

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

Effective as of January 1, 2014, issued February 25, 2014

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Appendix 1. Massachusetts-Specific Reporting Requirements

Introduction

The measures in this appendix are required reporting for all MMPs in the Massachusetts One Care Demonstration. CMS and MassHealth reserve the right to update the measures in this appendix for subsequent demonstration years. These state-specific measures directly supplement the Medicare-Medicaid Capitated Financial Alignment: 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>

MMPs should refer to the core document for additional details regarding Demonstration-wide definitions, reporting phases and timelines, and sampling methodology except as otherwise specified in this document.

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.

Definitions

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

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

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

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

Variation from the Core Document

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

- Measure 5.3 - Establishment of a consumer advisory board.
 - Definition: Initially, as the holding of a board meeting that includes Consumers within 90 days of the first Effective Enrollment Date for the Demonstration; and on an ongoing basis, as the holding of a board meeting that includes consumers at least quarterly.
 - Reporting: During the implementation period, MMPs must submit within 150 days of the first demonstration effective enrollment date the meeting minutes for the first board meeting that includes consumers and that is held within 90 days of the first effective enrollment date. During the ongoing reporting period, MMPs must annually submit meeting minutes for board meetings that include consumers and that are held at least quarterly. For the first year, MMPs are required to report both the first meeting minutes during the implementation reporting phase, and subsequent meeting minutes as part of annual reporting for the ongoing reporting phase.

Quality Withhold Measures

The following measures from The Medicare-Medicaid Capitated Financial Alignment: Core Reporting Requirements will be Quality Withhold Measures for demonstration years 2 and 3 for MMPs participating in the Massachusetts One Care Demonstration:

- Measure 3.1 - Members, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted within 24 hours of discharge to the facility or primary care provider or other health care professional designated for follow-up care. (NQF #0648)
- Measure 6.1 - Screening for Clinical Depression and Follow-up Plan. (NQF #0418)

Quality withhold measures for Demonstration year 2 and 3 will be released in future updates. Additional information on The Medicare-Medicaid Capitated Financial Alignment: Core Reporting Requirements 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>

Massachusetts Implementation, Ongoing, and Continuous Reporting Periods

Demonstration Year 1			
Phase		Dates	Explanation
Continuous Reporting	Implementation Period	1-1-14 through 6-30-14	From the first effective passive enrollment date through the end of the last (i.e., third) month of the wave of passive enrollment
	Ongoing Period	7-1-14 through 12-31-14	From the day after the end of the implementation period through the end of the first demonstration year.
Demonstration Year 2			
Continuous Reporting	Ongoing Period	1-1-15 through 12-31-15	From January 1st through the end of the second demonstration year.
Demonstration Year 3			
Continuous Reporting	Ongoing Period	1-1-16 through 12-31-16	From January 1st through the end of the third demonstration year.

Data Submission

All MMPs will submit data through an Excel template on a secure transmission site. This site can be accessed at the following web address:

<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>.

The template is available for download at:

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

MMPs should follow the instructions below on how to properly name each data file submitted.

- Required File Format is Microsoft Excel File.
- The file name extension should be “.xls”
- File name= MA_(CONTRACTID)_(REPORTING PERIOD)_(SUBMISSIONDATE).xls.
- 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 2014 would be 201402), and (SUBMISSIONDATE) the month, date, year, and century of the submission in CCYYMMDD format (e.g., March 30, 2014 would be 21140330).

Section MAI. Care Coordination

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

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

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

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

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of members sampled that met inclusion criteria.	Of the total reported in A, the number of members sampled that met inclusion criteria.	Field type: Numeric Note: Is a subset of A.
C.	Total number of members who are documented as unwilling to complete a care plan within 90 days of enrollment.	Of the total reported in B, the number of members who are documented as unwilling to complete a care plan within 90 days of enrollment.	Field type: Numeric Note: Is a subset of B.
D.	Total number of members the MMP was unable to locate, following three documented attempts within 90 days of enrollment.	Of the total reported in B, the number of members the MMP was unable to locate, following three documented attempts within 90 days of enrollment.	Field type: Numeric Note: Is a subset of B.
E.	Total number of members with a care plan completed within 90 days of enrollment.	Of the total reported in B, the number of members with a care plan completed within 90 days of enrollment.	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 elements C, D, and E.
 - MMPs should validate that data elements C, D, and E are less than or equal to data element A and less than or equal to data element B.
 - All data elements should be positive values.
- D. Analysis - how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of:

