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

Issued February 28, 2022

Table of Contents

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:

https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.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 HelpDesk at SCHelpDesk@norc.org with any question about the South Carolina state-specific appendix or the data submission process.

Definitions

All definitions for terms defined in this section and throughout this Reporting Requirements document apply whenever the term is used, unless otherwise noted.

Calendar Quarter: All quarterly measures are reported on calendar quarters. The four calendar quarters of each calendar year will be as follows: January 1 to March 31, April 1 to June 30, July 1 to September 30, and October 1 to December 31.

Calendar Year (CY): All annual measures are reported on a calendar year basis. For example, CY 2022 represents January 1, 2022 through December 31, 2022.

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

- 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
- Demonstration Year 4: January 1, 2019 - December 31, 2019
- Demonstration Year 5: January 1, 2020 - December 31, 2020
- Demonstration Year 6: January 1, 2021 - December 31, 2021

---

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

- Demonstration Year 7: January 1, 2022 - December 31, 2022
- Demonstration Year 8: January 1, 2023 - December 31, 2023

HCBS: Waiver-specific services provided to individuals enrolled in the Community Long Term Care (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 initial months of the demonstration during which MMPs reported to CMS and the state on a more intensive reporting schedule. The Implementation Period started with the first effective enrollment date and continued until the end of the first calendar year (February 1, 2015 – 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.

Variation from the Core Reporting Requirements 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 do not have long-term stays in a nursing facility.

Quality Withhold Measures

CMS and the state established a set of quality withhold measures, and MMPs are 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 through 8: (^ii). Note that an additional state-specific quality withhold measure is reported separately through HEDIS®.[2] For more information about the state-specific quality withhold measures, refer to the Quality Withhold Technical Notes (DY 1): South Carolina-Specific Measures and the Quality Withhold Technical Notes (DY 2-8): South Carolina-Specific Measures at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPQualityWithholdMethodologyandTechnicalNotes.html.

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

MMPs may complete comprehensive assessments prior to individuals' effective date of enrollment, provided that the MMP meets the requirements as articulated in the National MMP Enrollment and Disenrollment Guidance. Note that for individuals who are passively enrolled, the MMP may reach out to complete an assessment no sooner than 20 days before the individual's effective date of the passive enrollment.

For purposes of reporting data on assessments (Core 2.1 and Core 2.2), 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. 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 June 1 would reach their 90th day (i.e., three full months) on August 31. Therefore, these members would be reported in the data submission for the Quarter 3 reporting period, even if their assessment was marked as complete on the first effective enrollment date (i.e., June 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 Core 3.2 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.

---

[2] HEDIS® is a registered trademark of NCQA.

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

Comprehensive Assessments

To determine if an assessment should be conducted for a member who 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 their 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 the member's 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 the member's 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 three-way contract. If there are no changes, the MMP is not required to conduct a new assessment unless requested by the member (or the member's authorized representative). Please note, if the MMP prefers to conduct assessments on all re-enrollees regardless of status, it may continue to do so.

Once the MMP has conducted a new assessment as needed or confirmed that the prior assessment is still accurate, the MMP can mark the assessment as complete for the member's current enrollment. The MMP would then report that completion according to the specifications for Core 2.1 and Core 2.2. When reporting these 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. Additionally, in certain circumstances a new assessment that has been completed for a member upon reenrollment may also be reported in Core 2.3.

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 their 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 their 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 three-way contract. The MMP must make the requisite number of attempts to reach the member (at minimum) after their most recent enrollment effective date, even if the MMP reported that the member was unable to be reached during their prior enrollment. Similarly, members who 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 ICP accordingly within the timeframe prescribed by the three-way 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 Core 3.2 and SC2.2 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 their 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 three-way contract. The MMP must also follow the above guidance regarding reaching out to members who previously refused to participate or were not reached.

Annual Reassessments and ICP Updates

The MMP must follow the three-way 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.

Reporting on Passively Enrolled and Opt-In Enrolled Members

When reporting all South Carolina state-specific measures, MMPs should include all members who meet the criteria for inclusion in the measure regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.

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.

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: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.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.

