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

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Table of Contents

Massachusetts-Specific Reporting Requirements MA-3

Introduction MA-3

Definitions MA-3

Variation from the Core Document MA-4

Quality Withhold Measures MA-5

Reporting on Disenrolled and Retro-disenrolled Members MA-6

Guidance on Assessments and Care Plans for Members with a Break in Coverage MA-6

Hybrid Sampling MA-8

Value Sets MA-10

Massachusetts Implementation, Ongoing, and Continuous Reporting Periods MA-10

Data Submission MA-11

Resubmission of Data MA-11

Section MAI. Care Coordination MA-12

Section MAII. Enrollee Protections MA-22

Section MAIII. Organizational Structure and Staffing MA-24

Section MAIV. Performance and Quality Improvement MA-26

Section MAV. Systems MA-49

Section MAVI. Utilization MA-52

Massachusetts-Specific Reporting Requirements

Introduction

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

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

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

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

MMPs should contact the MA HelpDesk at MAHelpDesk@norc.org and the state contacts with any questions about the Massachusetts state-specific appendix or the data submission process.

Definitions

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

Calendar Year: All annual measures are reported on a calendar year basis. For example, calendar year 2015 will begin on January 1, 2015 and end on December 31, 2015.

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

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

Long Term Services and Supports (LTSS): A wide variety of services and supports that help people with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities.

Primary Care Provider: Nurse practitioners, physician assistants or physicians who are board certified or eligible for certification in one of the following specialties: family practice, internal medicine, general practice, obstetrics/gynecology, or geriatrics.

Variation from the Core Document

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

Core Measure 2.1 – Members with an assessment completed within 90 days of enrollment

One Care MMPs will submit data collected for this measure through the MassHealth-developed Monthly Enrollment and Assessment Progress Tracking tool, not HPMS. This measure will be reported monthly for the duration of the demonstration according to the reporting schedule for MassHealth's Monthly Enrollment and Assessment Tracking tool.

Core Measure 2.2 – Members with an assessment completed

One Care MMPs will submit data collected for this measure through the MassHealth-developed Monthly Enrollment and Assessment Progress Tracking tool, not HPMS.

Core Measure 5.3 – Establishment of consumer advisory board

For One Care MMPs, this is defined as the initial holding of a board meeting that includes Consumers within 90 days of the first effective enrollment date for the demonstration; and on an ongoing basis, as the holding of a board meeting that includes consumers at least quarterly.

During the implementation period, MMPs must submit within 150 days of the first demonstration passive enrollment effective date the meeting minutes for the first board meeting that includes consumers and that is held within 90 days of the first effective enrollment date. During the ongoing reporting period, MMPs must annually submit meeting minutes for board meetings that include consumers and that are held at least quarterly. For the first year, MMPs are required to report both the first meeting minutes during the implementation reporting phase, and subsequent meeting minutes as part of annual reporting for the ongoing reporting phase.

Core Measure 9.2 – Nursing Facility (NF) Diversion

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

Within Core 9.2, "nursing home certifiable" members are defined as "members living in the community, but requiring an institutional level of care" (see the Core Reporting Requirements for more information). For One Care MMPs, this definition includes the following types of members:

- Members classified in the C3A or C3B rating category.
- Members who have a claims history which illustrates nursing facility level of care.

According to the measure specifications, in order for members to be included in data element B, they must have been classified as nursing home certifiable for more than 100 days during the previous reporting period and must not have resided in a nursing facility for more than 100 continuous days during the previous reporting period.

- A small subset of these identified members could potentially be categorized as F1 at a point in time throughout the measurement year.
- F1 members are considered individuals who were at a facility for 90 days or more, therefore, a F1 individual could stay at a nursing facility anywhere between 90 and 100 days, without exceeding the 100 continuous day mark described above. These individuals should be included in data element B.

Quality Withhold Measures

CMS and the state will establish a set of quality withhold measures, and MMPs will be required to meet established thresholds. Throughout this document, Demonstration Year 1 state-specific quality withhold measures are marked with the following symbol: (ⁱ). For more information about the state-specific quality withhold measures for Demonstration Year 1, refer to the Quality Withhold Technical Notes (DY 1): Massachusetts-Specific Measures at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY1QualityWithholdGuidanceMass.pdf.

For more information about the state-specific quality withhold measures for Demonstration Years 2 and 3, refer to the Quality Withhold Technical Notes (DY 2 & 3): Massachusetts-Specific Measures at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY2and3QualityWithholdGuidanceMass.pdf. Updated technical notes to reflect Demonstration Years 4 and 5 will be forthcoming.

Reporting on Disenrolled and Retro-disenrolled Members

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

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

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

Comprehensive Assessments

If a MMP already completed an assessment for a member that was previously enrolled in that plan (either through passive or opt-in enrollment), the MMP is not necessarily required to conduct a new assessment if the member rejoins the same MMP within one year of his/her most recent assessment. Instead, the MMP can:

1. Confirm that the prior assessment results are recorded in the Centralized Enrollee Record (CER);

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

3. Ask the member (or his/her authorized representative) over the phone or in person if there has been a change in the member's health status or needs since the assessment was conducted. If there are no changes identified, ask if the member consents to use the prior assessment results going forward.

The MMP must document any risk stratification, claims data review, or other analyses that are performed to detect any changes in the member's condition. The MMP must also document its outreach attempts and the discussion(s) with the member (or his/her authorized representative) to determine if there was a change in the member's health status or needs, and if no changes are identified, that the member consents to use the

prior assessment results going forward. The discussion(s) should be documented in the CER.

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

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

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

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

Individualized Care Plans

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

If the MMP did not complete an ICP for the re-enrolled member during his/her prior enrollment period, or if it has been more than one year since the member's ICP was completed, the MMP is required to develop an ICP for the member within the timeframe

prescribed by the contract. The MMP must also follow the above guidance regarding reaching out to members that previously refused to participate or were not reached.

Continuity of Care

Continuity of Care provisions remain in effect at least until contact is made with the member. Please refer to the contract requirements about applicability after contact is made with the member.

Annual Reassessments and ICP Updates

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

Hybrid Sampling

Some demonstration-specific measures may allow 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.

Value Sets

The measure specifications in this document refer to code value sets that must be used to determine and report measure data element values. A value set is the complete set of codes used to identify a service or condition included in a measure. The Massachusetts-Specific Value Sets Workbook includes all value sets and codes needed to report certain measures included in the Massachusetts-Specific Reporting Requirements and is intended to be used in conjunction with the measure specifications outlined in this document. The Massachusetts-Specific Value Sets Workbook can be found on the CMS website at the following address: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html.