- Members who were unable to be located to have a care plan completed within 90 days of enrollment.
- Members who refused to have a care plan completed within 90 days of enrollment.
- Members who had a care plan completed within 90 days of enrollment.
- Members that were willing to participate and who could be located who had an 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. A subset of all members that are eligible will be included in the sample.
- 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.
- If an MMP does not elect to sample, data element B should be equal to data element A.
- The 90th day of enrollment should be based on each member's effective date.
- The effective date of enrollment is the first date of the member's coverage through the MMP.
- MMPs should refer to the Massachusetts MOU and three-way contract for specific requirements pertaining to care plans.
- Failed attempts to contact a member to complete a care plan must be documented and CMS and the state may validate this number.

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 transmission site established by CMS. This site can be accessed at the following web address:
<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

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

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

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members with a care plan developed.	Total number of members with a care plan developed 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 at least one documented discussion of care goals in the care plan.	Of the total reported in B, the number of members with at least one documented discussion of care goals in the care plan.	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.

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

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 elements C.
- MMPs should validate that data element C is less than or equal to data element A and less than or equal to data element B.
- All data elements should be positive values.

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

- CMS and the state will evaluate the percentage of members who had a care plan developed in the reporting period who had at least one documented discussion of care goals in the care plan.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. A subset of all members that are eligible will be included in the sample.
- For reporting, the MMPs may elect to sample since this measure requires additional 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.
- If an MMP does not elect to sample, data element B should be equal to data element A.
- The discussion of care goals is inclusive of the development of a member's care plan.
- Documented discussions of care goals will be recorded in a member's electronic health record (EHR).

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

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address:
<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

MA1.3 Members with LTSS needs who have an IL-LTSS Coordinator.ⁱ

IMPLEMENTATION				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
MA1. Care Coordination	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	Reporting Frequency	Level	Reporting Periods	Due Date
MA1. Care Coordination	Quarterly	Contract	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 newly identified with LTSS needs. ²	Total number of members newly identified with LTSS needs.	Field Type: Numeric
B.	Total number of members that refused an IL-LTSS coordinator.	Of members reported in A, total number of members that refused an IL-LTSS coordinator.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members that have an IL-LTSS coordinator assigned.	Of members reported in A, total number of members that have an IL-LTSS coordinator assigned.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of members that are in the C3 and F1 rating categories.	Of members reported in A, total number of members that are in the C3 and F1 rating categories.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
E.	Total number of members that are in the C3 and F1 rating categories that refused an IL-LTSS coordinator.	Of members reported in D, total number of members that are in the C3 and F1 rating categories that refused an IL-LTSS coordinator.	Field Type: Numeric Note: Is a subset of D.
F.	Total number of members that are in the C3 and F1 rating categories who have met with an IL-LTSS coordinator during the first 90 days following their effective enrollment date.	Of members reported in D, total number of members that are in the C3 and F1 rating categories who have met with an IL-LTSS coordinator during the first 90 days following their effective enrollment date.	Field Type: Numeric Note: Is a subset of D.

² Beneficiaries whose first or subsequent assessment identifies LTSS needs are considered “newly identified,” for the purpose of this measure. MassHealth will provide further guidance on the definition of “LTSS needs.”

- 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 threshold for this measure.
- 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 element D is greater than or equal to data elements E and F.
 - All data elements should be positive values.
- D. Analysis - how CMS will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of:
- Members with newly identified LTSS needs who refused an IL-LTSS coordinator.
 - Members with newly identified LTSS needs who have an IL-LTSS coordinator assigned.
 - Members with newly identified LTSS needs who are in the C3 and F1 rating categories.

