MEDICARE-MEDICAID CAPITATED FINANCIAL ALIGNMENT MODEL REPORTING REQUIREMENTS: SOUTH CAROLINA-SPECIFIC REPORTING REQUIREMENTS

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

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South Carolina-Specific Reporting Requirements Appendix

Introduction

The measures in this appendix are required reporting for all MMPs in the South Carolina Healthy Connections Prime 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 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 SC Help Desk at SCHelpDesk@norc.org with any question about the South Carolina 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 (CY): 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.

Demonstration Year (DY): The unit of time used in calculating savings percentages and quality withhold percentages:

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

Demonstration Year 1: February 1, 2015 - December 31, 2016
Demonstration Year 2: January 1, 2017 - December 31, 2017
Demonstration Year 3: January 1, 2018 - December 31, 2018

HCBS: Waiver-specific services provided to individuals enrolled in the CLTC waiver programs. Services are listed at: https://www.scdhhs.gov/historic/insideDHHS/Bureaus/BureauofLongTermCareServices/CLTCOverview.html

HCBS-like Services: Services typically provided only under the CLTC waiver programs. When these services are provided to individuals who do not meet the level of care requirements to receive these services as part of the waiver, the services are considered "HCBS-like" services. Services are listed at: https://www.scdhhs.gov/historic/insideDHHS/Bureaus/BureauofLongTermCareServices/CLTCOverview.html

Implementation Period: The period of time starting with the first effective enrollment date until December 31, 2015.

Long Term Services and Supports (LTSS): A variety of services and supports that help elderly individuals and/or individuals 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.

Variations from the Core Document

Core 9.2

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

Core 9.2 focuses on "nursing home certifiable" members, defined as "members living in the community, but requiring an institutional level of care" (see the Core Reporting Requirements for more information). SC MMPs should refer to the nursing facility level of care definition in the Division of Community Long Term Care Community Choice Policy and Procedure Manual (available at

https://phoenix.scdhhs.gov/files/policy/ch_3_loc.pdf). Individuals meeting either the skilled level of care or the intermediate level of care, as described in the chapter, should be reported as meeting an institutional level of care.

For reporting in Core 9.2, MMPs must confirm that such members are living in the community and not in long-term nursing facility stays.

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): South Carolina-Specific Measures at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html. Additional information on the withhold methodology and benchmarks for Demonstration Years 2 and 3 will be provided at a later time.

Reporting on Disenrolled and Retro-disenrolled Members

Unless otherwise indicated in the reporting requirements, MMPs should report on all members enrolled in the demonstration who meet the definition of the data elements, regardless of whether that member was subsequently disenrolled from the 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 in its reports members who had in fact disenrolled before the start of the reporting period. If MMPs are aware at the time of reporting that a member has been retro-disenrolled with a disenrollment effective date prior to the reporting period (and, therefore, was not enrolled during the reporting period in question), then MMPs may exclude that member from reporting. Please note that MMPs are ***not*** required to re-submit corrected data should they be informed of a retro-disenrollment subsequent to a reporting deadline. MMPs should act upon their best and most current knowledge at the time of reporting regarding each member's enrollment status.

Reporting on Comprehensive Assessments and ICPs Completed Prior To First Effective Enrollment Date

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

For purposes of reporting data on assessments (Core 2.1, Core 2.2 and state-specific measures SC1.1 and SC1.2), MMPs should report assessments completed prior to the first effective enrollment date as if they were completed on the first effective enrollment date. For example, if a member's first effective enrollment date was June 1 and the assessment for that member was completed on May 25, the MMP should report the assessment as if it were completed on June 1.

MMPs should refer to the Core reporting requirements for detailed specifications for reporting Core 2.1 and Core 2.2 and to the state-specific reporting requirements for specifications on reporting SC1.1 and SC1.2. For example, Core 2.1 should only include members whose 90th day of enrollment occurred during the reporting period. Members enrolled into the MMP on March 1, 2015, would reach their 90th day (i.e., three full months) on May 31, 2015. Therefore, these members would be reported in the data submission for the May monthly reporting period, even if their assessment was marked as complete on the first effective enrollment date (i.e., March 1).

MMPs must comply with contractually specified timelines regarding completion of Individualized Care Plans (ICPs) within 90 days of enrollment. In the event that an ICP is also finalized prior to the first effective enrollment date, MMPs should report completion of the ICP (for measures SC2.1 and SC2.2) as if they were completed on the first effective enrollment date. For example, if a member's first effective enrollment date was June 1 and the ICP for that member was completed on May 27, the MMP should report the ICP as if it were completed on June 1.

Guidance on Comprehensive Assessments and ICPs for Members with a Break in Coverage

<u>Comprehensive Assessments</u>

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 review the member's Phoenix case management record to determine if the member previously received an assessment from any MMP in the Healthy Connections Prime program. If the member did receive an assessment that is included in

Phoenix, 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 conduct a new assessment within the timeframe prescribed by the contract. 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 (and the applicable state-specific measures). When reporting these measures, the MMP should count the number of enrollment 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 Healthy Connections Prime, 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 completed 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 and loaded into Phoenix for the re-enrolled member during his/her prior enrollment period in Healthy Connections Prime, or if it has been more than one year since the member's ICP was completed, the MMP is required to complete 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.

