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

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

Table of Contents

Ohio-Specific Reporting Requirements Appendix

Introduction

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

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

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

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

MMPs should contact the OH Help Desk at OHHelpDesk@norc.org with any questions about the Core Reporting Requirements, Ohio state-specific appendix, or the data submission process.

Definitions

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

Calendar Year: All annual measures are reported on a calendar year basis. Calendar year 2014 (CY1) will be an abbreviated year, with data reported for the time period beginning May 1, 2014 and ending December 31, 2014. Calendar year 2015 (CY2) will represent January 1, 2015 through December 31, 2015.

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

Implementation Period: The initial months of the demonstration during which plans will report to CMS and the state on a more intensive reporting schedule. The Implementation Period starts on the first effective enrollment date and continues until the end of the first 2015 calendar year quarter (May 1, 2014 – March 31, 2015).

Long Term Services and Supports (LTSS): A range of home and community based services designed to meet a beneficiary's need as an alternative to long term nursing facility care to enable a person to live as independently as possible. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping and transportation.

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

Ohio MyCare Demonstration Reporting Population

Because some members in Ohio receive Medicare and Medicaid coverage through MyCare Ohio while others receive only their Medicaid benefits through MyCare Ohio, the distinction between these members for reporting purposes is clarified as follows.

For the purpose of all core and state-specific reporting, Ohio MMPs are to report only on members enrolled to receive both Medicare and Medicaid benefits through the MMP. Ohio MMPs should only report on members who are enrolled in the MMP's Medicare-Medicaid MyCare program. MMPs should not include members who are enrolled in the Medicaid-only portion of MyCare. Of note, passive enrollment for the Medicare-Medicaid MyCare Demonstration in Ohio began in January 2015. Data reported after passive enrollment should include both Medicare-Medicaid members who opt in[2] and Medicare-Medicaid members who are passively enrolled into the MMP at any point. MMPs can identify this information on the enrollment file using the enrollment source codes in the CMS DTRR file. Code J represents state-submitted passive enrollment and Code L represents the opt-in population or MMP beneficiary election. Reporting of both core measures in HPMS and state-specific measures via the FAI Data Collection System should exclude data for members who are Medicaid-only and should only include Medicare-Medicaid dual enrollees.

[2] For the Ohio Capitated Financial Alignment Demonstration, "opt-in" specifically refers to members who choose to actively enroll in a MMP at any point during the demonstration. Passive enrollment does not include members who were are automatically enrolled into a Medicaid-only program with an affiliated MMP.

Variation from the Core Document

Core 2.1 and Core 2.2

Due to MyCare Ohio's inclusion of a Medicaid-only product, in addition to a Medicare-Medicaid product, there are some caveats to the reporting of the core measures that pertain to assessments (i.e., Core Measure 2.1 and Core Measure 2.2).

Some members who were previously enrolled in the MMPs' affiliated Medicaid-only programs were passively enrolled into the Medicare-Medicaid program on January 1, 2015. Since the assessments used in MyCare are the same regardless of whether a member is in a Medicaid-only product or the MMP, MMPs will not be required to complete an additional assessment for individuals who have previously received a comprehensive initial assessment in the Medicaid-only MyCare program or from another MyCare MMP. As such, for formerly Medicaid-only members with an initial assessment completed prior to January 2015, MMPs are to report those assessments as having been completed in the January 2015 monthly reporting period.

Similarly, if a member in a MyCare Medicaid-only product opted out of passive enrollment in January, but subsequently chose to opt in to an MMP affiliated with the plan in which they were previously enrolled, the MMP does not need to complete a new assessment as long as the prior assessment was completed less than one year prior to opting in to the MMP. In this case, the MMP should report the assessment as having been completed in the month of opt-in.

MMPs should refer to the Core reporting requirements for detailed specifications for reporting Core 2.1 and Core 2.2. For example, Core 2.1 should only include members whose 90th day of enrollment occurred during the reporting period. Members enrolled into the Medicare-Medicaid MyCare Program on January 1, 2015 would reach their 90th day (3 full months) on March 31, 2015. Therefore, these members would be reported in the data submission for the March monthly reporting period, even if their assessment was marked as complete in January 2015.