- Members with newly identified LTSS needs who are in the C3 and F1 rating categories who refused an IL-LTSS coordinator.
 - Members with newly identified LTSS needs who are in the C3 and F1 rating categories who have met with an IL-LTSS coordinator during the first 90 days following their effective enrollment date.
- 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.
 - MMPs should refer to the Massachusetts MOU and three-way contract for specific requirements pertaining to an IL-LTSS coordinator.
 - F1 refers to facility-based care individuals identified as having a long-term facility stay of more than 90 days.
 - C-3 refers to community tier 3 high community need. Individuals who have a daily skilled need; two or more activities of daily living (ADL). Limitations and three days of skilled nursing need; and individuals with four or more ADL limitations.
 - Newly identified LTSS members refers to members who were identified during the reporting period as having LTSS needs.
 - Meeting with Coordinator refers to a face-to-face meeting with an IL-LTSS coordinator.
 - Refuse refers to anyone who refuses an IL-LTSS coordinator.
 - The effective date of enrollment is the first date of the member's coverage through the MMP.
- 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 transmission site established by CMS. This site can be accessed at the following web address:
<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

Section MAII. Enrollee Protections

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

IMPLEMENTATION				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
MA2. Enrollee Protections	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	Reporting Frequency	Level	Reporting Periods	Due Date
MA2. Enrollee Protections	Quarterly	Contract	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 members reported in A, 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.
- 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 transmission site established by CMS. This site can be accessed at the following web address:
<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

Section MAIII. Organizational Structure and Staffing

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

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
MA3. Organizational Structure and Staffing	Annually	Contract	Demonstration 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 new care coordinators.	Total number of new care coordinators in the MMP during the reporting period.	Field Type: Numeric
B.	Total number of new care coordinators that have undergone state-based training for supporting self-direction under the demonstration.	Of the total reported in A, the number of new care coordinators that have undergone state-based training for supporting self-direction under the demonstration.	Field Type: Numeric Note: Is a subset of A.

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

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

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

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

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

- CMS and the state will evaluate the percentage of new care coordinators that have undergone state-based training for supporting self-direction.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should refer to the Massachusetts MOU and three-way contract for specific requirements pertaining to a care coordinator.
 - MMPs should refer to the Massachusetts MOU and three-way contract for specific requirements pertaining 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 transmission site established by CMS. This site can be accessed at the following web address:
<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

Section MAIV. Performance and Quality Improvement

MA4.1 Mental Health Recovery Measure (MHRM[®])¹.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
MA4. Performance and Quality Improvement	Annually	Contract	Demonstration 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.			Field Type:
B.			Field Type:

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.

- To be determined.

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

- To be determined.

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

- To be determined.

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

- To be determined.

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

- To be determined.

MA4.2 Screening and brief counseling for unhealthy alcohol use. (PCPI Measure #3)

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Periods	Due Date
MA4. Performance and Quality Improvement	Annually	Contract	Two years	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 who were seen twice for any visits or who had at least one preventive care visit during the two-year reporting period	Total number of members who were seen twice for any visits or who had at least one preventive care visit during the two-year reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of members who were screened for unhealthy alcohol use at least once during the two-year reporting period using a systematic screening tool and, if positive, received brief counseling.	Of the total reported in A, the number of members who were screened for unhealthy alcohol use at least once during the prior or current reporting period using a systematic screening tool and, if positive, received brief counseling 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 who were screened for unhealthy alcohol use at least once during the two-year period using a systematic screening tool and, if positive, received brief counseling.

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

- The reporting period for this measure is two years, but reporting will occur on an annual basis. The first reporting period will consist of DY1 and DY2 with the first data submission due two months after the end of DY2. The second reporting period will consist of DY2 and DY3 and with data submission due two months after the end of DY3.

- MMPs should include all members aged 18 years and older², regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- MMPs should refer to pages 17-20 of The Physician Consortium for Performance Improvement, Preventive Care and Screening Set for further details on this measure:
http://www.ama-assn.org/ama1/pub/upload/mm/pcpi/pcs_final08.pdf.
- This measure will require a look-back period to identify denominator positive events for reporting beginning in demonstration year 2.
- AUDIT (The Alcohol Use Disorders Identification Test) is the systematic screening tool used for screening unhealthy alcohol use.

