MEDICARE-MEDICAID
CAPITATED FINANCIAL ALIGNMENT MODEL
REPORTING REQUIREMENTS

Effective as of January 1, 2014, issued November 25, 2013

Table of Contents

Introduction

The Medicare-Medicaid Financial Alignment Initiative is designed to test innovative models to better align Medicare and Medicaid financing and the services provided to Medicare-Medicaid enrollees.

The purpose of this document is to provide Medicare-Medicaid Plans (MMPs) with the reporting requirements for the capitated financial alignment model. It provides technical specifications to help assure a common understanding of the data to be reported by MMPs, to assist MMPs in preparing and submitting datasets, to ensure a high level of accuracy in the data reported to the Centers for Medicare & Medicaid Services (CMS) and the states, and to reduce the need for MMPs to correct and resubmit data.

The reporting requirements document is divided into three sections. The first section consists of all Medicare Part C reporting requirements the MMPs are responsible for submitting via the Health Plan Management System (HPMS). The second section consists of all Medicare Part D reporting requirements the MMPs are responsible for submitting via HPMS. These requirements are consistent with the Medicare Parts C and D plan reporting requirements. The third section consists of the core requirements for the capitated financial alignment model, which include some modified Part C and D measures. Specifications for these demonstration measures will indicate their reporting frequency and due dates.

Unmodified Part C and Part D measures, as described in the first two sections, will continue to be reported using existing processes and specifications. For Part D measures, an extra data element, letter “F”, has been added to the specifications to clarify that these measures are reported using HPMS. MMPs will be responsible for submitting data collected for the capitated financial alignment model through a secure transmission site that was developed specifically for the demonstrations. This site can be accessed at the following web address:

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

The following terms are used throughout the document:

Medicare-Medicaid Plan (MMP): An MMP is a managed care plan that has entered into a three-way contract with CMS and the state in which the plan will operate. Note: some demonstrations might use different terms to refer to their plans, such as One Care plans in Massachusetts.

State: The state with which the MMP has contracted.

Health Plan Management System (HPMS): The CMS centralized information system used by MMPs to submit Part C and Part D measure data.

Measures should be reported at the contract level, unless otherwise indicated.

Passive Enrollment and Stopping Enrollment

Under the capitated financial alignment model, demonstrations may allow for passive enrollment. During passive enrollment, MMPs must demonstrate adequate performance across a range of measures to remain eligible to receive passive enrollment of beneficiaries. Failure to adequately meet any single measure or set of measures may result in CMS and the state ceasing enrollment. CMS and each state, through the Contract Management Team (CMT), will have the option to discontinue passive enrollment for MMPs for various reasons, including for MMPs failing to completely and accurately report measures or to adequately meet performance standards.

Quality Withhold Measures

CMS and each state will also establish a set of quality withhold measures, and MMPs will be required to meet established thresholds. Throughout this document, these measures are marked with the following symbol: ([i]). Additional information on the withhold methodology and benchmarks will be provided at a later time.

Medicare Part C Reporting Requirements

Part C Section III. Serious Reportable Adverse Events (SRAE)

Reporting Section	Organization Types Required to Report	Reporting Frequency/ Level	Reporting Period(s)	Due Date
3. Serious Reportable Adverse Events	05 – MMP	1/Year Contract	1/1 – 12/31	2/28 of following year

Data elements reported under this reporting section are:

Element Number	Data Elements for Serious Reportable Adverse Events Reporting Section (includes SRAE and HAC)	Comments
3.1	Number of total surgeries.	Must have occurred in acute hospital.
3.2	Number of surgeries on wrong body part.	Must have occurred in acute hospital.
3.3	Number of surgeries on wrong patient.	Must have occurred in acute hospital.
3.4	Number of wrong surgical procedures on a patient.	Must have occurred in acute hospital.
3.5	Number of surgeries with postoperative death in normal health patient.	Must have occurred in acute hospital.
3.6	Number of surgeries with foreign object left in patient after surgery.	Must have occurred in acute hospital.
3.7	Number of Air Embolism events.	Must have occurred in acute hospital.
3.8	Number of Blood Incompatibility events.	Must have occurred in acute hospital.
3.9	Number of Stage III & IV Pressure Ulcers.	Must have occurred in acute hospital.
3.10	Number of fractures.	Must have occurred in acute hospital.
3.11	Number of dislocations.	Must have occurred in acute hospital.
3.12	Number of intracranial injuries.	Must have occurred in acute hospital.
3.13	Number of crushing injuries.	Must have occurred in acute hospital.
3.14	Number of burns.	Must have occurred in acute hospital.
3.15	Number of Vascular Catheter-Associated Infections.	Must have occurred in acute hospital and be diagnosed during hospital stay.
3.16	Number of Catheter-Associated UTIs.	Must have occurred in acute hospital and be diagnosed during hospital stay.
3.17	Number of Manifestations of Poor Glycemic Control.	Must have occurred in acute hospital and be diagnosed during hospital stay.

Element Number	Data Elements for Serious Reportable Adverse Events Reporting Section (includes SRAE and HAC)	Comments
3.18	Number of SSI (Mediastinitis) after CABG.	30-day inclusion period following discharge. Data for the CC/MCC code to be found from hospital claims only.*
3.19	Number of SSI after certain Orthopedic Procedures.	365-day inclusion period following discharge. Data for the CC/MCC code to be found from hospital claims only.*
3.20	Number of SSI following Bariatric Surgery for Obesity.	30-day inclusion period following discharge. Data for the CC/MCC code to be found from hospital claims only.*
3.21	Number of DVT and pulmonary embolism following certain orthopedic procedures.	Must have occurred in acute hospital and be diagnosed during hospital stay.

* Note: The inclusion periods for elements 3.18, 3.19, and 3.20 are specified by using a "look-back" approach. The hospital-acquired condition (HAC) diagnosis must occur during the reporting period (1/1 – 12/31). The procedure must have occurred prior to the HAC or at the same time as the HAC (implying association) and could be on a different claim. The inclusion period may have a look-back extended into the previous year—year prior to the reporting period.

Notes

This reporting section requires direct data entry into HPMS.

See Part C Appendix 1 for the codes to identify Serious Reportable Adverse Events (SRAE). Some SRAE do not have codes, but these events are so egregious and rare that the hospitals should be able to report them to the plans. Plans should use both primary and secondary diagnosis and procedure code fields to identify the event.

Note: Any patient admitted with SRAE and/or HAC is to be excluded from this reporting section. CMS reminds reporters that only those acute care inpatients who suffer SRAE and/or HAC after admission, during their hospital stay, should be included in this reporting section. Generally, the Present on Admission (POA) indicator must be 'N,' for 'No,' for a condition to be counted as a hospital-acquired condition. However, data elements 3.18, 3.19, and 3.20 are exceptions to this since they involve SRAE/HAC with long inclusion periods. If a beneficiary has SRAE/HAC that resulted from a previous hospitalization and is readmitted, either as a result of the SRAE/HAC and/or for other reasons, the POA indicator could be "Y" and the SRAE/HAC should still be counted.

Data elements 3.15 – 3.17 and 3.21 must have occurred during the stay. Data Elements 3.18 – 3.20 have follow-up periods that are specified in the reporting section; data for

the CC/MCC code to be found from hospital claims only (i.e., same hospital claim with the procedure and/or subsequent hospital claim).

SRAE and/or HAC acquired after admission to Long Term Acute Care facilities should not be counted for this reporting section (see below).

Organizations are required to report on these events and are also required to differentiate among the three possibilities listed: surgery on wrong body part, surgery on wrong patient, and wrong surgical procedures on a patient. These are egregious events that could require some plan follow-up with the hospitals involved.

For purposes of the Part C reporting requirements, plans should be reporting SRAE data consistent with the current CMS hospital reporting requirements unless those requirements conflict with these technical specifications. In most, if not all cases, plans will be receiving the SRAE data from hospitals; therefore, this should not ordinarily present a problem with reporting requirements.

An SRAE report should be pulled by date of service, and any re-run done as close as possible to the reporting date. However, if a report by date of service is not practical or possible then a report by discharge date is acceptable.

Plans should report the number of surgeries occurring only in acute inpatient hospital settings.

A single episode cannot count in more than one category unless multiple SRAE and/or HAC occur during that single episode. For purposes of this reporting section, you may use American Society of Anesthesiologists (ASA) category #1 to identify a person of normal health. For determining an ASA category #1 patient, CMS recommends following-up with the hospital to obtain the documentation from the medical record. SRAE are rare, and CMS believes hospitals should be able to report them to plans outside of an automated information system if no such system captures these events.

All SRAEs and HACs are mutually exclusive. If a claim has a code for a hip replacement and knee replacement, the SRAE or HAC would count for both—one SRAE or HAC associated with the hip replacement, and one associated with the knee replacement.

Surgical Site Infection (SSI) (Mediastinitis) after CABG (Data Element 3.18)

For the SSI (Mediastinitis) after CABG event, the diagnosis code and the procedure code may be on different claims. If they are on different claims, they do not need to be on the same date of service to be counted for this reporting section.

The inclusion period for dates of service should extend 30 days from discharge.

SSI after certain Orthopedic Procedures Data Element 3.19

After certain orthopedic procedures events, the diagnosis code and the procedure code may be on different claims, and do not have to occur on the same date of service. The inclusion period should extend 365 days after discharge.

SSI following Bariatric Surgery (Data Element 3.20)

For the SSI following bariatric surgery for obesity events, the diagnosis code and the procedure code can be on different claims, and may be on the same date of service. The inclusion period should extend 30 days after discharge.

Additional Guidance:

Events in the prior measurement year that were not reported because they were not confirmed should be reported in the current measurement year. For example, if an event occurred in 2011 and it is confirmed in 2012, include the event on the 2012 report that is due in 2013.

Only inpatient claims are to be used in identifying SRAE/HAC.

Surgeries are defined as the number of discharges accompanied by UB Revenue code 036X, excluding maternity-related discharges (HEDIS-like method).

Adverse health conditions present upon admission should be excluded from this reporting section.

For surgical site infection hospital-acquired conditions (HAC), the diagnosis code and procedure may be on the same claim, or on different claims.

Plans should only use paid claims for the SRAE reporting section.

Exception: Denied claims should be included if they are not reimbursable by CMS such as “Never Events” or HAC.

It is not necessary for SRAE claims to contain *every* qualifier to be counted for this reporting section. For example, Vascular-Catheter Associated Infections (Data Element 3.15) does not need an ICD9 (Dx), ICD9 (procedure), CPT and DRG on a claim. One of these code types (as specified in Part C Appendix 1, Tables 1-3) is sufficient to identify a claim as SRAE/HAC.

Plans may map their non-standard or homegrown codes to those codes provided in Part C Appendix 1 as necessary for identification of procedures associated with any SRAE or HAC. Plans may also map SRAE and HAC that are typically documented by Hospital Review personnel to codes in Part C Appendix 1 as necessary.

Location(s) of an ulcer on a patient is unimportant for this reporting section; it is only important to note that an ulcer(s) did not present on admission (POA).

For this reporting section, an ‘episode’ is defined as an interval of health care occurring in an acute care hospital care facility for a specific medical problem or condition. It consists of the period between admission and discharge or observation followed by admission and then discharge from the acute care hospital.

If an episode falls into more than one element, count all elements. For example, if a burn was followed by a crushing injury, report **both** the burn and the crushing injury.

For those instances where a member incurs multiple SRAE or HAC associated with multiple procedures, report the SRAE or HAC associated with all those procedures.

Plans may use ‘expanded ranges’ with procedure and disease codes. “Expanded ranges” refer to codes that further specify the procedure or disease.
Other Categorizations of SRAE:

Categorize as follows:

SRAE	**Categorize as**
Effects of reduced temperature (ICD-9-CM = 991)	Burns
Effects of heat/light (ICD-9-CM = 992)	Burns
Effects of air pressure (ICD-9-CM = 993)	Crushing Injuries

Part C Section V. Grievances

Reporting Section	Organization Types Required to Report	Reporting Frequency/ Level	Reporting Period(s)	Due Date
5. Grievances	05 – MMP	1/Year PBP	1/1 – 3/31 4/1 – 6/30 7/1 – 9/30 10/1 – 12/31	2/28 of following year

Data elements reported under this reporting section are:

Grievance Category	Total number of Grievances	Number of grievances which the Sponsor provided timely notification of its decision*
No. Fraud Grievances (5.1)		Does not apply to this category
Enrollment/Disenrollment (5.2)		(5.11)
Benefit Package Grievances (5.3)		(5.12)
Access Grievances (5.4)		(5.13)
Marketing Grievances (5.5)		(5.14)
Customer Service Grievances (5.6)		(5.15)
Privacy Issues Grievances (5.7)		Does not apply to this category
Quality Of Care Grievances (5.8)		(5.16)
Appeals Grievances (5.9)		(5.17)
Other Grievances (5.10)		(5.18)

* Timely notification of grievances means grievances for which the member is notified of decision according to the following timelines:

- For standard grievances: no later than 30 days after receipt of grievance.
- For standard grievances with an extension taken: no later than 44 days after receipt of grievance.
- For expedited grievances: no later than 24 hours after receipt of grievance.

Notes

This reporting section requires direct data entry into HPMS.