Massachusetts Implementation, Ongoing, and Continuous Reporting Periods

Phase		Dates	Explanation
Demonstration Year 1			
Continuous Reporting	Implementation Period	1-1-14 through 6-30-14	From January 1st through June 30th, 2014
	Ongoing Period	1-1-14 through 12-31-14	From January 1st through December 31st, 2014.
Demonstration Year 2			
Continuous Reporting	Ongoing Period	1-1-15 through 12-31-15	From January 1st through the end of the second demonstration year.
Demonstration Year 3			
Continuous Reporting	Ongoing Period	1-1-16 through 12-31-16	From January 1st through the end of the third demonstration year.
Demonstration Year 4			
Continuous Reporting	Ongoing Period	1-1-17 through 12-31-17	From January 1st through the end of the fourth demonstration year.
Demonstration Year 5			
Continuous Reporting	Ongoing Period	1-1-18 through 12-31-18	From January 1st through the end of the fifth demonstration year.

Data Submission

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

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

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

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

Resubmission of Data

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

1. Email the MA HelpDesk (MAHelpDesk@norc.org) and state contact to request resubmission.
    - Specify in the email which measures need resubmission;
    - Specify for which reporting period(s) the resubmission is needed; and
    - Provide a brief explanation for why the data need to be resubmitted.
2. After review of the request, the MA HelpDesk will notify the MMP once the FAI Data Collection System and/or HPMS has been re-opened.
3. Resubmit data through the applicable reporting system.
4. Notify the MA HelpDesk and state contact again after resubmission has been completed.

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

Section MAI. Care Coordination

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

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

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

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

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

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

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

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

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

D. Analysis - how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of members whose 90th day of enrollment occurred within the reporting period:

- Who refused to have a care plan completed within 90 days of enrollment.
- Who were unable to be reached to have a care plan completed within 90 days of enrollment.
- Who had a care plan completed within 90 days of enrollment.
- That were willing to participate and who could be reached who had a care plan completed within 90 days of enrollment.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in 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 refer to the Massachusetts three-way contract for specific requirements pertaining to care plans.
- 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 data element B or C should not also be reported in data 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 to participate in the care plan or could not be reached after three outreach attempts, but then subsequently completes the care plan 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 to complete the care plan within 90 days of enrollment, the member should be classified in data element B.
- For data element B, MMPs should report the number of members who were unwilling to participate in the development of the care plan if a member (or his or her authorized representative):
    - Affirmatively declines to participate in the care plan. Member communicates this refusal by phone, mail, fax, or in person.
    - Expresses willingness to complete the care plan but asks for it to be conducted after 90 days following the members effective enrollment date (despite being offered a reasonable opportunity to complete the care plan within 90 days). Discussions with the member must be documented by the MMP.
    - Expresses willingness to complete the care plan 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 care plan, but then declines to answer a majority of the questions in the care plan.
- 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 Massachusetts three-way contract or state guidance for any specific requirements pertaining to the method of outreach to members. MMPs must document each attempt to reach the member, including the method of the attempt (i.e., phone, mail, or email), as CMS and the state may validate this number. There may be instances when the MMP has a high degree of confidence that a member's contact information is correct, yet that member is not responsive to the MMP's

outreach efforts. So long as the MMP follows the guidance regarding outreach attempts, these members may be included in the count for this data element.

- There may be certain circumstances that make it impossible or inappropriate to complete a care plan within 90 days of enrollment. For example, a member may become medically unable to respond and have no authorized representative to do so on their behalf, or a member may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for a care plan. However, MMPs should not include such members in the counts for data elements B and C.
- If a care plan was started but not completed within 90 days of enrollment, then the care plan should not be considered completed and, therefore, would not be counted in data elements B, C, or D. However, this member would be included in data element A if the members 90th day of enrollment occurred within the reporting requirements.

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

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

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

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

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members with an initial care plan completed.	Total number of members with an initial care plan completed during the reporting period.	Field Type: Numeric
B.	Total number of members with at least one documented discussion of care goals in the initial care plan.	Of the total reported in A, the number of members with at least one documented discussion of care goals in the initial care plan.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of existing care plans revised.	Total number of existing care plans revised during the reporting period.	Field Type: Numeric
D.	Total number of revised care plans with at least one documented discussion of new or existing care goals.	Of the total reported in C, the number of revised care plans with at least one documented discussion of new or existing care goals.	Field Type: Numeric Note: Is a subset of C.

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

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

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

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

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

- Members who had a care plan completed in the reporting period who had at least one documented discussion of care goals in the care plan.
- Members who had a care plan developed as of the end of the reporting period.

- Care plans revised during the reporting period that had at least one documented discussion of new or existing care goals.

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

- 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).
- MMPs should include all care plans that meet the criteria outlined in data element C, regardless of whether the member is disenrolled as of the end of the reporting period (i.e., include all care plans regardless of whether the member is currently enrolled or disenrolled as of the last day of the reporting period).
- Data element A should include all members whose care plan was completed for the first time during the reporting period (i.e., the member did not previously have an care plan completed prior to the start of the reporting period). There can be no more than one initial care plan completed per member.
- MMPs should only include members in data element B when the discussion of care goals is clearly documented in the member's initial care plan.
- Data element C should include all existing care plans that were revised during the reporting period. MMPs should refer to the Massachusetts three-way contract for specific requirements pertaining to updating the care plan.
- MMPs should only include care plans in data element D when a new or previously documented care goal is discussed and is clearly documented in the member's revised care plan. If the initial care plan clearly documented the discussion of care goals, but those existing care goals were not revised or discussed, or new care goals are not discussed and documented during the revision of the care plan, then that care plan should not be reported in data element D.
- If a member has an initial care plan completed during the reporting period, and has their care plan revised during the same reporting period, then the member's initial care plan should be reported in data element A and the member's revised care plan should be reported in data element C.
- If a member's care plan is revised multiple times during the same reporting period, each revision should be reported in data element C. For example, if a member's care plan is revised twice during the same reporting period, two care plans should be counted in data element C.
- Documented discussions of care goals will be recorded in a member's electronic health record (EHR).

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

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

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

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

A. Data element definitions - details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated. Cell references under "Allowable Values" correspond to the MassHealth Monthly Enrollment and Assessment Tracking Tool.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members enrolled whose 90th day of enrollment occurred within the reporting period.	Total number of members enrolled whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric Corresponds to cell B27.
B.	Total number of members identified with LTSS needs within 90 days of enrollment.	Of the total reported in A, the number of members identified with LTSS needs within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A. Corresponds to cell A24.
C.	Total number of members with LTSS needs who refused an IL-LTSS coordinator within 90 days of enrollment.	Of the total reported in B, the number of members with LTSS needs who refused an IL-LTSS coordinator within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of B. Corresponds to cell B24.