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 transmission site established by CMS. This site can be accessed at the following web address:
<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

MA4.3 Tobacco use: screening and cessation. (NQF #0028)

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
MA4. Performance and Quality Improvement	Annually	Contract	Two years	By the end of the 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 who were seen twice for any visits or who had at least one preventive care visit during the two-year reporting period.	Total number of members who were seen twice for any visits or who had at least one preventive care visit during the two-year reporting period.	Field Type: Numeric

² Massachusetts Demonstration population includes individuals ages 21 through 64 at the time of enrollment; therefore, all members will be 18 years and older.

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of members who were screened for tobacco use at least once during the two-year reporting period.	Of the total reported in A, the number of members who were screened for tobacco use at least once during the two-year reporting period and, if positive, received tobacco cessation counseling 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 who were screened for tobacco use at least once during the reporting period and, if positive, received tobacco cessation counseling intervention. E. Notes - additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- The reporting period for this measure is two years, but reporting will occur on an annual basis. The first reporting period will consist of DY1 and DY2 with the first data submission due two months after the end of DY2. The second reporting period will consist of DY2 and DY3 and with data submission due two months after the end of DY3.
- MMPs should include all members aged 18 years and older³, regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- MMPs should refer to pages 10-13 of The Physician Consortium for Performance Improvement, Preventive Care and Screening set for further details on this measure:

³ Massachusetts Demonstration population includes individuals ages 21 through 64 at the time of enrollment; therefore, all members will be 18 years and older.

http://www.ama-assn.org/ama1/pub/upload/mm/pcpi/pcs_final08.pdf.

- This measure will require a look-back period to identify denominator positive events for reporting beginning in demonstration year 2.

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 transmission site established by CMS. This site can be accessed at the following web address:
<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

MA4.4 Medication reconciliation post-discharge.

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

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of acute or nonacute inpatient discharges.	Total number of acute or nonacute inpatient discharges that occurred during the reporting period.	Field Type: Numeric
B.	Total number of inpatient discharges sampled that met inclusion criteria.	Of the total reported in A, the number of inpatient discharges sampled that met inclusion criteria.	Field type: Numeric Note: Is a subset of A.
C.	Total number of inpatient discharges that resulted in a medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse within 30 days following the inpatient discharge.	Of the total reported in B, the number of inpatient discharges that resulted in a medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse within 30 days following the inpatient discharge.	Field Type: Numeric Note: Is a subset of B.

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

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

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

- Confirm those data elements listed above as subsets of other elements.

- MMPs should validate that data element B is less than or equal to data element A.
- MMPs should validate that data element C is less than or equal to data element B.
- All data elements should be positive values.

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

- CMS and the state will evaluate the percentage of inpatient discharges that resulted in a medication reconciliation conducted by a prescribing practitioner, clinical pharmacist or registered nurse within 30 days following the inpatient discharge 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 aged 21 years and older⁴, regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. A subset of all members that are eligible will be included in the sample.
- For reporting, the MMPs may elect to use a hybrid methodology and select a sample. Sampling should be systematic to ensure all eligible individuals have an equal chance of inclusion. The sample size should be 411, plus oversample to allow for substitution.
- If an MMP does not elect to sample, data element B should be equal to data element A.
- Members may not have any gaps in continuous enrollment and need to be continuously enrolled from the date of the inpatient discharge through 30 days after the inpatient discharge.
- For data element A, discharges should only be included for members who met continuous enrollment criteria.
- Medication reconciliation is a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record.
- The denominator for this measure is based on discharges, not members. If a member has more than one discharge, include all discharges on or between January 1 and December 1 of the reporting period.
- If the discharge is followed by a readmission or direct transfer to an acute or nonacute facility within the 30-day follow-up period count only the readmission discharge or the discharge from the facility to which the member was transferred.

