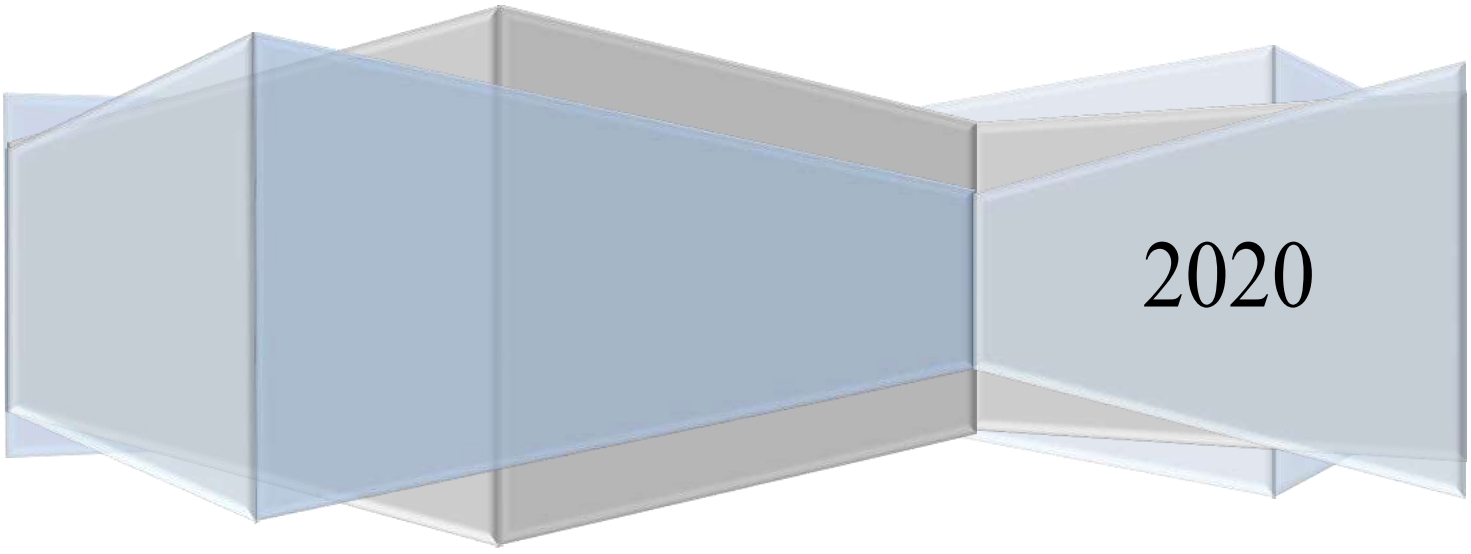
Medicare-Medicaid Plan (MMP) Care Coordination and Quality Improvement Program Effectiveness (CCQIPE) Program Area

AUDIT PROCESS AND DATA REQUEST



Contents

Audit Purpose and General Guidelines

1. **Purpose:** To evaluate MMP implementation and performance in the following areas as they relate to the contract executed between the Medicare-Medicaid Plan (MMP), State, and the Centers for Medicare & Medicaid Services (CMS): Care Coordination (CC) and Quality Improvement Program Effectiveness (QIPE). CMS will perform its audit activities using these instructions (unless otherwise noted).

2. **Review Period:** The review period for MMPs that have been operational for at least a year will be the (13) thirteen month period preceding and including the date of the audit engagement letter (for example, for an engagement letter sent on January 25, 2020, the universe review period would be December 1, 2018 through January 25, 2020). CMS reserves the right to expand the universe request as needed. The 13 month review period could span years that might be subject to different versions of the three-way contract executed between the Medicare-Medicaid Plan (MMP), State, and CMS depending on when the contract was last updated.

3. **Audit Process and Data Request document layout:** This document has been generalized to apply to MMPs across demonstrations. Auditors will evaluate MMPs in accordance with demonstration-specific compliance standards and terminology set forth in the contract between the MMP, State, and CMS, heretofore referred to as the contract. Where the contracts across demonstrations use varied terminology to label similar concepts, this document will reference unified terms applicable to all MMPs and provide definitions of those terms to ensure clarity.