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of members with LTSS needs who have a referral to an IL-LTSS coordinator within 90 days of enrollment.	Of the total reported in B, the number of members with LTSS needs who have a referral to an IL-LTSS coordinator within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of B. Corresponds to cell C24.
E.	Total number of members with LTSS needs that are in the C3 and F1 rating categories.	Of the total reported in B, the number of members with LTSS needs that are in the C3 and F1 rating categories.	Field Type: Numeric Note: Is a subset of B. Corresponds to cell D24.
F.	Total number of members with LTSS needs who are in the C3 and F1 rating categories who refused an IL-LTSS coordinator within 90 days of enrollment.	Of the total reported in E, the number of members with LTSS needs who are in the C3 and F1 rating categories who refused an IL-LTSS coordinator within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of E. Corresponds to cell E24.
G.	Total number of members with LTSS needs who are in the C3 and F1 rating categories who have a referral to an IL-LTSS coordinator within 90 days of enrollment.	Of the total reported in E, the number of members with LTSS needs who are in the C3 and F1 rating categories who have a referral to an IL-LTSS coordinator within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of E. Corresponds to cell F24.
H.	Total number of members with LTSS needs who are in the C3 and F1 rating categories who have met with an IL-LTSS coordinator within 90 days of enrollment.	Of the total reported in E, the number of members with LTSS needs who are in the C3 and F1 rating categories who have met with an IL-LTSS coordinator within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of E. Corresponds to cell H24.

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

- CMS and the state will perform an outlier analysis.

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

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

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

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

- With LTSS needs identified within 90 days of enrollment. (B/A)
- Who refused an IL-LTSS coordinator within 90 days of enrollment. (C/B)
- Who have a referral to an IL-LTSS coordinator within 90 days of enrollment. (D/B)
- With LTSS needs identified who are in the C3 and F1 rating categories. (E/B)
- Who are in the C3 and F1 rating categories who refused an IL-LTSS coordinator within 90 days of enrollment. (F/E)
- Who are in the C3 and F1 rating categories who have a referral to an IL-LTSS coordinator within 90 days of enrollment. (G/E)
- Who are in the C3 and F1 rating categories who have met with an IL-LTSS coordinator within 90 days of enrollment. (H/E)

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in 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.
- MMPs should refer to the Massachusetts MOU and three-way contract for specific requirements pertaining to an IL-LTSS coordinator.
- LTSC refers to long term services and supports coordinator.
- CBO refers to Community Based Organization.
- F1 refers to facility-based care individuals identified as having a long-term facility stay of more than 90 days.

- C3 refers to community tier 3 high community need. Individuals who have a daily skilled need; two or more activities of daily living (ADL). Limitations and three days of skilled nursing need; and individuals with four or more ADL limitations.
- Identified LTSS members refers to members who were identified during the reporting period as having LTSS needs.
- Meeting with Coordinator refers to a face-to-face meeting with an IL-LTSS coordinator.
- Refuse refers to anyone who refuses an IL-LTSS coordinator.
- The effective date of enrollment is the first date of the member's coverage through the MMP.
- Element A: See cell B27 ("Total Enrollment") on the Monthly Enrollment and Assessment Progress Tracking tool.
- Element B: See cell A24 ("Total LTSS need identified") on the Monthly Enrollment and Assessment Progress Tracking tool.
- Element C: See cell B24 ("Total refused LTSC referrals") on the Monthly Enrollment and Assessment Progress Tracking tool.
- Element D: See cell C24 ("Total LTSC referrals made to CBOs" on the Monthly Enrollment and Assessment Progress Tracking tool.
- Element E: See cell D24 ("C3/F1 LTSS needs identified") on the Monthly Enrollment and Assessment Progress Tracking tool.
- Element F: See cell E24 ("C3/F1 refused LTSC referrals") on the Monthly Enrollment and Assessment Progress Tracking tool.
- Element G: See cell F24 ("C3/F1 LTSC referrals made to CBOs") on the Monthly Enrollment and Assessment Progress Tracking tool.
- Element H: See cell H24 ("C3/F1 initial encounters by LTSCs") on the Monthly Enrollment and Assessment Progress Tracking tool.

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

- MMPs will submit data collected for this measure in the above specified format to MassHealth using MassHealth's Monthly Enrollment and Assessment Tracking tool.

Section MAII. Enrollee Protections

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

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
MA2. Enrollee Protections	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
MA2. Enrollee Protections	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

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

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

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

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

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

- All data elements should be positive values.

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

- CMS and the state will evaluate the number of critical incident and abuse reports per 1,000 members receiving LTSS 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 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).
- For data element B, MMPs should include all new critical incident and abuse cases that are reported during the reporting period, regardless if the case status is open or closed as of the last day of the reporting period.
- Critical incident and abuse reports could be reported by the MMP or any provider, and are not limited to only those providers defined as LTSS providers.
- It is possible for members to have more than one critical incident and/or abuse report during the reporting period. All critical incident and abuse reports during the reporting period should be counted.
- Critical incident refers to any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a member.
- Abuse refers to:
    - Willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish;
    - Knowing, reckless, or intentional acts or failures to act which cause injury or death to an individual or which places that individual at risk of injury or death;
    - Rape or sexual assault;
    - Corporal punishment or striking of an individual;
    - Unauthorized use or the use of excessive force in the placement of bodily restraints on an individual; and
    - Use of bodily or chemical restraints on an individual which is not in compliance with federal or state laws and administrative regulations.

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

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

Section MAIII. Organizational Structure and Staffing

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

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
MA3. Organizational Structure and Staffing	Annually	Contract	Calendar Year, beginning CY 2015	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of newly hired care coordinators (or those newly assigned to the MMP).	Total number of newly hired care coordinators (or those newly assigned to the MMP) during the reporting period.	Field Type: Numeric
B.	Total number of newly hired care coordinators (or those newly assigned to the MMP) that have undergone state-based training for supporting self-direction under the demonstration.	Of the total reported in A, the number of newly hired care coordinators (or those newly assigned to the MMP) that have undergone state-based training for supporting self-direction under the demonstration.	Field Type: Numeric Note: Is a subset of A.

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

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

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

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

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

- CMS and the state will evaluate the percentage of newly hired care coordinators that have undergone state-based training for supporting self-direction.

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

- MMPs should refer to the Massachusetts three-way contract for specific requirements pertaining to a care coordinator.
- MMPs should refer to the Massachusetts three-way contract for specific requirements pertaining to training for supporting self-direction.
- The total number of newly hired or newly assigned care coordinators includes all full-time and part-time staff.

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

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

Section MAIV. Performance and Quality Improvement

MA4.1 Mental Health Recovery Measure (MHRM©). – ***Suspended***

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

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

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members who were continuously enrolled in the MMP during the current two-year reporting period who had at least one outpatient visit or telephonic evaluation during the current two-year reporting period.	Total number of members who were continuously enrolled in the MMP between January 1 of the first year and December 31 of the second year in the current two-year reporting period who had at least one outpatient visit or telephonic evaluation during the current two-year reporting period.	Field Type: Numeric
B.	Total number of members sampled that met inclusion criteria.	Of the total reported in A, the number of members sampled that met inclusion criteria.	Field type: Numeric Note: Is a subset of A.
C.	Total number of members who were screened for unhealthy alcohol use at least once using a systematic screening method during the current two-year reporting period.	Of the total reported in B, the number of members who were screened for unhealthy alcohol use at least once using a systematic screening method during the current two-year reporting period.	Field Type: Numeric Note: Is a subset of B.