⁴ The HEDIS eligible population for this measure is limited to individuals 66 years of age and older. The Massachusetts Demonstration population includes individuals ages 21 through 64 at the time of enrollment; therefore, this measure has been modified to apply to this population.

- Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the reporting period.
- If a member remains in an acute or nonacute facility through December 1 of the reporting period, a discharge is not included in the measure for this member. However, the MMP must have a method for identifying the member’s status for the remainder of the reporting period, and may not assume the member remained in the facility based only on the absence of a discharge before December 1.

Administrative Specifications

- If the MMP elects to only use administrative data, please refer to the HEDIS® Medication Reconciliation Value Set codes provided in Table MA-1 to identify numerator positive hits when using administrative data.

Hybrid Specifications

- If the MMP elects to use hybrid sampling, refer to the *Administrative Specifications* to identify positive numerator hits from administrative data.
- When reviewing a members medical record, any of the following evidence should be documented in the medical record to meet criteria for this measure:
 1. Notation that the medications prescribed or ordered upon discharge were reconciled with the current medications (in the outpatient record) by the appropriate practitioner type; or
 2. A medication list in a discharge summary that is present in the outpatient chart and evidence of a reconciliation with the current medications conducted by an appropriate practitioner type (the MMP must be able to distinguish between the members discharge medications and the members current medications); or
 3. Notation that no medications were prescribed or ordered upon discharge.
- Only documentation in the outpatient chart meets the intent of the measure, but an outpatient visit is not required.

Table MA-1: Codes to Identify Medication Reconciliation	
CPT	
99495, 99496, 1111F	

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 transmission site established by CMS. This site can be accessed at the following web address:
<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

MA4.5 Care for Adults

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

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

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

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of members who had one functional status assessment completed during the reporting period.	Of the total reported in B, the number of members who had one functional status assessment completed during the reporting period.	Field Type: Numeric Note: Is a subset of B.
E.	Total number of members who had at least one pain screening or pain management plan completed during the reporting period.	Of the total reported in B, the number of members who had at least one pain screening or pain management plan completed during the reporting period.	Field Type: Numeric Note: Is a subset of B.

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

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

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

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

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

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

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

- MMPs should include all members aged 21 years and older⁵, regardless of whether the member was enrolled through passive enrollment or opt-in

⁵ The HEDIS eligible population for this measure is limited to individuals 66 years of age and older. The Massachusetts Demonstration population includes individuals ages 21 through 64 at the time of enrollment; therefore, this measure has been modified to apply to this population.

enrollment. A subset of all members that are eligible will be included in the sample.

- For reporting, the MMPs may elect to use a hybrid methodology and select a sample. Sampling should be systematic to ensure all eligible individuals have an equal chance of inclusion. The sample size should be 411, plus oversample to allow for substitution.
- If an MMP does not elect to sample, data element B should be equal to data element A.
- Members may not have more than one gap in continuous enrollment of up to 45 days during the reporting period.
- A medication list is a list of the member's medications in the medical record. The medication list may include medication names only or may include medication names, dosages and frequency, over-the-counter (OTC) medications and herbal or supplemental therapies.
- A medication review is a review of all a member's medications, including prescription medications, OTC medications, and herbal or supplemental therapies.
- A clinical pharmacist is a pharmacist with extensive education in the biomedical, pharmaceutical, sociobehavioral and clinical sciences. Clinical pharmacists are experts in the therapeutic use of medications and are a primary source of scientifically valid information and advice regarding the safe, appropriate and cost-effective use of medications. Most clinical pharmacists have a Doctor of Pharmacy (PharmD) degree and many have completed one or more years of post-graduate training (e.g., a general and/or specialty pharmacy residency). In some states, clinical pharmacists have prescriptive authority.
- A prescribing practitioner is a practitioner with prescribing privileges, including nurse practitioners, physician assistants and other non-MDs who have the authority to prescribe medications.

Administrative Specifications

Medication Review

- If the MMP elects to only use administrative data to identify members with a medication review completed (data element C), please refer to the HEDIS[®] Medication Review Value Set and Medication List Value Set codes provided in Table MA-2 to identify numerator positive hits when using administrative data. To be included in data element C, members must have had both completed on the same date of service during the reporting period.