4. **Responding to Documentation Requests:** The MMP is expected to present its supporting documentation during the audit, such as uploading the supporting documentation, as requested, to the secure site using the designated naming convention and within the timeframe specified by the CMS Audit Team.

5. **MMP Disclosed Issues:** MMPs will be asked to provide a list of all disclosed issues of non-compliance that are relevant to the program areas being audited and may be detected during the audit. A disclosed issue is one that has been reported to CMS prior to the receipt of the audit start notice (which is also known as the "engagement letter"). Issues identified by CMS through on-going monitoring or other account management/oversight activities during the plan year are not considered disclosed.

   MMPs must provide a description of each disclosed issue as well as the status of correction and remediation using the Pre-Audit Issue Summary template. This template is due within 5 business days after the receipt of the audit engagement letter. The MMP's Contract Management Team (CMT) Medicare representative, otherwise referred to as Account Manager for purposes of this protocol, will review the summary to validate that "disclosed" issues were known to CMS prior to receipt of the audit engagement letter. These are the "disclosed" issues that are reported to the CMT in the region that includes the state where the MMP is issued.

   When CMS determines that a disclosed issue was promptly identified, corrected (or is actively undergoing correction), and the risk to members has been mitigated, CMS will not apply the Immediate Corrective Action Required (ICAR) condition classification to that condition.

6. **Impact Analysis (IA):** An impact analysis must be submitted as requested by CMS. The impact analysis must identify all members subjected to or impacted by the issue of non-compliance. MMPs will have up to 10 business days to complete the requested impact analysis templates. CMS may validate the accuracy of the impact analysis submission(s). In

the event an impact analysis cannot be produced, CMS will report that the scope of non-compliance could not be fully measured and impacted an unknown number of members across all contracts audited.

7. **Calculation of Score:** CMS will determine if each condition cited is an Observation (0 points), Corrective Action Required (CAR) (1 point) or an ICAR (2 points). Invalid Data Submission (IDS) conditions will be cited when a MMP is not able to produce an accurate universe within 3 attempts. IDS conditions will be worth one point.

   CMS will then add the score for that audit element to the scores for the remainder of the audit elements in a given protocol and then divide that number (i.e., total score), by the number of audit elements tested to determine the sponsor's overall MMP-CCQIPE audit score. Some elements and program areas may not apply to certain sponsors and therefore will not be considered when calculating program area and overall audit scores. Observations will be recorded in the draft and final reports, but will not be scored and therefore will not be included in the program area and audit scores.

8. **Informing MMP of Results:** CMS will provide daily updates regarding conditions discovered that audit day (unless the case has been pended for further review). CMS will provide a preliminary summary of its findings at the exit conference. The CMS Audit team will do its best to be as transparent and timely as possible in its communication of audit findings. MMPs will receive a draft audit report which they may formally comment on and then a final report will be issued after consideration of MMP comments on the draft.

MMP Care Coordination Terminology

Definitions: Throughout this document, some terms have been standardized such that they may be applied to MMPs operating in any state. For the purposes of ease of readability and conciseness, the following definitions apply to the below terms included in this document:

- Health Risk Assessment (HRA): The comprehensive clinical assessment of a member that includes a full diagnostic evaluation (e.g., medical, behavioral health service, social needs, and community-based or facility-based long-term services and supports, LTSS) and informs treatment planning.
- Interdisciplinary Care Team (ICT): A team comprised of providers, care coordinators, and other individuals (at the discretion of the member) who work with the member to develop, implement, and maintain the Individualized Care Plan.
- Individualized Care Plan (ICP): A plan of care developed by a member and a member's Interdisciplinary Care Team.
- Quality Improvement Program (QI Program): A quality improvement organizational and program structure that supports the application of the principles of continuous quality improvement to the MMP's service delivery system.

For the audit, the MMP will be evaluated in accordance with the terminology definitions set forth in the applicable contract agreement between the MMP, State, and CMS.

