MEDICARE-MEDICAID CAPITATED FINANCIAL ALIGNMENT MODEL REPORTING REQUIREMENTS: NEW YORK-SPECIFIC REPORTING REQUIREMENTS

Effective as of January 1, 2015; Issued April 16, 2015

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New York-Specific Reporting Requirements Appendix

Introduction

The measures contained in this document are required reporting for all plans participating in the New York Fully Integrated Duals Advantage (FIDA) Demonstration. CMS and the State of New York reserve the right to update the measures in this appendix for subsequent demonstration years. These State-specific measures directly supplement the Medicare-Medicaid Capitated Financial Alignment: Core Reporting Requirements, which can be found at the following web address:

http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html

FIDA Plans should refer to the core document for additional details regarding definitions, reporting phases and timelines, and sampling methodology, except as otherwise specified in this document.

The core and State-specific measures supplement existing Part C and Part D reporting requirements, as well as measures that FIDA Plans report via other vehicles or venues, such as HEDIS®[1] and HOS. CMS and the State 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.

FIDA Plans should contact the NY Help Desk at NYHelpDesk@norc.org with any questions about the New York State-specific appendix or the data submission process.

Definitions

Calendar Quarter: All quarterly measures are reported on calendar quarters. The four calendar quarters of each calendar year will be as follows: 1/1 – 3/31, 4/1 – 6/30, 7/1 – 9/30, and 10/1 – 12/31.

Calendar Year: All annual measures are reported on a calendar year basis. Calendar Year 2015 (CY1) will represent January 1, 2015 through December 31, 2015.

[1] HEDIS® is a registered trademark of the National Committee of Quality Assurance (NCQA).

Community-based Long Term Services and Supports (LTSS): A range of medical, habilitation, rehabilitation, home care, or social services a person needs over months or years in order to improve or maintain function or health which are provided in the person's home or community-based setting such as assisted-living facilities. These home and community-based services are designed to meet an individual's needs as an alternative to long-term nursing facility care and to enable a person to live as independently as possible. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping and transportation.

Facility-based Long-Term Services and Supports (LTSS): Facility-based LTSS are a range of medical, social, or rehabilitation services a person needs over months or years in order to improve or maintain function or health which are provided in a long-term care facility, such as a nursing facility (not including assisted living residences).

Implementation Period: The initial months of the demonstration during which FIDA plans will report to CMS and the State on a more intensive reporting schedule. The Implementation Period starts on the first effective enrollment date and continues until the end of the first 2015 calendar year quarter after the end of passive enrollment (January 1, 2015 – September 30, 2015).

Long stay: A long stay is an episode with cumulative days in facility greater than or equal to 101 days.

New to service: Eligible individuals who are not already receiving Facility-based or Community-based LTSS.

Primary Care Provider (PCP): Primary care physicians licensed by the State of New York and board certified in family practice, internal medicine, general practice, obstetrics/gynecology, or geriatrics, State licensed physician assistants, or a physician extender who is a registered nurse practitioner or advanced practice nurse or advanced practice nurse group practice within an acceptable specialty as required under State regulation.

Quality Withhold Measures

CMS and the State of New York will establish a set of quality withhold measures, and FIDA Plans will be required to meet established thresholds. Throughout this document, quality withhold measures for Demonstration Year 1 (DY 1) are marked with the following symbol: (^{i}). CMS and the State of New York will update the quality withhold measures for subsequent demonstration years closer to the start of demonstration year 2 (DY 2). Additional information on the withhold methodology and benchmarks will be provided at a later time.

In addition to the quality withhold measures identified in this appendix and the Core Reporting Requirements, the following measure from the Core Reporting Requirements will be a quality withhold measure for plans participating in the FIDA Demonstration:

- Measure 9.2 – Nursing Facility Diversion

Please note, FIDA Plans are not required to report this measure for DY 1. The NYS Department of Health will calculate this measure on behalf of FIDA Plans for DY 1. However, FIDA Plans will be required to report this measure for DY 2 according to the specifications in the Core Reporting Requirements.

Reporting on Disenrolled and Retro-disenrolled Participants

Unless otherwise indicated in the reporting requirements, FIDA Plans should report on all Participants enrolled in the demonstration who meet the definition of the data elements, regardless of whether that Participant was subsequently disenrolled from the FIDA Plans. Measure-specific guidance on how to report on disenrolled Participants is provided under the Notes section of each State-specific measure.