Table MA-2: Codes to Identify Medication Review and Presence of Medication List	
CPT	
90862, 90863, 99605, 99606, 1160F	

AND

CPT	OR	HCPCS
1159F		G8427

Functional Status Assessment

- If the MMP elects to only use administrative data to identify members with a functional status assessment completed (data element D), please refer to the HEDIS® Functional Status Assessment Value Set codes provided in Table MA-3 to identify numerator positive hits when using administrative data.

Table MA-3: Codes to Identify Functional Status Assessment	
CPT	
1170F	

Pain Assessment

- If the MMP elects to only use administrative data to identify members with a pain assessment completed (data element E), please refer to the HEDIS® Pain Assessment Value Set codes provided in Table MA-4 to identify numerator positive hits when using administrative data.

Table MA-4: Codes to Identify Pain Assessment	
CPT	
1125F, 1126F	

Hybrid Specifications

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

Medication Review

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

- An outpatient visit is not required to meet criteria.

Functional Status Assessment

- When reviewing a member's medical record, documentation must include evidence of a complete functional assessment and the date when it was performed.
- Notations for a complete functional status assessment must include one of the following:
 1. Notation that Activities of Daily Living (ADL) were assessed (includes bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking).
 2. Notation that Instrumental Activities of Daily Living (IADL) were assessed (includes shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances).
 3. Result of assessment using a standardized functional status assessment tool, not limited to:
 1. SF-36[®].
 2. Assessment of Living Skills and Resources (ALSAR).
 3. Barthel ADL Index Physical Self-Maintenance (ADLS) Scale.
 4. Bayer Activities of Daily Living (B-ADL) Scale.
 5. Barthel Index.
 6. Extended Activities of Daily Living (EADL) Scale.
 7. Independent Living Scale (ILS).
 8. Katz Index of Independence in Activities of Daily Living.
 9. Kenny Self-Care Evaluation.
 10. Klein-Bell Activities of Daily Living Scale.
 11. Kohlman Evaluation of Living Skills (KELS).
 12. Lawton & Brody's IADL scales.
 4. Notation that at least three of the following four components were assessed:
 1. Cognitive status.
 2. Ambulation status.
 3. Sensory ability (including hearing, vision and speech).
 4. Other functional independence (e.g., exercise, ability to perform job).
- A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) does not meet criteria for a comprehensive functional status assessment. The components of the functional status assessment numerator may take place during separate visits within the reporting period.

Pain Assessment

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

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

- MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address:
<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

Section MAV. SystemsMA5.1 ICO Centralized Enrollee Record.ⁱ

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

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

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

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

- B. QA Checks/Thresholds - procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- Guidance will be forthcoming on the established threshold 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.
- D. Analysis - how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
- CMS and the state will obtain enrollment information from CMS' Web site and will evaluate the following:
 - The percentage of members whose race data are collected and maintained in the ICO Centralized Enrollee Record.
 - The percentage of members whose ethnicity data are collected and maintained in the ICO Centralized Enrollee Record.
 - The percentage of members whose primary language data are collected and maintained in the ICO Centralized Enrollee Record.
 - The percentage of members whose homelessness data are collected and maintained in the ICO Centralized Enrollee Record.
 - The percentage of members whose disability type data are collected and maintained in the ICO Centralized Enrollee Record.
- E. Notes - additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.

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 transmission site established by CMS. This site can be accessed at the following web address:
<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

Section MAVI. Utilization

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

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

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of member months for members age 40 and older.	Total number of member months during the reporting period for members age 40 and older.	Field Type: Numeric
B.	Total number of non-maternal discharges with an ICD-9-CM principal diagnosis code for COPD or asthma for members age 40 and older.	The number of non-maternal discharges with an ICD-9-CM principal diagnosis code for COPD or asthma for members age 40 and older during the reporting period.	Field Type: Numeric Note: Select codes appearing in the primary diagnosis position must be accompanied by a secondary diagnosis of COPD.