Universe Preparation & Submission

1. **Responding to Universe Requests**: MMPs will submit 2 universe types to CMS for the MMP-CCQIPE program area. The record layouts in Appendix A of this document specify the data content and format of each universe required.

   The MMP is expected to provide accurate and timely universe submissions within 15 business days of the engagement letter date. CMS may request a revised universe if data issues are identified. The resubmission request may occur before and/or after the entrance conference depending on when the issue was identified. MMPs will have a maximum of 3 attempts to provide complete and accurate universes, whether these attempts all occur prior to the entrance conference or they include submissions prior to and after the entrance conference. However, 3 attempts may not always be feasible depending on when the data issues are identified and the potential for impact to the audit schedule. When multiple attempts are made, CMS will only use the last universe submitted.

   If the MMP fails to provide accurate and timely universe submissions twice, CMS will document this as an observation in the MMP's program audit report. After the third failed attempt, or when the MMP determines after fewer attempts that they are unable to provide an accurate universe within the timeframe specified during the audit, the MMP will be cited an IDS condition relative to each element that cannot be tested, grouped by the type of case.

2. **Pull Universes and Submit Background Information:** The universes collected for this program area test the MMP's care coordination (CC) and quality improvement program effectiveness (QIPE) per the requirements set forth in the contract. The MMP will provide a universe consisting of all MMP members who have been continuously enrolled for a period of at least 13 months as of the engagement letter date.

   Also, the MMP will submit quality measurement and performance improvement metrics utilized per the organization's Quality Improvement Program. All applicable fields of the QIPE record layout should be completed. If a sponsor has multiple MMPs, the sponsor should submit separate QIPE record layouts for each MMP. MMPs may opt to submit one workbook with a separate tab for each MMP contract, or may submit multiple workbooks within a single zip file.

   The universes should be compiled using the appropriate MMP record layout as described in Appendix A. These record layouts include:

   - Medicare-Medicaid Plan Members (MMPM) Record Layout (Table 1)
   - Quality Improvement Program Effectiveness (QIPE) Record Layout (Table 2)

   NOTE: For MMPM, the MMP should include all cases that match the description for that universe for all applicable MMP contracts in its organization as identified in the audit engagement letter (i.e., for all members enrolled in your organizations' MMPs during the review period).

   The MMP will provide the following background information documentation that is applicable to the audit timeframe:

   - Copies of the HRA tool(s) used by the MMP(s)
   - Copies of policies and procedures related to the administration of the HRA tool(s), the development of the ICP, the composition and functions of the ICT, and the coordination of

members' transitioning across care settings
- Copies of policies and procedures on the monitoring and evaluation of the QIP(s)
- Copies of performance monitoring/evaluation report(s) submitted to MMP quality oversight staff and/or Board
- List of first tier, downstream or related entities (FDRs) that assist with MMP care coordination and QIP functions/deliverables
- Responses to a supplemental questionnaire on care coordination policies and procedures related to HRAs, ICPs, and the ICT

This documentation will have the same submission deadline as the universes, except for the supplemental questionnaire, which will be due 5 business days after receipt of the audit engagement letter. The auditors will conduct a desk review of these materials prior to the audit start date to gain an understanding of the criteria and protocols the MMP has implemented. The background information to be submitted may have been implemented outside of the audit period, but must be in effect during the audit period.

There will be no findings assessed based on the review of these documents prior to the audit.

3. **Submit Universes to CMS:** MMPs should submit each universe in a Microsoft Excel (.xlsx) file format with a header row (or Text (.txt) file format without a header row) following the record layouts shown in Appendix A, Tables 1 and 2. The MMP should submit all background information and additional documentation with its universes.

Audit Elements

I. Care Coordination

1. **Select Sample Cases:** CMS will select a sample of 30 members from the MMPM universe submitted. The sample selection will be provided to the MMP by the close of business on the Thursday before the week the MMP-CCQIPE audit begins.

2. **Review Sample Case Documentation**: During the webinar review, CMS will sample all case file documentation for MMP implementation of care coordination in relation to the following areas: HRA administration; ICP appropriateness and implementation; ICT composition, qualifications, and functioning; and coordination of member transition across care settings.