For an explanation of Medicare Part C grievance procedures, refer to CMS regulations and guidance: 42 CFR Part 422, Subpart M, and Chapter 13 of the Medicare Managed Care Manual, and the CMS website: http://www.cms.gov/MMCAG/. For an explanation of grievance procedures for MMPs, refer to the state-specific contract and/or Memorandum of Understanding (MOU).

CMS requires plans to use one of eighteen categories described in this section to report grievances to CMS (Elements 5.1 – 5.18). For purposes of Reporting Section 5 (V):

- **Grievances** are defined as those grievances completed (i.e., plan has notified enrollee of its decision) during the reporting period, regardless of when the request was received; and include grievances filed by the enrollee or his or her representative.

Reporting Inclusions:

Report:

- Only those grievances processed in accordance with the plan grievance procedures outlined in 42 CFR Part 422, Subpart M (i.e., Part C grievances).
- Report grievances involving multiple issues under each applicable category.
- Report grievances if the member is ineligible on the date of the call to the plan but was eligible previously.

Reporting Exclusions:

Do not report:

- Enrollee complaints only made through the CMS Complaints Tracking Module (CTM). CTM complaints are addressed through a process that is separate and distinct from the plan's procedures for handling enrollee grievances. Therefore, plans should not report their CTM records to CMS as their grievance logs.
- Withdrawn grievances.
- Enrollee grievances processed in accordance with the grievance procedures described under 42 C.F.R., Part 423, Subpart M (i.e., Part D grievances).

Additional Guidance

- If an enrollee files a grievance and then files a subsequent grievance on the same issue prior to the organization's decision or deadline for decision notification (whichever is earlier), then the issue is counted as one grievance.
- If an enrollee files a grievance and then files a subsequent grievance on the same issue after the organization's decision or deadline for decision notification (whichever is earlier), then the issue is counted as a separate grievance.
- For MA-PD contracts: Include only grievances that apply to the Part C benefit. (If a clear distinction cannot be made for an MA-PD, cases are reported as Part C grievances.)
- For additional details concerning Reporting Section 5 reporting requirements, see Part C Appendix 3: FAQs: Reporting Sections 5 (V) & 6 (VI).

Part C Section VI. Organization Determinations/Reconsiderations

Reporting Section	Organization Types Required to Report	Reporting Frequency/ Level	Reporting Period(s)	Due Date
6. Organization Determinations/ Reconsiderations	05 – MMP	1/Year Contract	1/1 – 3/31 4/1 – 6/30 7/1 – 9/30 10/1 – 12/31 (2/28 reporting will include each quarter).	2/28 of following year

Data elements reported under this reporting section are:

Element Number	Data Elements for Organization Determinations/Reconsiderations
6.1	Number of Organization Determinations – Fully Favorable
6.2	Number of Organization Determinations – Partially Favorable
6.3	Number of Organization Determinations – Adverse
6.4	Number of Reconsiderations – Fully Favorable
6.5	Number of Reconsiderations – Partially Favorable
6.6	Number of Reconsiderations – Adverse

Notes

This reporting section requires direct data entry into HPMS.

For an explanation of Part C organization determination and reconsideration procedures, refer to CMS regulations and guidance: 42 CFR Part 422, Subpart M, and Chapter 13 of the Medicare Managed Care Manual, and the CMS website: http://www.cms.gov/MMCAG/.

All plan types listed in the table at the beginning of this section are required to report: organization determinations and reconsiderations, as described in this guidance, regardless of whether the request was filed by an enrollee, the enrollee's representative, a physician or a noncontract provider who signed a Waiver of Liability.

For instances when the organization approves an initial request for an item or service (e.g., physical therapy services) and the organization approves a separate additional request to extend or continue coverage of the same item or service, include the decision to extend or continue coverage of the same item or service as another, separate, fully favorable organization determination.

CMS requires plans to report requests for organization determinations and reconsiderations submitted to the plan. For purposes of Reporting Section 6 (VI):

- An **organization determination** is a plan's response to a request for coverage (payment or provision) of an item or service – including auto-adjudicated claims, prior authorization requests, and requests to continue previously authorized ongoing courses of treatment. It includes requests from both contract and non-contract providers.
- A **reconsideration** is a plan's review of an adverse or partially favorable organization determination.
- A **Fully Favorable** decision means an item or service was covered in whole.
- A **Partially Favorable** decision means an item or service was partially covered. For example, if a claim has multiple line items, some of which were paid and some of which were denied, it would be considered partially favorable. Also, if a pre-service request for 10 therapy services was processed, but only 5 were authorized, this would be considered partially favorable.
- An **Adverse** decision means an item or service was denied in whole.
- In contrast to claims (payment decisions), **service authorizations** include all service related decisions, including pre-authorizations, concurrent authorizations and post authorizations.

If a provider (e.g., a physician) declines to provide coverage an enrollee has requested or offers alternative services, the provider is making a treatment decision, not an organization determination on behalf of the plan. In this situation, if the enrollee disagrees with the provider's
decision, and still wishes to obtain coverage of the service or item, the enrollee must contact the Medicare health plan to request an organization determination or the provider may request the organization determination on the enrollee's behalf.

Reporting Inclusions:

Organization Determinations:

- All fully favorable payment (claims) and service-related organization determinations for contract and non-contract providers/suppliers.
- All partially favorable payment (claims) and service-related organization determination for contract and non-contract providers/suppliers.
- All adverse payment (claims) and service-related organization determinations for contract and non-contract providers/suppliers.

Reconsiderations:

- All fully favorable payment (claims) and service-related reconsideration determinations for contract and non-contract providers/suppliers.
- All partially favorable payment (claims) and service-related reconsideration
  determinations for contract and non-contract providers/suppliers.
- All adverse payment (claims) and service-related reconsideration determinations for contract and non-contract providers/suppliers.

Additional Guidance

Report:

Completed organization determinations and reconsiderations (i.e., plan has notified enrollee of its decision concerning a requested item or service or adjudicated a claim) during the reporting period, regardless of when the request was received. Plans are only to report the coverage determination or reconsideration requests as described in this section and processed in accordance with the organization determination and reconsideration procedures described under 42 C.F.R. Part 422, Subpart M.

Claims with multiple line items at the "summary level."

- A **request for payment** as a separate and distinct organization determination, even if a pre-service request for that same item or service was also processed.21
- A denial of **Medicare payment** for item or service as either partially favorable or adverse, regardless of whether Medicaid payment ultimately is provided, in whole or in part, for that item or service.

Do not report:

- Withdrawals and dismissals.
- Independent Review Entity (IRE) decisions.
- Duplicate payment requests concerning the same service or item. Payment requests returned to a provider/supplier in which a substantive decision (fully favorable, partially favorable or adverse) has not been made– e.g., payment requests or forms are incomplete, invalid or do not meet the requirements for a Medicare claim (e.g., due to a clerical error).
- A Quality Improvement Organization (QIO) review of an individual's request to continue Medicare-covered services (e.g., a SNF stay) and any related claims/requests to pay for continued coverage based on such QIO decision.
- Enrollee complaints only made through the CMS Complaints Tracking Module
  (CTM).

NOTE: For purposes of this current reporting effort, plans are not required to distinguish between standard and expedited organization determinations or standard and expedited reconsiderations.

For additional details concerning the Reporting Section 6 reporting requirements, see Part C Appendix 3: FAQs: Reporting Sections 5 (V) & 6 (VI)

Part C Section XV. Part C Appendix 1: Codes to Identify Serious Reportable Adverse Events

Important: The Present on Admission (POA) indicator must be 'N,' for 'No,' for a condition to be counted as a serious reportable adverse event or as a hospital-acquired condition.

Table 1: Serious Adverse Reportable Events Codes [ii]

Event Description	CPT	ICD-9-CM Procedure	ICD-9-CM Diagnosis	MS-DRG
Surgery on Wrong Body Part	n/a	n/a	E876.7 Performance of correct operation on wrong side/body part	n/a
Surgery on Wrong Patient	n/a	n/a	E876.6 Performance of operation on patient not scheduled for surgery: performance of operation on wrong patient	n/a
Wrong Surgical Procedures on a Patient	n/a	n/a	E876.5 Performance of wrong operation on correct patient AND/OR E876.6: Performance of operation on patient not scheduled for surgery: performance of operation on wrong patient	n/a
Surgery with Post-Operative Death in Normal Health Patient	ASA category 1 (a normal healthy patient).			

[ii] Refer to pages 47206—47213 42 CFR Parts 411, 412, 413, and 489 Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Federal Register/ Vol. 72, No. 162 / Wednesday, August 22, 2007 / Rules and Regulations.

Tables 2 and 3 below lists the codes for identifying HAC data.

CPT only copyright 2012 American Medical Association. All rights reserved.

Table 2: Hospital Acquired Conditions (HAC) from 2008 IPPS Final Rule [iii]

Selected HAC	CC/MCC (ICD-9-CM Codes)
Foreign Object Retained After Surgery	998.4 (CC) 998.7 (CC)
Air Embolism	999.1 (MCC)
Blood Incompatibility	999.6 (CC)
Stage III & IV Pressure Ulcers	The diagnosis codes for stage III and IV Pressure Ulcers are as follows: 707.23 Pressure ulcer, stage III 707.24 Pressure ulcer, stage IV
Falls and Trauma: -Fractures -Dislocations -Intracranial Injuries -Crushing Injuries -Burns	Codes within these ranges on the CC/MCC List: 800-829 (Fractures) 830-839 (Dislocations) 850-854 (Intracranial Injuries) 925-929 (Crushing Injuries) 940-949 (Burns)
Vascular Catheter-Associated Infection	999.31 (CC)

[iii] Refer to pages 47200—47220 42 CFR Parts 411, 412, 413, and 489 Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates; Federal Register/ Vol. 72, No. 162 / Wednesday, August 22, 2007 / Rules and Regulations.

Table 3: Hospital Acquired Conditions from 2009 IPPS Rule [iv]

Selected HAC	CC/MCC (ICD-9-CM Codes)
Catheter- Associated UTI	996.64
Vascular Catheter-Associated Infection	999.31 (CC)
Manifestations of Poor Glycemic Control	250.10-250.13 (MCC)250.20-250.23 (MCC)251.0 (CC) 249.10-249.11 (MCC) 249.20-249.21 (MCC)
Surgical Site Infection-Mediastinitis after Coronary Artery Bypass Graft (CABG)	519.2 (MCC) And one of the following procedure codes: 36.10–36.19
Surgical Site Infection Following Certain Orthopedic Procedures	996.67 (CC) 998.59 (CC) And one of the following procedure codes: 81.01-81.08, 81.23-81.24, 81.31-81.83,81.85

Selected HAC	CC/MCC (ICD-9-CM Codes)
Surgical Site Infection Following Bariatric Surgery for Obesity	Principal Diagnosis – 278.01 998.59 (CC) and one of the following procedure codes: 44.38, 44.39, or 44.95
Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures	415.11 (MCC) 415.19 (MCC) 453.40-453.42 (MCC) And one of the following procedure codes: 00.85-00.87, 81.51-81.52, or 81.54

[iv] Based on CMS-approved document (p. 240) submitted to the Office of the Federal Register (OFR) for publication. The document may vary slightly from the published document if minor editorial changes have been made during the OFR review process. Upon publication in the Federal Register, all regulations can be found at http://www.gpoaccess.gov/fr/ and at http://www.cms.hhs.gov/QuarterlyProviderUpdates/. The document published in The Federal Register is the official CMS-approved document.

Part C Section XVII. Part C Appendix 3: FAQs: Reporting Sections 5 (V) & 6 (VI)

Grievances, Organization Determinations, & Reconsiderations

	Plan Inquires	CMS Responses
1.	Should plans report informal complaints as Grievances under the Part C reporting requirements? For example: During the course of a home visit, a member expresses dissatisfaction regarding a particular issue. The member does not contact the plan directly to file a complaint, but the plan representative determines the member is not happy and logs the issue for Quality Improvement tracking.	Plans are to report any grievances filed directly with the plan and processed in accordance with the plan grievance procedures outlined under 42 CFR Part 422, Subpart M. Plans are not to report complaints made to providers, such as the complaint in the example provided, that are not filed with the plan.
2.	Should plans report all Dual Eligible member grievances to CMS?	Plans will report Part C Grievances as outlined in Part C Section V (pg. 11) which should only be those Dual Eligible enrollee grievances processed in accordance with the plan grievance procedures outlined under 42 CFR Part 422, Subpart M. In addition, plans will report grievances as outlined in MMP Section 4.2 (pg.64) of this document which will include grievances filed under the state Medicaid process.
3.	Is a plan to report a grievance, organization determination or reconsideration to CMS when the plan makes the final decision or when the request is received?	Plans are to report grievances, organization determinations and reconsiderations that were completed (i.e., plan has notified enrollee of its decision or provided or paid for a service, if applicable) during the reporting period, regardless of when the request was received.