MMPs will be required to contact enrollees to ensure there are no changes to the health status or additional needs as a result of expanded coverage per the requirements in Section 2.5.3.2.3.7 of the three-way contract and update the member care plan as necessary. For instance, a person whose hypertension was well maintained under Medicare FFS and Medicare Part D may need support through transition to the new MMP. This information may have been captured in the assessment, but not specifically addressed since it was covered through a separate benefit. Necessary updates should be made to the member care plan. MMPs should not report these contacts through Core 2.1 or 2.2, however.

Core 2.3

For Core 2.3, Members with an annual reassessment, MMPs should determine whether members are eligible for an annual reassessment using the actual date an assessment was completed, even if that date occurred when the member was enrolled in the Medicaid-only MyCare program.

Core 9.2

The following section provides additional guidance about identifying individuals enrolled in the MMP that are "nursing home certifiable," or meeting the nursing facility level of care (NF LOC), 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). Ohio MMPs should consider any members who are enrolled in the MyCare Waiver and who are also in the Medicare-Medicaid product to be considered nursing home certifiable. As with all measures, members enrolled in the Medicaid-only product are not eligible to be reported in Core 9.2. MMPs should refer to the benefit plan code on the enrollment file to identify members who are enrolled in the MyCare Waiver.

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

Comprehensive Assessments

To determine if an assessment should be conducted for a member that re-enrolled in the same or a different MMP, the MMP should first determine if the member previously received an assessment from any plan in the MyCare Ohio program. If the member did receive an assessment and it was completed within one year of his/her most recent enrollment date, then the MMP is not necessarily required to conduct a new assessment. Instead, the MMP can:

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

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

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

If a change is identified, the MMP must update the prior assessment accordingly or conduct a new assessment within the timeframe prescribed by the contract. If there are no changes, the MMP is not required to revise or conduct the assessment unless requested by the member (or his/her authorized representative or provider). 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 revised or conducted the 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 an assessment was not completed for the re-enrolled member during his/her prior enrollment period in MyCare Ohio, 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 member was reported as 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 updates the prior assessment or 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 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 an ICP was not completed for the re-enrolled member during his/her prior enrollment period in MyCare Ohio, 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.

Annual Reassessments and ICP Updates

The MMP must follow contract requirements 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 assessment was actually completed, even if that date was during the member's prior enrollment period.

Quality Withhold Measures

CMS and the state will establish a set of quality withhold measures, and MMPs will be required to meet established thresholds. Throughout this document, state-specific quality withhold measures are marked with the following symbol for Demonstration Year 1: ([i]) and the following symbol for Demonstration Years 2 and 3: ([ii]). For more information about the state-specific quality withhold measures for Demonstration Year 1, refer to the Quality Withhold Technical Notes (DY 1): Ohio-Specific Measures at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html. Additional information on the withhold methodology and benchmarks for Demonstration Years 2 and 3 will be provided at a later time.

Reporting on Disenrolled and Retro-disenrolled Members

Unless otherwise indicated in the reporting requirements, MMPs should report on all Medicare-Medicaid 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 in which there is a lag between a member's effective disenrollment date and the date on which the MMP is informed about that disenrollment. This time lag might create occasional data inaccuracies if an MMP includes members in reports who had in fact disenrolled before the start of the reporting period. If MMPs are aware at the time of reporting that a member has been retro-disenrolled with a disenrollment

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

Value Sets

The measure specifications in this document refer to code value sets that must be used to determine and report measure data element values. A value set is the complete set of codes used to identify a service or condition included in a measure. The Ohio-Specific Value Sets Workbook includes all value sets and codes needed to report certain measures included in the Ohio-Specific Reporting Requirements and is intended to be used in conjunction with the measure specifications outlined in this document. The Ohio-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.

