Core Measure 2.1: Frequently Asked Questions (FAQs)

Last Updated: August 25, 2016

The following FAQs provide guidance for Core Measure 2.1: Members with an assessment completed within 90 days of enrollment. Detailed specifications for this measure can be found in the Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements. Additional guidance regarding this measure was also issued by CMS via a March 6, 2015 HPMS memorandum titled "Update to Contract Year 2015 Medicare-Medicaid Plan Reporting Requirements." The reporting requirements document and HPMS memorandum are available on the following website: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html.

Core Measure 2.1 General Guidance

1. What is the intent of Core Measure 2.1?

The intent of the measure is to capture the number of members who had an initial comprehensive assessment completed within their first 90 days of enrollment. It also captures the number of members who were unwilling to participate in the comprehensive assessment within 90 days of enrollment, or were unable to be located by the MMP within 90 days of enrollment.

2. What type of assessment meets the requirements of Core Measure 2.1?

The assessment for this measure should be an initial comprehensive health risk assessment, as applicable per demonstration-specific guidance. The requirements pertaining to the assessment tool and how the tool should be administered (e.g., in-person, phone, etc.) may vary by demonstration. The assessment tool should meet any state-specific criteria and include the appropriate domains. MMPs should refer to their three-way contract for specific requirements.

Additional guidance is included in the state-specific reporting appendices. MMPs should refer to their state-specific reporting appendix for information on reporting initial assessments completed by the MMP prior to a member's effective enrollment date, reporting initial assessments for members with a break in coverage, and reporting initial assessments completed previously by the MMP's affiliated product. Note that the applicability of such guidance varies across demonstrations.

Identifying Data Element A

3. How should MMPs determine if a member's 90th day of enrollment occurred within the reporting period?

The 90th day of enrollment is based on each member's effective date of Medicare-Medicaid enrollment. For purposes of reporting Core Measure 2.1, 90 days of enrollment is equivalent to three full calendar months, not 90 calendar days. Further, the 90th day of enrollment will always occur on the last day of the 3rd month following a member's effective enrollment date. For example, a member enrolled on January 1, 2015 would reach his/her 90th day of enrollment on March 31, 2015.

When reporting quarterly results for Ongoing reporting periods, MMPs should report all members who reached their 90th day of enrollment at any point during the three months included in the quarter (e.g., members enrolled on May 1, June 1, and July 1 reached their 90th day of enrollment during the third quarter; therefore, these members should be included in Ongoing reporting for the third quarter).

4. **Should MMPs include members who were disenrolled as of the end of the reporting period?**

   MMPs should not report members in data element A who are no longer enrolled on the last day of the reporting period. The last day of the reporting period is the anchor date, or the date on which all reported members must be enrolled in the MMP. For example, if a member enrolled in the MMP on February 1 and disenrolled on June 1, he/she would not be reported in data element A for the second quarter reporting, because the member was not enrolled on the last day of the reporting period (i.e., June 30).

5. **Should MMPs include passively enrolled or opt-in only members?**

   MMPs should include all Medicare-Medicaid members in data element A regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Members receiving only Medicaid coverage during the reporting period should not be included in data element A.

Identifying Data Element B

6. **Should MMPs include indirect refusals when reporting members as unwilling to participate in the assessment within 90 days of enrollment?**

   Any of the following scenarios would indicate that a member (or his/her authorized representative) was unwilling to participate in the assessment. The MMP must be able to demonstrate during performance measure validation that information from the following scenarios was clearly documented.

   1. *Affirmatively declines to participate in the assessment, affirmatively declines care management activities overall, or refuses any contact with the MMP. Member communicates the declination or refusal by phone, mail, fax, or in person.*
   2. *Expresses willingness to complete the assessment but asks for it to be conducted after 90 days (despite being offered a reasonable opportunity to complete the assessment within 90 days). Discussions with the member must be documented by the MMP.*
   3. *Expresses willingness to complete the assessment, but reschedules or is a no-show and then is subsequently non-responsive. Attempts to contact the member must be documented by the MMP.*
   4. *Initially agrees to complete the assessment, but then declines to answer a majority of the questions in the assessment.*

7. **Upon reaching out to a member to complete the assessment or during an inbound call from the member, if a member declines care management services or unsubscribes from all communication from the MMP, can the member be categorized as unwilling to participate in the assessment within 90 days of enrollment?**

   Yes. The MMP must clearly document why a member was unwilling to participate.

8. **If a member is disgruntled or hangs up on the MMP during an outreach attempt, can the member be categorized as unwilling to participate in the assessment within 90 days of enrollment?**

   No. The MMP must continue to conduct outreach to the member until the member meets the criteria for refusing to participate in the assessment as outlined in item #6 above.

Identifying Data Element C

9. **What types of outreach are allowed to be counted in the three documented outreach attempts as part of data element C?**

   MMPs are encouraged to attempt to locate members via multiple methods (e.g., phone, mail, email, or face-to-face visits) and over various times and days of the week during the course of the member's first 90 days of enrollment.

   MMPs should refer to their three-way contract or other demonstration-specific guidance for any requirements pertaining to the method of outreach to members. MMPs must document each attempt to reach the member, including the method of the attempt (e.g., phone, mail, email, or in-person). If less than three outreach attempts are made to the member within 90 days of enrollment, then the member should not be included in data element C.

