporting period in YYYYMM format (e.g., February 2014 would be 201402), (MEETINGDATE) with the month, date, and year of the meeting in YYYYMMDD format (e.g., March 31, 2014 would be 21140331).

Section VI. Performance and Quality Improvement

6.1 Screening for Clinical Depression and Follow-up Plan. (modified from NQF #0418)[ii] – ***Suspended for 2017***

Section VII. Provider Network

7.1 Medicare Provider Network.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
7. Provider Network	Annually	Contract	Current network as of the date of submission.	By the third Tuesday of September

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.	MMP Health Service Delivery Provider Table	Refer to MMP Medicare Network Submission Guidance for data definitions.	Field Type: Data Entry
B.	MMP Health Service Delivery Facility Table	Refer to MMP Medicare Network Submission Guidance for data definitions.	Field Type: Data Entry

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

- CMS and the state will assess Health Service Delivery (HSD) tables against Medicare MMP standards that are available on the MMCO website.

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

- Confirm HSD tables will properly upload into HPMS using the plan upload functionality.
- MMPs should validate that MMP Medicare Networks meet MMP standards using the plan upload functionality prior to the MMP Medicare Network Annual submission.

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

- CMS will assess the submitted HSD tables against the MMP Medicare Network Standards.

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

- MMPs should refer to the MMP Medicare Network Submission Guidance that will be issued separately for the relevant reporting year.

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

Section VIII. Systems

8.1 LTSS clean claims paid within 30 days, 60 days, and 90 days.

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

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of LTSS clean claims paid within the reporting period.	Total number of LTSS clean claims paid within the reporting period.	Field Type: Numeric
B.	Total number of clean claims paid within 30 calendar days of receipt.	Of the total reported in A, the number of clean claims paid within 30 calendar days of receipt.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of clean claims paid within 60 calendar days of receipt.	Of the total reported in A, the number of clean claims paid within 60 calendar days of receipt.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of clean claims paid within 90 calendar days of receipt.	Of the total reported in A, the number of clean claims paid within 90 calendar days of receipt.	Field Type: Numeric Note: Is a subset of A.

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

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

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

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

D. Analysis - how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of LTSS clean claims that were paid within:

- 30 calendar days of receipt.
- 60 calendar days of receipt.
- 90 calendar days of receipt.

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

- Long Term Services and Supports (LTSS) will be defined in the state-specific appendix.
- A “clean” claim is one that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.
- The 30, 60, and 90-day cutoffs should be calculated using individual calendar days, unlike core measures 2.1 and 2.2 where “90 days of enrollment” is considered equivalent to three full calendar months.
- MMPs should include LTSS clean claims if they were paid during the reporting period. LTSS clean claims submitted during the reporting period, but not paid during the reporting period, should not be included.

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

Section IX. Utilization

9.1 Emergency room behavioral health services utilization.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
9. Utilization	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the 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 behavioral health-related ED visits with a CPT or UB Revenue code for an emergency department visit and a principal diagnosis related to behavioral health.	Total number of behavioral health-related ED visits with a CPT or UB Revenue code for an emergency department visit and a principal diagnosis related to behavioral health during the reporting period.	Field Type: Numeric

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

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

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

- Data element should be a positive value.

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

- CMS and the state will obtain enrollment information to evaluate the total number of behavioral health-related ED visits per 1,000 members during the reporting period.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all behavioral health-related ED visits 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 members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- MMPs should use the ED value set to identify emergency department visits.
- MMPs should use the Mental Health Diagnosis value set to identify a behavioral health diagnosis.
- MMP should exclude members if they are admitted as inpatients.

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

9.2 Nursing Facility (NF) Diversion.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
9. Utilization	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 who were continuously enrolled in the MMP for at least 5 out of the last 6 months during the previous reporting period ***and*** continuously enrolled in the MMP for at least 11 out of 12 months during the current reporting period.	Total number of members who were continuously enrolled in the MMP for at least 5 out of the last 6 months during the previous reporting period ***and*** continuously enrolled in the MMP for at least 11 out of 12 months during the current reporting period.	Field Type: Numeric
B.	The total number of members who were classified as nursing home certifiable for more than 100 continuous days during the previous reporting period who did not reside in a NF for more than 100 continuous days during the previous reporting period.	Of the total reported in A, the number of members who were classified as nursing home certifiable for more than 100 continuous days during the previous reporting period who did not reside in a NF for more than 100 continuous days during the previous reporting period.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of members who did not reside in a NF for more than 100 continuous days during the current reporting period.	Of the total reported in B, the number of members who did not reside in a NF for more than 100 continuous days during the current reporting period.	Field Type: Numeric Note: Is a subset of B.