Ohio's Implementation, Ongoing, and Continuous Reporting Periods

Phase		Dates	Explanation
Demonstration Year 1			
Continuous Reporting	Implementation Period	5-1-14 through 3-31-15	From the first effective enrollment date through the end of the first quarter of 2015.
	Ongoing Period	5-1-14 through 12-31-15	From the first effective enrollment date through the end of the first demonstration year.
Demonstration Year 2			
Continuous Reporting	Ongoing Period	1-1-16 through 12-31-16	From January 1st through the end of the second demonstration year.
Demonstration Year 3			
Continuous Reporting	Ongoing Period	1-1-17 through 12-31-17	From January 1st through the end of the third demonstration year.

Data Submission

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

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

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

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

Resubmission of Data

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

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

2. After review of the request, the OH 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 OH HelpDesk again after resubmission has been completed.

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

Section OHI. Care Coordination

OH1.1 Members with care plans within 90 days of enrollment.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH1. 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**
OH1. 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 were documented as unwilling to complete a care plan within 90 days of enrollment.	Of the total reported in A, the number of members who were 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:

- Who were unable to be reached to have a care plan completed within 90 days of enrollment.
- Who refused to have a care plan completed within 90 days of enrollment.
- Who had a care plan completed within 90 days of enrollment.
- Who 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 enrolled voluntarily or was passively enrolled. Medicaid-only members should not be included.
- The 90th day of enrollment should be based on each member's enrollment effective date. For 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 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 whose 90th day of enrollment occurred within the reporting period regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- MMPs should refer to the Ohio three-way contract for specific requirements pertaining to a care plan.
- Members reported in data elements B, C, and D must also be reported in data element A since these data elements are subsets of data element A. Additionally, data elements B, C, and D should be mutually exclusive (e.g., a member reported in element B or C should not also be reported in element D). If a member could meet the criteria for multiple data elements (B, C, or D) use the following guidance to ensure the member is included in only one of those three elements:
    i. 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.
    ii. If a member was not reached after three outreach attempts, but then subsequently is reached and refuses 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):
    i. Affirmatively declines to participate in the care plan. Member communicates this refusal by phone, mail, fax, or in person.
    ii. Expresses willingness to complete the care plan but asks for it to be conducted after 90 days following the member's 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.

iii. 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.
iv. 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 OH 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 member's 90th day of enrollment occurred within the reporting period.
- For Medicare-Medicaid members who were formerly Medicaid-only members prior to enrollment into the Medicare-Medicaid product, MMPs are still required to contact enrollees to ensure that there are no changes to health status or additional needs as a result of expanded coverage. MMPs must make necessary updates to the care plan accordingly.

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.

OH1.2 Members with documented discussions of care goals.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH1. 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**
OH1. 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

Element Letter	Element Name	Definition	Allowable Values
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 with an initial care plan completed during the reporting period who had at least one documented discussion of care goals in the initial care plan.
- Existing 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 enrolled voluntarily or was passively enrolled. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all 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 members are disenrolled

as of the end of the reporting period (i.e., include all care plans regardless of whether the members are 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 a 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 Ohio 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.
- For Medicare-Medicaid members who were formerly Medicaid-only members prior to enrollment into the Medicare-Medicaid benefit plan, MMPs are still required to contact enrollees to ensure that there are no changes to health status or additional needs as a result of expanded coverage. MMPs must make necessary updates to the care plan accordingly.

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.

OH1.3 Members with first follow-up visit within 30 days of inpatient hospital discharge.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
OH1. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the fourth month following the last day of the reporting period

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

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

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

- CMS and the state will perform an outlier analysis.
- As data are received from 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 inpatient hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of the discharge from the hospital.