Phase		Dates	Explanation
Demonstration Year 2			
Continuous Reporting	Ongoing Period	1-1-17 through 12-31-17	From January 1, 2017 through the end of the second demonstration year.
Demonstration Year 3			
Continuous Reporting	Ongoing Period	1-1-18 through 12-31-18	From January 1, 2018 through the end of the third demonstration year.
Demonstration Year 4			
Continuous Reporting	Ongoing Period	1-1-19 through 12-31-19	From January 1, 2019 through the end of the fourth demonstration year.
Demonstration Year 5			
Continuous Reporting	Ongoing Period	1-1-20 through 12-31-20	From January 1, 2020 through the end of the fifth demonstration year.
Demonstration Year 6			
Continuous Reporting	Ongoing Period	1-1-21 through 12-31-21	From January 1, 2021 through the end of the sixth demonstration year.
Demonstration Year 7			
Continuous Reporting	Ongoing Period	1-1-22 through 12-31-22	From January 1, 2022 through the end of the seventh demonstration year.
Demonstration Year 8			
Continuous Reporting	Ongoing Period	1-1-23 through 12-31-23	From January 1, 2023 through the end of the eighth demonstration year.

Data Submission

All MMPs will submit state-specific measure data through the web-based Financial Alignment Initiative Data Collection System (FAI DCS), unless otherwise specified in the measure description. All data submissions must be submitted to this site by 5:00 p.m.

ET on the applicable due date. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

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

    a. Specify in the email which measure(s) need resubmission;

    b. Specify for which reporting period(s) the resubmission is needed; and

    c. 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 DCS 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. – ***Retired***

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

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

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] – ***Retired***

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 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 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 who were currently enrolled as of the last day of the reporting period.	Field Type: Numeric
B.	Total number of members who had an initial ICP completed.	Of the total reported in A, the number of members who had an initial 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.

- MMPs should validate that data element B is less than or equal to data element A.

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 initial ICP completed as of the end of the reporting period.
  - Percentage = (B / A) * 100

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

Data Element A

- MMPs should only include those members who are currently enrolled as of the last day of the reporting period, including deceased members who were enrolled through the end of the reporting period. The last day of the reporting

period is the anchor date, or the date on which all reported members must be enrolled in the MMP.

- The 90th day of enrollment should be based on each member's most recent effective enrollment date in the MMP. Members must be continuously enrolled from the most recent effective enrollment date through 90 days of enrollment (or longer) with no gaps in enrollment.
- For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months.

Data Element B

- The initial ICPs reported in data element B could have been completed at any time from the member's first day of enrollment through the end of the reporting period.
- MMPs should only report completed ICPs in data element B when the member or the member's authorized representative was involved in the development of the ICP.

General Guidance

- 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 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.

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

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

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.	Total number of acute inpatient hospital discharges.	Total number of acute inpatient hospital discharges that occurred during the reporting period for members who were continuously enrolled from the date of the inpatient hospital discharge through 30 days after the inpatient hospital discharge, with no gaps in enrollment.	Field Type: Numeric
B.	Total number of acute inpatient hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge from the inpatient hospital stay.	Of the total reported in A, the number of acute inpatient hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge from the inpatient hospital stay.	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 4 through 8 is 85%. For more information, refer to the Quality Withhold Technical Notes (DY 2-8): South Carolina-Specific Measures.

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

- MMPs should validate that data element B is less than or equal to data element A.

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 acute inpatient hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of the discharge from the inpatient hospital stay.
  - Percentage = (B / A) * 100

- Use enrollment data to evaluate the total number of acute inpatient hospital discharges per 10,000 member months during the reporting period.
    - Rate = (A / Total Member Months) * 10,000

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

Data Element A

- MMPs should include all acute inpatient hospital discharges for members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period.
- The denominator for this measure is based on acute inpatient hospital discharges, not members.
- To identify all acute inpatient hospital discharges during the reporting period:
    - Identify all acute and nonacute inpatient stays (Inpatient Stay value set).
    - Exclude nonacute inpatient stays (Nonacute Inpatient Stay value set)
    - Identify the discharge date for the stay. The date of discharge must be within the reporting period.
    - Report on all inpatient stays identified with discharges within the reporting period, including denied and pended claims.