	Plan Inquires	CMS Responses
4.	Are plans to report only those organization determinations defined under 42 C.F.R. 422.566?	CMS requires plans to report requests for payment and services, as described in the Part C Technical Specifications, Reporting section 6. Plans are to report requests for payment and services consistent with CMS regulations at 42 C.F.R. Part 422, Subpart M as "organization determinations" – i.e., a relatively broader category of requests for coverage. For example, plans are to include adjudicated claims in the reportable data for Organization Determinations.
5.	We are seeking information on how we should report pre-service requests and claims requests for this category. Do you want fully favorable, partially favorable, and adverse for both pre-service requests and claims requests?	Yes. Plans are to report fully favorable, partially favorable, and adverse pre-service and claims requests (organization determinations and reconsiderations).
6.	If we have a prior authorization request and a claim for the same service - is that considered a duplicate or should we report both?	Plans are to report both a prior authorization request and a claim for the same service; this is not considered a duplicate.
7.	Is a request for a predetermination to be counted as an organization determination? Does it matter who requests the predetermination – contracted provider, non-contracted provider or member? If so, should they also be counted as partially and fully unfavorable?	Organization determinations include a request for a pre-service ("predetermination") decision submitted to the plan, regardless of who makes the pre-service request – e.g., a contracted provider, non-contracted provider or member. Plans are to report partially favorable, adverse and fully favorable pre-service organization determinations.
8.	Should plans report determinations made by delegated entities or only decisions that are made directly by the plan – e.g., should plans report decisions made by contracted radiology or dental groups?	Yes. Plans are to report decisions made by delegated entities – such as an external, contracted entity responsible for organization determinations (e.g., claims processing and pre-service decisions) or reconsiderations.

	Plan Inquires	CMS Responses
9.	The Tech Specs advise plans to exclude certain duplicate/edits when reporting on the claim denial requirement. Is the intent to exclude duplicates or is it to exclude "billing" errors or both? For example, if a claim is denied because the provider didn't submit the claim with the required modifier, should that be excluded from the count?	Plans are to report organization determinations where a substantive decision (fully favorable, partially favorable, and adverse) has been made. Plans should exclude duplicate claim submissions (e.g., a request for payment concerning the same service) and claims returned to a provider/supplier due to error (e.g., claim submissions or forms that are incomplete, invalid or do not meet the requirements for a Medicare claim).
10.	Do we have to include lab claims for this reporting section? Do we need to report the ones which involve no pre-service as well as the ones that involve pre-service?	Yes. Plans are to report lab claims. Even in the absence of a pre-service request, a request for payment (claim) is a reportable organization determination.
11.	Enrollee is hospitalized for heart surgery, no prior authorization is required and the claim is paid timely in accordance with full benefit coverage. Our reading of the Medicare Managed Care Manual reveals that the organization is only required to notify the enrollee of Partially Favorable or Adverse decisions. There is no requirement to notify enrollees of Fully Favorable decisions. Is this an organization determination?	Prior authorization is not required to consider a decision an organization determination. A submitted claim is a request for an organization determination. All paid claims are reportable (fully favorable) organization determinations. Timeframe and notification requirements for Fully Favorable determinations are described under 42 C.F.R 422.568(b) and (c). Written notice is required for Partially Favorable, and Adverse determinations.
12.	Enrollee obtains a rhinoplasty for purely cosmetic reasons, which is a clear exclusion on the policy. Enrollee and provider both know this is likely not covered but they submit the claim. Claim is denied as an exclusion/ noncovered service. Neither the enrollee nor the provider pursues it any further. Is this an organization determination?	The plan is to report this denial as an organization determination. A request for payment (claim) is a reportable organization determination.

	Plan Inquires	CMS Responses
13.	Enrollee is out of area and in need of urgent care. Provider is out of area / network. The enrollee calls plan and requests a coverage determination for this service. Health Plan approves use of out of area services. Claim is submitted and paid in full. Is this counted as one event (i.e., pre-auth and claim not counted as two events)?	In this example, both the pre-service decision and claim are counted as two, separate fully favorable organization determinations. A claim submitted for payment is an organization determination request. Claims paid in full are reportable (fully favorable) organization determinations.
14.	When an organization determination is extended into the future does that extension count in the reporting of org determinations (e.g. on-going approval for services approved in the initial decision)?	Yes. Plans generally are to count an initial request for an organization determination (request for an ongoing course of treatment) as separate from any additional requests to extend the coverage. For example, plans are to count an initial approved request for physical therapy services as one organization determination. If the plan, later, approves a subsequent request to continue the ongoing services, the plan should count the decision to extend physical therapy services as another, separate organization determination.
15.	Our interpretation is that the term “contracted provider” means “contracted with the health plan” not “contracted with Medicare.”	Yes. For purposes of Part C Reporting Section 6 reporting requirements, “contracted provider” means “contracted with the health plan” not “contracted” (or participating) with Medicare.”
16.	When we make an adverse determination that is sent to the QIO for review and later our adverse determination is overturned, should we count and report the initial Adverse determination that goes to the QIO? We understand that QIO determinations are excluded from our reporting.	Yes. Regardless of whether a QIO overturns an Adverse organization determination, plans are to report the initial adverse or partially favorable organization determination.

	Plan Inquires	CMS Responses
17.	Should cases forwarded to the Part C IRE be counted once in the reporting section, i.e., as the Partially Favorable or adverse decision prior to sending to the IRE?	When a plan upholds its adverse or partially favorable organization determination at the reconsideration level, the plan generally must report both the adverse or partially favorable organization determination and reconsideration. Exceptions: Plans are not to report: 1.) Withdrawn or dismissed cases, or 2.) QIO determinations concerning an inpatient hospital, skilled nursing facility, home health and comprehensive outpatient rehabilitation facility services terminations.

Medicare Part D Reporting Requirements

Part D Section I. Enrollment and Disenrollment

CMS provides guidance for Part D Sponsors' processing of enrollment and disenrollment requests.

Both Chapter 2 of the Medicare Managed Care Manual and Chapter 3 of the Medicare Prescription Drug Manual outline the enrollment and disenrollment periods (Section 30) enrollment (Section 40) and disenrollment procedures (Section 50) for all Medicare health and prescription drug plans.

CMS will collect data on the elements for these requirements, which are otherwise not available to CMS, in order to evaluate Sponsors' processing of enrollment and disenrollment requests in accordance with CMS requirements. For example, while there are a number of factors that result in an individual's eligibility for a Special Enrollment Period (SEP), Sponsors are currently unable to specify each of these factors when submitting enrollment transactions. Sponsors' reporting of data regarding SEP reasons for which a code is not currently available will further assist CMS in ensuring Sponsors are providing support to beneficiaries, while complying with CMS policies.

Data elements 1.A-1.O must include all enrollments. Disenrollments must not be included in Section 1 Enrollment.

Section 2 Disenrollment must include all opt-in disenrollment transactions.

Reporting timeline:

	Period 1	**Period 2**
Reporting Period	January 1 - June 30	July 1 – December 31
Data due to CMS/HPMS	August 31	February 28

Data elements to be entered into the HPMS at the Contract level:

1. **Enrollment:**
   A. The total number of enrollment requests received in the specified time period.
   B. Of the total reported in A, the number of enrollment requests complete at the time of initial receipt (i.e. required no additional information from applicant or his/her authorized representative).
   C. Of the total reported in A, the number of enrollment requests for which the Sponsor was required to request additional information from the applicant (or his/her representative).
   D. Of the total reported in A, the number of enrollment requests denied due to the Sponsor's determination of the applicant's ineligibility to elect the plan (i.e. individual not eligible for an election period).

E. Of the total reported in C, the number of incomplete enrollment requests received that are incomplete upon initial receipt and completed within established timeframes.
F. Of the total reported in C, the number of enrollment requests denied due to the applicant or his/her authorized representative not providing information to complete the enrollment request within established timeframes.
G. Of the total reported in A, the number of paper enrollment requests received.
H. Of the total reported in A, the number of telephonic enrollment requests received (if Sponsor offers this mechanism).
I. Of the total reported in A, the number of internet enrollment requests received via plan website (if Sponsor offers this mechanism).
J. Of the total reported in A, the number of Medicare Online Enrollment Center (OEC) enrollment requests received.
K. For stand-alone prescription drug plans (PDPs) only: Of the total reported in A, the number of enrollment requests effectuated by sales persons (as defined in Chapter 3 of the Medicare Managed Care Manual).
L. Of the total reported in A, the number of enrollment transactions submitted using the SEP Election Period code "S" related to creditable coverage.
M. Of the total reported in A, the number of enrollment transactions submitted using the SEP Election Period code "S" related to SPAP.
N. For stand-alone prescription drug plans (PDPs) only: Of the number reported in A, the total number of enrollment transactions submitted using the SEP Election Period code "S" that coordinates with the Medicare Advantage Disenrollment Period.
O. Of the total reported in A, the number of enrollment transactions submitted using the SEP Election Period Code “S” for individuals affected by a contract nonrenewal, plan termination or service area reduction.

2. Disenrollment:

A. The total number of opt-in disenrollment requests received in the specified time period.
B. Of the total reported in A, the number of disenrollment requests complete at the time of initial receipt (i.e. required no additional information from enrollee or his/her authorized representative).
C. Of the total reported in A, the number of disenrollment requests denied by the Sponsor for any reason.

Part D Section III. Medication Therapy Management Programs

The requirements stipulating that Part D Sponsors provide Medication Therapy Management (MTM) programs are described in Title I, Part 423, Subpart D, § 423.153. For monitoring purposes, Part D Sponsors will be responsible for reporting several data elements related to their MTM program. Data will be uploaded in a data file.

Reporting timeline:

	YTD
Reporting Period	January 1 - December 31
Data due to CMS/HPMS	February 28

Sponsors are required to target beneficiaries for the MTM program who meet specific criteria as specified by CMS in § 423.153(d). Some Sponsors also offer enrollment in the MTM program to other members who do not meet the specific CMS targeting criteria.

The following information will be collected for each beneficiary identified as being eligible for the Part D MTM program, whether based on CMS' specifications or other plan-specific targeting criteria within the reporting period. Regardless of this designation, the corresponding MTM services delivered to each beneficiary (such as targeted medication review or comprehensive medication review) must meet CMS definitions. The reported beneficiaries must receive MTM services that meet or exceed CMS' MTM program requirements.

A. Contract Number.
B. HICN or RRB Number.
C. Beneficiary first name.
D. Beneficiary middle initial.
E. Beneficiary last name.
F. Beneficiary date of birth.
G. Met the specified targeting criteria per CMS – Part D requirements. (Y (yes) or N (no)).
H. Beneficiary identified as cognitively impaired at time of comprehensive medication review (CMR) offer or delivery of CMR. (Y (yes), N (no), or U (unknown)).
I. Date of MTM program enrollment.
J. Date met the specified targeting criteria per CMS – Part D requirements. Required if met the specified targeting criteria per CMS – Part D requirements. (May be same as Date of MTM program enrollment)
K. Date of MTM program opt-out.
L. Reason participant opted-out of MTM program (Death; Disenrollment from Plan; Request by beneficiary; or Other). Required if Date of MTM program opt-out is applicable.
M. Offered annual CMR. (Y (yes) or N (no)). Required if met the specified targeting criteria per CMS – Part D requirements.
N. If offered, date of (initial) offer.
O. Received annual CMR with written summary in CMS standardized format. (Y (yes) or N (no)). Required if offered annual CMR.
P. Number of CMRs received with written summary in CMS standardized format. Required if received annual CMR.

Q. Date(s) of CMR(s) with written summary in CMS standardized format. (If more than 1 CMR is received, up to 5 dates will be allowed.) Required if received annual CMR.
R. Method of delivery for the annual CMR. (Face-to-face; Telephone; Telehealth consultation; or Other). (If more than 1 CMR is received, report the method of delivery for the initial CMR). Required if received annual CMR.
S. Qualified Provider who performed the initial CMR. (Physician; Registered Nurse; Licensed Practical Nurse; Nurse Practitioner; Physician's Assistant; Local Pharmacist; LTC Consultant Pharmacist; Plan Sponsor Pharmacist; Plan Benefit Manager (PBM) Pharmacist; MTM Vendor Local Pharmacist; MTM Vendor In-house Pharmacist; Hospital Pharmacist; Pharmacist – Other; or Other). Required if received annual CMR.
T. Recipient of CMR. (Beneficiary, Beneficiary's prescriber; Caregiver; or Other authorized individual). Required if received annual CMR.
U. Number of targeted medication reviews. Required if met the specified targeting criteria per CMS – Part D requirements.
V. Number of drug therapy problem recommendations made to beneficiary's prescriber(s) as a result of MTM services. (For reporting purposes, a recommendation is defined as a suggestion to take a specific course of action related to the beneficiary's drug therapy. If the same recommendation is made to multiple prescribers or repeated on multiple dates, then that recommendation should only be counted and reported once. Examples include, **but are not limited to**: Needs additional therapy; Unnecessary drug therapy; Dosage too high; Dosage too low; More effective drug available; Adverse drug reaction; or Medication Non-compliance/Non-adherence).
W. Number of drug therapy problem resolutions resulting from recommendations made to beneficiary's prescriber(s) as a result of MTM recommendations. (For reporting purposes, a resolution is defined as a change or variation from the beneficiary's previous drug therapy. Examples include, **but are not limited to**: Initiate drug; Change drug (such as product in different therapeutic class, dose, dosage form, quantity, or interval); Discontinue or substitute drug (such as discontinue drug, generic substitution, therapeutic substitution, or formulary substitution); Medication compliance/adherence).
X. Topics discussed with the beneficiary during the CMR, including the medication or care issue to be resolved or behavior to be encouraged. (If more than 1 topic discussed, up to 5 topics will be allowed to be reported.) These are the descriptions of the topics listed on the beneficiary's written summary in CMS standardized format in the Medication Action Plan under '*What we talked about*'. Required if received annual CMR.