   For each case, the MMP must produce all relevant documentation including, **but not limited to**:

   - The member's completed HRA(s)
   - The member's ICP
   - Care and case management documentation associated with the ICP submitted for the member during the audit review period. Specific documentation will be selected by the audit team based on the content of the ICP. This could include data related to any Medicare or Medicaid covered services. Examples of care and case management documentation that CMS may request include:
     - Claims
     - Encounters
     - Prescription drug events (This includes evidence for all pharmacy claims, including Part D.)
     - Communications between the MMP and members or providers (e.g., notifications inviting members or providers to attend ICT meetings, notifications to members regarding ICP updates)
   - Membership in the ICT with evidence of appropriate credentials as specified in the contract.

3. **Apply Compliance Standard**: At a minimum, CMS will evaluate cases against the following criteria. CMS may review factors not specifically addressed in these questions if it is determined that there are other related contract requirements not being met.

   3.1. HRAs:

   3.1.1. Did the MMP conduct the initial HRA? CMS will consider if the MMP made the requisite number of attempts to complete the HRA based on the requirements in the applicable contract.

   3.1.2. Did the MMP conduct the initial HRA within the required timeframe?

   3.1.3. Did the MMP appropriately review, analyze and stratify the HRA?

   3.1.4. Did the completed HRA include the review of all requisite assessment domains specified per the contract, for example, the goals and preferences associated with the medical, psychosocial, cognitive, functional, and mental health needs of the member?

3.1.5. Did the MMP administer HRAs subsequent to the initial HRA/reassessments within the required timeframe (e.g., an annual HRA)? If not, are any mitigating factors documented (e.g., member preference to meet at a later date, member declined to participate in HRA, inability to conduct an appropriate HRA due to hospitalization, etc.)?

3.1.6. Did the personnel who conducted the HRA possess the appropriate professional knowledge and credentials to the extent specified in the contract?

3.1.7. Was the HRA completed in the appropriate setting or method to the extent specified in the contract?

3.2. ICP:

3.2.1. Did the MMP complete the ICP according to the contract requirements (including, to the extent possible, with active participation from the member/caregiver)?

3.2.2. Did the ICP include specific interventions designed to meet the needs, member goals and preferences identified in the HRA?

3.2.3. Did the ICP include measurable outcomes (as applicable in the contract)?

3.2.4. Was the ICP reviewed/revised with the appropriate frequency based on the member's health condition(s) and in accordance with contract requirements?

3.2.5. Did the MMP provide documentation to verify the implementation of the ICP, such as proof of claims and/or documentation of social services provided?

3.2.6. Did the MMP coordinate communication of the ICP among personnel, providers, and members?

3.3. ICT:

3.3.1. Was member care coordinated by an ICT comprised of the appropriate clinical disciplines and consistent to member preferences, as required per the contract?

3.3.2. Was the ICT composed of team members who possess the training required per the contract?

3.3.3. Did the ICT appropriately perform all prescribed functions as set forth in the contract (e.g., involvement in the ICP development)?

3.3.4. Did the ICT attempt to involve the member in the ICT discussions/meetings?

3.4. Care Transitions:

3.4.1. Did the MMP plan and implement transition protocols between settings to ensure that the delivery of care to the member remains stable, and services are consistent and unduplicated?

4. **Sample Case Results**: CMS will test each of the 30 cases. If there is lack of evidence that the MMP is appropriately coordinating care and if CMS requirements are not met, conditions (findings) are cited. If CMS requirements are met, no conditions (findings) are cited.

   NOTE: Cases and conditions may have a one-to-one or a one-to-many relationship. For example, one case may have a single condition or multiple conditions of non-compliance.

II. Quality Improvement Program Effectiveness (QIPE)

1. **Select Sample Cases:** CMS will review the level of performance for all quality improvement project metrics in the MMP's Quality Improvement (QI) Work Plan and determine whether the MMP implemented appropriate corrective action when a performance goal was not attained.