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

- MMPs should include all inpatient hospital discharges for members regardless of whether the member enrolled voluntarily or was passively enrolled. Medicaid-only members should not be included.
- MMPs should include all inpatient hospital discharges for members who meet the criteria outlined in data element A and who were continuously enrolled from the date of the hospital discharge through 30 days after the hospital discharge, regardless if they are disenrolled as of the end of the reporting period.
- The date of discharge must occur within the reporting period, but the follow-up may not be in the same reporting period. For example, if a discharge occurs during the last month of the reporting period, look to the first month of the following reporting period to identify the follow-up visit.
- The member needs to be enrolled from the date of the hospital discharge through 30 days after the hospital discharge, with no gaps in enrollment to be included in this measure.
- A follow-up visit is defined as an ambulatory care follow-up visit to assess the member's health following a hospitalization. Codes to identify follow-up visits are provided in the Ambulatory Visits value set and Other Ambulatory Visits value set. MMPs should report ambulatory care follow-up visits based on all visits identified, including denied and pended claims, and including encounter data as necessary in cases where follow-up care is included as part of a bundled payment covering the services delivered during the inpatient stay. MMPs should use all information available, including encounter data supplied by providers, to ensure complete and accurate reporting.
- To identify all inpatient discharges during the reporting period (data element A):
    i. Identify all acute and non-acute inpatient stays (Inpatient Stay value set).
    ii. Identify the discharge date for the stay. The date of discharge should be within the reporting period.

  MMPs should report discharges based on all inpatient stays identified, including denied and pended claims.
- Exclude discharges in which the patient was transferred directly or readmitted to an acute or non-acute facility on the date of the discharge or within 30 days after discharge. These discharges are

excluded because a re-hospitalization or transfer may prevent an outpatient follow-up visit from taking place. To identify readmissions to an acute or non-acute inpatient care setting:

i. Identify all acute and non-acute inpatient stays (Inpatient Stay value set).
ii. Identify the admission date for the stay. The date of admission should be within the reporting period or 30 days after the end of the reporting period.
iii. Determine if the admission date for the stay occurred within 30 days of a previous inpatient discharge. If yes, exclude the initial discharge.

For example, the following direct transfers/readmissions should be excluded from this measure:

- An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1 (a direct transfer)
- An inpatient discharge on June 1, followed by a readmission to a hospital on June 15 (readmission within 30 days)

- Exclude discharges due to death, using the Discharges due to Death value set.

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

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

Section OHII. Organizational Structure and Staffing

OH2.1 Waiver service coordinator training for supporting self-direction under the demonstration.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH2. Organizational Structure and Staffing	Annually	Contract	Calendar Year	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of waiver service coordinators.	Total number of waiver service coordinators employed for at least 30 days with the MMP during the reporting period.	Field Type: Numeric
B.	Total number of waiver service coordinators that have undergone MCOP training for supporting self-direction under the demonstration.	Of the total reported in A, the number of waiver service coordinators that have undergone MCOP 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 waiver service coordinators that have undergone MCOP 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 Ohio three-way contract for specific requirements pertaining to a waiver care coordinator.
- MMPs should refer to Section 2.5.3.3.5.4.1.5 of the Ohio three-way contract for specific requirements pertaining to training for supporting self-direction.
- A waiver service coordinator includes all full-time and part-time staff.
- If a waiver service coordinator was not currently with the MMP at the end of the reporting period, but was with the MMP for at least 30 days, they should be included in this measure.

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 OHIII. Performance and Quality Improvement

OH3.1 Long-term care overall balance.[ii]

Please note: No MMP reporting is required for this measure; however, MMPs must assist ODM with data collection and analysis as needed. The full specifications for this measure can be found in ODM's MyCare Ohio Rebalancing and Long Term Care Measures Methods document.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH3. Performance and Quality Improvement	Annually	Contract	Calendar Year	N/A

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

- Guidance will be forthcoming on the established benchmark, baseline, and methodology for this measure for Demonstration Years 2 and 3.

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

- CMS and the state will evaluate the total number of members residing in a nursing facility per 1,000 member months for members in the MMP during the measurement year.

OH3.2 Long-term care rebalancing.

Please note: No MMP reporting is required for this measure; however, MMPs must assist ODM with data collection and analysis as needed. The full specifications for this measure can be found in ODM's MyCare Ohio Rebalancing and Long Term Care Measures Methods document.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH3. Performance and Quality Improvement	Annually	Contract	Calendar Year	N/A

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

- CMS and the state will perform an outlier analysis.
- As rates are calculated over time, CMS and the state will apply threshold checks.

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

- CMS and the state will evaluate the percentage of nursing facility residents who were discharged to a community setting from a nursing facility and did not return to the nursing facility during the current reporting period as a proportion of members who resided in a nursing facility for 100 cumulative days or more during the previous reporting period.

OH3.3 Nursing facility residents whose need for help with Activities of Daily Living (ADLs) has increased.

Please note: No MMP reporting is required for this measure; however, MMPs must assist ODM with data collection and analysis as needed. The full specifications for this measure can be found in ODM's MyCare Ohio Rebalancing and Long Term Care Measures Methods document.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
OH3. Performance and Quality Improvement	Annually	Contract	Calendar Year	N/A

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

- CMS and the state will perform an outlier analysis.
- As rates are calculated over time, CMS and the state will apply threshold checks.

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

- CMS and the state will evaluate the percentage of long-stay residents whose need for help with late-loss Activities of Daily Living (ADLs) has increased when compared to the prior assessment.

OH3.4 Nursing facility residents who have/had a catheter inserted and left in their bladder.

Please note: No MMP reporting is required for this measure; however, MMPs must assist ODM with data collection and analysis as needed. The full specifications for this measure can be found in ODM's MyCare Ohio Rebalancing and Long Term Care Measures Methods document.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
OH3. Performance and Quality Improvement	Annually	Contract	Calendar Year	N/A

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

- CMS and the state will perform an outlier analysis.
- As rates are calculated over time, CMS and the state will apply threshold checks.

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

- CMS and the state will evaluate the percentage of long-stay residents who have/had an indwelling catheter in the last 7 days.

OH3.5 Nursing facility residents who were physically restrained.

Please note: No MMP reporting is required for this measure; however, MMPs must assist ODM with data collection and analysis as needed. The full specifications for this measure can be found in ODM's MyCare Ohio Rebalancing and Long Term Care Measures Methods document.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
OH3. Performance and Quality Improvement	Annually	Contract	Calendar Year	N/A

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

- CMS and the state will perform an outlier analysis.
- As rates are calculated over time, CMS and the state will apply threshold checks.

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

- CMS and the state will evaluate the percentage of long-stay nursing facility residents who are physically restrained on a daily basis.

OH3.6 Nursing facility residents experiencing one or more falls with a major injury.

Please note: No MMP reporting is required for this measure; however, MMPs must assist ODM with data collection and analysis as needed. The full specifications for this measure can be found in ODM's MyCare Ohio Rebalancing and Long Term Care Measures Methods document.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
OH3. Performance and Quality Improvement	Annually	Contract	Calendar Year	N/A

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

- CMS and the state will perform an outlier analysis.
- As rates are calculated over time, CMS and the state will apply threshold checks.

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

- CMS and the state will evaluate the percentage of long-stay residents who have experienced one or more falls with major injury reported in the reporting period or look-back period.

OH3.7 Nursing facility residents with a urinary tract infection.

Please note: No MMP reporting is required for this measure; however, MMPs must assist ODM with data collection and analysis as needed. The full specifications for this measure can be found in ODM's MyCare Ohio Rebalancing and Long Term Care Measures Methods document.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
OH3. Performance and Quality Improvement	Annually	Contract	Calendar Year	N/A

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

- CMS and the state will perform an outlier analysis.
- As rates are calculated over time, CMS and the state will apply threshold checks.

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

- CMS and the state will evaluate the percentage of long-stay residents who have a urinary tract infection.

OH3.8 Nursing facility diversion.[i, ii]

Please note: No MMP reporting is required for this measure; however, MMPs must assist ODM with data collection and analysis as needed. The full specifications for this measure can be found in ODM's MyCare Ohio Rebalancing and Long Term Care Measures Methods document.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH3. Performance and Quality Improvement	Annually	Contract	Calendar Year	N/A

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

- For Demonstration Year 1, the benchmark is a minimum 5% decrease in the performance year rate compared to the baseline rate for the MMP's demonstration population. For more information,

refer to the Quality Withhold Technical Notes (DY 1): Ohio-Specific Measures.
- For Demonstration Years 2 and 3, guidance will be forthcoming on the established benchmark, baseline, and methodology for this measure.

B. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
    - CMS and the state will evaluate the number of total patient days in a nursing facility per 1,000 member months for members in the MMP during the measurement year.

OH3.9 High-risk residents with pressure ulcers.

Please note: No MMP reporting is required for this measure; however, MMPs must assist ODM with data collection and analysis as needed. The full specifications for this measure can be found in ODM's MyCare Ohio Rebalancing and Long Term Care Measures Methods document.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH3. Performance and Quality Improvement	Annually	Contract	Calendar Year	N/A

A. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
    - CMS and the state will perform an outlier analysis.
    - As rates are calculated over time, CMS and the state will apply threshold checks.

B. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
    - CMS and the state will evaluate the percentage of long-stay, high-risk residents with Stage II through IV pressure ulcers.

Section OHIV. Systems

OH4.1 MyCare Centralized Enrollee Record.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH4. Organizational Structure and Staffing	Annually	Contract	Calendar Year	By the end of the second month following the last day of the reporting period

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

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

- Race data are collected and maintained in the MyCare Centralized Enrollee Record.
- Ethnicity data are collected and maintained in the MyCare Centralized Enrollee Record.
- Primary language data are collected and maintained in the MyCare Centralized Enrollee Record.
- Homelessness data are collected and maintained in the MyCare Centralized Enrollee Record.
- Disability type data are collected and maintained in the MyCare 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 enrolled voluntarily or was passively enrolled. Medicaid-only members should not be included.
- For all data elements, please include the total number of members whose status is document in the MyCare Centralized Enrollee Record, regardless of the value.
    i. For example, data element D captures the number of members whose homelessness data are collected and maintained in the MyCare 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 OHV. Utilization

OH5.1 Unduplicated members receiving HCBS and unduplicated members receiving nursing facility services.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
OH5. Utilization	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members.	Total number of members that were continuously enrolled in the MMP for six months during the reporting period.	Field Type: Numeric
B.	Total number of members receiving HCBS.	Of the total reported in A, the number of members receiving HCBS during the reporting period who did not receive nursing facility services during the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members receiving nursing facility services.	Of the total reported in A, the number of members receiving nursing facility services during the reporting period who did not receive HCBS during the reporting period.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of members receiving both HCBS and nursing facility services during the reporting period.	Of the total reported in A, the number of members receiving both HCBS and nursing facility services during the reporting period.	Field Type: Numeric Note: Is a subset of A.

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

- CMS and the state will perform an outlier analysis.
- As data are received from 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 obtain enrollment data and will evaluate the percentage of members receiving:

- HCBS during the reporting period who did not receive nursing facility services during the reporting period.
- Nursing facility services during the reporting period who did not receive HCBS during the reporting period.
- Both HCBS and nursing facility services 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 enrolled voluntarily or was passively enrolled. 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).
- Members must be continuously enrolled for six months during the reporting period, with no gaps in enrollment, to be included in this measure.

- Members receiving only HCBS should be counted for data element B (unduplicated). Members receiving only nursing facility services should be counted for data element C (unduplicated). Members receiving both HCBS and nursing facility services should be counted for data element D (unduplicated). Data elements B, C, and D are mutually exclusive.
- Unduplicated means a member should only be counted once for the type of service they receive. For example, if a member received nursing facility services in two different facilities during the reporting period, they would only count once toward members receiving nursing facility services during the reporting period (data element C).
- Include members who were receiving HCBS or nursing facility services for any length of time during the reporting period.
- HCBS refers to Home and Community Based Services. MMPs should refer to the MyCare Waiver Procedure Codes document shared by the state, containing waiver procedure codes, modifiers, and service descriptions to identify services that fall under HCBS.
- Nursing facility services include any type of nursing facility care, including skilled and custodial services.

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.