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of members who were positively identified as an unhealthy alcohol user during the current two-year reporting period.	Of the total reported in C, the number of members who were positively identified as an unhealthy alcohol user based on the results of the systematic screening method during the current two-year reporting period.	Field Type: Numeric Note: Is a subset of C.
E.	Total number of members who received brief counseling or other follow-up care at least once within 30 days of the positive finding during the current two-year reporting period.	Of the total reported in D, the number of members who received brief counseling or other follow-up care at least once within 30 days of the positive finding during the current two-year reporting period.	Field Type: Numeric Note: Is a subset of D.

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

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

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

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- MMPs should validate that data element C is less than or equal to data element B.
- MMPs should validate that data element D is less than or equal to data element C.
- MMPs should validate that data element E is less than or equal to data element D.
- 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 continuously enrolled in the MMP during the current two-year reporting period with at least one outpatient visit or telephonic evaluation during the current two-year reporting period who were screened for unhealthy alcohol use at least once using a systematic screening method.

- Members identified as an unhealthy alcohol user who received brief counseling or other follow-up care at least once within 30 days of the positive finding during the current two-year reporting period.

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

- MMPs should include all members aged 21 years and older as of January 1 of the first year of the reporting period, regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. A subset of all members that are eligible will be included in the sample. Medicaid-only members should not be included.
- MMPs should only include members who were continuously enrolled in the MMP between January 1 of the first year and December 31st of the second year in the current two-year reporting period, with no more than one gap in enrollment of up to 45 days during each year of the two year reporting period (e.g., January 1, 2016 through December 31, 2016 and January 1, 2017 through December 31, 2017). 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).
    - When reporting the first two-year reporting period for this measure, January 1 – December 31, 2014 will be the first year and January 1 – December 31, 2015 will be the second year. A member can have no more than one gap in enrollment between January 1 – December 31, 2014 and no more than one gap in enrollment between January 1 – December 31, 2015 to be included in this measure.
- The reporting period for this measure is two years, but reporting will occur on an annual basis. The first reporting period will consist of data from CY14 and CY15, with the first data submission due six months after the end of CY15. The second reporting period will consist of data from CY15 and CY16 with data submission due six months after the end of CY16.
- For reporting, medical record review is required. Sampling should be systematic to ensure all eligible individuals have an equal chance of inclusion. The sample size should be 411, plus oversample to allow for substitution. For further instructions on selecting the sample size, please see page MA-8 of the introductory section of this document.
- For data element A, MMPs should use the Outpatient #1 value set to identify members with at least one outpatient visit during the reporting period. MMPs should use a designated field within the Centralized Enrollee Record (CER) to capture telephonic evaluations that occurred during the reporting period.
- The CER may be used to identify numerator events and exclusions.
- Unhealthy alcohol use is defined as the consumption of alcohol associated with health risks or consequences. It covers the full spectrum of alcohol use associated with consequences and, therefore, includes amounts

known to be associated with increased risk (e.g., 5 or more standard drinks on an occasion for men, 4 for women, or >14 (men) or >7 (women) drinks per week on average, as defined by NIAAA), drinking in certain circumstances (e.g., while pregnant or taking a medication that interacts with alcohol), drinking already associated with a problem or consequence but not meeting criteria for an alcohol use disorder, and the alcohol use disorders, alcohol abuse and dependence.

- Systematic screening method is defined as: (1) asking the patient about their weekly use (alcoholic drinks per week); (2) asking the patient about their per occasion use (alcoholic drinks per drinking day); (3) using a standardized tool such as AUDIT, AUDIT-C, or CAGE; or (4) using another standardized tool.
- Brief counseling refers to one or more counseling sessions, a minimum of 5-15 minutes, which may include at least one of the following: (1) feedback on alcohol use and harms; (2) identification of high risk situations for drinking and coping strategies; or (3) increase the motivation to reduce drinking.
- Other follow-up care is defined as: (1) follow-up visit to the same provider for unhealthy alcohol use; (2) referral to other services for unhealthy alcohol use; or (3) visit with another provider for unhealthy alcohol use.
- The following does not meet criteria for brief counseling or other appropriate follow-up: (1) no assessment, counseling, or education about the risks of unhealthy alcohol use; (2) assessment or counseling prior to or after the reporting period; (3) Notation of “health education” or “anticipatory guidance” without any mention of specifics indicating that unhealthy alcohol use was addressed.
- Standardized screening tools include: AUDIT, CAGE, AUDIT-C, MDS7, LIFESTYLE (Drinking/Smoking) (Code for drinking or smoking), Alcohol Dependence Scale (ADS), Alcohol, Smoking, and Substance Abuse Involvement Screening Test (ASSIST), MacAndrew Alcoholism Scale (MAC – MAC-R), Michigan Alcoholism Screening Test (MAST), National Institute on Alcohol Abuse and Alcoholism (NIAAA) Alcohol Consumption Questions, Fast Alcohol Screening Test (FAST), Composite International Diagnostic Interview (CIDI), and Impaired Control Scale (ICS).
- MMPs should exclude members diagnosed with a terminal illness. A terminal illness is a progressive disease that cannot be cured or adequately treated, and where death as a consequence of that disease can be reasonably expected within 6 months. Common examples include: end stage heart disease, end stage lung disease, end stage liver disease, ALS, stroke/CVA, end stage renal disease, end stage HIV/AIDS, end stage Alzheimer’s disease.
- For data element B, MMPs should exclude:
    - Members who refuse to participate in the alcohol use screening, or
    - Members in an urgent or emergent situation due to a medical reason where time is of the essence and to delay treatment would jeopardize the member’s health status, or

  - Members whose functional capacity or motivation to improve may impact the accuracy of the results of the standardized assessment (e.g., certain court appointed cases of cases of delirium)
- For data element C, documentation in the medical record must include both a note indicating the date the screening for unhealthy alcohol use was performed and the result or finding.
- For data element D, documentation in the medical record must include both a note indicating the date when the screening for unhealthy alcohol use was performed and the result or finding indicating the member screened positive for unhealthy alcohol use. If more than one screening occurred during the current two-year reporting period, use the most recent screening.
- For data element E, MMPs should use the most recent documented unhealthy alcohol use screening with positive results including the encounter date. Documentation should indicate that brief counseling or other follow-up care was offered to the member within 30 days of the positive finding, including the encounter date.
- The date of the positive identification as an unhealthy alcohol user must occur within the reporting period, but the brief counseling or other follow-up care may or may not occur within the same reporting period. For example, if a member is positively identified as an unhealthy alcohol user during the last month of the reporting period, look to the first month of the following reporting period to determine if the member received brief counseling or other follow-up care within 30 days of the positive finding. If so, the member should be counted in data element E.