    Additionally, MMPs should use UB Type of Bill codes 11x, 12x, 41x, and 84x or any acute inpatient facility code to identify discharges from an inpatient hospital stay.
- If the discharge is followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period, count only the last discharge for reporting in data element A. To identify readmissions and direct transfers to an acute inpatient care setting:
    - Identify all acute and nonacute inpatient stays (Inpatient Stay value set).
    - Exclude nonacute inpatient stays (Nonacute Inpatient Stay value set).
    - Identify the admission date for the stay.

Data Element A Exclusions

- Exclude discharges for members who use hospice services or elect to use a hospice benefit at any time between the hospital discharge date and 30 days following the hospital discharge. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record, claims/encounter data (Hospice Encounter value set; Hospice Intervention value set), or supplemental data.
- Exclude discharges due to death, using the Discharges due to Death value set.
- Exclude from data element A any discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period. To identify readmissions and direct transfers to a nonacute inpatient care setting:
    - Identify all acute and nonacute inpatient stays (Inpatient Stay value set).

- o Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay value set) on the claim.
  - o Identify the admission date for the stay.

  These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.
- For example, the following direct transfers/readmissions should be excluded from this measure:
  - o An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1 (a direct transfer).
  - o An inpatient discharge on June 1, followed by a readmission to a hospital on June 15 (readmission within 30 days).

Data Element B

- The date of discharge must occur within the reporting period, but the follow-up visit may not be in the same reporting period.
  - o 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.
- A follow-up visit is defined as an ambulatory care follow-up visit to assess the member's health following a hospitalization. Codes to identify follow-up visits are provided in the Ambulatory Visits value set, Other Ambulatory Visits value set, and Telephone 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.

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] – ***Retired***

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 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

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.

- N/A.

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 following per 10,000 member months:

- Inpatient hospital discharges to nursing facilities during the reporting period.
  - Rate = (B / A) * 10,000
- Inpatient hospital discharges to the community during the reporting period.
  - Rate = (C / A) * 10,000
- Inpatient hospital admissions from the community during the reporting period.
  - Rate = (D / A) * 10,000
- Nursing facility admissions from the community during the reporting period.
  - Rate = (E / A) * 10,000
- Nursing facility discharges to the community during the reporting period.
  - Rate = (F / A) * 10,000
- Inpatient hospital admissions from nursing facilities during the reporting period.
  - Rate = (G / A) * 10,000

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

Definition

- 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.

o 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.

Data Element A

- MMPs should include all member months for members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).

General Guidance

- 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 and the fact sheet with updates included in the CY 2016 Hospital Outpatient Prospective Payment System (OPPS) final rule: https://www.cms.gov/newsroom/fact-sheets/fact-sheet-two-midnight-rule-0#:~:text=In%20general%2C%20the%20original%20Two,record%20supported%20that%20reasonable%20expectation.

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.

- N/A.

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

- Number of critical incident and abuse reports per 1,000 members receiving LTSS during the current reporting period.
  - Rate = (B / A) * 1,000
- Average number of critical incident and abuse reports for members receiving LTSS during the prior four reporting periods (i.e., rolling year).
  - Average number = Sum of B for prior four reporting periods / 4
- Weighted average number of critical incident and abuse reports per 1,000 members receiving LTSS during the prior four reporting periods.
  - Rate = (Sum of B for prior four reporting periods / Sum of A for prior four reporting periods) * 1,000

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

Definitions

- Critical incident refers to any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a member.
- Abuse refers to:
  - Willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish;
  - Knowing, reckless, or intentional acts or failures to act which cause injury or death to an individual or which place that individual at risk of injury or death;
  - Rape or sexual assault;
  - Corporal punishment or striking of an individual;
  - Unauthorized use or the use of excessive force in the placement of bodily restraints on an individual; and
  - Use of bodily or chemical restraints on an individual which is not in compliance with federal or state laws and administrative regulations.

Data Element A

- MMPs should include all members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).

Data Element B

- For data element B, MMPs should include all new critical incident and abuse cases that are reported during the reporting period, regardless of whether 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.