2. **Review Documentation:** During the webinar review, CMS will assess the effectiveness of the MMP's QI Program in relation to its QI Program monitoring and evaluation efforts, and the appropriateness of the MMP's response to the outcomes of such activities. The MMP must produce all relevant documentation including, **but not limited to:**

   - QI Work Plan(s) effective during the audit review period
   - Methodology for collecting, analyzing, reporting and evaluating quality data
   - Information regarding the personnel having responsibility for overseeing the QI Program
   - Evidence of data collection/results of internal analysis/evaluation, including reports generated based on findings from internal analysis (i.e., progress toward goals/objectives, areas for improvement, etc.)
   - Quality Improvement Committee or workgroup meeting minutes.
   - Corrective Action Plans (CAPs) developed and implemented as a result of internal analysis and the results of the CAPs, if applicable
   - The most recent evaluation of the QI Work Plan
   - Documentation of communications to stakeholders regarding results of the QI Program
   - Meeting minutes showing approval of the QI Program, CAPs, and performance progress/outcomes by the governing body as required per the contract.

   NOTE: This documentation will vary by MMP based on the provisions of the MMP's QI Program. The documentation to be obtained will be more specific after CMS has completed the desk review of the background information that would have been submitted with the universe.

3. **Apply Compliance Standard**: At a minimum, CMS will evaluate the QI Program against the following criteria. CMS may review factors not specifically addressed in these questions if it is determined that there are other related MMP QI Program requirements not being met.

   3.1. Did the MMP collect, analyze, and evaluate quality data relevant to MMP members (e.g., specific data sources, specific performance and outcome measures, etc.), including medical, behavioral health, and LTSS data?

   3.2. Did the MMP use the analyzed results of performance measures to improve the QI Program (e.g., internal committee and other structured mechanism)?

   3.3. When necessary, did the MMP develop and implement corrective actions?

   3.4. Did the MMP show evidence of communicating performance monitoring results and improvements to stakeholders and/or leadership, in accordance with the contract requirements?

3.5. Did the MMP provide members/authorized representatives with opportunities to participate in quality management activities?

3.6. Are the appropriate personnel responsible for oversight of the QI Program's evaluation and monitoring process?

4. **Quality Improvement Program Effectiveness Review Results:** CMS will review documentation regarding the monitoring and evaluation of quality improvement project metrics established in the QI Program and any resulting corrective action undertaken by the MMP. If there is lack of evidence that the MMP is effectively implementing its QI Program and if CMS requirements are not met, conditions (findings) are cited. If CMS requirements are met, no conditions (findings) are cited.

Appendix

Appendix A – Medicare-Medicaid Plan Care Coordination and Quality Improvement Program Effectiveness (MMP-CCQIPE) Record Layouts

The universes for the Medicare-Medicaid Plan Care Coordination and Quality Improvement Effectiveness (MMP-CCQIPE) program area must be submitted as a Microsoft Excel (.xlsx) file with a header row (or Text (.txt) file without a header row). Do not include additional information outside of what is dictated in the record layout. Submissions that do not strictly adhere to the record layout will be rejected.

NOTE: There is a maximum of 4,000 characters per record row and spaces count toward this 4,000 character limit. Therefore, should additional characters be needed for a response, enter this information on the next record at the appropriate start position.

Table 1: Medicare-Medicaid Plan Members (MMPM) Record Layout

- Provide a universe consisting of all MMP members who have been continuously enrolled for a period of at least 13 months as of the engagement letter date.

Column ID	Field Name	Field Type	Field Length	Description
A	Member First Name	CHAR Always Required	50	First name of the member.
B	Member Last Name	CHAR Always Required	50	Last name of the member.
C	First Tier, Downstream, and Related Entities	CHAR Always Required	70	First Tier, Downstream, and Related Entities assigned to the member (e.g., Independent Physician Association, Physicians Medical Group or Third Party Administrator, any/all third party, downstream, or related organizations that the MMP contracts with in order to implement and/or manage the care). Enter NA if not applicable.
D	Member ID	CHAR Always Required	11	Enter the Medicare Beneficiary Identifier (MBI) of the enrollee. An MBI is the non-intelligent unique identifier that replaced the HICN on Medicare cards as a result of The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The MBI contains uppercase alphabetic and numeric characters throughout the 11-digit identifier and is unique to each Medicare enrollee. This number must be submitted excluding hyphens or dashes.

