DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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MEDICARE-MEDICAID COORDINATION OFFICE

DATE: November 2, 2020

TO: Medicare-Medicaid Plans

FROM: Lindsay P. Barnette
Director, Models, Demonstrations and Analysis Group

SUBJECT: CY 2021 Core Reporting Requirements for Medicare-Medicaid Plans

The purpose of this memorandum is to announce the release of the Calendar Year (CY) 2021 Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements and Value Sets Workbook. Medicare-Medicaid Plans (MMPs) should follow these revised requirements for all reporting periods that commence on or after January 1, 2021.

As with every annual update cycle, we revised the requirements in an effort to streamline and clarify reporting expectations for MMPs. Please see below for a summary of the substantive changes as compared to the CY 2020 Core Reporting Requirements.

Should you have any questions, please contact the Medicare-Medicaid Coordination Office at mmcocapsreporting@cms.hhs.gov.

SUMMARY OF CHANGES

Core Measure 2.1 – In the Notes section, clarified that data element A should include deceased members who were enrolled through the end of the reporting period. Additionally, revised guidance in the Notes section for data element B to clarify the criteria that qualify a member as unwilling to participate in the assessment.

Core Measure 2.3 – In the Notes section, added additional guidance for reporting data element A, including clarifying that data element A should include deceased members who were enrolled through the end of the reporting period.

Core Measure 3.2 – In the Notes section, clarified that data element A should include deceased members who were enrolled through the end of the reporting period. Additionally, revised guidance in the Notes section for data element B to clarify the criteria that qualify a member as unwilling to complete a care plan.

Core Measure 4.2 – In the Notes section, clarified that MMPs should exclude grievances and appeals that were withdrawn or dismissed.

Core Measure 5.1 – In the Notes section, clarified that MMPs should refer to their state's three-way contract for the definition of care coordinator (or similar term).

Core Measure 9.1 – In the Notes section, added guidance that MMPs should use facility claims to identify emergency department visits. Additionally, clarified the definition of adjudicated claims, which includes paid and denied claims.

Core Measure 9.3 – In the Notes section, added additional explanations to the steps for identifying risk adjustment weights.