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

DATE: April 13, 2017

TO: Medicare-Medicaid Plans in South Carolina

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

SUBJECT: Revised South Carolina-Specific Reporting Requirements and Value Sets Workbook

The purpose of this memorandum is to announce the release of the revised Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: South Carolina-Specific Reporting Requirements and corresponding South Carolina-Specific Value Sets Workbook. The documents are designed to provide updated guidance, technical specifications, and applicable codes for the state-specific measures that South Carolina Medicare-Medicaid Plans (MMPs) are required to collect and report under the demonstration.

Please see below for a high-level summary of the changes that were made to the South Carolina-Specific Reporting Requirements. Note that the South Carolina-Specific Value Sets Workbook also includes changes; South Carolina MMPs should carefully review and incorporate the updated value sets, particularly for measure SC2.4.

South Carolina MMPs must use the updated specifications and value sets for measures due on or after May 31, 2017. Should you have any questions, please contact the Medicare-Medicaid Coordination Office at mmcocapsreporting@cms.hhs.gov.

SUMMARY OF CHANGES

Introduction

- Added the "Variations from the Core Document" section, which provides guidance regarding how to identify nursing home certifiable members for purposes of reporting Core 9.2. Note that this guidance was previously released via the South Carolina HelpDesk on February 2, 2017.
- In the "Quality Withhold Measures" section, added a link to the Quality Withhold Technical Notes (DY 1): South Carolina-Specific Measures. Also added the DY 1

quality withhold benchmark information and the DY 2-3 quality withhold designation to the relevant measures within the document.

Measure SC1.1

- In the Notes section, clarified that MMPs should include members classified as low-risk on the first effective date of enrollment, even if the member is subsequently reclassified as moderate- or high-risk.

Measure SC1.2

- In the Notes section, clarified that MMPs should include members classified as moderate- or high-risk on the first effective date of enrollment, even if the member is subsequently reclassified as low-risk.

Measure SC2.1

- Added additional instruction in the Notes section regarding risk group classification in order to align with the three-way contract. Also clarified that MMPs should categorize members into a single risk classification level (i.e., low-, moderate-, or high-risk) as of the first effective date of enrollment, even if the member is subsequently reclassified.

Measure SC2.3

- Revised data element A to capture members whose 90th day of enrollment in the HCBS waiver occurred within the reporting period. Also revised data element B to capture members with a waiver service plan approved within 90 days of enrollment in the HCBS waiver.
- Revised the Analysis section and Notes section to align with the revisions to the data elements described above.
- Note that MMPs are required to commence reporting of this measure as of the Q1 2017 reporting period.

Measure SC2.4

- Revised the Notes section to provide guidance on identifying follow-up visits that are included in bundled payments. Also clarified the steps for identifying inpatient discharges and identifying exclusions for this measure.

Measure SC4.1

- Revised data elements A and B to more clearly articulate that only newly hired care coordinators (or those newly assigned to the MMP) should be included in the measure.

Measure SC5.1

- Removed data elements D and E given that responsibility for HCBS claims adjudication will not be transitioned to the MMPs at this time.

- In the Notes section, clarified that MMPs should include all clean, non-duplicated claims for members who meet the criteria outlined in data element A, regardless if the members are disenrolled as of the end of the reporting period. Also clarified that MMPs should not include reprocessed claims or denied claims.

Measure SC6.3

- In the Notes section, provided additional guidance on identifying members for inclusion in data elements A and B.