Column ID	Field Name	Field Type	Field Length	Description
E	Contract ID	CHAR Always Required	5	The contract number (e.g., H1234) of the organization.
F	Plan ID	CHAR Always Required	3	The plan number (e.g., 001) of the organization.
G	Enrollment Effective Date	CHAR Always Required	10	Effective date of enrollment for the member (PBP level). Submit in CCYY/MM/DD format (e.g., 2020/01/01).
H	Member's Initial Risk Stratification Level	CHAR Always Required	50	Enter the member's initial risk stratification level in accordance with the risk stratification levels set forth in the contract. Enter NA if no risk stratification level has been assigned.
I	Date of member initial Risk Stratification Level assignment	CHAR Always Required	10	Date of initial member risk stratification level assigned. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter NA if no risk stratification level has been assigned.
J	Was an initial HRA completed within the required timeframe?	CHAR Always Required	3	(Yes/No) Enter Yes if an initial HRA was completed within the required timeframe per the contract. Enter No if an initial HRA was not completed within the required timeframe per the contract or no HRA was completed.
K	Date initial HRA was completed?	CHAR Always Required	10	Date of the member's first HRA after enrolling. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter NA if no HRA was completed.
L	Did the MMP conduct an HRA during the current audit period?	CHAR Always Required	3	Enter Yes if an HRA was completed within the 13-month audit period. Enter No if an HRA was not completed within the 13-month audit period.

Column ID	Field Name	Field Type	Field Length	Description
M	Date of completion for HRA conducted during the audit period.	CHAR Always Required	10	Date of completion for the last HRA conducted during the 13-month audit period. Submit in CCYY/MM/DD format (e.g., 2020/01/01). Enter NA if an HRA was not conducted during the 13-month audit period.
N	Date of previous HRA/reassessment	CHAR Always Required	10	Date the HRA or reassessment was conducted most recently prior to the last HRA. If there were multiple HRAs conducted during the audit period, provide the one conducted most recently to the last HRA conducted during the audit review period. If there was only one HRA conducted during the audit review period, provide the HRA conducted most recently prior to the audit review period. If there was no HRA conducted during the audit period then include the most recent HRA that was conducted. Submit date in CCYY/MM/DD format (e.g. 2020/01/01) Enter NA if an HRA/reassessment has never been conducted.
O	Was an ICP completed?	CHAR Always Required	3	Enter Yes if an ICP was developed for the member any time before the end of the 13-month audit period. Enter No if an ICP was not developed for the member or was developed after the end of the 13-month audit period.
P	Member's Current Risk Stratification Level	CHAR Always Required	50	Current Member Risk Stratification Level is the member's risk stratification level on the last day of the review period. See *Audit Purpose and General Guidelines* for guidance on the review period. Enter the member's current risk stratification level in accordance with the risk stratification levels set forth in the contract. Enter NA if no risk stratification level has been assigned.

Table 2: Quality Improvement Program Effectiveness (QIPE) Record Layout

- Include each quality improvement project metric and its corresponding data that was tracked during the audit review period.
- Submit one universe for each MMP if the sponsor has multiple MMPs.