Part D Section IV. Prompt Payment by Part D Sponsors

The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 added requirements with regard to prompt payment by Part D Sponsors for all clean claims submitted by network pharmacies within specified timeframes for electronic and all other (non-electronically submitted) claims. Mail-order and long-term care (LTC) pharmacies are excluded from these provisions.

Consistent with section 1860D-12(b)(4)(A)(ii) of the Act, a clean claim is defined as a claim that has no defect or impropriety – including any lack of any required substantiating documentation – or particular circumstance requiring special treatment that prevents timely payment of the claim from being made. Part D Sponsors must make payment for clean claims within 14 calendar days of the date on which an electronic claim is received and within 30 calendar days of the date on which non-electronically submitted claims are received. Claims submitted with 100% beneficiary responsibility, i.e., zero plan payment amount, are excluded from this requirement (it is not possible for a Sponsor to pay a pharmacy late for a $0.00 dollar due claim).

Receipt of an electronic claim is defined as the date on which the claim is transferred, and receipt of a non-electronically submitted claim as the 5th calendar day after the postmark day of the claim or the date specified in the time stamp of the transmission, whichever is sooner.

A claim will be deemed to be a clean claim to the extent that the Part D Sponsor that receives the claim does not issue notice to the submitting network pharmacy of any deficiency in the claim within 10 calendar days after an electronic claim is received and within 15 calendar days after a non-electronically submitted claim is received. A claim deemed to be a clean claim must be paid by the Sponsor within 14 calendar days (for an electronic claim) or 30 calendar days (for a non-electronic claim) of the date on which the claim is received.

Reporting timeline:

	Period 1	**Period 2**
Reporting Period	January 1 - June 30	July 1 - December 31
Data due to CMS/HPMS	August 31	February 28

Data elements to be entered into the HPMS at the Contract level:

A. Total number of paid claims.
B. Total number of paid electronic claims.
C. Total number of paid non-electronic (e.g. paper) claims.
D. Total number of paid electronic claims which were not paid timely, according to appropriate time-periods.
E. Total number of paid non-electronic claims which were not paid timely, according to appropriate time-periods.

Part D Section V. Grievances

According to MMA statute, a grievance is any complaint or dispute, other than a coverage determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Part D organization, regardless of whether remedial action is requested. Part D Sponsors are required to notify enrollees of their decision no later than 30 days after receiving their grievance. An extension up to 14 days is allowed if it is requested by the enrollee, or if the Part D Sponsor needs additional information and documents that this extension is in the interest of the enrollee. An expedited grievance that involves refusal by a Part D Sponsor to process an expedited coverage determination or redetermination requires a response from the Part D Sponsor within 24 hours.

When categorizing grievances into core categories, Sponsors may report based on their investigations subsequent to the enrollees' filing of the grievances.

For reporting, Sponsors should:

- Report data based on the date the grievance decision was made.
- Track multiple grievances by a single complainant and report as separate grievances.

For reporting, Sponsors should not:

- Report requests for coverage determinations, exceptions, or redeterminations inappropriately as grievances.
- Only base grievances reporting on CTM data.
- Report general inquiries or questions as grievances.
- Dismiss or exclude any grievances filed by beneficiaries or their appointed representatives from this reporting section.

Sponsors will report quarterly data on an annual basis.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Reporting Period	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	February 28 (reporting for all quarters due on this date)			

Data to be reported at the Contract level:

	Total number of grievances	Number of grievances in which timely notification was given
Total Grievances		
Number of Expedited Grievances		
Enrollment/Disenrollment Grievances		
Plan Benefit Grievances		
Pharmacy Access Grievances		
Marketing Grievances		
Customer Service Grievances		
Coverage Determination and Redetermination Process Grievances		
Quality of Care Grievances		
Grievances related to “CMS Issues”		
Other Grievances		

Part D Section VI. Coverage Determinations and Redeterminations

Title I, Part 423, Subpart M describes Part D Sponsors' requirements for coverage determinations (including formulary and tier exceptions, and exceptions to established drug utilization management programs) and redeterminations, including timeframes for standard and expedited requests. Part B vs. Part D coverage determinations and redeterminations should be included in this reporting. Sponsors should report data based on the date the coverage determination or redetermination decision is made. A Sponsor's complete decision includes making the determination, appropriately notifying the enrollee of the determination, and authorizing coverage or sending payment, where applicable.

Coverage decisions (both coverage determinations and redeterminations) may result in a partially favorable decision.

- Example of a fully favorable decision: Non-formulary exception request approved for drug and quantity prescribed.
- Example of a partially favorable decision: Non-formulary exception request approved for drug, but full quantity prescribed not approved.

Sponsors should also include reopened coverage determination and redetermination data in this reporting, based on the date the revised decision is made. Reopening includes any revision to a binding determination for any reason, including but not limited to clerical errors and new and material evidence not available or known at the time of the determination.

Sponsors will report quarterly data on an annual basis. All data elements to be entered into the HPMS at the Contract level, except reopenings data in element B to be uploaded in a data file.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Reporting Period	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	February 28 (reporting for all quarters due on this date)			

1. Coverage Determinations and Exceptions

Data elements to be entered into the HPMS at the Contract level:

A. The total number of pharmacy transactions in the time period above.
B. Of the total reported in A, the number of pharmacy transactions rejected due to non-formulary status.
C. Of the total reported in A, the number of pharmacy transactions rejected due to prior authorization (PA) requirements.

D. Of the total reported in A, the number of pharmacy transactions rejected due to step therapy requirements.
E. Of the total reported in A, the number of pharmacy transactions rejected due to quantity limits (QL) requirements based on CMS approved formulary. Safety edits and rejections due to early refills should be excluded.
F. Did the plan have high cost edits for compounds in place during the time period above? ((Y (yes) or N (no)).
G. If yes to element F, the cost threshold used.
H. Did the plan have high cost edits for non-compounds in place during the time period above? ((Y (yes) or N (no)).
I. If yes to element H, the cost threshold used.
J. Of the total reported in A, the total number of claims rejected due to high cost edits for compounds.
K. Of the total reported in A, the total number of claims rejected due to high cost edits for non-compounds.
L. The total number of coverage determinations decisions made in the reporting time period above.
M. Of the number reported in element L, the total number of exception decisions made in the reporting time period above.
N. Of the number reported in element L, the number processed timely.
O. Of the number reported in element L, the number that were fully favorable.
P. Of the number reported in element L, the number that were partially favorable.
Q. Of the number reported in element L, the number that were adverse.
R. The total number of requests for coverage determinations that were withdrawn in the reporting time period above.
S. The total number of requests for coverage determinations that were dismissed in the reporting time period above.

2. Redeterminations

Data elements to be entered into the HPMS at the Contract level:
A. The total number of redeterminations made in the reporting time period above.
B. Of the number reported in element A, the total number of exception decisions made in the reporting time period above.
C. Of the number reported in element A, the number processed timely.
D. Of the number reported in element A, the number that were fully favorable.
E. Of the number reported in element A, the number that were partially favorable.
F. Of the number reported in element A, the number that were adverse.
G. The total number of requests for redeterminations that were withdrawn in the reporting time period above.
H. The total number of requests for redeterminations that were dismissed in the reporting time period above.

3. Reopenings

Data elements to be uploaded in a data file at the Contract level:

A. The total number of reopened (revised) decisions, for any reason, in the time period above.
B. For each case that was reopened, the following information will be uploaded in a data file:
    1. Contract Number;
    2. Plan ID;
    3. Case ID;
    4. Date of original disposition;
    5. Original disposition (Fully Favorable; Partially Favorable or Adverse);
    6. Case level (Coverage Determination or Redetermination);
    7. Date case was reopened;
    8. Reason(s) for reopening (Clerical Error, New and Material Evidence, Fraud or Similar Fault, or Other)
    9. Date of reopening disposition (revised decision);
    10. Reopening disposition (Fully Favorable; Partially Favorable, Adverse, or Pending).

Part D Section VII. Long-Term Care (LTC) Utilization

LTC network pharmacies receive access/performance rebates that may create financial incentives that conflict with Part D Sponsors' formularies or drug utilization management (DUM) programs. These incentives can negatively impact formulary adherence as well as overall drug costs associated with beneficiaries served by LTC pharmacies. CMS will collect data for LTC pharmacies' formulary and non-formulary cost and utilization, for comparison to retail pharmacies' cost and utilization patterns.

Sponsors will report the number of 31-day equivalent prescriptions dispensed by each LTC pharmacy, and the aggregate number of 30-day equivalent prescriptions dispensed by network retail pharmacies. These are calculated by summing days supply of all covered Part D prescriptions dispensed by the respective pharmacy or group of pharmacies, and then dividing by either 31 or 30 days. Prescription cost is defined as the sum of ingredient cost, dispensing fee, and sales tax; the ingredient cost should reflect the Sponsor's negotiated price. A network LTC pharmacy is a network pharmacy owned by or under contract with a LTC facility to provide prescription drugs to the facility's residents.

Reporting timeline:

	Period 1	**Period 2**
Reporting Period	January 1 - June 30	July 1 – December 31
Data due to CMS/HPMS	August 31	February 28

Data elements to be entered or uploaded into the HPMS at the Contract level:

Data file to be uploaded through the HPMS at the Contract level as specified below:

A. The total number of network LTC pharmacies in the service area.
B. The total number of network retail pharmacies in the service area.
C. The total number of beneficiaries in LTC facilities for whom Part D drugs have been provided under the Contract.
D. For each network LTC pharmacy in the service area:
    1. LTC pharmacy name;
    2. LTC pharmacy NPI number;
    3. Contract entity name of LTC pharmacy;
    4. Chain code of LTC pharmacy;
    5. Number of 31-day equivalent formulary prescriptions dispensed;
    6. Number of 31-day equivalent non-formulary prescriptions dispensed;
    7. Cost of formulary prescriptions;
    8. Cost of non-formulary prescriptions.
E. In aggregate, for all retail pharmacies in the service area:
    1. Number of 30-day equivalent formulary prescriptions dispensed;
    2. Number of 30-day equivalent non-formulary prescriptions dispensed;

3. Cost of formulary prescriptions;
4. Cost of non-formulary prescriptions.

Part D Section VIII. Fraud, Waste and Abuse Compliance Programs

Note: Employer Direct plan Sponsors are exempt from this reporting section.

Compliance plan requirements for Part D Sponsors are described in 42 C.F.R. §423.504 (b)(4)(vi)(G), including procedures to voluntarily self-report potential fraud or misconduct related to the Part D program to CMS or its designees. Chapter 9 of the Prescription Drug Benefit Manual and Chapter 21 of the Medicare Managed Care Manual, Compliance Program Guidelines", provides interpretive rules and guidelines to Part D Sponsors for implementing the regulatory requirements to have a compliance plan under 42 C.F.R. §423.504(b)(4)(vi)(A-G), and the requirement mandated by Congress in section 1860D-4(c)(1)(D) of the Act that Part D Sponsors have a "program to control fraud, waste and abuse".

Part D Sponsors may voluntarily report aggregate data related to their anti-fraud, waste and abuse activities. Aggregate reporting will allow CMS to monitor Sponsors' fraud, waste and abuse programs. These data will measure the types of incidents, the sources by which incidents are identified to Sponsors, as well as the activities taken by Sponsors to respond to the incidents. Sponsors should refer to §423.504(b)(4)(vi)(G)(1) and § 423.504(b)(4)(vi)(G)(2) for sponsors' requirements to conduct inquiries and to design corrective actions to prevent future misconduct as well as address underlying problems.

For this data collection, the following definitions will apply:

- A fraud incident/complaint is defined as a statement, oral or written, alleging that a provider, pharmacy, pharmacist, PBM, Plan, Plan Agent, broker, or beneficiary knowingly and willfully executed, or attempted to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of any health care benefit program.
- Abuse includes actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. This applies to a provider, pharmacy, pharmacist, PBM, Plan, Plan Agent, broker or beneficiary.
- Closed incidents include, but are not limited to, incidents with corrective action(s) initiated and completed, and incidents referred to appropriate authorities and accepted.

Reporting timeline:

	YTD
Reporting Period	January 1 - December 31
Data due to CMS/HPMS	February 28

Data elements to be entered into the HPMS at the Contract level:

A. The number of potential fraud and abuse incidents related to inappropriate billing. Inappropriate billing by pharmacies should be included.
B. The number of potential fraud and abuse incidents related to providing false information.
C. The number of potential fraud and abuse incidents related to doctor shopping/drug seeking beneficiary.
D. The number of potential fraud and abuse incidents related to attempting to steal identity/money.
E. The number of potential fraud and abuse incidents related to other areas not listed above (e.g. OIG exclusion list, and broker/agent complaints).
F. The total number of potential fraud and abuse incidents identified.
G. Of the total reported in F, the number identified through internal efforts.
H. Of the total reported in F, the number of incidents received from external sources. Incidents reported through the Complaints Tracking Module (CTM) or as grievances should be included.
I. Of the total reported in F, the number of potential fraud and abuse incidents that were closed.
J. The number of inquiries initiated by the Sponsor as a result of potential fraud and abuse incidents.
K. The number of corrective actions initiated by the Sponsor as a result of potential fraud and abuse incidents.
L. The number of potential fraud and abuse incidents referred to CMS for action; includes referrals to CMS staff, MEDICs, or other CMS designated program safeguard contractor.
M. The number of potential fraud and abuse incidents referred to federal law enforcement for action. This includes referrals to the OIG, FBI, DEA, and FDA.
N. The number of potential fraud and abuse incidents referred to local law enforcement for action; this includes but is not limited to referrals to state, county, township, or province police.
O. The number of potential fraud and abuse incidents referred to State Insurance Commissioners (SICs) or state licensing authorities.