Due to retro-disenrollment of Participants, there may be instances where there is a lag between a Participant's effective disenrollment date and the date on which the FIDA Plan is informed about that disenrollment. This time lag might create occasional data inaccuracies if a FIDA Plan includes Participants in reports who had in fact disenrolled before the start of the reporting period. If FIDA Plans are aware at the time of reporting that a Participant has been retro-disenrolled with a disenrollment effective date prior to the reporting period (and therefore was not enrolled during the reporting period in question), then FIDA Plans may exclude that Participant from reporting. Please note that FIDA Plans are ***not*** required to re-submit corrected data should they be informed of a retro-disenrollment subsequent to a reporting deadline. FIDA Plans should act upon their best and most current knowledge at the time of reporting regarding each Participant's enrollment status.

Reporting on Assessments and PCSPs Completed Prior To First Effective Enrollment Date

For FIDA Plans that have requested and obtained CMS approval to do so, assessments may be completed up to 20 days prior to the individual's coverage effective date for individuals who are passively enrolled. Early assessment outreach for opt-in Participants is permitted for all participating FIDA Plans.

For purposes of reporting data on assessments (Core 2.1, Core 2.2 and state-specific measures NY1.1 and NY1.2), FIDA Plans should report any assessments completed prior to the first effective enrollment date as if they were completed on the first effective enrollment date. For example, if a Participant's first effective enrollment date was June 1 and the assessment for that Participant was completed on May 25, the FIDA Plan should report the assessment as if it were completed on June 1.

FIDA Plans should refer to the Core reporting requirements for detailed specifications for reporting Core 2.1 and Core 2.2 and to the state-specific reporting requirements for specifications on reporting NY1.1 and NY1.2. For example, Core 2.1 should only include Participants whose 90th day of enrollment occurred during the reporting period. Participants enrolled into the FIDA Plan on January 1, 2015 would reach their

90th day (three full months) on March 31, 2015. Therefore these Participants would be reported in the data submission for the March monthly reporting period, even if their assessment was marked as complete on the first effective enrollment date (i.e. January 1).

FIDA Plans must comply with contractually specified timelines regarding completion of Person-Centered Service Plans (PCSPs) following the assessment. In the event that a PCSP is also finalized prior to the first effective enrollment date, FIDA Plans should report completion of the PCSP (for measures NY2.1 and NY2.2) as if the assessment were completed on the first effective enrollment date. For example, using an effective enrollment date of June 1, if the assessment was completed on May 25 and the PCSP was completed on May 27 (a difference of two days), the FIDA Plan should report the assessment as if it were completed on June 1 and the PCSP as if it were completed on June 3 (again, a difference of two days). If the assessment is completed prior to the effective date of coverage but the PCSP is not, the FIDA Plan should still report the PCSP as if the assessment was completed on the first effective enrollment date. For example, using an effective enrollment date of June 1, if the assessment is completed on May 25 and the PCSP is completed on June 24 (a difference of 30 days), the FIDA Plan should report the assessment as if it were completed on June 1 and the PCSP as if it were completed on July 1 (again, a difference of 30 days).

Guidance on Assessments and PCSPs for Participants with a Break in Coverage

Assessments

If a FIDA Plan already completed an assessment for a Participant that was previously enrolled, the FIDA Plan is not necessarily required to conduct a new assessment if the Participant rejoins the same FIDA Plan within six months of his/her most recent assessment. Instead, the FIDA Plan must:

1. Perform any risk stratification, claims data review, or other analyses as required by the three-way contract to detect any changes in the Participant's condition since the assessment was conducted; and

2. Ask the Participant (or his/her authorized representative) if there has been a change in the Participant's health status or needs since the assessment was conducted.

The FIDA Plan must document any risk stratification, claims data review, or other analyses that are performed to detect any changes in the member's condition. The FIDA Plan must also document the discussion(s) with the member (or his/her authorized representative) to determine if there was a change in the member's health status or needs.

If a change is identified, the FIDA Plan must conduct a new assessment within the timeframe prescribed by the contract. If there are no changes, the FIDA Plan is not required to conduct a new assessment unless requested by the Participant (or his/her authorized representative).

Once the FIDA Plan has conducted a new assessment as needed or confirmed that the prior assessment is still accurate, the FIDA Plan can mark the assessment as complete for the Participant's current enrollment. The FIDA Plan would then report that completion according to the specifications for Core 2.1, Core 2.2, NY1.1, and NY1.2. When reporting these measures, the FIDA Plan should count the number of enrollment days from the Participant's most recent enrollment effective date, and should report the assessment based on the date the prior assessment was either confirmed to be accurate or a new assessment was completed.