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 full-time and part-time care coordinators (or those newly assigned to the MMP) employed by the MMP for at least three months during the reporting period.	Field Type: Numeric
B.	Total number of newly hired care coordinators who have undergone training for supporting self-direction under the demonstration.	Of the total reported in A, the number of newly hired care coordinators who 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.

- MMPs should validate that data element B is less than or equal to data element A.

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 full-time and part-time care coordinators who have undergone training for supporting self-direction.
  - Percentage = (B / A) * 100

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

Data Element A

- 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 three months at any point during the reporting period, they should be included in this measure.

General Guidance

- MMPs should refer to the South Carolina three-way contract for specific requirements pertaining to a care coordinator and to training for supporting self-direction.

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.

- 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.

- MMPs should validate that data elements B and C are less than or equal to data element A.

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.
    - Percentage = (B / A) * 100
- Adjudicated and approved clean, non-duplicated, non-HCBS claims paid within 90 days.
    - Percentage = (C / A) * 100

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

Definitions

- Clean claims are those which can be processed without obtaining additional information from the physician or from a third party.
- 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.

Data Element A

- MMPs should include all clean, non-duplicated claims for members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- In the case of duplicated claims, only the first claim should be included when reporting this measure.

Data Element A Exclusion

- Do not include reprocessed claims or denied claims.

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) – ***Retired***

Section SCVI. Utilization

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

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, with no gaps in enrollment.	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 services 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 services and nursing facility services during the reporting period.	Of the total reported in A, the number of members receiving both HCBS-like services 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 services, 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 apply threshold checks.

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

- MMPs should validate that data elements B, C, D, E, F, G, and H are less than or equal to data element A.

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 receiving:

- HCBS during the reporting period who did not receive HCBS-like services or nursing facility services during the reporting period.
  - Percentage = (B / A) * 100
- HCBS-like services during the reporting period who did not receive HCBS or nursing facility services during the reporting period.
  - Percentage = (C / A) * 100
- Nursing facility services during the reporting period who did not receive HCBS or HCBS-like services during the reporting period.
  - Percentage = (D / A) * 100
- Both HCBS and nursing facility services during the reporting period who did not receive HCBS-like services during the reporting period.
  - Percentage = (E / A) * 100

- Both HCBS-like services and nursing facility services during the reporting period who did not receive HCBS during the reporting period.
  - Percentage = (F / A) * 100
- Both HCBS and HCBS-like services during the reporting period who did not receive any nursing facility services during the reporting period.
  - Percentage = (G / A) * 100
- HCBS, HCBS-like services, and nursing facility services during the reporting period.
  - Percentage = (H / A) * 100

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

Definition

- 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).
- HCBS refers to Home and Community Based Services. Additionally, HCBS are waiver-specific services provided to individuals enrolled in the CLTC waiver programs
- 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.
- HCBS and HCBS-like services are listed at: https://www.scdhhs.gov/historic/insideDHHS/Bureaus/BureauofLongTermCareServices/CLTCOverview.html.

Data Element A

- MMPs should include all members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).

Data Element B

- Members receiving HCBS should only be counted for data element B (unduplicated).

Data Element C

- Members receiving HCBS-like services should only be counted for data element C (unduplicated).

Data Element D

- Members receiving nursing facility services should only be counted for data element D (unduplicated).

Data Element E

- Members receiving both HCBS and nursing facility services should only be counted for data element E (unduplicated).

Data Element F

- Members receiving both HCBS-like services and nursing facility services should only be counted for data element F (unduplicated).

Data Element G

- Members receiving both HCBS and HCBS-like services should only be counted for data element G (unduplicated).

Data Element H

- Members receiving HCBS, HCBS-like services, and nursing facility services should only be counted for data element H (unduplicated).

General Guidance

- For purposes of reporting this measure, MMPs may utilize claims reconciliation reports generated by SCDHHS and the service authorization reports generated in Phoenix.
- Include members who were receiving HCBS, HCBS-like services, or nursing facility services for any length of time during the reporting period.
- Data elements C, F, G, and H apply only to those MMPs offering HCBS-like benefits.
- Data elements B, C, D, E, F, G, and H are mutually exclusive.

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 – ***Retired***