Part D Section X. Plan Oversight of Agents

NOTE: This reporting section applies only to Sponsors of stand-alone prescription drug plans, which do not also have MA-PD plans. Sponsors of MA-PD plans already report these data as part of the Part C reporting requirements and are therefore exempt from this Part D reporting section. Employer/union group plans are exempt from this reporting section.

Sponsors are required to comply with State requests for information about the performance of licensed agents or brokers as part of a state investigation into the individual's conduct. Plans are responsible for monitoring the conduct of their agents. While the states oversee agent licensing, CMS will monitor agent complaints to determine if Sponsors are investigating identified complaints and imposing disciplinary actions as well as reporting poor conduct to the state.

Complaints include both complaints from the Complaint Tracking Module (CTM) and other complaints or grievances made directly to the Sponsor. Complaints may result in various disciplinary actions, ranging from verbal warning to termination of employment or contract.

Reporting timeline:

	YTD
Reporting Period	January 1 - December 31
Data due to CMS/HPMS	February 28

Data elements to be uploaded in two data files at the Contract level:

1. Agent/Broker:

For each agent that received compensation (including commission and salary) in the reporting period (initial enrollments and renewal payments received), indicate:

A. Contract Number.
B. Agent/Broker Type (Captive, Employed, Independent, None).
C. Agent/Broker Last Name.
D. Agent/Broker First Name.
E. Agent/Broker Middle Initial.
F. Agent/Broker State Licensed. For agents licensed in multiple states, complete a row for each state in which the agent is licensed.
G. Agent/Broker National Producer Number (NPN).
H. Plan Assigned Agent/Broker Identification Number.
I. Agent/Broker Current License Effective Date.
J. Agent/Broker Appointment Date.
K. Agent/Broker Training Completion Date.
L. Agent/Broker Testing Completion Date.

M. In aggregate, the number of Agent/Broker complaints for the reporting period. If multiple lines are needed for an agent (licensed in more than one state) only fill out this data element for the first line. For example, if an agent has four complaints and is licensed in Florida and Georgia, all four complaints should be listed under the Florida line.
N. In aggregate, the number of Agent/Broker disciplinary actions taken in the reporting period (related to Marketing). Examples of disciplinary actions include: retraining, verbal or written warnings, suspension, termination, etc. If multiple lines are needed for an agent (licensed in more than one state) only fill out this data element for the first line. For example, if an agent has received two disciplinary actions and is licensed in Florida and Georgia, both actions should be listed under the Florida line.
O. Agent/Broker Termination Date (if applicable).
P. Termination for Cause? (Y(yes) or N (no)).
Q. Third-party Marketing Organization (TMO)/Field Marketing Organization Name (FMO), if applicable.
R. The number of new enrollments in the reporting period. If more than one line is filled out because of agent being licensed in multiple states, please put enrollments in by state.

2. New Enrollments:

For all new enrollments (initial or renewal) during the reporting period for which an Agent/Broker is associated (includes instances where the agent/broker was assigned after the enrollment was initiated), indicate:

A. Contract Number.
B. Plan Beneficiary Package (PBP) Number.
C. Beneficiary Last Name.
D. Beneficiary First Name.
E. Beneficiary Middle Initial.
F. Beneficiary HICN or RRB Number.
G. Agent/Broker Last Name.
H. Agent/Broker First Name.
I. Agent/Broker Middle Initial.
J. Agent/Broker National Producer Number (NPN).
K. Plan Assigned Agent/Broker Identification Number.
L. Enrollment Mechanism. (Plan/Plan Representative Online; CMS Online Enrollment Center; Plan Call Center; 1-800-MEDICARE; Paper Application; Auto-Assigned/Facilitated; Other).
M. Enrollment Application Date.
N. Enrollment Effective Date.
O. The number of Agent/Broker complaints filed by the beneficiary in the reporting period.
P. Of the number reported in O, the number of Marketing related complaints.

MMP Specific Core Reporting Requirements

Introduction

The core reporting requirements section includes new measures developed for all capitated financial alignment demonstrations. State-specific appendices capture the reporting requirements specific to each state's demonstration. The new core and state-specific measures supplement existing Medicare Part C and Part D reporting requirements, as well as measures that MMPs report via other vehicles or venues, such as HEDIS®, HOS, CAHPS® and state Medicaid agencies.[1,2] 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.

Passive Enrollment and Stopping Enrollment

Under the capitated financial alignment model, demonstrations may allow for passive enrollment. During passive enrollment, MMPs must demonstrate adequate performance across a range of measures to remain eligible to receive passive enrollment of beneficiaries. Failure to adequately meet any single measure or set of measures may result in CMS and the state ceasing enrollment. CMS and each state, through the Contract Management Team (CMT), will have the option to discontinue passive enrollment for MMPs for various reasons, including for MMPs failing to completely and accurately report measures or to adequately meet performance standards.

Quality Withhold Measures

CMS and each state will also establish a set of quality withhold measures, and MMPs will be required to meet established thresholds. Throughout this document, these measures are marked with the following symbol: (^{i}). Additional information on the withhold methodology and benchmarks will be provided at a later time.

Reporting Phases

There are three distinct types of reporting phases for demonstration measures: "Implementation," "Ongoing," and "Continuous Reporting."

The Implementation phase corresponds with the initial months of the demonstration and will be further defined in each state-specific appendix. Monitoring will be more intensive during this phase to allow CMS and the state to quickly become aware of any

[1] HEDIS® is a registered trademark of the National Committee of Quality Assurance (NCQA).
[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

performance or access issues. MMPs will report measures on the Implementation reporting timeline only during the Implementation Phase.

The Ongoing phase begins at the same time as the Implementation phase but continues for the life of the demonstration MMPs will report measures on the Ongoing reporting timeline during the Ongoing phase. Note: Measures that have both an Implementation and Ongoing phase should be reported concurrently (e.g., Measure 2.1. Members with an assessment completed within 90 days of enrollment). MMPs will cease reporting on the Implementation reporting timeline once the Implementation phase is complete. Some measures do not include an Ongoing phase, meaning data are collected only during the Implementation phase.

Continuous Reporting measures do not include an Implementation phase. These measures will be reported at the same frequency for the duration of the demonstration. The first reporting period for these measures begins on the first day of the demonstration.

Reporting timelines are defined in terms of calendar days. Table 1 and Table 2 below are examples of reporting timelines that will be found throughout. The introduction of each state-specific appendix provides tables describing each state's Implementation, Ongoing, and Continuous Reporting periods.

Table 1. Sample Implementation and Ongoing reporting timeline

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
Example	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**
Example	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

Table 2. Sample Continuous reporting timeline

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
Example	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

Measure Specifications

Each measure specification includes information regarding the following subjects:

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.

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.

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

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

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

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

Hybrid Sampling

Some demonstration-specific measures may require medical record/supplemental documentation review to identify the numerator. In these instances, the sample size should be 411, plus additional records to allow for substitution. Sampling should be systematic to ensure that all individuals eligible for a measure have an equal chance of inclusion.

MMPS should complete the following steps for each measure that requires medical record review:

Step 1: Determine the eligible population. Create a list of eligible members, including full name, date of birth, and event (if applicable).

Step 2: Determine the final sample size. The final sample size will be 411 plus an adequate number of additional records to make substitutions. Oversample only enough to guarantee that the targeted sample size of 411 is met. The following oversampling rates are acceptable: 5 percent, 10 percent, 15 percent, or 20 percent. If oversampling, round up to the next whole number when determining the final sample size.

Step 3: If the eligible population exceeds the final sample size as determined in Step 2, proceed to Step 5. If the eligible population is less than or equal to the final sample size as determined in Step 2, proceed to Step 4.

Step 4: If the eligible population is less than or equal to the final sample size as determined in Step 2, the sample size can be reduced from 411 cases to a reduced final sample size by using the following formula:

$$Reduced\ Final\ Sample\ Size = \frac{\text{Original Final Sample Size}}{1 + \left(\frac{Original\ Final\ Sample\ Size}{Eligible\ Population}\right)}$$

Where the *Original Final Sample Size* is the number derived from Step 2, and the *Eligible Population* is the number derived from Step 1.

Step 5: Sort the list of eligible members in alphabetical order by last name, first name, date of birth and event (if applicable). Sort this list by last name from A to Z during even reporting periods and from Z to A in odd reporting periods (i.e., name will be sorted from A to Z in 2014, 2016, and 2018 and from Z to A in 2015, 2017, and 2019.

Note: Sort order applies to all components. For example, for reporting period 2014, the last name, first name, date of birth, and events will be ascending.

Step 6: Calculate *N*, which will determine which member will start your sample. Round down to the nearest whole number.

$$N = \frac{\text{Eligible Population}}{\text{Final Sample Size}}$$

Where the *Eligible Population* is the number derived from Step 1. The *Final Sample Size* is either:

- The number derived from Step 2, for instances in which the eligible population exceeds the final sample size as determined in Step 2.
  OR
- The number derived in Step 4, for instances in which the eligible population was less than or equal to the number derived from Step 2.

Step 7: Randomly select starting point, *k*, by choosing a number between one and N using a table of random numbers or a computer-generated random number.

Step 8: Select every *kth* record thereafter until the selection of the sample size is completed.

Section I. Access

1.1 Claims (excluding pharmacy point of sale [POS]) denied during the first 90 days of enrollment with the MMP, by reason for denial.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
1. Access	The first two waves of passive enrollment	Contract	90 days of enrollment	Within 15 days of the last day of the reporting period

MMPs will be required to submit a list of non-pharmacy denied claims during the reporting period at the contract level for the 90 days following each member's effective enrollment date in a particular MMP. The list of non-pharmacy denied claims should be reported at the line level and limited to the following denial reasons: non-covered services, prior authorization, and provider not in network. A template for providing these claims is attached to this document.

Claim
(Non-Pharmacy) Reje

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.

- Required File Format is Microsoft Excel File.
- The file name extension should be ".xls"
- File name= NORX_(STATEABBREVIATION)_(CONTRACTID)_(REPORTING PERIOD)_(SUBMISSIONDATE).xls.
- Replace (STATEABBREVIATION) with the two-character state abbreviation (e.g., Massachusetts is MA), (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).

File Layout

Field Name	Field Description	Allowable Values
HICN	Health insurance claim number (HICN) refers to the number assigned by the Social Security Administration to an individual for the purpose of identifying him/her as a Medicare beneficiary. The HICN will be shown on the beneficiary's insurance card and it is on the basis of this number that a beneficiary's Medicare claims are processed.	Field Type: Alpha-numeric
Cardholder ID	Insurance ID assigned to the cardholder or identification number used by the MMP. May be the same as HICN.	Field Type: Alpha-numeric
CCN	Claim Control Number (CCN). A claim control number is a unique number given to each claim.	Field Type: Alpha-numeric
Claim Line	A line item control number is a unique number assigned to each service line.	Field Type: Numeric
CMS Contract ID	Designation assigned by CMS that identifies a specific sponsor.	Field Type: Alpha-numeric
CMS Plan ID	CMS Plan ID.	Field Type: Alpha-numeric
Date of Service	Identifies date the service was rendered. If more than one date on the claim, provide the first date of service.	Field Type: Date in CCYYMMDD format
Date of Rejection	Identifies the date the claim was rejected.	Field Type: Date in CCYYMMDD format
Rejection Category (1=NC, 2=PA, 3= Non-NW)	Rejection Category: Use category 1 if the rejection is for Non-Covered Services. Use category 2 if the rejection is for Prior Authorization. Use category 3 if the rejection is for Provider not in Network.	Field Type: Numeric Valid Values: 1=Non-Covered Services 2=Prior Authorization 3=Non-Network Provider
Reject Code 1	Reject code used in MMP's claim adjudication system.	Field Type: Alpha-numeric
Reject Message 1	Reject Message used in MMP's claim adjudication system.	Field Type: Text
Reject Code 2	Reject code used in MMP's claim adjudication system.	Field Type: Alpha-numeric
Reject Message 2	Reject Message used in MMP's claim adjudication system.	Field Type: Text
Reject Code 3	Reject code used in MMP's claim adjudication system.	Field Type: Alpha-numeric
Reject Message 3	Reject Message used in MMP's claim adjudication system.	Field Type: Text

Field Name	Field Description	Allowable Values
***MMP must provide all reject codes and messaging, not limited to the number of fields in the template. Please insert columns as necessary. ***	Provide any additional reject codes and messaging.	

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.

- An audit of a sample of claims will be performed. A sample of 30 potentially inappropriate claims will be selected for further review. MMPs will be required to review claims and address the following:
  - Was the claim an appropriate rejection (Y/N)?
  - Provide a brief explanation as to why the claim was appropriate or inappropriate.
  - Was the claim paid (Y/N)?
  - Provide the dates of service for paid claims for the service in question.