If the FIDA Plan did not complete an assessment for the re-enrolled Participant during his/her prior enrollment period, or if it has been more than six months since the Participant's assessment was completed, the FIDA Plan is required to conduct an assessment for the Participant within the timeframe prescribed by the contract. The FIDA Plan must make the requisite number of attempts to reach the Participant (at minimum) after their most recent enrollment effective date, even if the FIDA Plan reported that the Participant was unable to be located during his/her prior enrollment. Similarly, Participants that refused the assessment during their prior enrollment must be asked again to participate (i.e., the FIDA Plan may not carry over a refusal from one enrollment period to the next).

Person-Centered Service Plans (PCSP)

If the FIDA Plan conducts a new assessment for the re-enrolled Participant, the Interdisciplinary Team (IDT) must revise the PCSP accordingly within the timeframe prescribed by the contract. Once the PCSP is revised, the FIDA Plan may mark the PCSP as complete for the Participant's current enrollment. If the FIDA Plan determines that the prior assessment is still accurate and therefore the IDT does not need to update the previously developed PCSP, the FIDA Plan may mark the PCSP as complete for the current enrollment at the same time that the assessment is marked complete. The FIDA Plan would then follow the applicable state-specific measure specifications for reporting the completion. Please note, when reporting NY2.2, this PCSP should be classified as an *initial* PCSP.

If the IDT did not complete a PCSP for the re-enrolled Participant during his/her prior enrollment period, or if it has been more than six months since the Participant's PCSP was completed, the IDT is required to develop a PCSP for the Participant within the timeframe prescribed by the contract. The IDT must also follow the above guidance regarding reaching out to Participants that previously refused to participate or were not located.

Reassessments and PCSP updates

The FIDA Plan must follow contract requirements regarding the completion of reassessments at least every six months, and the IDT should update the PCSP as necessary following the reassessment. If the FIDA Plan determined that an assessment from a Participant's prior enrollment was accurate and marked that assessment as complete for the Participant's current enrollment, the FIDA Plan should count from the date that the assessment was completed in the prior enrollment period to determine the due date for the reassessment and PCSP update. For

example, when reporting Core 2.3, the FIDA Plan should count 365 days from the date when the assessment was actually completed, even if that date was during the Participant's prior enrollment period.

New York State's Implementation, Ongoing, and Continuous Reporting Periods

Demonstration Year 1			
Phase		**Dates**	**Explanation**
Continuous Reporting	Implementation Period	1-1-15 through 9-30-15	From the first effective enrollment date through the end of the first full quarter after the end of passive enrollment.
	Ongoing Period	1-1-15 through 12-31-15	From the first effective enrollment date through the end of the first demonstration year.
Demonstration Year 2			
Continuous Reporting	Ongoing Period	1-1-16 through 12-31-16	From January 1st through the end of the second demonstration year.
Demonstration Year 3			
Continuous Reporting	Ongoing Period	1-1-17 through 12-31-17	From January 1st through the end of the third demonstration year.

Data Submission

All FIDA Plans will submit State-specific measure data through the web-based Financial Alignment Initiative (FAI) Data Collection System (unless otherwise specified in the measure description). All data submissions must be submitted to this site by 5:00p.m. ET on the applicable due date. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

(Note: Prior to the first use of the system, all FIDA Plans will receive an email notification with the username and password that has been assigned to their plan. This information will be used to log in to the FAI system and complete the data submission).

All FIDA Plans will submit core measure data in accordance with the Core Reporting Requirements. Submission requirements vary by measure, but most core measures are reported through the Health Plan Management System (HPMS).

Please note that late submissions may result in compliance action from CMS.

Resubmission of Data to the FAI Data Collection System or HPMS

FIDA Plans must comply with the following steps to resubmit data after an established due date:

1. Email the NY HelpDesk to request resubmission.
    - Specify in the email which measures need resubmission;
    - Specify for which reporting period(s) the resubmission is needed; and
    - Provide a brief explanation for why the data need to be resubmitted.

2. After review of the request, the NY HelpDesk will notify the FIDA Plan once the FAI Data Collection System and/or HPMS has been re-opened.