10. **Can MMPs include multiple modes of outreach when reporting three attempts for a single member (e.g., two telephonic attempts and one attempt via postal mail), or do all three attempts need to be the same mode of outreach (e.g., three telephonic attempts)?**

    MMPs should count the first three outreach attempts, regardless of the outreach method. For example, if a member was called on day 3 after the effective enrollment date, was mailed an assessment on day 21, and was called again on day 40, the MMP can count these three individual attempts for data element C as long as the attempts were completed within 90 days of enrollment. All three outreach attempts must be clearly documented.

Additional Guidance – Scenario Examples

11. **If a member was documented as unwilling to participate in the assessment and then subsequently completed an assessment within the first 90 days of enrollment, in what data element should the member be reported?**

    If a member was documented as unwilling to participate in the assessment and also had an assessment completed within 90 days of enrollment, the member should be reported in data element D, not data element B.

12. **If a member was documented as unable to be located to have an assessment completed and then subsequently completed an assessment within the first 90 days of enrollment, in what data element should the member be reported?**

    If a member was documented as unable to be located to have an assessment completed and also had an assessment completed within 90 days of enrollment, the member should be reported in data element D, not data element C.

13. If a member was contacted by phone and the phone number was invalid or disconnected, the member was sent a paper assessment in the mail, and no additional outreach attempts were made, can this member be reported in data element C?

This member cannot be reported in data element C as there were only two outreach attempts documented. The MMP should make all efforts to obtain updated contact information for the member, which may include contacting the member's primary care provider for updated contact information or attempting to visit the member in person. Even if there are no additional methods for contacting the member, he/she should not be reported in data element C as the MMP did not conduct and document three attempts to locate the member.

14. If a member calls the MMP (e.g., to request information regarding the demonstration), can this inbound call be counted as one of the three documented outreach attempts for data element C?

Any inbound calls by the member to the MMP cannot be counted as part of the three required outreach attempts. All outreach attempts must be outbound attempts by the MMP to be counted in data element C. If the member calls the MMP and the assessment is completed during the same telephone call, the member would be included in data element D. Similarly, if the member calls the MMP and refuses to complete the assessment during the same telephone call, the member would be included in data element B.

15. If a member's assessment is in progress, but is not completed within 90 days of enrollment, should the assessment be considered complete?

Since the assessment was not completed within 90 days of enrollment, then the assessment cannot be considered complete, and therefore, the member cannot be counted in data element D.

16. If the MMP is confident that a member's contact information is correct, yet the member is not responsive to the MMP's outreach efforts, can this member be reported in data element C?

So long as the MMP follows the guidance regarding outreach attempts, these members may be included in the count for data element C.

17. There may be certain circumstances that make it impossible or inappropriate to complete an assessment within the required timeframes. For example, a member may be medically unable to respond and have no authorized representative to do so on their behalf, or a member may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for an assessment. In these cases, should members be counted in data elements B or C?

MMPs should not include such members in the counts for data elements B or C.

18. If the MMP contacts the member's pharmacy, primary care physician, or other provider to obtain updated contact information for the member, can this call be counted as one of the three documented outreach attempts for data element C?

No. Any calls to the member's pharmacy, primary care physician, or other provider cannot be counted as part of the three required outreach attempts. Only outreach attempts made to the member or the member's authorized representative can be counted as an outreach attempt for data element C.

19. If the MMP reviews a member's file/record in its care management system and discovers there is no phone information available for the member, can this member be reported in data element C?

No. MMPs should not include such members in the counts for data element C. MMPs should make all efforts to obtain updated contact information for members, attempt to visit the members in person, or mail letters to the members. Even if there are no additional methods for contacting the members, they should not be reported in data element C as the MMP did not conduct and document three outreach attempts to reach the members.

Validation Checks

20. What validation checks should MMPs perform internally to help ensure that reported data are valid prior to submitting data element values to the Health Plan Management System (HPMS)?

MMPs should ensure members reported in data elements B, C, and D are also reported in data element A since these data elements are subsets of data element A. The sum of data elements B, C, and D should be less than or equal to data element A. Additionally, data elements B, C, and D should be mutually exclusive (e.g., a member reported in data element B or C should not also be reported in data element D).

For data element A: MMPs should validate that members included in data element A were enrolled for at least 90 days, and the 90th day of enrollment occurred within the reporting period. Note that for purposes of reporting this measure, 90 days of enrollment is equivalent to three full calendar months (see FAQ #3 for more information). All members in data element A must be enrolled as of the last day of the reporting period.

For data element B: MMPs should validate that members included in data element B were included in data element A, but were not reported in data elements C or D. MMPs should validate that members reported in data element B were clearly documented as unwilling to participate in the assessment within 90 days of enrollment and never had an assessment completed within 90 days of enrollment.

For data element C: MMPs should validate that members included in data element C were included in data element A, but were not included in data elements B or D. MMPs should validate that members reported in data element C had three outreach attempts clearly documented within 90 days of enrollment and never had as assessment completed within 90 days of enrollment.

For data element D: MMPs should validate that members reported in data element D were included in data element A, but were not reported in data elements B or C. MMPs should validate that members reported in data element D had a completed initial assessment clearly documented within 90 days of enrollment.