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

- The CMS Contract ID is formatted as 5 alpha-numeric characters.
- The CMS Contract ID matches the submitting Contract ID.
- The CMS Plan ID is not zero or missing, or is more than three numeric characters.
- The CMS Plan ID is a valid ID for the current contract year.
- The Date of Service is in the CCYYMMDD format.
- The Date of Rejection is in the CCYYMMDD format.
- The Date of Rejection is during the reporting period.
- The Date of Rejection is on or after the Date of Service.
- The Rejection Category is 1, 2, or 3.

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 calculate an overall score once the MMPs have reviewed and provided comments. An overall score will be calculated as follows: The number of failures (numerator) will be divided by a sample size of 30 (denominator) to calculate an overall compliance score.

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

- This measure assesses only the following three denial types: non-covered services, prior authorization, and provider not in network.
  - Non-Covered Services are those for which a member is not eligible.
  - Prior Authorization is a prospective process to verify coverage of proposed care, pharmaceutical therapy or establish a covered length of stay.
  - Provider not in network refers to a provider that is not contracted with the MMP.
- MMP may have more than one type per denied claim. MMPs must provide all rejection codes and messaging.
- The reporting period for this measure will begin at the start of the passive enrollment period. Once reporting begins, members should be included

regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- MMPs should include all denied claims including adjusted and reprocessed claims.
- Passive enrollment periods may vary by state. MMPs should refer to their state's contract and/or MOU for specific requirements.
- CMS reserves the right to extend the reporting frequency after the passive enrollment period, if necessary.
  The Date of Rejection must occur within the reporting period, but it is acceptable if the Date of Service is outside of the reporting period as long as the Date of Rejection is after the Date of Service.

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

1.2 Pharmacy point-of-sale (POS) claims denied during the first 90 days of enrollment, by reason for denial.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
1. Access	The first two waves of passive enrollment	Contract	First two weeks of the first two waves of passive	Every 72 hours for the first two weeks of the reporting period

MMPs will be required to submit a list of pharmacy POS denied claims at the contract level for the first two weeks following the first effective date of passive enrollment for the first two waves of passive enrollment. The list of pharmacy POS denied claims will be limited to claims denied for the following reasons: non-formulary, prior authorization, and step therapy. A template for providing these claims is attached to this document.

Pharmacy Rejected Claims Template

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

- Required File Format is Microsoft Excel File.
- The file name extension should be ".xls"
- File name= RX_(STATEABBREVIATION)_(CONTRACTID)_(REPORTING PERIOD)_(SUBMISSIONDATE).xls.

- Replace (STATEABBREVIATION) with the two-character state abbreviation (e.g., Massachusetts is MA), (CONTRACTID) with the contract ID, (REPORTINGPERIOD) with the month and year 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).

File Layout

Field Name	Field Description	Allowable Values
HICN	Health insurance claim number (HICN) refers to the number assigned by the Social Security Administration to an individual for the purpose of identifying him/her as a Medicare beneficiary. HICN will be shown in the beneficiary's insurance card and it is on the basis of this number that a beneficiary's Medicare claims are processed.	Field Type: Alpha-numeric
Cardholder ID	Insurance ID assigned to the cardholder or identification number used by the MMP. May be the same as HICN.	Field Type: Alpha-numeric
CCN	Claim Control Number (CCN). A claim control number is a unique number given to each claim.	Field Type: Alpha-numeric
CMS Contract ID	Designation assigned by CMS that identifies a specific sponsor.	Field Type: Alpha-numeric
CMS Plan ID	CMS Plan ID.	Field Type: Numeric
NDC 11 (no hyphens)	National Drug Code Drug products are identified and reported using a unique, three-segment number, called the National Drug Code (NDC), which serves as a universal product identifier for drugs. FDA publishes the listed NDC numbers and the information submitted as part of the listing information in the NDC.	Field Type: Numeric Note: 11-digit NDC code with no hyphens
Date of Service	Identifies date the prescription was filled.	Field Type: Date in CCYYMMDD Format
Date of Rejection	Identifies the date the claim was rejected.	Field Type: Date in CCYYMMDD Format
Claim Quantity	Quantity dispensed expressed in metric decimal units.	Field Type: Numeric Allowable Values: >0
Claim Days Supply	Estimated number of days the prescription will last.	Field Type: Numeric Allowable Values: >0; < 999

Field Name	Field Description	Allowable Values
Compound Code	Code indicating whether or not the prescription is a compound.	Field Type: Numeric Allowable Values: 0 = not specified 1 = not a compound 2 = compound
Rejection Category (1=NF, 2=PA, 3=ST)	Rejection Category: Use category 1 if the rejection is for Non-Formulary drug. Use category 2 if the rejection is for Prior Authorization. Use category 3 if the rejection is for Step Therapy.	Field Type: Numeric Allowable Values: 1=Non-Formulary 2=Prior Authorization 3=Step Therapy
Reject Code 1	Reject code used in MMP's claim adjudication system.	Field Type: Alpha-numeric
Pharmacy Message 1	Reject Message used in MMP's claim adjudication system.	Field Type: Text
Reject Code 2	Reject code used in MMP's claim adjudication system.	Field Type: Alpha-numeric
Pharmacy Message 2	Reject Message used in MMP's claim adjudication system.	Field Type: Text
Reject Code 3	Reject code used in MMP's claim adjudication system.	Field Type: Alpha-numeric
Pharmacy Message 3	Reject Message used in MMP's claim adjudication system.	Field Type: Text
MMP must provide all reject codes and messaging, not limited to the number of fields in the template. Please insert columns as necessary.	Provide any additional reject codes and messaging.	

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.

- An audit of a sample of claims will be performed. Claims not excluded from the analysis will be flagged as "potentially inappropriate." A sample of 30 potentially inappropriate claims will be selected for further review: 15 protected class drugs and 15 non-protected class drugs. MMPs will be required to review claims and address the following:
  - Was the claim an appropriate Rejection (Y/N)?
  - Provide a brief explanation as to why the claim was appropriate or inappropriate.
  - Was the claim paid (Y/N)?
  - Provide the dates of service for paid claims for the drug in question.

C. Edits and Validation checks - validation checks that should be performed by each MMP prior to data submission. Any claims that do not pass validation will be excluded from the analysis. These checks will include the following:

- The CMS Contract ID is formatted as 5 alpha-numeric characters.
- The CMS Contract ID matches the submitting Contract ID.
- The CMS Plan ID is not zero or missing, or is more than three numeric characters.
- The CMS Plan ID is a valid ID for the current contract year.
- The NDC consists of 11 numeric characters.
- The NDC is a valid NDC.
- The Date of Service is in the CCYYMMDD format.
- The Date of Rejection is in the CCYYMMDD format.
- The Date of Rejection is during the reporting period.
- The Date of Rejection is on or after the Date of Service.
- The Rejection Category is 1, 2, or 3.
- The Claim Quantity is greater than zero.
- The Claim Days Supply is greater than zero.
- The Claim Days Supply is between 1 and 3 numeric characters (1-999).

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 calculate an overall score once MMPs have reviewed and provided comments.
    - For all class drugs, the number of failures (numerator) will be divided by a sample size of 30 (denominator) to calculate an overall compliance score.
    - For protected class drugs, the number of failures (numerator) will be divided by a sample size of 15 (denominator) to calculate an overall compliance score.
    - For unprotected class drugs, the number of failures (numerator) will be divided by a sample size of 15 (denominator) to calculate an overall compliance score.

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

- This measure assesses only the following three denial types: non-formulary, prior authorization, and step therapy.
    - Non-formulary drugs are drugs that are not on an MMP's formulary but approved for coverage via the exceptions process, or under the transition policy.
    - Prior Authorization is a prospective process to verify coverage of proposed care, pharmaceutical therapy or establish a covered length of stay.
    - Step Therapy is a process whereby prescriptions are filled with an effective, but more affordable medication (Step 1). When appropriate, a more costly (Step 2) medication can be authorized if the Step 1 prescription is not effective in treating the condition.
- The reporting period for this measure will begin at the start of the passive enrollment period. Once reporting begins, members should be included

regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.

- Passive enrollment periods may vary by state. MMPs should refer to their state's contract and/or MOU for specific requirements.
- CMS reserves the right to extend the reporting frequency after the first two waves of passive enrollment, if necessary.
- For the first two weeks of reporting, denied claims reports are due by 5:00pm EST every 72 hours (noting that the first submission will be longer than 72 hours considering that the benefit begins at 12:00am). Plans will be expected to meet reporting due dates that occur on weekends and holidays within this initial two week period.
- MMPs should include all denied claims including adjusted and reprocessed claims.
- The Date of Rejection must occur within the reporting period, but it is acceptable if the Date of Services is outside of the reporting period as long as the Date of Rejection is after the Date of Service.
- Include all denied pharmacy claims, even if repeated claims are attempted on the same day.
- Rejections due to early refills should be excluded.

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 II. Assessment

2.1 Members with an assessment completed within 90 days of enrollment.[i]

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
2. Assessment	Monthly during the implementation period, beginning after 90 days of implementation	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period Ex: Demo implementation is January 1, 2014; 90 days after enrollment is March 31, 2014; first report is due by April 30, 2014; the next report would be due May 31, 2014
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
2. Assessment	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 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 and who were currently enrolled at the end of the reporting period.	Field type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of members who are documented as unwilling to participate in the assessment within 90 days of enrollment.	Of the total reported in A, the number of members who are documented as unwilling to participate in the assessment and who never had an assessment completed within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members the MMP was unable to locate, following three attempts, within 90 days of enrollment.	Of the total reported in A, the number of members the MMP was unable to locate following three attempts, to participate in the assessment and who never had an assessment completed within 90 days of enrollment.	Field type: Numeric Note: Is a subset of A. Attempts must be documented and CMS and the state may validate this number.
D.	The number of members with an assessment completed within 90 days of enrollment.	Of the total reported in A, the number of members with an assessment completed within 90 days of enrollment.	Field type: Numeric Note: Is a subset of A.

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

- 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.
- 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 unwilling to participate in the assessment and who never had an assessment completed within 90 days of enrollment.
- Members the MMP was unable to locate, following three attempts, to participate in the assessment and who never had an assessment completed within 90 days of enrollment.
- Members who had an assessment 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 (i.e., data element A minus data elements B and C will serve as the denominator).

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

- The assessment for this measure should be the comprehensive health risk assessment. Some states may require an initial screen or assessment; these are not the focus of this measure.
- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- The 90th days of enrollment should be based on each member's effective date of enrollment.
- The effective date of enrollment is the first date of the member's coverage through the MMP.
- If a member's assessment is in progress, but is not completed by the end of the reporting period, then the assessment should not be considered completed and, therefore, would not be counted in any data element during the reporting period.
- If the MMP makes only one or two attempts to contact a member to complete an assessment, and no assessment is completed by the end of the reporting period, then these attempts should not be included in data element C.
- The specific requirements pertaining to an assessment may vary by state. MMPs should refer to their three-way contract for specific requirements.

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

2.2 Members with an assessment completed.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
2. Assessment	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members with an assessment completed within the reporting period.	The number of members with an assessment completed within the reporting period.	Field Type: Numeric
B.	Total number of members enrolled for 90 days or longer as of the last day of the reporting period.	The number of members enrolled for longer than 90 days as of the last day of the reporting period.	Field type: Numeric
C.	Total number of members enrolled for 90 days or longer who had an assessment completed.	Of the number reported in B, the number of members who had an assessment completed.	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 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 obtain enrollment data to evaluate to evaluate the percentage of members:

- Enrolled at the end of the reporting period who had an assessment completed within the reporting period.
- Enrolled for longer than 90 days as of the last day of the reporting period who had an assessment completed.

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

- The assessment for this measure should be the comprehensive health risk assessment. Some states may require an initial screen or assessment; these are not the focus of this measure.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- The 90th days of enrollment should be based on each member's effective date of enrollment.
- The effective date of enrollment is the first date of the member's coverage through the MMP.
- The specific requirements pertaining to an assessment may vary by state. MMPs should refer to their three-way contract for specific requirements.
- Data elements B and C will not be reported until after 90 days. The assessments reported in element C could have been completed at any time, not necessarily during the reporting period.

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

Section III. Care Coordination

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.[3] (NQF #0648)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
3. 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, regardless of age, discharged from an inpatient facility to home/self-care or any other sites of care.	Total number of members, regardless of age, discharged from an inpatient facility (hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other sites of care 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.

[3] Please refer to the following URL for additional information on this measure: http://www.ama-assn.org/ama1/pub/upload/mm/pcpi/care-transitions-ms.pdf.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of members for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.	Of the total reported in B, the number of members for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of 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 plan 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 element C.
- All data elements should be positive values.

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

- CMS and the state will evaluate the percentage of members, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.

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.
- The primary care provider (PCP) or other health care professional designated for follow-up care may be the designated primary care physician, medical specialist, or other physician or health care professional.