3. Resubmit data through the applicable reporting system.

4. Notify the NY HelpDesk again after resubmission has been completed.

Please note, requests for resubmission after an established due date may result in compliance action from CMS.

Section NYI. Assessment

NY1.1 Participants who enrolled through opt-in enrollment with an initial assessment completed within 30 days of enrollment.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
NY1. Assessment	Monthly	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**
NY1. Assessment	Quarterly	Contract	Current Calendar Quarter Ex: 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 Participants enrolled through opt-in enrollment whose 30th day of enrollment occurred within the reporting period.	Total number of Participants enrolled through opt-in enrollment whose 30th day of enrollment occurred within the reporting period.	Field Type: Numeric
B.	Total number of documented Participants who were unwilling to participate in the initial assessment within 30 days of enrollment.	Of the total reported in A, the number of documented Participants who were unwilling to participate in the initial assessment within 30 days of enrollment.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of Participants the FIDA Plan was unable to locate, following no fewer than three documented attempts within 30 days of enrollment.	Of the total reported in A, the number of Participants the FIDA Plan was unable to locate, following no fewer than three documented attempts within 30 days of enrollment.	Field type: Numeric Note: Is a subset of A.
D.	The number of Participants with an initial assessment completed within 30 days of enrollment.	Of the total reported in A, the number of Participants with an initial assessment completed within 30 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.

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

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

- Confirm those data elements listed above as subsets of other elements.
- FIDA Plans should validate that data element 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 new Participants who were enrolled through opt-in enrollment who were new to service who:

- Were unable to be located to have an initial assessment completed within 30 days of enrollment.
- Refused to have an initial assessment completed within 30 days of enrollment.
- Had an initial assessment completed within 30 days of enrollment.
- Were willing to participate and who could be located and had an initial assessment completed within 30 days of enrollment.

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

- FIDA Plans should include all Participants who were enrolled through opt-in enrollment.
- FIDA Plans should include all Participants who meet the criteria outlined in Element A, regardless if they are slated for disenrollment as of the

end of the reporting period (i.e., include all Participants whose 30th day of coverage falls within the reporting period even if the 30th day is his/her last effective day of coverage). If a Participant is enrolled for fewer than 30 days, he/she should not be included.

- The 30th day of enrollment should be based on each Participant's effective date of enrollment.
- The effective date of enrollment is the first date of the Participant's coverage through the FIDA Plan.
- FIDA Plans should refer to the New York's final IDT policy, and three-way contract for specific requirements pertaining to assessments.
- For data element B, FIDA Plans should report the number of Participants who were unwilling to participate in the health risk assessment if a Participant (or his or her authorized representative):
    1. Affirmatively declines to participate in the assessment. Participant communicates this refusal by phone, mail, fax, or in person.
    2. Expresses willingness to complete the assessment but asks for it to be conducted after 30 days (despite being offered a reasonable opportunity to complete the assessment within 30 days). Discussions with the Participant must be documented by the FIDA Plan.
    3. Expresses willingness to complete the assessment, but reschedules or is a no-show and then is subsequently non-responsive. Attempts to contact the Participant must be documented by the FIDA Plan.
    4. Initially agrees to complete the assessment, but then declines to answer a majority of the questions in the assessment.
- For data element C, FIDA Plans should report the number of Participants the FIDA Plan was unable to locate after three attempts to contact the Participant. FIDA Plans should refer to the NY three-way contract or state guidance for any specific requirements pertaining to the method of outreach to Participants. FIDA Plans must document each attempt to locate the Participant, including the method of the attempt (i.e. phone, mail, or email), as CMS and the State may validate this number. There may be instances when the FIDA Plan has a high degree of confidence that a Participant's contact information is correct, yet that Participant is not responsive to the FIDA Plan's outreach efforts. So long as the FIDA Plan follows the guidance regarding outreach attempts, these Participants may be included in the count for this data element.
- There may be certain circumstances that make it impossible or inappropriate to complete an assessment within 30 days of enrollment. For example, a Participant may be medically unable to respond and have no authorized representative to do so on their behalf, or a Participant may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for an assessment. However, FIDA plans should <u>not</u> include such Participants in the counts for data elements B and C.
- If a Participant's assessment was started but not completed within 30 days of enrollment, then the assessment should not be considered

completed and, therefore, would not be counted in data elements B, C or D. However, this Participant would be included in data element A.