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

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

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

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

- For members classified as nursing home certifiable for more than 100 continuous days during the previous reporting period who did not reside in a NF for more than 100 continuous days during the previous reporting period, CMS and the state will evaluate the percentage of members who did not reside in a NF for more than 100 continuous days during the current reporting period.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- For the purposes of this measure, the “previous reporting period” is defined as the previous calendar year. The “current reporting period” is defined as the current calendar year. For example, for data submitted on February 28, 2018, the previous reporting period is January 1, 2016 – December 31, 2016, and the current reporting period is January 1, 2017 – December 31, 2017.
- The member must be enrolled as of the last day of both the previous and current reporting periods to be included in this measure.

- For reporting members in data element A, members must meet both continuous enrollment criteria in order to be included in this data element. Therefore, the member must be continuously enrolled as a Medicare-Medicaid member in the MMP for at least 5 out of the last 6 months during the previous reporting period ***and*** continuously enrolled as a Medicare-Medicaid member in the MMP for at least 11 out of 12 months during the current reporting period. Members meeting this criteria for only one of the reporting periods should not be included in data element A.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during each reporting period (i.e., July through December [previous reporting period] and January through December [current reporting period]). 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).
- Nursing home certifiable members are defined as members living in the community, but requiring an institutional level of care. Additionally, members who have a stay in a NF may be considered nursing home certifiable depending on the length of stay. MMPs should refer to their state's specific definition for additional information.
- To identify members for inclusion in data element B, MMPs should first identify all members who were nursing home certifiable for more than 100 continuous days at any point during the previous reporting period (January through December). Then, MMPs should exclude any of these members who resided in a NF for at least 101 continuous days during the previous reporting period.
    - For example, a member who entered a NF on September 4 and remained there on December 31 of the previous reporting period has more than 100 continuous days in a NF in the previous reporting period (119 days within the previous reporting period) and would not be included in data element B. A member who entered a NF on October 4 of the previous reporting period and remained there through February 1 of the current reporting period would not have more than 100 continuous days in a NF during the previous reporting period (residing there only 89 days during the previous reporting period) and would be included in data element B as long as they were nursing home certifiable for more than 100 continuous days during the previous reporting period.
    - MMPs should use all available data to document and confirm a member's status as nursing home certifiable. In the event of missing data for members who had a single, 1-month-long gap in coverage during the previous reporting period and who were documented as nursing home certifiable before the 1-month gap and after the 1-month gap, MMPs may assume that the member was nursing home certifiable during the 1-month gap.

- For reporting data element C, MMPs should exclude all members who reached their 101st continuous day of a NF stay during the current reporting period. This may include members who entered the NF within the **previous** reporting period as well as members who entered the NF during the **current** reporting period.
    - For example, a member who entered a NF on October 4 of the previous reporting period and remained there on February 1 of the current reporting period reached his or her 101st day on January 13 and, therefore, would be excluded from data element C. Alternatively, a member who entered a NF on August 1 of the current reporting period and remained there on December 31 of the current reporting period reached his or her 101st day on November 9 and would also be excluded from data element C.
- For data elements B and C, when determining the number of continuous days a member resided in the NF, if a member is transferred or discharged from the NF and then is readmitted to any NF within 30 days, the transfer/discharge and subsequent readmission do not disrupt the count of continuous days. For example, if a member is transferred from the NF to the hospital on day 57 and is subsequently readmitted to the same or a different NF 29 days later, this will be counted as the same episode. The member's first day after returning to a NF (i.e., the day the member is readmitted to the NF) will count as day 58 for that episode, not as day 1. If a member is transferred from the NF and then is readmitted to any NF after 30 days, the date of readmission is the start of a new episode in the NF and will count as day 1 toward the member's continuous days in the facility.
- NF services are those services provided by nursing homes certified by Medicaid, Medicare, or other state agencies. NF includes skilled nursing facilities (not Adult Family Care Homes [AFCH], Assisted Living Facilities [ALF], Intermediate Care Facilities [ICF], or Supportive Living Facilities [SLF]).
- MMPs should exclude members who are transitioned to hospice services in either the current or previous reporting periods when reporting this measure.
- MMPs should exclude members who expired in either the current or previous reporting period when reporting this measure using the Discharges due to Death value set.
- This measure will not be reported until Calendar Year 2 (e.g., Calendar Year 2017 will be Calendar Year 2 for all MMPs whose demonstration effective enrollment dates began in Calendar Year 2016).

F. Data Submission - how MMPs will submit data collected to CMS and the State.

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).