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 discharges with a primary diagnosis of COPD or asthma per 100,000 member months for members age 40 and older.
- 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.
 - MMPs should refer to pages 36-37 of the CMS Technical Specifications and Resource Manual for Federal Fiscal Year 2013 related to the Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Medicaid Adult Core Set) for further details on this measure: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-Adult-Core-Set-Manual.pdf>. This measure incorporates updates to the Medicaid Adult Core measures, as outlined in the 2013 Addendum to the Medicaid Adult Core Set Specifications: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-Adult-Core-Set-Manual-Addendum.pdf>.
 - To identify all non-maternal discharges with an ICD-9-CM principal diagnosis code for COPD, please refer to Table MA-5. Codes with an asterisk must be accompanied by a secondary diagnosis code of COPD. Please refer to Table MA-6 for secondary diagnosis of COPD; ICD-9-CM Asthma diagnosis codes.
 - Member months refers to the number of months each Medicare-Medicaid member was enrolled in the MMP in the year. Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable. Determine member months using the 1st of the month. This date must be used consistent from member to member, month to month and from year to year. For example, if Ms. X is enrolled in the organization on January 1, Ms. X contributes one member month in January.
 - Age is based on date of admission.
 - MMPs should exclude:
 - Transfer from a hospital (different facility).
 - Transfer from a skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF).
 - Transfer from another health care facility.
 - MDC 14 (pregnancy, childbirth, and puerperium).

Table MA-5: Codes to Identify Chronic Obstructive Pulmonary Disease

ICD-9-CM

4660*, 490*, 4910, 4911, 49120, 49121, 4918, 4919, 4920, 4828, 494, 4940, 4941, 469

Table MA-6: Codes to Identify Asthma	
ICD-9-CM	
49300, 49301, 49302, 49310, 49311, 49312, 49320, 49321, 49322, 49381, 49382, 49390, 49391, 49392	

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 transmission site established by CMS. This site can be accessed at the following web address:
<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>

MA6.2 Congestive heart failure (CHF) admission rate.

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

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of member months.	Total number of member months during the reporting period.	Field Type: Numeric
B.	Total number of non-maternal discharges with an ICD-9-CM principal diagnosis code for CHF.	The number of non-maternal discharges with an ICD-9-CM principal diagnosis code for CHF 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 discharges with a primary diagnosis of CHF per 100,000 member months.
- E. Notes - additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should include all members aged 18 years and older,⁶ regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
 - MMPs should refer to pages 38-43 of the CMS Technical Specifications and Resource Manual for Federal Fiscal Year 2013 related to the Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Medicaid Adult Core Set) for further details on this measure: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-Adult-Core-Set-Manual.pdf>. This measure incorporates updates made to the Medicaid Adult Core measures, as outlined in the 2013 Addendum to the Medicaid Adult Core Set Specifications: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-Adult-Core-Set-Manual-Addendum.pdf>.
 - To identify all non-maternal discharges with an ICD-9-CM principal diagnosis code for CHF, please refer to Table MA-7.
 - Member months refers to the number of months each Medicare-Medicaid member was enrolled in the MMP in the year. Each member should have a member month value between 1 and 12. A value greater than 12 is not acceptable. Determine member months using the 1st of the month. This date must be used consistent from member to member, month to month and from year to year. For example, if Ms. X is enrolled in the organization on January 1, Ms. X contributes one member month in January.
 - Age is based on date of admission.
 - MMPs should exclude:
 - Transfer from a hospital (different facility).
 - Transfer from a skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF).

⁶ Massachusetts Demonstration population includes individuals ages 21 through 64 at the time of enrollment; therefore, all members will be 18 years and older.

- Transfer from another health care facility.
- MDC 14 (pregnancy, childbirth, and puerperium).

Table MA-7: Codes to Identify Congestive Heart Failure
ICD-9-CM
39891, 4280, 4281, 42820, 42821, 42822, 42823, 42830, 42831, 42832, 42833, 42840, 42841

- 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 transmission site established by CMS. This site can be accessed at the following web address:
<https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx>