DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTERS FOR MEDICARE & MEDICAID SERVICES

DATE: March 25, 2016

TO: Medicare-Medicaid Plans in California

FROM: Lindsay Barnette
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SUBJECT: Revised California-Specific Reporting Requirements

The purpose of this memorandum is to announce the release of the revised Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: California-Specific Reporting Requirements. The document is designed to provide updated guidance and technical specifications for the state-specific measures that California Medicare-Medicaid Plans (MMPs) are required to collect and report under the demonstration.

Please see below for a high-level summary of the changes that were made to the California-Specific Reporting Requirements. California MMPs must use the updated specifications for all measures due on or after May 2, 2016. Should you have any questions, please contact the Medicare-Medicaid Coordination Office at mmcocapsreporting@cms.hhs.gov.

SUMMARY OF CHANGES

Introduction

- In the "Quality Withhold Measures" section, updated information about quality withhold measures for DY 2 and 3. Also added the DY 2 and 3 quality withhold designation to relevant measures throughout the document.
- Added a "Value Sets" section that provides information about the separate California State-Specific Value Sets Workbook, which contains all codes needed to report certain measures. The California State-Specific Value Sets Workbook is also included with this memorandum.

Measures CA1.1 and CA1.3

- Clarified that data element D should include all members with an initial Health Risk Assessment (HRA) that was completed during the reporting period (i.e., MMPs should

not include any reassessments). Note that new HRAs completed following a member's break in coverage should be reported as initial HRAs in data element D. Additional guidance on HRAs and Individualized Care Plans (ICPs) for members with a break in coverage can be found on pages CA-7 through CA-9.

- Clarified that members reported in data elements B, C and D must also be reported in data element A, while members reported in data elements E, F and G must also be reported in data element D. Since the data elements that are subsets of A and D must be mutually exclusive, added guidance about how to classify members that could meet the criteria for multiple data elements.

Measures CA1.2 and CA1.4

- Clarified that data element A should include all members with an initial HRA that was completed during the reporting period (i.e., MMPs should not include any reassessments). Note that new HRAs completed following a member's break in coverage should be reported as initial HRAs in data element A. Additional guidance on HRAs and ICPs for members with a break in coverage can be found on pages CA-7 through CA-9.
- Clarified that members reported in data elements B, C, and D must also be reported in data element A. Since data elements B, C, and D must be mutually exclusive, added guidance about how to classify members that could meet the criteria for multiple data elements.

Measure CA1.6

- Clarified that the ICP must be completed in order for the member to be counted under data element A.

Measure CA1.11

- Clarified that the measure should include all inpatient stays and ambulatory care follow-up visits identified, including denied and pended claims.
- Removed the code tables since applicable codes are now provided separately in the California State-Specific Value Sets Workbook. Note that the workbook also includes updated codes for this measure due to the ICD-10 conversion effective October 1, 2015.

Measure CA2.1

- Added guidance about how to report members that receive services from more than one type of LTSS during the same quarterly reporting period.

Measure CA3.1

- For data element A, removed the references to an oversight committee since there is currently no existing requirement for MMPs to establish a committee of this nature.

Measure CA4.1

- Removed the code tables since applicable codes are now provided separately in the California State-Specific Value Sets Workbook. Note that the workbook also includes updated codes for this measure due to the ICD-10 conversion effective October 1, 2015.

Measure CA4.3

Note: Due to the extensive edits to this measure, the due date for the CY 2015 submission is delayed to May 31, 2016.

- Clarified that data elements H and I are a subset of data element G.
- Clarified that the date of transfer and discharge back to any nursing facility must occur within the same reporting period.
- Removed the note that the member needs to be enrolled from the date of the transfer and admission to an acute care hospital through 30 days following the admission, with no gaps in enrollment.
- Provided detailed steps for identifying members with diabetes, which aligns with the HEDIS methodology for identifying members with diabetes. This revision to align with HEDIS introduced several new value sets, including pharmacy data.
- Added clarification that a member could be diagnosed with both diabetes and COPD, and that members with multiple conditions should be reported in all applicable data elements (including data elements for any medical diagnosis).
- Removed the code tables since applicable codes are now provided separately in the California State-Specific Value Sets Workbook. Note that the workbook also includes updated codes for this measure due to the ICD-10 conversion effective October 1, 2015.