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

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

MA4.3 Tobacco use: screening and cessation.

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

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members who were continuously enrolled in the MMP during the current two-year reporting period who had at least one outpatient visit or telephonic evaluation during current two-year reporting period.	Total number of members who were continuously enrolled in the MMP between January 1 of the first year and December 31 of the second year in the current two-year reporting period who had at least one outpatient visit or telephonic evaluation during the current two-year reporting period.	Field Type: Numeric
B.	Total number of members sampled that met inclusion criteria.	Of the total reported in A, the number of members sampled that met inclusion criteria.	Field type: Numeric Note: Is a subset of A.
C.	Total number of members who were screened for tobacco use at least once during the current two-year reporting period .	Of the total reported in B, the number of members who were screened for tobacco use at least once during the current two-year reporting period.	Field Type: Numeric Note: Is a subset of B.
D.	Total number of members who were positively identified as a tobacco user during the current two-year reporting period.	Of the total reported in C, the number of members who were positively identified as a tobacco user based on results of the tobacco screening during the current two-year reporting period.	Field Type: Numeric Note: Is a subset of C.
E.	Total number of members who received a tobacco use cessation intervention within 30 days of the positive finding during the current two-year reporting period.	Of the total reported in D, the number of members who received a tobacco use cessation intervention within 30 days of the positive finding during the current two-year reporting period.	Field Type: Numeric Note: Is a subset of D.

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

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

C. Edits and Validation Checks - validation checks that should be performed by each MMP prior to data submission.
    - Confirm those data elements listed above as subsets of other elements.
    - MMPs should validate that data element B is less than or equal to data element A.
    - MMPs should validate that data element C is less than or equal to data element B.
    - MMPs should validate that data element D is less than or equal to data element C.
    - MMPs should validate that data element E is less than or equal to data element D.
    - 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 continuously enrolled in the MMP during the current two-year reporting period with at least one outpatient visit or telephonic evaluation during the current two-year reporting period who were screened for tobacco use at least once.
    - Members identified as a tobacco user who received a tobacco use cessation intervention within 30 days of the positive finding during the current two-year reporting period.

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

    - MMPs should include all members aged 21 years and older as of January 1 of the first year of the current reporting period, regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. A subset of all members that are eligible will be included in the sample. Medicaid-only members should not be included.
    - MMPs should only include members who were continuously enrolled in the MMP between January 1 of the first year and December 31st of the second year in the current two-year reporting period, with no more than one gap in enrollment of up to 45 days during each year of the two year reporting period (e.g., January 1, 2016 through December 31, 2016 and January 1, 2017 through December 31, 2017). 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).
        - When reporting the first two-year reporting period for this measure, January 1 – December 31, 2014 will be the first year and January 1 – December 31, 2015 will be the second year. A member can have no more than one gap in enrollment between January 1 – December 31, 2014 and no more than one gap in enrollment between January 1 – December 31, 2015 to be included in this measure.

- The reporting period for this measure is two years, but reporting will occur on an annual basis. The first reporting period will consist of data from CY14 and CY15, with the first data submission due six months after the end of CY15. The second reporting period will consist of data from CY15 and CY16 with data submission due six months after the end of CY16.
- For reporting, medical record review is required. Sampling should be systematic to ensure all eligible individuals have an equal chance of inclusion. The sample size should be 411, plus oversample to allow for substitution. For further instructions on selecting the sample size, please see page MA-8 of the introductory section of this document.
- For data element A, MMPs should use the Outpatient #1 value set to identify members with at least one outpatient visit during the reporting period. MMPs should use a designated field within the Centralized Enrollee Record (CER) to capture telephonic evaluations that occurred during the reporting period.
- The CER may be used to identify numerator events and exclusions.
- Types of tobacco are, but not limited to: cigarettes, cigars, pipe smoking, and smokeless tobacco.
- Tobacco use status is any documentation of active or current use of tobacco products, including smoking. Tobacco use status can be identified by any of the following criteria:
    - Documentation stating that the patient has been asked if they are one of the following during the reporting period:
        - Current tobacco user
        - Former tobacco user
        - Non-tobacco user
    - Documentation indicating that tobacco use was verified (for example, a Yes/No flag during the reporting period regardless of status of tobacco use)
- Cessation counseling intervention includes counseling or pharmacotherapy, combined counseling and pharmacotherapy, or referral to a tobacco use cessation program.
- MMPs should exclude members diagnosed with a terminal illness. A terminal illness is a progressive disease that cannot be cured or adequately treated, and where death as a consequence of that disease can be reasonably expected within 6 months. Common examples include: end stage heart disease, end stage lung disease, end stage liver disease, ALS, stroke/CVA, end stage renal disease, end stage HIV/AIDS, end stage Alzheimer's disease.
- For data element B, MMPs should exclude:
    - Members who refuse to participate in the tobacco use screening, or
    - Members in an urgent or emergent situation due to a medical reason where time is of the essence and to delay treatment would jeopardize the member's health status, or

    - Members whose functional capacity or motivation to improve may impact the accuracy of the results of the standardized assessment (e.g., certain court appointed cases or cases of delirium)
- For data element C, documentation in the medical record must include both a note indicating the date the tobacco use screening was performed and the result or finding. Any of the following meets criteria:
    - Notation about current or past behavior regarding tobacco use
    - Use of a checklist that tobacco use was addressed
- Any of the following do not meet criteria for data element C:
    - No assessment about the risks of tobacco usage
    - Assessment prior to or after the reporting period
    - Notation of "health education" or "anticipatory guidance" without any mention of specifics indicating that tobacco use was addressed
- For data element D, documentation in the medical record must include both a note indicating the date when the tobacco use screening was performed and the result or finding indicating that the member is a tobacco user.
- For data element E, documentation in the medical record must include one of the following:
    - A note indicating the date of tobacco cessation counseling or treatment
    - A note indicating the date of prescription of smoking cessation medication(s)
    - A note indicating the date of distribution of educational materials pertaining to tobacco use cessation
    - A note indicating the date of "anticipatory guidance" for tobacco use
- Any of the following do not meet criteria for data element E:
    - No assessment or counseling about the risks of tobacco usage
    - Assessment or counseling prior to or after the reporting period
    - Prescription or dispensing of medications that have uses beyond cessation (such as antidepressants) without any of the above documentation
    - Notation of "health education" or "anticipatory guidance" without any mention of specifics indicating that tobacco use was addressed
- The date of the positive identification as a tobacco user must occur within the reporting period, but the tobacco use cessation intervention may or may not occur within the same reporting period. For example, if a member is positively identified as a tobacco user during the last month of the reporting period, look to the first month of the following reporting period to determine if the member received a tobacco use cessation intervention within 30 days of the positive finding. If so, the member should be counted in data element E.

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

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

MA4.4 Medication reconciliation post-discharge.