Column ID	Field Name	Field Type	Field Length	Description
A	Metric	CHAR Always Required	250	Identify the goal, objective or metric being measured. Example: Improving access to preventive health services— Increase the percentage of members vaccinated annually against seasonal influenza.
B	What is the duration of the baseline period?	CHAR Always Required	30	Enter the number of months used to establish the baseline performance against which future performance is assessed (e.g., 4 months, 12 months, etc.).
C	Baseline Period Start Date	CHAR Always Required	10	Indicate the start date for the baseline period used to establish the baseline performance against which future performance is assessed. Submit in CCYY/MM/DD format (e.g., 2020/01/01).
D	Baseline Period End Date	CHAR Always Required	10	Indicate the end date of the baseline period used to establish the baseline performance against which future performance is assessed. Submit in CCYY/MM/DD format (e.g., 2020/03/31).
E	Baseline Result	CHAR Always Required	10	Enter the baseline result value (e.g., percentage 66.6%, ratio 33:50, etc.). If no measurement was conducted enter NA.
F	Target Goal	CHAR Always Required	10	Enter the target goal value (e.g., percentage 95%, ratio 49:50, etc.).
G	Data Source	CHAR Always Required	250	Indicate data source(s) for the measurements (goals, objectives, and metrics) reported in the baseline rate and target rate columns. Example: Claims data, HPMS, HEDIS

Column ID	Field Name	Field Type	Field Length	Description
H	How often is performance assessed (after the baseline period)?	CHAR Always Required	30	Indicate how often performance is assessed after the baseline period (e.g., monthly, quarterly, yearly).
I	Measurement Period 1 Start Date	CHAR Always Required	10	MMP will report data for the 2 most recently conducted data measurement/ assessments. Enter the start date of the 1st measurement period. Submit in CCYY/MM/DD format. Example: if the 1st of the 2 most recent measurement periods began on March 1, 2020, then enter 2020/03/01. Enter NA if no measurement was conducted.
J	Measurement Period 1 End Date	CHAR Always Required	10	Enter the end date of the 1st measurement period. Submit in CCYYMMDD format. Example: if the 1st of the 2 most recent measurement periods ended on March 31, 2020, then enter 2020/03/31. Enter NA if no measurement was conducted.
K	Measurement Period 1 Result	CHAR Always Required	10	MMP should enter the value of the result for measurement period 1 (e.g., percentage 70.6%, ratio 29:50.) Enter NA if no measurement was conducted.
L	Goal Met/Not Met	CHAR Always Required	3	Determination of whether the target value was met after the 2nd measurement period. (Yes/No/NA) Enter Yes if the goal was met. Enter No if the goal was not met. Enter NA if no information was collected/ available.

Column ID	Field Name	Field Type	Field Length	Description
M	Corrective Action Plan (CAP)	CHAR Always Required	3	Indicate whether a Corrective Action Plan (CAP) was developed and implemented when MMP goals were not met (Yes, No, NA). Enter Yes if a CAP was developed when the MMP's goal was not met. Enter No if a CAP was not developed when the MMP's goal was not met. Enter NA if the goal was met (no CAP necessary).
N	Measurement Period 2 Start Date	CHAR Always Required	10	MMP will report data for the 2 most recently conducted data measurement/ assessments. Enter the start date of the 2nd measurement period. Submit in CCYY/MM/DD format. Example: if the 2nd of the 2 most recent measurement periods began on April 1, 2020, then enter 2020/04/01. Enter NA if no measurement was conducted.
O	Measurement Period 2 End Date	CHAR Always Required	10	Enter the end date of the 2nd measurement period. Submit in CCYY/MM/DD format (e.g., 2020/06/30). Example: if the 2nd of the 2 most recent measurement periods ended on April 30, 2020, then enter 2020/04/30. Enter NA if no measurement was conducted.
P	Measurement Period 2 Result	CHAR Always Required	10	MMP should enter the value of the result for measurement period 1 (e.g., percentage 86.6%, ratio 42:50). Enter NA if no measurement was conducted.
Q	Goal Met/Not Met	CHAR Always Required	3	Determination of whether the target value was met after the 2nd measurement period. (Yes/No/ NA) Enter Yes if the goal was met. Enter No if the goal was not met. Enter NA if no information was collected/ available.

Column ID	Field Name	Field Type	Field Length	Description
R	Corrective Action Plan (CAP)	CHAR Always Required	3	Indicate whether a Corrective Action Plan (CAP) was developed and implemented when MMP goals were not met (Yes, No, NA). Enter Yes if a CAP was developed when the MMP's goal was not met. Enter No if a CAP was not developed when the MMP's goal was not met. Enter NA if the goal was met (no CAP necessary).