Core Measure 3.2: Frequently Asked Questions (FAQs)

Last Updated: March 2019

The following FAQs provide guidance for reporting Core Measure 3.2: *Members with a care plan completed within 90 days of enrollment*. Detailed specifications for this measure can be found in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements. The reporting requirements document is available on the following website: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html.

NOTE: Beginning with Quarter 1 2018 reporting, CMS retired several of the state-specific measures that assessed timely care plan completion and transitioned to Core Measure 3.2.[1]

Core Measure 3.2 General Guidance

1. What is the intent of Core Measure 3.2?

The intent of the measure is to capture the number of members who had an initial care plan completed within their first 90 days of continuous enrollment. It also captures the number of members who were unwilling to complete a care plan within 90 days of enrollment, or were unable to be reached by the MMP within 90 days of enrollment.

2. What type of care plan meets the requirements of Core Measure 3.2?

The care plan for this measure should be the initial care plan that is developed with participation from the member (or his/her authorized representative), as applicable per demonstration-specific guidance. The requirements pertaining to the care plan completion (e.g., signature requirements) and how the care plan should be developed with the member (e.g., in-person, phone, etc.) may vary by demonstration. The care plan 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 care plans completed by the MMP prior to a member's effective enrollment date, reporting initial care plans for members with a break in coverage, and reporting initial care plans 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?

[1] The state-specific measures that assessed timely care plan completion included: CA1.2, CA1.4, IDD1.1, IL3.1, MA1.1, MI2.1, NY2.1, OH1.1, RI1.1, SC2.1, and TX1.1.

The 90th day of enrollment is based on each member's most recent effective date of Medicare-Medicaid enrollment. For purposes of reporting Core Measure 3.2, 90 days of continuous enrollment is equivalent to three full calendar months, not 90 calendar days. Further, the 90th day of continuous enrollment will always occur on the last day of the 3rd month following a member's most recent effective enrollment date. For example, a member enrolled on January 1, 2019 would reach his/her 90th day of enrollment on March 31, 2019.

When reporting quarterly results for Ongoing reporting periods, MMPs should report all members who reached their 90th day of continuous 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 [July – September]; therefore, these members should be included in Ongoing reporting for the third quarter as long as they were still enrolled on the last day of the reporting period).

4. **Should a member be continuously enrolled in the MMP from their most recent effective enrollment date through the 90th day of enrollment?**

   Yes. In addition to reporting members who are currently enrolled on the last day of the reporting period, the member may have no breaks in enrollment from his/her most recent effective enrollment date through his/her 90th day of enrollment. For example, if a member enrolled on April 1, disenrolled on May 1, then re-enrolled on June 1 and remained enrolled on September 30, the most recent effective enrollment date would be June 1, not April 1. Since this member was continuously enrolled from June 30 through 90 days of enrollment and remained enrolled on the last day of the reporting period (i.e., September 30), the member would be included in data element A for the third quarter.

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.

6. **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).

Identifying Data Element B

7. **Should MMPs include indirect refusals when reporting members as unwilling to complete a care plan within 90 days of enrollment?**

   Any of the following scenarios would indicate that a member (or his/her authorized representative) was unwilling to complete a care plan. The MMP must be able to demonstrate

during performance measure validation that information from the following scenarios was clearly documented.

1. *Affirmatively declines to complete the care plan, affirmatively declines care management activities overall, or refuses any contact with the MMP. The member may communicate the declination or refusal by phone, mail, fax, or in person. The declination or refusal must be documented by the MMP.*
2. *Expresses willingness to complete the care plan but asks for it to be conducted after 90 days (despite being offered a reasonable opportunity to complete the care plan within 90 days). Discussions with the member must be documented by the MMP.*
3. *Schedules an appointment to complete the care plan, but cancels 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 care plan, but then declines to participate in the development of the care plan. The declination must be documented by the MMP.*

8. How should the MMP document the declination by the member to complete a care plan?

The MMP must clearly document why a member was unwilling to complete a care plan (i.e., document notes from the encounter with the member explaining the reason the member declined participation). Simply checking a box or a drop-down menu item that the member refused or was unwilling to participate, without accompanying narrative, does not constitute documented declination.

9. If a member was contacted and documented as unwilling to participate in the initial comprehensive assessment (i.e., Core Measure 2.1), can the member automatically be categorized as unwilling to complete a care plan?

No. Refusal to participate in the assessment cannot be automatically applied to the care plan. The MMP must also ask the member if he/she is willing to participate in the development of a care plan. This can be accomplished in the same conversation with the member.

10. Upon reaching out to a member to complete the care plan 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 complete a care plan within 90 days of enrollment?

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

11. If a member is disgruntled, hangs up on the MMP, or states they do not want to speak with the MMP "at this time" during an outreach attempt, can the member be categorized as unwilling to complete a care plan 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 complete a care plan as outlined in FAQ #7 above.