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

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of inpatient discharges during the reporting period.	Total number of inpatient discharges that occurred between January 1 and December 1 during the reporting period.	Field Type: Numeric
B.	Total number of inpatient discharges sampled that met inclusion criteria.	Of the total reported in A, the number of inpatient discharges sampled that met inclusion criteria.	Field type: Numeric Note: Is a subset of A.
C.	Total number of inpatient discharges for which a medication reconciliation was conducted by a prescribing practitioner, clinical pharmacist or registered nurse on the date of discharge through 30 days following the inpatient discharge (31 days total).	Of the total reported in B, the number of inpatient discharges for which a medication reconciliation was conducted by a prescribing practitioner, clinical pharmacist or registered nurse on the date of discharge through 30 days following the inpatient discharge (31 days total).	Field Type: Numeric Note: Is a subset of B.

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

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

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

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

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

- CMS and the state will evaluate the percentage of inpatient discharges from January 1–December 1 of the reporting period for which a medication reconciliation was conducted by a prescribing practitioner, clinical pharmacist or registered nurse on the date of discharge through 30 days following the inpatient discharge during the reporting period (31 days total).

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

- MMPs should include all inpatient discharges for members aged 21 years and older[2], regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. A subset of all inpatient discharges for members that are eligible will be included in the sample. Medicaid-only members should not be included.
- For reporting, the MMPs may elect to use a hybrid methodology and select a sample. Sampling should be systematic to ensure all eligible individuals have an equal chance of inclusion. The sample size should be 411, plus oversample to allow for substitution. For further instructions on selecting the sample size, please see page MA-8 of the introductory section of this document.
- If an MMP does not elect to sample, data element B should be equal to data element A.
- MMPs should include all inpatient discharges that meet the criteria outlined in data element A for all members who were continuously enrolled from the date of discharge through 30 days after the discharge, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include discharges for all members regardless of whether the member was currently enrolled or disenrolled as of the last day of the reporting period).
- The denominator for this measure is based on discharges, not members. If a member has more than one discharge, include all discharges on or

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

between January 1 and December 1 of the reporting period. To identify acute and non-acute inpatient discharges:
    - Identify all acute and non-acute inpatient stays (Inpatient Stay value set)
    - Identify the discharge date for the stay
- Members may not have any gaps in continuous enrollment and need to be continuously enrolled from the date of the inpatient discharge through 30 days after the inpatient discharge to be included in this measure.
- Medication reconciliation is a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.
- For data element A, if the discharge is followed by a readmission or direct transfer to an acute or non-acute inpatient care setting on the date of discharge through 30 days after discharge (31 total days), count only the last discharge. To identify readmissions during the 31-day period:
    - Identify all acute and non-acute inpatient stays (Inpatient Stay value set)
    - Identify the admission date for the stay (the admission date must occur during the 31-day period)
    - Identify the discharge date for the stay (the discharge date is the event date)
- For data element A, exclude both the initial and the readmission/direct transfer discharges if the last discharge occurs after December 1 of the reporting period.
- If a member remains in an acute or non-acute care setting through December 1 of the reporting period, a discharge is not included in the measure for this member, but the MMP must have a method for identifying the member's status for the remainder of the reporting period, and may not assume the member remained admitted based only on the absence of a discharge before December 1. If the MMP is unable to confirm the member remained in the acute or non-acute care setting through December 1, disregard the readmission or direct transfer and use the initial discharge date.
- Members in hospice are excluded from the eligible population.

Administrative Specifications

- If the MMP elects to only use administrative data, please refer to the Medication Reconciliation value set to identify numerator positive hits when using administrative data.

Hybrid Specifications

- If the MMP elects to use hybrid sampling, refer to the *Administrative Specifications* to identify positive numerator hits from administrative data.
- When reviewing a member's medical record, any of the following evidence of medication reconciliation and the date when it was performed should be documented in the medical record to meet criteria for this measure:

  - Documentation that the provider reconciled the current and discharge medications;
  - Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications);
  - Documentation of the member's current medications with a notation that the discharge medications were reviewed;
  - Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service;
  - Evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review;
  - Documentation in the discharge summary that the discharge medications were reconciled with the current medications. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days);
  - Notation that no medications were prescribed or ordered upon discharge.
- Only documentation in the outpatient chart meets the intent of the measure, but an outpatient visit is not required.

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

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

MA4.5 Care for Adults

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

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

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

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

- CMS and the state will perform an outlier analysis.

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

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

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

D. Analysis - how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of members who had each of the following completed during the reporting period:

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

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

- MMPs should include all members aged 21 years and older[3], regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. A subset of all members that are eligible will be included in the sample. Medicaid-only members should not be included.
- For reporting, the MMPs may elect to use a hybrid methodology and select a sample. Sampling should be systematic to ensure all eligible individuals have an equal chance of inclusion. The sample size should be 411, plus oversample to allow for substitution. For further instructions on selecting the sample size, please see page MA-8 of the introductory section of this document.
- If an MMP does not elect to sample, data element B should be equal to data element A.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during the reporting period (i.e., January through December). To determine continuous enrollment for a 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).
- A medication list is a list of the member's medications in the medical record. The medication list may include medication names only or may include medication names, dosages and frequency, over-the-counter (OTC) medications and herbal or supplemental therapies.

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

- A medication review is a review of all a member's medications, including prescription medications, OTC medications, and herbal or supplemental therapies.
- A clinical pharmacist is a pharmacist with extensive education in the biomedical, pharmaceutical, socio-behavioral and clinical sciences. Clinical pharmacists are experts in the therapeutic use of medications and are a primary source of scientifically valid information and advice regarding the safe, appropriate and cost-effective use of medications. Most clinical pharmacists have a Doctor of Pharmacy (PharmD) degree and many have completed one or more years of post-graduate training (e.g., a general and/or specialty pharmacy residency). In some states, clinical pharmacists have prescriptive authority.
- A prescribing practitioner is a practitioner with prescribing privileges, including nurse practitioners, physician assistants and other non-MDs who have the authority to prescribe medications.
- Members in hospice are excluded from the eligible population.

Administrative Specifications

Medication Review

- If the MMP elects to only use administrative data to identify members with a medication review completed (data element C), any of the following meet criteria:
    - Both of the following on the same date of service during the reporting period:
        1. A least one medication review (Medication Review value set) conducted by a prescribing practitioner or clinical pharmacist
        2. The presence of a medication list in the medical record (Medication List value set)
    - Transitional care management services (TCM 7 Day value set; TCM 14 Day value set) during the reporting period.
- Transitional care management is a 30-day period that begins on the date of discharge and continues for the next 29 days. The date of service on the claim is the date of the face-to-face visit. Medication management must be furnished no later than the date of the face-to-face visit. To reduce reporting burden the date of the face-to-face visit (e.g., the claim date) is used as the medication management/review date.