- Transition record may be transmitted to the facility or physician or other health care professional designated for follow-up care via fax, secure e-mail, or mutual access to an electronic health record (EHR).
- A transition record is defined as a core, standardized set of data elements related to patient's diagnosis, treatment, and care plan that is discussed with and provided to patient in printed or electronic format at each transition of care, and transmitted to the facility/physician/other health care professional providing follow-up care. Electronic format may be provided only if acceptable to patient.
- MMPs may use sampling for this measure since documentation review is required 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. Refer to the codes provided in Table 1 to identify total members discharged from an inpatient facility. To determine the numerator, MMPs will need to obtain medical records from the discharge facility for each member within the sample to verify if a transition record was transmitted.
- If MMPs do not elect to sample, data element B should be equal to data element A.
- MMP should exclude patients who died and patients who left against medical advice or discontinued care. Codes to identify exclusions are provided in Table 2.
- If a discharge occurs on the last day of the report period, look 1 day past the reporting period to identify if a transition record was transmitted within 24 hours.

Table 1: Codes to Identify Members Discharged from an Inpatient Facility

Type of Bill Codes		Discharge Status		Revenue Code
0111, 0121, 0114, 0124, 0211, 0214, 0221, 0224, 0281, 0284	***AND***	01, 02, 03, 04, 05, 06, 43, 50, 51, 61, 62, 63, 64, 65, 66, 70		
0131, 0134	***AND***	01, 02, 03, 04, 05, 06, 43, 50, 51, 61, 62, 63, 64, 65, 66, 70	***AND***	0762, 0490, 0499

Table 2: Codes to Identify Exclusions

UB-04
07, 20, 40, 41, 42

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

Section IV. Enrollee Protections

4.1 Part D appeals. –Please refer to Medicare Part D Reporting Requirements Sections VII (Coverage Determinations and Exceptions) and Section VIII (Redeterminations) when reporting Part D appeals data for MMPs. The measures indicated in Section VII and Section VIII of the Medicare Part D Reporting Requirements are the exact same for MMPs except for timing frequency.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
4. 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

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.

- Plans should refer to Medicare Part D Reporting Requirements Sections VII (Coverage Determinations and Exceptions) and Section VIII (Redeterminations) when reporting Part D appeals data for MMPs. All Data Elements indicated in Part D Section VII (A through CC) and Part D Section VIII (A through D) for MMPs should be reported on a Monthly Reporting Frequency as indicated above.

Note: Part D appeals will exclude Coverage Determinations, Exceptions and Redeterminations that were auto-forwarded to the Part D Independent Review Entity (IRE). This will be reported separately.

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.

- For information on QA Checks/Thresholds, MMPs should refer to Part D Reporting Requirements Sections VII (Coverage Determinations and Exceptions) and Section VIII (Redeterminations).

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

- For information on Edits and Validation Checks, MMPs should refer to Part D Reporting Requirements Sections VII (Coverage Determinations and Exceptions) and Section VIII (Redeterminations).

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

- For information on Analysis, MMPs should refer to Part D Reporting Requirements Sections VII (Coverage Determinations and Exceptions) and Section VIII (Redeterminations).

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

- This measure mirrors current Part D reporting on appeals, but will occur on a more frequent (monthly) basis during the Implementation phase of the demonstration to allow for early detection of performance issues. MMPs should refer to Part D Sections VII (Coverage Determinations and Exceptions) and Section VIII (Redeterminations) for specific guidelines on definitions and reporting of Part D appeals.

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

4.2 Grievances and Appeals.

IMPLEMENTATION					
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**	**Data Elements**
4. 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	A,B
ONGOING					
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**	**Data Elements**
4. 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-L

Note: Plans should report all non-Part D (i.e., Part C and Medicaid) grievances and appeals for data elements A-L, in addition to reporting the already required Medicare Part C and D appeals and grievances as follows:

- Part D grievances are reported according to Part D reporting requirements (see Part D Section V Grievances on page 49 above);
  Part C grievances are also reported through Part C reporting requirements (see Section V Grievances on page 11 above); and Plans will continue to report appeals data consistent with Medicare Part C Reporting Requirements (see Part C Section VI Organization Determinations/Reconsiderations on page 13 above).

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.

Grievances

Element Letter	Element Name	Definition	Allowable Values
A1.	Inability to get an appointment with a primary care provider (PCP) – Total number of grievances.	The number of grievances related to an inability to get an appointment with a PCP.	Field Type: Numeric Is based on the date the decision was made.

Element Letter	Element Name	Definition	Allowable Values
A2.	Inability to get an appointment with a primary care provider (PCP) – Number of grievances which the MMP provided timely notification of its decision.	The number of grievances related to an inability to get an appointment with a PCP that resulted in timely notification of decision.	Field Type: Numeric. Is a subset of A1. See Part C reporting requirements on page 11 above for definition of timely grievance notification.
B1.	Inability to get an appointment with a specialist – Total number of grievances.	The number of grievances related to an inability to get an appointment with a specialist.	Field Type: Numeric Is based on the date the decision was made.
B2.	Inability to get an appointment with a specialist – Number of grievances which the MMP provided timely notification of its decision.	The number of grievances related to an inability to get an appointment with a specialist that resulted in timely notification of decision.	Field Type: Numeric. Is a subset of B1. See Part C reporting requirements on page 11 above for definition of timely grievance notification.
C1.	Excessive wait time to get an appointment with a PCP – Total number of grievances.	The number of grievances related to excessive wait time to get an appointment with a PCP.	Field Type: Numeric Is based on the date the decision was made.
C2.	Excessive wait time to get an appointment with a PCP – Number of grievances which the MMP provided timely notification of its decision.	The number of grievances related to excessive wait time to get an appointment with a PCP that resulted in timely notification of decision.	Field Type: Numeric. Is a subset of C2. See Part C reporting requirements on page 11 above for definition of timely grievance notification.
D1.	Excessive wait time to get an appointment with a specialist – Total number of grievances.	The number of grievances related to excessive wait time to get an appointment with a specialist.	Field Type: Numeric Is based on the date the decision was made.

Element Letter	Element Name	Definition	Allowable Values
D2.	Excessive wait time to get an appointment with a specialist – Number of grievances which the MMP provided timely notification of its decision.	The number of grievances related to excessive wait time to get an appointment with a specialist that resulted in timely notification of decision.	Field Type: Numeric. Is a subset of D2. See Part C reporting requirements on page 11 above for definition of timely grievance notification.
E1.	Other grievances related to areas not mentioned above – Total number of grievances.	The number of grievances related to other grievances related to areas not mentioned above.	Field Type: Numeric Is based on the date the decision was made.
E2.	Other grievances related to areas not mentioned above – Number of grievances which the MMP provided timely notification of its decision.	The number of grievances related to other grievances related to areas not mentioned above that resulted in timely notification of decision.	Field Type: Numeric. Is a subset of E2. See Part C reporting requirements on page 11 above for definition of timely grievance notification.

Appeals

Element Letter	Element Name	Definition	Allowable Values
F1.	Denial or limited authorization of specialty services – Fully Favorable.	The number of appeals related to denial or limited authorization of specialty services for which the MMP Coverage Decision or Reconsideration was fully favorable.	Field Type: Numeric The sum of data elements F1, F2, and F3 should equal the total number of appeals related to denial or limited authorization of specialty services.
F2.	Denial or limited authorization of specialty services – Partially Favorable.	The number of appeals related to denial or limited authorization of specialty services for which the MMP Coverage Decision or Reconsideration was partially favorable.	Field Type: Numeric
F3.	Denial or limited authorization of specialty services – Adverse.	The number of appeals related to denial or limited authorization of specialty services for which the MMP Coverage Decision or Reconsideration was adverse.	Field Type: Numeric
G1.	Denial or limited authorization of LTSS services – Fully Favorable.	The number of appeals related to denial or limited authorization of LTSS services (total) for which the MMP Coverage Decision or Reconsideration was fully favorable.	Field Type: Numeric The sum of data elements G1, G2, and G3 should equal the total number of appeals related to denial or limited authorization of LTSS services.
G2.	Denial or limited authorization of LTSS services – Partially Favorable.	The number of appeals related to denial or limited authorization of LTSS services (total) for which the MMP Coverage Decision or Reconsideration was partially favorable.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
G3.	Denial or limited authorization of LTSS services – Adverse.	The number of appeals related to denial or limited authorization of LTSS services (total) for which the MMP Coverage Decision or Reconsideration was adverse.	Field Type: Numeric
H1.	Denial or limited authorization of HCBS services – Fully Favorable.	The number of appeals related to denial or limited authorization of HCBS services for which the MMP Coverage Decision or Reconsideration was fully favorable.	Field Type: Numeric Note: Is a subset of G. The sum of data elements H1, H2, and H3 should equal the total number of appeals related to denial or limited authorization of HCBS services.
H2.	Denial or limited authorization of HCBS services – Partially Favorable.	The number of appeals related to denial or limited authorization of HCBS services for which the MMP Coverage Decision or Reconsideration was partially favorable.	Field Type: Numeric Note: Is a subset of G.
H3.	Denial or limited authorization of HCBS services – Adverse.	The number of appeals related to denial or limited authorization of HCBS services for which the MMP Coverage Decision or Reconsideration was adverse.	Field Type: Numeric Note: Is a subset of G.
I1.	Denial or limited authorization of institutional services – Fully Favorable.	The number of appeals related to denial or limited authorization of institutional services for which the MMP Coverage Decision or Reconsideration was fully favorable.	Field Type: Numeric Note: Is a subset of G. The sum of data elements I1, I2, and I3 should equal the total number of appeals related to denial or limited authorization of institutional services.

Element Letter	Element Name	Definition	Allowable Values
I2.	Denial or limited authorization of institutional services – Partially Favorable.	The number of appeals related to denial or limited authorization of institutional services for which the MMP Coverage Decision or Reconsideration was partially favorable.	Field Type: Numeric Note: Is a subset of G.
I3.	Denial or limited authorization of institutional services – Adverse.	The number of appeals related to denial or limited authorization of institutional services for which the MMP Coverage Decision or Reconsideration was adverse.	Field Type: Numeric Note: Is a subset of G.
J1.	Denial or limited authorization of mental health services – Fully Favorable.	The number of appeals related to denial or limited authorization of mental health services for which the MMP Coverage Decision or Reconsideration was fully favorable.	Field Type: Numeric The sum of data elements J1, J2, and J3 should equal the total number of appeals related to denial or limited authorization of mental health services.
J2.	Denial or limited authorization of mental health services – Partially Favorable.	The number of appeals related to denial or limited authorization of mental health services for which the MMP Coverage Decision or Reconsideration was partially favorable.	Field Type: Numeric
J3.	Denial or limited authorization of mental health services – Adverse.	The number of appeals related to denial or limited authorization of mental health services for which the MMP Coverage Decision or Reconsideration was adverse.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
K1.	Denial or limited authorization of substance use treatment services – Fully Favorable.	The number of appeals related to denial or limited authorization of substance use treatment services for which the MMP Coverage Decision or Reconsideration was fully favorable.	Field Type: Numeric The sum of data elements K1, K2, and K3 should equal the total number of appeals related to denial or limited authorization of substance use treatment services.
K2.	Denial or limited authorization of substance use treatment services – Partially Favorable.	The number of appeals related to denial or limited authorization of substance use treatment services for which the MMP Coverage Decision or Reconsideration was partially favorable.	Field Type: Numeric
K3.	Denial or limited authorization of substance use treatment services – Adverse.	The number of appeals related to denial or limited authorization of substance use treatment services for which the MMP Coverage Decision or Reconsideration was adverse.	Field Type: Numeric
L1.	Other appeals related to areas not mentioned above – Fully Favorable.	The number of appeals related to other appeals related to areas not mentioned above (includes all Medicare and Medicaid demonstration related appeals) for which the MMP Coverage Decision or Reconsideration was fully favorable.	Field Type: Numeric The sum of data elements L1, L2, and L3 should equal the total number of appeals related to denial or limited authorization services not mentioned above.

Element Letter	Element Name	Definition	Allowable Values
L2.	Other appeals related to areas not mentioned above – Partially Favorable.	The number of appeals related to other appeals related to areas not mentioned above (includes all Medicare and Medicaid demonstration related appeals) for which the MMP Coverage Decision or Reconsideration was partially favorable.	Field Type: Numeric
L3.	Other appeals related to areas not mentioned above – Adverse.	The number of appeals related to other appeals related to areas not mentioned above (includes all Medicare and Medicaid demonstration related appeals) for which the MMP Coverage Decision or Reconsideration was adverse.	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.

- CMS and the state will evaluate denial or limited authorization rates per 1,000 enrollees and will trend rates from quarter to quarter and from previous year.
- 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:

- Number of grievances related to:
  1) Inability to get appointment with a PCP per 1,000 members.
  2) Inability to get appointment with a PCP that resulted in timely notification of decision per 1,000 members.
  3) Inability to get an appointment with a specialist per 1,000 members.
  4) Inability to get an appointment with a specialist that resulted in timely notification of decision per 1,000 members.
  5) Excessive wait time to get an appointment with a PCP per 1,000 members.
  6) Excessive wait time to get an appointment with a PCP that resulted in timely notification of decision per 1,000 members.
  7) Excessive wait time to get an appointment with a specialist per 1,000 members.
  8) Excessive wait time to get an appointment with a specialist that resulted in timely notification of decision per 1,000 members.
  9) Other grievances related to areas not mentioned above per 1,000 members.
  10) Other grievances related to areas not mentioned above that resulted in timely notification of decision per 1,000 members.
- Number of appeals related to denial or limited authorization of:
  1) Specialty services for which the MMP coverage decision or reconsideration was fully favorable per 1,000 members.
  2) Specialty services for which the MMP coverage decision or reconsideration was partially favorable per 1,000 members.
  3) Specialty services for which the MMP coverage decision or reconsideration was adverse per 1,000 members.
  4) LTSS services (total) for which the MMP coverage decision or reconsideration was fully favorable per 1,000 members.
  5) LTSS services (total) for which the MMP coverage decision or reconsideration was partially favorable per 1,000 members.
  6) LTSS services (total) for which the MMP coverage decision or reconsideration was adverse per 1,000 members.
  7) HCBS services for which the MMP coverage decision or reconsideration was fully favorable per 1,000 members.
  8) HCBS services for which the MMP coverage decision or reconsideration was partially favorable per 1,000 members.
  9) HCBS services for which the MMP coverage decision or reconsideration was adverse per 1,000 members.
  10) Institutional services for which the MMP coverage decision or reconsideration was fully favorable per 1,000 members.
  11) Institutional services for which the MMP coverage decision or reconsideration was partially favorable per 1,000 members.
  12) Institutional services for which the MMP coverage decision or reconsideration was adverse per 1,000 members.