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

South Carolina's Implementation, Ongoing, and Continuous Reporting Periods

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

Data Submission

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

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

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

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

Resubmission of Data

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

1. Email the SC HelpDesk (SCHelpDesk@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 SC 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 SC 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 SCI. Assessment

SC1.1 Low-risk members with a comprehensive assessment completed within 90 days of enrollment.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
SC1. Assessment	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**
SC1. Assessment	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of low-risk members enrolled whose 90th day of enrollment occurred within the reporting period.	Total number of low-risk members enrolled whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric
B.	Total number of low-risk members who are documented as unwilling to participate in the comprehensive assessment within 90 days of enrollment.	Of the total reported in A, the number of low-risk members who are documented as unwilling to participate in the comprehensive assessment 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 low-risk members the MMP was unable to reach, following three documented attempts within 90 days of enrollment.	Of the total reported in A, the number of low-risk members the MMP was unable to reach, following three documented attempts within 90 days of enrollment.	Field type: Numeric Note: Is a subset of A.
D.	The number of low-risk members with a comprehensive assessment completed within 90 days of enrollment.	Of the total reported in A, the number of low-risk members with a comprehensive assessment 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 low-risk members who:

- Were unable to be reached following three documented attempts to have their comprehensive assessment completed within 90 days of enrollment.
- Were unwilling to participate in a comprehensive assessment within 90 days of enrollment.
- Had a comprehensive assessment completed within 90 days of enrollment.
- Were willing to participate and who could be reached who had a comprehensive assessment 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. 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 include members classified as low-risk on the first effective date of enrollment in this measure, even if the member is reclassified as moderate- or high-risk within the first 90 days of enrollment.
- Members reported in data elements B, C, and D must also be reported in data element A since these data elements are subsets of data element A. Additionally, data elements B, C, and D should be mutually exclusive (e.g., a member reported in element B or C should not also be reported in element D). If a member could meet the criteria for multiple data elements (B, C, or D) use the following guidance to ensure the member is included in only one of those three elements:
    - If a member initially refused the assessment or could not be reached after three outreach attempts, but then subsequently completes the assessment within 90 days of enrollment, the member should be classified in data element D.
    - If a member was not reached after three outreach attempts, but then subsequently is reached and refuses the assessment within 90 days of enrollment, the member should be classified in data element B.
- MMPs should refer to the South Carolina three-way contract for specific requirements pertaining to criteria for identifying low-risk members.
- MMPs should refer to the South Carolina three-way contract for specific requirements pertaining to a comprehensive assessment.
- For data element B, MMPs should report the number of members who were unwilling to participate in the comprehensive assessment if a member (or his or her authorized representative):
    - Affirmatively declines to participate in the assessment. Member communicates this refusal by phone, mail, fax, or in person.

  - Expresses willingness to complete the assessment but asks for it to be conducted after 90 days (despite being offered a reasonable opportunity to complete the assessment within 90 days). Discussions with the members must be documented by the MMP.
  - Expresses willingness to complete the assessment, but reschedules or is a no-show and then is subsequently non-responsive. Attempts to contact the member must be documented by the MMP.
  - Initially agrees to complete the assessment, but then declines to answer a majority of the questions in the assessment.

- For data element C, MMPs should report the number of members the MMP was unable to reach after three attempts to contact the member. MMPs should refer to the SC 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 members contact information is correct, yet that member is not responsive to the MMPs 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 an assessment within 90 days of enrollment. For example, a member may be medically unable to respond and have no authorized representative to do so on their behalf, or a member may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for an assessment. However, MMPs should not include such members in the counts for data elements B and C.
- If a member's assessment was started but not completed within 90 days of enrollment, then the assessment 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.

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.

SC1.2 Moderate- and high-risk members with a comprehensive assessment completed within 60 days of enrollment.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
SC1. Assessment	Monthly, beginning after 60 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**
SC1. Assessment	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of moderate- and high-risk members enrolled whose 60th day of enrollment occurred within the reporting period.	Total number of moderate- and high-risk members enrolled whose 60th day of enrollment occurred within the reporting period.	Field Type: Numeric
B.	Total number of moderate- and high -risk members who are documented as unwilling to participate in the comprehensive assessment within 60 days of enrollment.	Of the total reported in A, the number of moderate- and high -risk members who are documented as unwilling to participate in the comprehensive assessment within 60 days of enrollment.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of moderate- and high -risk members the MMP was unable to reach, following three documented attempts within 60 days of enrollment.	Of the total reported in A, the number of moderate- and high -risk members the MMP was unable to reach, following three documented attempts within 60 days of enrollment.	Field type: Numeric Note: Is a subset of A.
D.	The number of moderate- and high -risk members with a comprehensive assessment completed within 60 days of enrollment.	Of the total reported in A, the number of moderate- and high -risk members with a comprehensive assessment completed within 60 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 moderate- and high-risk member who:

- Were unable to be reached to have their comprehensive assessment completed within 60 days of enrollment.
- Were unwilling to participate in a comprehensive assessment within 60 days of enrollment.
- Had a comprehensive assessment completed within 60 days of enrollment.
- Were willing to participate and who could be reached who had a comprehensive assessment completed within 60 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 60th day of enrollment should be based on each member's effective date. For the purposes of reporting this measure, 60 days of enrollment will be equivalent to two full calendar months.
- The effective date of enrollment is the first date of the member's coverage through the MMP.
- MMPs should include members classified as moderate- or high-risk on the first effective date of enrollment in this measure, even if the member is reclassified as low-risk within the first 60 days of enrollment.
- Members reported in data elements B, C, and D must also be reported in data element A since these data elements are subsets of data element A. Additionally, data elements B, C, and D should be mutually exclusive (e.g. a member reported in element B or C should not also be reported in element D). If a member could meet the criteria for multiple data elements (B, C, or D) use the following guidance to ensure the member is included in only one of those three elements:
    - If a member initially refused the assessment or could not be reached after three outreach attempts, but then subsequently completes the assessment within 60 days of enrollment, the member should be classified in data element D.
    - If a member was not reached after three outreach attempts, but then subsequently is reached and refuses the assessment within 60 days of enrollment, the member should be classified in data element B.
- MMPs should refer to the South Carolina three-way contract for specific requirements pertaining to criteria for identifying moderate- and high-risk members.
- MMPs should refer to the South Carolina three-way contract for specific requirements pertaining to a comprehensive assessment.
- For data element B, MMPs should report the number of members who were unwilling to participate in the comprehensive assessment if a member (or his or her authorized representative):

  - Affirmatively declines to participate in the assessment. Member communicates this refusal by phone, mail, fax, or in person.
  - Expresses willingness to complete the assessment but asks for it to be conducted after 60 days (despite being offered a reasonable opportunity to complete the assessment within 60 days). Discussions with the member must be documented by the MMP.
  - Expresses willingness to complete the assessment, but reschedules or is a no-show and then is subsequently non-responsive. Attempts to contact the member must be documented by the MMP.
  - Initially agrees to complete the assessment, but then declines to answer a majority of the questions in the assessment.

- For data element C, MMPs should report the number of members the MMP was unable to reach after three attempts to contact the member. MMPs should refer to the SC 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 members contact information is correct, yet that member is not responsive to the MMPs 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 an assessment within 60 days of enrollment. For example, a member may be medically unable to respond and have no authorized representative to do so on their behalf, or a member may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for an assessment. However, MMPs should not include such members in the counts for data elements B and C.
- If a member's assessment was started but not completed within 60 days of enrollment, then the assessment 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.

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.

SC1.3 Suicide risk assessment (PCPI Measure #2, Adult Major Depressive Disorder set).

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
SC1. Assessment	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 aged 21 years and older with a diagnosis of new or recurrent episode of major depressive disorder.	Total number of members aged 21 years and older with a diagnosis of new or recurrent episode of major depressive disorder during 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 with a suicide risk assessment completed during the visit in which a diagnosis of new or recurrent episode was identified.	Of the total reported in B, the number of members with a suicide risk assessment completed during the visit in which a diagnosis of new or recurrent episode was identified.	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 and greater than or equal to data element C.
- 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 members aged 21 years and older with a suicide risk assessment completed during the visit in which a diagnosis of new or recurrent episode of major depressive disorder was identified.

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 members that are eligible will be included in the sample. 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 reporting, the MMPs may elect to sample since this measure requires documentation review to identify the numerator. 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 the Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements on the CMS website: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans
- If MMPs do not elect to sample, data element B should be equal to data element A.
- For data element A, members must have a diagnosis of major depressive disorder and have a patient encounter during the reporting period.
    - Codes to identify a single episode or recurrent episode of major depressive disorder are provided in the Major Depression value set.

    - Codes to identify a member encounter/visit during the reporting period are provided in the Patient Encounter value set.
- For data element C, members must have a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.
    - Codes to identify members with a suicide risk assessment completed are provided in the Suicide Risk Assessment value set or MMPs may elect to perform a documentation record review.
- The suicide risk assessment must include questions about the following:
    - Suicidal ideation
    - Member's intent of initiating a suicide attempt

  And, if either of these are present, questions about:
    - Member's plans for a suicide attempt
    - Whether the member has means for completing suicide
- Codes to identify members with a suicide risk assessment completed are provided in the Suicide Risk Assessment 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 SCII. Care Coordination

SC2.1 Low-, moderate-, and high-risk members with an Individualized Care Plan (ICP) completed within 90 days of enrollment.[i]

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
SC2. 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**
SC2. 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 low-risk members enrolled whose 90th day of enrollment occurred within the reporting period.	Total number of low-risk members enrolled whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric
B.	Total number of low-risk members who are documented as unwilling to complete an ICP within 90 days of enrollment.	Of the total reported in A, the number of low-risk members who are documented as unwilling to complete an ICP 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 low-risk members the MMP was unable to reach, following three documented attempts within 90 days of enrollment.	Of the total reported in A, the number of low-risk members the MMP was unable to reach, following three documented attempts within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of low-risk members with an ICP completed within 90 days of enrollment.	Of the total reported in A, the number of low-risk members with an ICP completed within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A.
E.	Total number of moderate-risk members enrolled whose 90th day of enrollment occurred within the reporting period.	Total number of moderate-risk members enrolled whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric
F.	Total number of moderate-risk members who are documented as unwilling to complete an ICP within 90 days of enrollment.	Of the total reported in E, the number of moderate-risk members who are documented as unwilling to complete an ICP within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of E.
G.	Total number of moderate-risk members the MMP was unable to reach, following three documented attempts within 90 days of enrollment.	Of the total reported in E, the number of moderate-risk members the MMP was unable to reach, following three documented attempts within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of E.
H.	Total number of moderate-risk members with an ICP completed within 90 days of enrollment.	Of the total reported in E, the number of moderate-risk members with an ICP completed within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of E.

Element Letter	Element Name	Definition	Allowable Values
I.	Total number of high-risk members enrolled whose 90th day of enrollment occurred within the reporting period.	Total number of high-risk members enrolled whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric
J.	Total number of high-risk members who are documented as unwilling to complete an ICP within 90 days of enrollment.	Of the total reported in I, the number of high-risk members who are documented as unwilling to complete an ICP within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of I.
K.	Total number of high-risk members the MMP was unable to reach, following three documented attempts within 90 days of enrollment.	Of the total reported in I, the number of high-risk members the MMP was unable to reach, following three documented attempts within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of I.
L.	Total number of high-risk members with an ICP completed within 90 days of enrollment.	Of the total reported in I, the number of high-risk members with an ICP completed within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of I.

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

- The quality withhold benchmark for DY 1 is set at the percentage achieved by the highest scoring MMP minus 10 percentage points. For withhold purposes, the measure is calculated as follows:
    - Denominator: The total number of low, moderate, and high-risk members whose 90th day of enrollment occurred within the reporting period, excluding the total number of low, moderate, and high-risk members who were documented as unwilling to complete an ICP within 90 days of enrollment and the total number of low, moderate, and high-risk members the MMP was unable to reach, following three documented attempts within 90 days of enrollment (data elements A + E + I – B – C – F – G – J – K) summed over the applicable number of quarters.

    - Numerator: The total number of low, moderate, and high-risk members with an ICP completed within 90 days of enrollment (data elements D + H + L) summed over the applicable number of quarters.
- For more information, refer to the Quality Withhold Technical Notes (DY 1): South Carolina-Specific Measures.

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

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data elements B, C, and D are less than or equal to data element A.
- MMPs should validate that data elements F, G, and H are less than or equal to data element E.
- MMPs should validate that data elements J, K, and L are less than or equal to data element I.
- 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:

- Low-risk members who were unable to be reached to have an ICP completed within 90 days of enrollment.
- Low-risk members who refused to have an ICP completed within 90 days of enrollment.
- Low-risk members who had an ICP completed within 90 days of enrollment.
- Low-risk members who were willing to participate and who could be reached who had an ICP completed within 90 days of enrollment.
- Moderate-risk members who were unable to be reached to have an ICP completed within 90 days of enrollment.
- Moderate-risk members who refused to have an ICP completed within 90 days of enrollment.
- Moderate-risk members who had an ICP completed within 90 days of enrollment.
- Moderate-risk members who were willing to participate and who could be reached who had an ICP completed within 90 days of enrollment.
- High-risk members who were unable to be reached to have a ICP completed within 90 days of enrollment.
- High-risk members who refused to have an ICP completed within 90 days of enrollment.
- High-risk members who had an ICP completed within 90 days of enrollment.

- High-risk members who were willing to participate and who could be reached who had an ICP 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 low-, moderate-, and high-risk 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 elements A, E, and I 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. 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.
- Members reported in data elements B, C, and D (low-risk members), F, G and H (moderate-risk members), and J, K and L (high-risk members) must also be reported in data elements A (low-risk), E (moderate-risk) or I (high-risk), respectively, since these data elements are each subsets of data elements A, E, and I. Additionally, subset data elements should be mutually exclusive (e.g., a member reported in element B or C should not also be reported in element D). This is true for data elements B, C and D for low-risk members; data elements F, G and H for moderate-risk members; and J, K, and L for high-risk members. If a member could meet the criteria for multiple data elements, use the following guidance to ensure the member is included in only one of those three elements:
    - If a member initially refused the ICP or could not be reached after three outreach attempts, but then subsequently completes the ICP within 90 days of enrollment, the member should be classified in data element D, H, or L depending on his or her risk level.
    - If a member was not reached after three outreach attempts, but then subsequently is reached and refuses to complete the ICP within 90 days of enrollment, the member should be classified in data element B, F, or J depending on his or her risk level.
- MMPs should refer to the South Carolina three-way contract for specific requirements to identify low-, moderate-, and high-risk members.

- MMPs should refer to the South Carolina three-way contract for specific requirements pertaining to an ICP.
- Low-, moderate-, and high-risk members should be classified based off of the risk category determined using predictive modeling and surveillance data, which can be supplemented by the health risk screening. MMPs can also utilize demographics, medical conditions, functional status, care patterns, resource utilization data along with hierarchical condition categories (HCC) risk scores.
- MMPs should categorize members into a single risk classification level (i.e., low-, moderate-, or high-risk) based on their classification level on the first effective date of enrollment in this measure, even if the member is reclassified to another risk level within the first 90 days of enrollment.
- For data elements B, F, and J, MMPs should report the number of members who were unwilling to participate in the development of the ICP if a member (or his or her authorized representative):
    - Affirmatively declines to participate in the ICP. Member communicates this refusal by phone, mail, fax, or in person.
    - Expresses willingness to complete the ICP but asks for it to be conducted after 90 days following the completion of the assessment (despite being offered a reasonable opportunity to complete the ICP within 90 days). Discussions with the member must be documented by the MMP.
    - Expresses willingness to complete the ICP, 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 ICP, but then declines to answer a majority of the questions in the ICP.
- For data elements C, G, and K, 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 SC 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 ICP 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 ICP. However, MMPs should not include such members in the counts for data elements B, C, F, G, J, or K.

- If a ICP was started but not completed within 90 days of enrollment, then the ICP should not be considered completed and, therefore, would not be counted in data elements B, C, D, F, G, H, J, K, or L. However, this member would be included in data elements A, E, and I.
- Low-risk members will have their ICP continuously monitored and reviewed every 120 days.
- Moderate-risk members will have their ICP continuously monitored and reviewed every 90 days.
- High-risk members will have their ICP continuously monitored and reviewed every 30 days.

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.

SC2.2 Members with an ICP completed.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
SC2. 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**
SC2. 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, including examples, methods for calculations, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members enrolled for 90 days or longer as of the end of the reporting period.	Total number of members enrolled for 90 days or longer as of the end of the reporting period.	Field Type: Numeric
B.	Total number of members who had an ICP completed.	Of the total reported in A, the number of members who had an ICP completed as of the end of 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 element B is less than or equal to data element A.
- All data elements should be positive values.

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

- CMS and the state will evaluate the percentage of members enrolled for 90 days or longer who had an ICP completed as of the end of the reporting period.

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

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

- The effective date of enrollment is the first date of the member's coverage through the MMP.
- The ICPs reported in element B could have been completed at any time after enrollment, not necessarily during the reporting period.
- MMPs should refer to the South Carolina three-way contract for specific requirements pertaining to ICPs.

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

- 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.

SC2.3 Members eligible for HCBS with an approved waiver service plan within 90 days of enrollment.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
SC2. Care Coordination	Quarterly, beginning in the quarter in which responsibility for HCBS waiver service plan development is transitioned to the MMPs	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members whose 90th day of enrollment in the HCBS waiver occurred within the reporting period.	Total number of members whose 90th day of enrollment in the HCBS waiver occurred within the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of members with a waiver service plan approved within 90 days of enrollment in the HCBS waiver.	Of the total reported in A, the number of members with a waiver service plan approved within 90 days of enrollment in the HCBS waiver.	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 members with a waiver service plan approved within 90 days of enrollment in the HCBS waiver.

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 in the HCBS waiver, as opposed to enrollment into the MMP. For the purposes of reporting this measure, 90 days of enrollment will be equivalent to 90 calendar days.
- The effective date of enrollment is the first date of the member's coverage through the HCBS waiver.

- MMPs should refer to the South Carolina three-way contract for specific requirements pertaining to a waiver service plan.

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.

SC2.4 Members with first follow-up visit within 30 days of hospital discharge.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
SC2. 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 hospital discharges.	Total number of hospital discharges during the reporting period.	Field Type: Numeric
B.	Total number of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge from the hospital.	Of the total reported in A, the number of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge from the hospital.	Field Type: Numeric 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 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 members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all hospital discharges for members who meet the criteria outlined in data element A and who were continuously enrolled from the date of the hospital discharge through 30 days after the hospital discharge, regardless if they are disenrolled as of the end of the reporting period.
- The date of discharge must occur within the reporting period, but the follow-up visit may not be in the same reporting period. For example, if a discharge occurs during the last month of the reporting period, look to the first month of the following reporting period to identify the follow-up visit.
- 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 and Other Ambulatory Visits value set. MMPs should report ambulatory care follow-up visits based on all visits identified, including denied and pended claims, and including encounter data as necessary in cases where follow-up care is included as part of a bundled payment covering the services delivered during the inpatient stay. MMPs should use all information available, including encounter data supplied by providers, to ensure complete and accurate reporting.

- To identify all inpatient discharges during the reporting period (data element A):
    - Identify all acute and non-acute inpatient stays (Inpatient Stay value set).
    - Identify the discharge date for the stay. The date of discharge should be within the reporting period.

  MMPs should report discharges based on all inpatient stays identified, including denied and pended claims.
- Exclude discharges in which the patient was transferred directly or readmitted to an acute or non-acute facility on the date of the discharge or within 30 days after discharge. These discharges are excluded because a re-hospitalization or transfer may prevent an outpatient follow-up visit from taking place. To identify readmissions to an acute or non-acute inpatient care setting:
    - Identify all acute and non-acute inpatient stays (Inpatient Stay value set).
    - Identify the admission date for the stay. The date of admission should be within the reporting period or 30 days after the end of the reporting period.
    - Determine if the admission date for the stay occurred within 30 days of a previous inpatient discharge. If yes, exclude the initial discharge.

  For example, the following direct transfers/readmissions should be excluded from this measure:
    - An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1 (a direct transfer)
    - An inpatient discharge on June 1, followed by a readmission to a hospital on June 15 (readmission within 30 days)
- Exclude discharges due to death, using the Discharges due to Death value set.

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

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

SC2.5 MMPs with established work plan and systems in place, utilizing Phoenix as appropriate, for ensuring smooth transition to and from hospitals, nursing facilities, and the community.[i]

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
SC2. Care Coordination	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.	Policies and procedures regarding timely identification of planned and unplanned transitions.	Policies and procedures regarding timely identification of planned and unplanned transitions, such as an internal system to alert the MMP to transitions, requirements for contracted facilities to report transitions, etc.	Field Type: N/A Note: File will be uploaded to FTP site as a separate attachment.
B.	Policies and procedures regarding supporting members' movement between care settings.	Policies and procedures regarding supporting members' movement between care settings, including the items to be completed by each care setting and the process for communicating with members and other responsible parties.	Field Type: N/A Note: File will be uploaded to FTP site as a separate attachment.

Element Letter	Element Name	Definition	Allowable Values
C.	Policies and procedures regarding identifying members at risk of transitions and reducing transitions.	Policies and procedures regarding identifying members at risk of transitions and reducing transitions, such as how data are collected and analyzed at specified intervals to identify members who are at risk for a health status change and potential transition and how care managers contact at-risk members to assess needs and arrange appropriate services.	Field Type: N/A Note: File will be uploaded to FTP site as a separate attachment.
D.	Policies and procedures regarding annual review and update.	Policies and procedures regarding annual review and update of the key steps included in data elements A through C.	Field Type: N/A Note: File will be uploaded to FTP site as a separate attachment.

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

- The quality withhold benchmark for DY 1 is 100% compliance. For more information, refer to the Quality Withhold Technical Notes (DY 1): South Carolina-Specific Measures.

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

- All policies and procedures should be implemented with supporting documentation.

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 review the MMP's policies and procedures to ensure that they are sufficiently comprehensive and appropriate.

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

- A transition is the movement of a member from one care setting to another as the member's health status changes; for example, moving from home to a hospital as the result of an exacerbation of

a chronic condition or moving from the hospital to a rehabilitation facility after surgery.
- A planned transition includes a scheduled procedure, elective surgery, or a decision to enter a long-term care facility.
- An unplanned transition includes an emergency leading to a hospital admission from the emergency department.

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://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx
- For data submission, each data element above should be uploaded as a separate attachment.
- Required File Format is Microsoft Word File.
- The file name extension should be ".docx"
- File name= SC_(CONTRACTID)_(REPORTING PERIOD)_(SUBMISSIONDATE)_(ELEMENTNAME).docx.
- Replace (CONTRACTID) with the contract ID, (REPORTINGPERIOD) with the year and month of the beginning of the reporting period in YYYYMM format (e.g., February 2015 would be 201502), (SUBMISSIONDATE) with the year, month, and date of the submission in YYYYMMDD format (e.g., April 30, 2016 would be 20160430), and (ELEMENTNAME) with the element name listed below.
- For element letter "A", the (ELEMENTNAME) should be (Timely Identification).
- For element letter "B", the (ELEMENTNAME) should be (Supporting Members Movement).
- For element letter "C", the (ELEMENTNAME) should be (Identify Members at Risk).
- For element letter "D", the (ELEMENTNAME) should be (Annual Review).

SC2.6 Transition (admissions and discharge) between hospitals, nursing facilities and the community. [ii]

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
SC2. 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 member months during the reporting period.	Total number of member months during the reporting period.	Field Type: Numeric
B.	Total number of inpatient hospital discharges to nursing facilities.	The number of inpatient hospital discharges to the nursing facilities during the reporting period.	Field Type: Numeric
C.	Total number of inpatient hospital discharges to the community.	The number of inpatient hospital discharges to the community during the reporting period.	Field Type: Numeric
D.	Total number of inpatient hospital admissions from the community.	The number of inpatient hospital admissions from the community during the reporting period.	Field Type: Numeric
E.	Total number of nursing facility admissions from the community.	The number of nursing facility admissions from the community during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
F.	Total number of nursing facility discharges to the community.	The number of nursing facility discharges to the community during the reporting period.	Field Type: Numeric
G.	Total number of inpatient hospital admissions from nursing facilities.	The number of inpatient hospital admissions from nursing facilities during the reporting period.	Field Type: Numeric
H.	Number of care transitions recorded via Phoenix.	Of the total transitions reported in B through G, the number of transitions that were recorded via Phoenix within 30 calendar days of the transition.	Field Type: Numeric Note: Is a subset of the sum of B, C, D, E, F, and G.

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.

- Guidance will be forthcoming on the established benchmark for this measure.

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.
- MMPs should validate that data element H is less than or equal to the sum of data elements B through G.

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:

- Inpatient hospital discharges to nursing facilities during the reporting period per 1,000 member months.
- Inpatient hospital discharges to the community during the reporting period per 1,000 member months.
- Inpatient hospital admissions from the community during the reporting period per 1,000 member months.
- Nursing facility admissions from the community during the reporting period per 1,000 member months.
- Nursing facility discharges to the community during the reporting period per 1,000 member months.
- Inpatient hospital admissions from nursing facilities during the reporting period per 1,000 member months.

- The percent of care transitions recorded via Phoenix within 30 calendar days of the transition.

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).
- A transition is the movement (i.e., admission or discharge) of a member from one care setting to another as the member's health status changes; for example, moving from home to a hospital as the result of an exacerbation of a chronic condition or moving from the hospital to a rehabilitation facility after surgery.
- Inpatient hospital admissions and discharges are based on the CMS 2 midnight rule. The 2 midnight rule requires members to be admitted to the hospital for a minimum of 2 midnights to be considered an inpatient hospital admission. For further guidance on applying the 2 midnight rule, please review the FAQ posted on the CMS website: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/Questions_andAnswersRelatingtoPatientStatusReviewsforPosting_31214.pdf

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 SCIII. Enrollee Protections

SC3.1 The number of critical incident and abuse reports for members receiving LTSS.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
SC3. 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**
SC3. 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.

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:
  1. Willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish;
  2. 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;
  3. Rape or sexual assault;
  4. Corporal punishment or striking of an individual;
  5. Unauthorized use or the use of excessive force in the placement of bodily restraints on an individual; and
  6. 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 SCIV. Organizational Structure and Staffing

SC4.1 Care coordinator training for supporting self-direction under the demonstration.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
SC4. Organizational Structure and Staffing	Annually	Contract	Calendar Year	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of newly hired care coordinators (or those newly assigned to the MMP).	Total number of newly hired care coordinators (or those newly assigned to the MMP) employed by the MMP for at least 3 months during the reporting period.	Field Type: Numeric
B.	Total number of newly hired care coordinators that have undergone training for supporting self-direction under the demonstration.	Of the total reported in A, the number of newly hired care coordinators that have undergone 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 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 South Carolina three-way contract for specific requirements pertaining to a care coordinator.
- MMPs should refer to the South Carolina three-way contract for specific requirements pertaining to training for supporting self-direction.
- A care coordinator includes all full-time and part-time staff.
- All care coordinators newly hired and beginning employment with the MMP during the reporting period, or newly assigned during the reporting period to the MMP from another role, should be reported in data element A. If a care coordinator was not currently with the MMP at the end of the reporting period, but was with the MMP for at least 3 months during the reporting period, 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 SCV. Performance and Quality Improvement

SC5.1 Adjudicated claims.[i, ii]

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
SC5. Performance and Quality Improvement	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 clean, non-duplicated claims for services other than HCBS, adjudicated and approved.	Total number of clean, non-duplicated claims for services other than HCBS, adjudicated and approved during the reporting period.	Field Type: Numeric
B.	Total number of adjudicated and approved non-HCBS claims paid using the correct rate and within 30 days.	Of the total reported in A, the number of adjudicated and approved non-HCBS claims paid using the correct rate and within 30 days.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of adjudicated and approved non-HCBS claims paid using the correct rate and within 90 days.	Of the total reported in A, the number of adjudicated and approved non-HCBS claims paid using the correct rate and within 90 days.	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.

- The quality withhold benchmark for DY 1 is 90% of all clean claims paid within 30 days of the date of receipt. For withhold purposes, the measure is calculated as follows:
    - Denominator: The total number of clean, non-duplicated claims for services other than HCBS, adjudicated and approved during the reporting period (data element A) summed over the applicable number of quarters.
    - Numerator: The total number of adjudicated and approved non-HCBS claims paid using the correct rate and within 30 days (data element B) summed over the applicable number of quarters.
- For more information, refer to the Quality Withhold Technical Notes (DY 1): South Carolina-Specific Measures. Separate guidance will be forthcoming on the established benchmark for this measure for DY 2 and 3.

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

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data elements B and C 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:

- Adjudicated and approved clean, non-duplicated, non-HCBS claims paid within 30 days.
- Adjudicated and approved clean, non-duplicated, non-HCBS claims paid within 90 days.

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

- MMPs should include all clean, non-duplicated claims 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).
- Claims adjudication refers to the process in which MMPs verify that the services provided are covered benefits, certify admission where appropriate, conduct prepayment utilization screening, and authorize payment for those claims.
- Clean claims are those which can be processed without obtaining additional information from the physician or from a third party.
- Do not include reprocessed claims or denied claims.

- In the case of duplicated claims, only the first claim should be included when reporting 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.

SC5.2 Diabetes: foot exam (modified from NQF #0056)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
SC5. Performance and Quality Improvement	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members with a diagnosis of diabetes.	Total number of members with a diagnosis of diabetes (type 1 or type 2) who were continuously enrolled in the MMP during the reporting period.	Field Type: Numeric
B.	Total number of members who received a foot exam.	Of the total reported in A, the number of members who received a foot exam (visual inspection with either a sensory exam or pulse exam) 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 element B is less than or equal to data element A.
- All data elements should be positive values.