Functional Status Assessment

- If the MMP elects to only use administrative data to identify members with a functional status assessment completed (data element D), please refer to the Functional Status Assessment value set to identify numerator positive hits when using administrative data.

Pain Assessment

- If the MMP elects to only use administrative data to identify members with a pain assessment completed (data element E), please refer to the Pain

Assessment value set to identify numerator positive hits when using administrative data.

Hybrid Specifications

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

Medication Review

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

Functional Status Assessment

- When reviewing a member's medical record, documentation must include evidence of a complete functional assessment and the date when it was performed.
- Notations for a complete functional status assessment must include one of the following:
  - Notation that Activities of Daily Living (ADL) were assessed or that at least five of the following were assessed: bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking.
  - Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances.
  - Result of assessment using a standardized functional status assessment tool, not limited to:
    1. SF-36®.
    2. Assessment of Living Skills and Resources (ALSAR).
    3. Barthel ADL Index Physical Self-Maintenance (ADLS) Scale.
    4. Bayer ADL (B-ADL) Scale.
    5. Barthel Index.
    6. Extended ADL (EADL) Scale.
    7. Independent Living Scale (ILS).
    8. Katz Index of Independence in ADL.
    9. Kenny Self-Care Evaluation.
    10. Klein-Bell ADL Scale.
    11. Kohlman Evaluation of Living Skills (KELS).

12. Lawton & Brody's IADL scales.
13. Patient Reported Outcome Measurement Information System (PROMIS) Global or Physical Function Scales

- Notation that at least three of the following four components were assessed:
  1. Cognitive status.
  2. Ambulation status.
  3. Hearing, vision and speech (i.e., sensory ability).
  4. Other functional independence (e.g., exercise, ability to perform job).

- A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) does not meet criteria for a comprehensive functional status assessment. The components of the functional status assessment numerator may take place during separate visits within the reporting period.

Pain Assessment

- When reviewing a member's medical record, documentation in the medical record must include evidence of a pain assessment and the date when it was performed.
- Notations for a pain assessment must include one of the following:
  - Documentation that the patient was assessed for pain (which may include positive or negative findings for pain).
  - Result of assessment using a standardized pain assessment tool, not limited to:
    1. Numeric rating scales (verbal or written)
    2. Face, Legs, Activity, Cry, Consolability (FLACC) scale.
    3. Verbal descriptor scales (5–7 Word Scales, Present Pain Inventory).
    4. Pain Thermometer.
    5. Pictorial Pain Scales (Faces Pain Scale, Wong-Baker Pain Scale).
    6. Visual analogue scale.
    7. Brief Pain Inventory.
    8. Chronic Pain Grade.
    9. PROMIS Pain Intensity Scale.
    10. Pain Assessment in Advanced Dementia (PAINAD) Scale.
- Notation of a pain management plan alone does not meet criteria.
- Notation of a pain treatment plan alone does not meet criteria.
- Notation of screening for chest pain alone or documentation of chest pain alone does not meet criteria.

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

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

MA4.6 Depression screening and follow-up.

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

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members who were continuously enrolled in the MMP who had at least one outpatient visit or telephonic evaluation during the reporting period.	Total number of members who were continuously enrolled in the MMP during the current reporting period who had at least one outpatient visit or telephonic evaluation during the reporting period.	Field Type: Numeric
B.	Total number of members sampled that met the inclusion criteria.	Of the total reported in A, the number of members sampled that met inclusion criteria.	Field type: Numeric Note: Is a subset of A.
C.	Total number of members who were screened for clinical depression using an age-appropriate standardized screening tool at least once during the reporting period.	Of the total reported in B, the number of members who were screened for clinical depression using an age-appropriate standardized screening tool at least once during the reporting period.	Field Type: Numeric Note: Is a subset of B.
D.	Total number of members who screened positive for clinical depression during the reporting period.	Of the total reported in C, the number of members who screened positive for clinical depression during the reporting period.	Field Type: Numeric Note: Is a subset of C.

Element Letter	Element Name	Definition	Allowable Values
E.	Total number of members who had a follow-up plan documented within 30 days of the positive depression finding.	Of the total reported in D, the number of members who had a follow-up plan documented within 30 days of the positive depression finding.	Field Type; Numeric Note: Is a subset of D.

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

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

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

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- MMPs should validate that data element C is less than or equal to data element B.
- MMPs should validate that data element D is less than or equal to data element C.
- MMPs should validate that data element E is less than or equal to data element D.
- 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 continuously enrolled in the MMP during the current reporting period with at least one outpatient visit or telephonic evaluation during the current reporting period who were screened for clinical depression using an age-appropriate standardized screening tool at least once during the reporting period.
- Members positively screened for clinical depression who had a follow-up plan documented within 30 days of the positive depression finding 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. A subset of all members that are eligible will be included in the sample. Medicaid-only members should not be included.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during the reporting period (i.e., January through

December). To determine continuous enrollment for a 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).

- For reporting, medical record review is required. Sampling should be systematic to ensure all eligible individuals have an equal chance of inclusion. The sample size should be 411, plus oversample to allow for substitution. For further instructions on selecting the sample size, please see page MA-8 of the introductory section of this document.
- The Centralized Enrollee Record (CER) may be used identify denominator and numerator events.
- Clinical Depression is not a specific term for a single diagnostic condition. Depressive disorders generally consist of major depressive disorder (MDD), dysthymia, and minor depression, but not other conditions with depressive features, such as bipolar disorder.
- A Standardized Depression Screening Tool is a normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the appropriate standardized depression screening tool utilized must be documented in the medical record.
- Active diagnosis refers to the principal diagnosis of an episode of care and should be present at the start of the episode of care.
- For data element A, MMPs should use the Outpatient #2 value set to identify members with at least one outpatient visit during the reporting period. MMPs should use a designated field within the CER to capture telephonic evaluations that occurred during the reporting period.
- For data element B, MMPs should exclude:
    - Members with documentation of an active diagnosis of depression (Major Depression value set) or bipolar disorder (Bipolar Disorder value set and Other Bipolar Disorder value set) during the reporting period.
    - Members with documentation of a depression screening conducted prior to the start of the reporting period who are undergoing treatment for depression.
    - Members with documentation of severe mental and/or physical incapacity where the member is unable to express himself/herself in a manner understood by others.
        - For example, cases such as delirium or severe cognitive impairment, where depression cannot be accurately assessed through the use of nationally recognized standardized depression assessment tools.
- For data element C, documentation in the medical record must include both of the following:
    - A note indicating the date when the depression screening was performed and the name of the standardized screening tool
    - The result or finding