12. If a member mentions during an outreach attempt that they are traveling and are outside of the service area and will not return within 90 days of enrollment, can the member be categorized as unwilling to complete a care plan within 90 days of enrollment?

Yes, if the care plan is required to be completed in person or if the member prefers to complete the care plan in person. However, the MMP should continue to conduct outreach to the member once the member has returned within the service area to complete the care plan.

Identifying Data Element C

13. What types of outreach can be counted in the three documented outreach attempts as part of data element C?

MMPs are encouraged to attempt to reach members via multiple modes (e.g., phone, mail, email, or in-person visits) and over various times and days of the week during the course of the member's first 90 days of enrollment. MMPs are also encouraged to work with community organizations, network providers, and other available resources to help determine accurate contact information for its members and promote member engagement through the member's trusted support networks.

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.

14. 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 made to complete a care plan, regardless of the outreach method. For example, if a member was called on day 3 after the most recent effective enrollment date, was mailed an unable-to-reach letter on day 21, and was called again on day 40 to complete the care plan, 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.

15. Can MMPs count all outreach attempts made using the same mode of outreach that occur on the same day?

No. For example, if a member was called twice on day 6 and mailed an unable-to-reach letter on the same day, the MMP can only count the first phone call and the mail attempt for data element C. Outreach attempts made using the same mode of outreach must be conducted on different days of the week in order to count each outreach attempt. MMPs should refer to their three-way contract or other demonstration-specific guidance for any requirements pertaining to the method of outreach to members.

16. Can MMPs count the same documented outreach attempts under both Core Measure 2.1 and Core Measure 3.2?

Given that MMPs may conduct initial outreach to a member for the purpose of completing both an assessment and care plan, it is permissible to count the same documented outreach attempts under both measures if the member was unreachable. More specifically, as long as the MMP documented at least three unsuccessful outreach attempts during the first 90 days of enrollment,

and the member was never reached, then the MMP may report the member in data element C under both Core Measure 2.1 and Core Measure 3.2.

However, if the member was reached for the purpose of completing an assessment (e.g., the member refused the assessment, scheduled a separate time for the assessment, or completed the assessment), then the MMP must make and document at least three new outreach attempts to the member for the purpose of completing the care plan before the member can be counted in data element C under Core Measure 3.2. In other words, the previously documented outreach attempts to complete the assessment cannot count toward Core Measure 3.2.

Note that there may be instances when the MMP speaks to the member (or his/her authorized representative) during an outreach attempt, but may not be able to meaningfully engage the member. For example, the member may say they are busy and abruptly hang up. Such instances would be considered an unsuccessful outreach attempt and may count toward the three outreach attempts required to classify a member in data element C.

Additional Guidance – Scenario Examples

17. If a member was documented as unwilling to complete a care plan and then subsequently completed a care plan within the first 90 days of enrollment, in what data element should the member be reported?

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

18. If a member was documented as unable to be reached to have a care plan completed and then subsequently completed a care plan 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 reached to have a care plan completed and also had a care plan completed within 90 days of enrollment, the member should be reported in data element D, not data element C.

19. If a member tells the MMP that they want to disenroll from the MMP during an outreach attempt, can this member be reported in data element B?

No. This member cannot be reported in data element B as there was no documented refusal to complete the care plan. For inclusion in data element B, the member must meet the criteria for refusing to participate in the care plan as outlined in FAQ #7 above.

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

No. 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 (or other recently utilized providers/pharmacies) for updated contact information or attempting an unscheduled visit to 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 reach the member.

21. 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?

No. 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 care plan 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 care plan during the same telephone call, the member would be included in data element B.

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

No. Since the care plan was not completed within 90 days of enrollment, the care plan cannot be considered complete, and therefore, the member cannot be counted in data element D.

23. 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?

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

24. There may be certain circumstances that make it impossible or inappropriate to complete a care plan 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 a care plan. In these cases, should members be counted in data elements B or C?

No. MMPs should not include such members in the counts for data elements B or C.

25. 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.

26. 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.

27. If the member refused to complete a care plan or could not be reached to complete a care plan, and the MMP still completes a care plan for the member using assessment results or other available information, can the member be reported in data element D?

No. Members should be reported in data element D only when the member (or his/her authorized representative) participated in the completion of the care plan. Members that were unwilling to complete a care plan or that could not be reached to complete a care plan should be counted in data elements B or C, respectively.

Validation Checks

28. 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 continuously 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 continuous 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. MMPs should also perform cross-measure comparisons, where applicable. For instance, MMPs should compare Core Measure 3.2 data element A to Core Measure 2.1 data element A, as the definitions of these data elements are identical.

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 complete a care plan within 90 days of enrollment and never had a care plan 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 a care plan 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 care plan clearly documented within 90 days of enrollment.