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

- CMS and the state will evaluate the percentage of members with a diagnosis of diabetes (type 1 or type 2) who received a foot exam 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.
- 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 foot exam is a visual inspection with either a sensory exam or a pulse exam.
- To identify members with diabetes, use the codes provided in the Diabetes value set *with* the Diabetes Encounter value set.
- The code to identify a foot exam is provided in the Foot Exam 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 SCVI. Utilization

SC6.1 HCBS members who experienced an increase or decrease in authorized hours. – ***Suspended***

SC6.2 Unduplicated members receiving HCBS, unduplicated members receiving HCBS-like services, and unduplicated members receiving nursing facility services.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
SC6. 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 who 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 HCBS-like or nursing facility services during the reporting period.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of members receiving HCBS-like services.	Of the total reported in A, the number of members receiving HCBS-like services during the reporting period who did not receive HCBS or nursing facility services during the reporting period.	Field Type: Numeric Note: Is a subset of A.
D.	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 or HCBS-like services during the reporting period.	Field Type: Numeric Note: Is a subset of A.
E.	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 who did not receive any HCBS-like services during the reporting period.	Field Type: Numeric Note: Is a subset of A.
F.	Total number of members receiving both HCBS-like and nursing facility services during the reporting period.	Of the total reported in A, the number of members receiving both HCBS-like and nursing facility services during the reporting period who did not receive any HCBS during the reporting period	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
G.	Total number of members receiving both HCBS and HCBS-like services during the reporting period.	Of the total reported in A, the number of members receiving both HCBS and HCBS-like services during the reporting period who did not receive any nursing facility services during the reporting period	Field Type: Numeric Note: Is a subset of A.
H.	Total number of members receiving HCBS, HCBS-like, and nursing facility services during the reporting period.	Of the total reported in A, the number of members receiving HCBS, HCBS-like services, 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 consider applying 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, D, E, F, G, and H 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:

- HBCS during the reporting period who did not receive HCBS-like or nursing facility services during the reporting period.
- HCBS-like services during the reporting period who did not receive HCBS or nursing facility services during the reporting period.
- Nursing facility services during the reporting period who did not receive HCBS or HCBS-like services during the reporting period.
- Both HCBS and nursing facility services during the reporting period who did not receive HCBS-like services during the reporting period.

- Both HCBS-like services and nursing facility services during the reporting period who did not receive HBCS during the reporting period.
- Both HCBS and HCBS-like services during the reporting period who did not receive any nursing facility services during the reporting period.
- HCBS, HCBS-like services, 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 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 purposes of reporting this measure, MMPs may utilize claims reconciliation reports generated by SCDHHS and the service authorization reports generated in Phoenix.
- Members receiving HCBS should only be counted for data element B (unduplicated). Members receiving HCBS-like should only be counted for data element C (unduplicated). Members receiving nursing facility services should only be counted for data element D (unduplicated). Members receiving both HCBS and nursing facility services should only be counted for data element E (unduplicated). Members receiving both HCBS-like and nursing facility services should only be counted for data element F (unduplicated). Members receiving both HCBS and HCBS-like should only be counted for data element G (unduplicated). Members receiving HCBS, HCBS-like, and nursing facility services should only be counted for data element H (unduplicated). Data elements B, C,D, E, F, G, and H 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 towards members receiving nursing facility services during the reporting period (data element C).
- Data elements C, F, G, and H apply only to those MMPs offering HCBS-like benefits.
- Include members who were receiving HCBS, HCBS-like, or nursing facility services for any length of time during the reporting period.
- HCBS refers to Home and Community Based Services. Additionally, HCBS are waiver-specific services provided to

individuals enrolled in the CLTC waiver programs. Services are listed at: https://www.scdhhs.gov/historic/insideDHHS/Bureaus/BureauofLongTermCareServices/CLTCOverview.html

- HCBS-like services are services typically provided only under the CLTC waiver programs. When these services are provided to individuals who do not meet the level of care requirements to receive these services as part of the waiver, the services are considered "HCBS-like" services. Services are listed at: https://www.scdhhs.gov/historic/insideDHHS/Bureaus/BureauofLongTermCareServices/CLTCOverview.html

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.

SC6.3 Palliative Care

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
SC6. Utilization	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members enrolled and eligible to receive palliative care.	Total number of members enrolled and eligible to receive palliative care during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of members receiving palliative care.	Total number of members receiving palliative care 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 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 eligible members receiving palliative care 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 A, MMPs should use any and all data available, including both claims and care management data (if necessary), to identify individuals who are eligible for palliative care services, as outlined in the South Carolina three-way contract. MMPs should include members who have a history of hospitalizations, a history of acute care utilization for pain and/or symptom management, or the recommendation of a physician or the multidisciplinary team to be eligible to receive palliative care services. Additionally, members may have at least one of the diagnoses listed in the Palliative Care value set. MMPs may also use the Charleston Co-morbidity Index

Code Cross Walk to identify members who are appropriate for a palliative care referral.

- For data element B, MMPs should identify any members reported in data element A who are also receiving palliative care treatment. MMPs should use any and all data available to identify such members, including but not necessarily limited to claims, care management data and the Charleston Co-morbidity Index Code Cross Walk, as appropriate.
- Palliative care provides pain and symptom control for members experiencing pain and discomfort due to a serious illness.

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.