- Standardized screening tools include: Patient Health Questionnaire (PHQ-9); Beck Depression Inventory (BDI or BDI-II); Center for Epidemiologic Studies Depression Scare (CES-D); Depression Scale (DEPS); Duke Anxiety-Depression Scale (DADS); Geriatric Depression Scale (GDS); Cornell Scale Screening; PRIME MD-PHQ2; MDS Section E. Mood and Behavior Patterns – Scoring a Positive Depression Screen (Indicators of Depression, Anxiety, Sad Mood with a score of 1 or 2 for questions 1a, 1d, or 1h AND Mood Decline with a score of Yes or 1 on the mood decline questions).
- A follow-up plan for a positive depression screening must include one or more of the following:
    - Additional evaluation for depression
    - Suicide risk assessment
    - Referral to a practitioner who is qualified to diagnose and treat depression
    - Pharmacological interventions
    - Other interventions or follow-up for the diagnosis or treatment of depression
- For data element E, documentation in the medical record must include both of the following:
    - A note indicating the date when the depression screening was performed and the positive result or finding
    - A note indicating the date and a plan for follow-up on the positive depression findings
        - Notation of counseling or referral for treatment for depression
        - Prescription of antidepressant medications or discussion of antidepressants for depression (not for off label uses such as smoking cessation)
        - Notation on counseling or symptoms of depression or where to get help
        - Notation of education on symptoms, treatment, or strategies to deal with depression
        - Distribution of educational material that may include symptoms of depression, treatment alternatives, red flag warnings, and where to get help
- The following are not positive findings for depression screening and follow-up:
    - No assessment or counseling or education on depression
    - Mental health treatment for other conditions
    - Assessment or counseling or education on depression prior or after the reporting period
    - Use of “psychiatric” or “mental health” check boxes or global statements of “normal” without indication that depression screening specifically included

  - Use of a checklist indicating mental health was addressed, without specific reference to depression
  - Notation of assessment or counseling or education of a single symptom, such as sleep patterns, without any reference to screening for other symptoms related to depression
- The date of the screening must occur within the reporting period, but the follow-up plan may or may not be completed within the same reporting period. For example, if a screening occurs during the last month of the reporting period, look to the first month of the following reporting period to determine if a follow-up plan was documented within 30 days of the positive depression finding. If so, the member should be counted in data element E.

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

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

Section MAV. Systems

MA5.1 ICO Centralized Enrollee Record.[i]

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
MA5. Systems	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
MA5. Systems	Annually	Contract	Calendar Year	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members whose race data are collected and maintained in the ICO Centralized Enrollee Record.	Total number of members enrolled at the end of the reporting period whose race data are collected and maintained in the ICO Centralized Enrollee Record.	Field Type: Numeric
B.	Total number of members whose ethnicity data are collected and maintained in the ICO Centralized Enrollee Record.	Total number of members enrolled at the end of the reporting period whose ethnicity data are collected and maintained in the ICO Centralized Enrollee Record.	Field Type: Numeric
C.	Total number of members whose primary language data are collected and maintained in the ICO Centralized Enrollee Record.	Total number of members enrolled at the end of the reporting period whose primary language data are collected and maintained in the ICO Centralized Enrollee Record.	Field Type: Numeric

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

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

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

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

- All data elements should be positive values.

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

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

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.

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

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

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

Section MAVI. Utilization

MA6.1 Chronic obstructive pulmonary disease (COPD) or asthma in older adults admission rate. (PQI #05)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
MA6. Utilization	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the sixth month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of member months for members age 40 and older.	Total number of member months during the reporting period for members age 40 and older.	Field Type: Numeric
B.	Total number of discharges for members age 40 years and older with a principal ICD-10-CM diagnosis code for COPD (excluding acute bronchitis); or a principal ICD-10-CM diagnosis code for asthma.	Of the total reported in A, the number of discharges for members age 40 years and older with a principal ICD-10 CM diagnosis code for COPD (excluding acute bronchitis); or a principal ICD-10-CM diagnosis code for asthma.	Field Type: Numeric

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

- CMS and the state 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.

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

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

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

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all member months for members who meet the criteria outlined in data element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The numerator for this measure is based on inpatient discharges, not members.
- Member months refers to the number of months each Medicare-Medicaid member was enrolled in the MMP in the year. Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable. Determine member months using the 1st of the month. This date must be used consistent from member to member, month to month and from year to year. For example, if Ms. X is enrolled in the organization on January 1, Ms. X contributes one member month in January.
- For data element A, use the members' age on the specified day of each month to determine the age group to which member months will be contributed. For example, if an MMP tallies members on the 1st of each month and Ms. X turns 40 on April 3 and is enrolled for the entire year, then she contributes eight months to the 40 and older age group category.
- To identify data element B, MMPs should include discharges for members age 40 years and older with either:
    - A principal ICD-10-CM diagnosis for COPD (excluding acute bronchitis) (COPD [Excluding Acute Bronchitis] value set); or
    - A principal ICD-10-CM diagnosis for Asthma (Asthma value set)
- For data element B, age is based on the date of admission.
- MMPs should exclude the following cases:

- Transfer from a hospital (different facility), a skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), or another health care facility (Admission Codes for Transfers value set)
- Obstetric admissions (Note: By definition, admissions with a principle diagnosis of COPD, asthma, or acute bronchitis are precluded from the assignment of MDC 14 by grouper software and, therefore, not included in this measure)
- With any listed ICD-10-CM diagnosis codes for cystic fibrosis and anomalies of the respiratory system (Cystic Fibrosis and Anomalies of Respiratory System value set)

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

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

MA6.2 Congestive heart failure (CHF) admission rate. (PQI #08)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
MA6. Utilization	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the sixth month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of member months for members age 18 and older.	Total number of member months during the reporting period for members age 18 and older.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of discharges for members age 18 years and older with a principal ICD-10-CM diagnosis code for heart failure.	Of the total reported in A, the number of discharges for members age 18 years and older with a principal ICD-10-CM diagnosis code for heart failure.	Field Type: Numeric

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

- CMS and the state 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.

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

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

- CMS and the state will evaluate the number of admissions (discharges) for members age 18 years and older with a principal ICD-10-CM diagnosis code for heart failure per 100,000 member months.

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

- MMPs should include all members aged 18 years and older[4], regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all member months for members who meet the criteria outlined in 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 numerator for this measure is based on inpatient discharges, not members.
- Member months refers to the number of months each Medicare-Medicaid member was enrolled in the MMP in the year. Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable. Determine member months using the 1st of the month. This

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

date must be used consistent from member to member, month to month and from year to year. For example, if Ms. X is enrolled in the organization on January 1, Ms. X contributes one member month in January.

- Age is based on date of admission.
- Codes to identify heart failure are provided in the Heart Failure value set.
- MMPs should exclude the following cases:
    - Transfer from a hospital (different facility), a skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), or another health care facility (Admission Codes for Transfers value set).
    - Obstetric admissions (Note: By definition, admissions with a principle diagnosis of COPD, asthma, or acute bronchitis are precluded from the assignment of MDC 14 by grouper software and, therefore, not included in this measure.
    - With any listed ICD-10-PCD procedure codes for cardiac procedure listed in the Cardiac Procedure value set.

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

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