13) Mental health services for which the MMP coverage decision or reconsideration was fully favorable per 1,000 members.
14) Mental health services for which the MMP coverage decision or reconsideration was partially favorable per 1,000 members.
15) Mental health services for which the MMP coverage decision or reconsideration was adverse per 1,000 members.
16) Substance use treatment services for which the MMP coverage decision or reconsideration was fully favorable per 1,000 members.
17) Substance use treatment services for which the MMP coverage decision or reconsideration was partially favorable per 1,000 members
18) Substance use treatment services for which the MMP coverage decision or reconsideration was adverse per 1,000 members

- Number of appeals related to areas not mentioned above for which the MMP coverage decision or reconsideration was fully favorable per 1,000 members.
- Number of appeals related to areas not mentioned above for which the MMP coverage decision or reconsideration was partially favorable per 1,000 members.
- Number of appeals related to areas not mentioned above for which the MMP coverage decision or reconsideration was adverse per 1,000 members.

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

- This measure supplements existing Part C Reporting Requirements for MMPs related to grievances and appeals.
- The date the decision was made should be used to assess which reporting period the appeal or grievance should be reported.
- MMPs should refer to the explanatory notes in the Part C Reporting Requirements on page 11 above for further reporting information, including inclusion and exclusion criteria, definitions of timeliness and category assignments.
- One grievance involving multiple issues should be reported under each applicable category.
- If a member files a grievance and then files a subsequent grievance on the same issue prior to the organization's decision or deadline for decision notification (whichever is earlier), the issue is counted as one grievance.
- If a member files a grievance and then files a subsequent grievance on the same issue after the organization's decision or deadline for decision notification (whichever is earlier), the issue is counted as a separate grievance.
- There are no minimum enrollment criteria for these measures. All grievances and appeals should be reported regardless how long a member has been enrolled in the MMP or if they have disenrolled from the MMP.

- For reporting, MMPs should exclude grievances related to supplemental benefits as these are additional benefits provided by MMPs which are outside of reporting requirements.
- Long Term Services and Supports (LTSS) will be defined in the state-specific appendix.
- Primary Care Provider (PCP) will be defined in the state-specific appendix.

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 V. Organizational Structure and Staffing

5.1 Care coordinator to member ratio.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
5. Organizational Structure and Staffing	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
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
5. 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 full time equivalent (FTE) care coordinators involved in the Demonstration.	Total number of FTE care coordinators involved in the Demonstration as of the end of the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total FTE care coordinators assigned to care management and conducting assessments.	Of the total reported in A, the number of FTE care coordinators assigned to care management and conducting assessments.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of newly hired FTE care coordinators (or those newly assigned to the MMP).	Of the total reported in A, the number of newly hired FTE care coordinators during the reporting period.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of FTE care coordinators that left the MMP.	Of the total reported in A, the number of FTE care coordinators that left the MMP during the reporting period.	Field type: Numeric Note: Is a subset of A.

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

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

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

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

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

This measure is not adjusted for case mix, plus care coordination will vary for each demonstration and each MMP's care plan model structure. Therefore, this measure will be used solely to track care coordination investments and changes in each MMP's care coordinator to member ratio longitudinally. CMS will compare each MMP's submitted staffing plan to the reported data elements.

CMS and the state will:

- Obtain enrollment data from CMS' Web site to evaluate the number of FTE care coordinators.

- Evaluate the percentage of new FTE care coordinators assigned to care management and conducting assessments.
- Evaluate the percentage of newly hired FTE care coordinators during the reporting period.
- Evaluate the percentage of new FTE care coordinators that left the MMP during the reporting period.

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

- Care coordinator will be defined in the state-specific appendix. Different terms may be used in different states.
- All part-time and full-time care coordinators will be counted, regardless of whether they are subcontracted or employed directly by the MMP.

- FTE is defined as full time equivalent. To calculate this, add up all of the care coordinators' work hours during the reporting period and divide this value by the number of normal working hours that occurred during the reporting period. In instances where care coordinators support multiple lines of business, include only the time associated with the demonstration/MMP.

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

5.2 Annual Staffing Worksheets.

Guidance will be forthcoming for MMPs to annually report their staffing information.

5.3 Establishment of consumer advisory board or inclusion of consumers on a pre-existing governance board consistent with contractual requirements.[i]

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

MMPs will be required to submit information on each consumer advisory board and/or governance board during the annual reporting period. A template for providing information is attached to this document. One template per meeting should be completed and submitted.

5.3 Template.docx

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.	Date.	Date each meeting occurred during the annual reporting period.	Field Type: N/A Note: Date in CCYYMMDD Format
B.	Name of board members invited.	Name of all consumer advisory board/governance board members invited to the meeting.	Field Type: N/A
C.	Name of board members in attendance.	Name of all consumer advisory board/governance board members in attendance either in-person or remotely.	Field Type: N/A

Element Letter	Element Name	Definition	Allowable Values
D.	Name of board members invited who are actual beneficiaries or family caregivers.	Number of board members invited who are actual beneficiaries or family caregivers. Professional advocates should not be included unless they are also members or caregivers for members of the MMP.	Field Type: N/A
E.	Name of board members who are actual beneficiaries or family caregivers in attendance.	Number of board members who are actual beneficiaries or family caregivers in attendance either in-person or remotely. Professional advocates should not be included unless they are also members or caregivers for members of the MMP.	Field Type: N/A
F.	Agenda.	Agenda for each meeting during the annual period.	Field Type: N/A
G.	Minutes.	Minutes for each meeting held during the annual reporting period.	Field Type: N/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.

- 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.

- Meeting dates are within the performance period.

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 analyze attendance and participation of MMP members in board meetings.

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

- MMPs should submit one template per meeting.

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
- Required File Format is Microsoft Word File.
- The file name extension should be ".docx"
- File name= (STATEABBREVIATION)_(CONTRACTID)_(REPORTING PERIOD)_(MEETINGDATE).docx.
- Replace (STATEABBREVIATION) with the two-character state abbreviation (e.g., Massachusetts is MA), (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), (MEETINGDATE) the month, date, year, and century of the meeting in CCYYMMDD format (e.g., March 30, 2014 would be 21140330).

Section VI. Performance and Quality Improvement

6.1 Percent of high-risk residents with pressure ulcers (long-stay).

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
6. Performance and Quality Improvement	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 long-stay nursing home residents with a selected target assessment who met the definition of high risk.	Total number of long-stay nursing home residents with a selected target assessment who met the definition of high risk during the reporting period.	Field Type: Numeric
B.	Total number of long-stay residents who had one or more Stage 2-4 pressure ulcer.	Of the total reported in A, the number long-stay residents who had one or more Stage 2-4 pressure ulcer 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 high-risk long-stay nursing home residents who had one or more Stage 2-4 pressure ulcer during the reporting period.

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

- Please refer to the MDS 3.0 Quality Measure User's Manual for further details on this measure: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html.
- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- Long stay refers to residents who have been in the nursing facility for greater than 100 cumulative days during the most recent episode.
- Residents are defined as high-risk if they meet one or more of the following three criteria:
    - Impaired bed mobility or transfer indicated, by either or both of the following:
        - Bed mobility, self-performance
        - Transfer, self-performance
    - Comatose
    - Malnutrition or at risk of malnutrition

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

6.2 Screening for Clinical Depression and Follow-up Plan. (NQF #0418)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
6.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.	Total number of members age 18 and older screened for clinical depression using a standardized tool.	The number of members age 18 and older screened for clinical depression using a standardized tool during the reporting period.	Field Type: Numeric
B.	Total number of screening tests that were positive.	Of the total reported in A, the number of screening tests that were positive.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members who had a follow-up plan documented on the date of the positive screen.	Of the total reported in B, the number of members who had a follow-up plan documented on the date of the positive screen.	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 members screened for clinical depression using a standardized tool AND, if positive, whose follow-up plan was documented on the date of the positive screen during the reporting period.

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

- MMPs should include all members, regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- MMPs should refer to pages 27-28 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.
- Screening refers to the completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition.
- A standardized tool refers to an assessment tool that has been appropriately normalized and validated for the population in which it is being utilized. Please see page 27 of the Medicaid Adult Core Set for a list of acceptable depression screening tools.
- A follow-up plan refers to the proposed outline of treatment to be conducted as a result of a clinical depression screening. Follow-up for a positive depression screening much include one (1) or more of the following:
    - Additional evaluation
    - Suicide Risk Assessment
    - Referral to a practitioner who is qualified to diagnose and treat depression
    - Pharmacological interventions
    - Other interventions or follow-up for the diagnosis or treatment of depression

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

Section VII. Provider Network

Guidance will be forthcoming for MMPs to annually report the Medicare and Medicaid provider, facility, and pharmacy networks.

Section VIII. Systems

8.1 LTSS clean claims paid within 30 days, 60 days, and 90 days.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
8. Systems	Semi-Annual	Contract	1/1-6/30 7/1-12/31	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 LTSS clean claims paid within the reporting period.	Total number of LTSS clean claims paid within the reporting period.	Field Type: Numeric
B.	Total number of clean claims paid within 30 calendar days of receipt.	Of the total reported in A, the number of clean claims paid within 30 calendar days of receipt.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of clean claims paid within 60 calendar days of receipt.	Of the total reported in A, the number of clean claims paid between 31 and 60 calendar days of receipt.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of clean claims paid within 90 calendar days of receipt.	Of the total reported in A, the number of clean claims paid between 61 and 90 calendar days of receipt.	Field Type: Numeric Note: Is a subset of A.

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

- CMS and the state will perform an outlier analysis.

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

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

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

D. Analysis - how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of LTSS clean claims paid:

- Within 30 calendar days of receipt.
- Between 31 and 60 calendar days of receipt.
- Between 61 and 90 calendar days of receipt.

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

- Long Term Services and Supports (LTSS) will be defined in the state-specific appendix.
- A “clean” claim is one that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.
- MMPs should include LTSS clean claims if they were paid during the reporting period. LTSS clean claims submitted during the reporting period, but not paid during the reporting period, should not be included.

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

Section IX. Utilization

9.1 Emergency room behavioral health services utilization.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
9. Utilization	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 behavioral health-related ED visits with a CPT or UB Revenue code for an emergency department visit and a principal diagnosis related to behavioral health.	Total number of behavioral health-related ED visits with a CPT or UB Revenue code for an emergency department visit and a principal diagnosis related to behavioral health 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 obtain enrollment information from CMS' Web site to evaluate the total number of behavioral health-related ED visits per 1,000 members during the reporting period.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- Refer to the codes provided in Table 3 to identify emergency department visits.
- Refer to the codes provided in Table 4 to identify a behavioral health diagnosis.
- MMP should exclude members if they are admitted as inpatients.

Table 3: Codes to Identify ED Visits	
CPT® Codes[1]	**UB Revenue Codes**
99281-99285	045x, 0981

Table 4: Codes to Identify Behavioral Health Diagnosis
ICD-9 Principal Diagnosis Code
290, 293-302, 306-316

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

[1] CPT is a registered trademark of the American Medical Association.

9.2 Nursing Facility (NF) Diversion.[i]

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
9. Utilization	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 nursing home certifiable members who did not reside in a NF for more than 100 continuous days during the ***previous*** reporting period.	Total number of nursing home certifiable members who did not reside in a NF for more than 100 continuous days during the previous reporting period.	Field Type: Numeric
B.	Total number of members who did not reside in a NF for more than 100 continuous days during the ***current*** reporting period.	Of the total reported in A, the number of members who did not reside in a NF for more than 100 continuous days during the current 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.

- 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.
- 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.

- For members who did not reside in a NF for more than 100 continuous days during the ***previous*** reporting period, CMS and the State will evaluate the percentage of nursing home certifiable members who did not reside in a NF for more than 100 continuous days during the ***current*** reporting period.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- A member must be enrolled in the MMP for 11 out of 12 months during the current reporting period to be included in this measure.
- A member must be Medicaid eligible for 11 out of 12 months during the previous reporting period to be included in this measure.
- Nursing facility services are provided by Medicaid, Medicare, or other state agencies certified nursing homes.
- Exclude members who expired during the reporting period. Codes to identify patients who have expired are provided in Table-5.
- This measure will not be reported until Demonstration Year 2.

Table-5: Codes to Identify Patients who Expired

Discharge Status Code
20

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).