F. Data Submission - how FIDA Plans will submit data collected to CMS and the State.

- FIDA Plans will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

NY1.2 Participants who are passively enrolled with an initial assessment completed within 60 days of enrollment.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
NY1. Assessment	Monthly, beginning 60 days after passive enrollment begins	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period Ex: Passive enrollment begins April 1, 2015; the first monthly reporting period would be May 2015 and the first due date for monthly reporting would be June 30, 2015
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
NY1. Assessment	Quarterly, beginning 60 days after passive enrollment begins	Contract	Current Calendar Quarter Ex: 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 Ex: Passive enrollment begins April 1, 2015; the first quarterly reporting period would be Q2 2015 and the first due date for quarterly reporting would be August 31, 2015

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 Participants passively enrolled whose 60th day of enrollment occurred within the reporting period.	Total number of Participants passively enrolled whose 60th day of enrollment occurred within the reporting period.	Field Type: Numeric
B.	Total number of documented Participants who were unwilling to participate in the initial assessment within 60 days of enrollment.	Of the total reported in A, the number of documented Participants who were unwilling to participate in the initial assessment within 60 days of enrollment.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of Participants the FIDA Plan was unable to locate, following no fewer than three documented attempts within 60 days of enrollment.	Of the total reported in A, the number of Participants the FIDA Plan was unable to locate, following no fewer than three documented attempts within 60 days of enrollment.	Field type: Numeric Note: Is a subset of A.
D.	The number of Participants passively enrolled with an initial assessment completed within 60 days of enrollment.	Of the total reported in A, the number of Participants passively enrolled with an initial assessment completed within 60 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.

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

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

- Confirm those data elements listed above as subsets of other elements.
- FIDA Plans 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 Participants who were passively enrolled who:

- Were unable to be located to have an initial assessment completed within 60 days of enrollment.
- Refused to have an initial assessment completed within 60 days of enrollment.
- Had an initial assessment completed within 60 days of enrollment.
- Were willing to participate and who could be located who had an initial assessment completed within 60 days of enrollment.

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

- FIDA Plans should include all Participants enrolled through passive enrollment. Medicaid-only Participants should not be included.
- FIDA Plans should include all Participants who meet the criteria outlined in Element A, regardless if they are slated for disenrollment as of the end of the reporting period (i.e., include all Participants whose 60th day of coverage falls within the reporting period even if the 60th day is his/her last effective day of coverage). If a Participant is enrolled for fewer than 60 days, he/she should not be included.
- The 60th day of enrollment should be based on each Participant's effective date of enrollment. For purposes of reporting this measure, 60 days of enrollment will be equivalent to two full calendar months.
- The effective date of enrollment is the first date of the Participant's coverage through the FIDA Plan.
- FIDA Plans should refer to the New York's final IDT policy and three-way contract for specific requirements pertaining to assessments.
- For data element B, FIDA Plans should report the number of Participants who were unwilling to participate in the health risk assessment if a Participant (or his or her authorized representative):
    1. Affirmatively declines to participate in the assessment. Participant communicates this refusal by phone, mail, fax, or in person.
    2. Expresses willingness to complete the assessment but asks for it to be conducted after 60 days (despite being offered a reasonable opportunity to complete the assessment within 60 days). Discussions with the Participant must be documented by the FIDA Plan.
    3. Expresses willingness to complete the assessment, but reschedules or is a no-show and then is subsequently non-responsive. Attempts to contact the Participant must be documented by the FIDA Plan.
    4. Initially agrees to complete the assessment, but then declines to answer a majority of the questions in the assessment.
- For data element C, FIDA Plans should report the number of Participants the FIDA Plan was unable to locate after three attempts to contact the Participant. FIDA Plans should refer to the NY three-way contract or state guidance for any specific requirements pertaining to the

method of outreach to Participants. FIDA Plans must document each attempt to locate the Participant, including the method of the attempt (i.e. phone, mail, or email), as CMS and the State may validate this number. There may be instances when the FIDA Plan has a high degree of confidence that a Participant's contact information is correct, yet that Participant is not responsive to the FIDA Plan's outreach efforts. So long as the FIDA Plan follows the guidance regarding outreach attempts, these Participants may be included in the count for this data element.

- There may be certain circumstances that make it impossible or inappropriate to complete an assessment within 60 days of enrollment. For example, a Participant may be medically unable to respond and have no authorized representative to do so on their behalf, or a Participant may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for an assessment. However, FIDA plans should not include such Participants in the counts for data elements B and C.
- If a Participant's assessment was started but not completed within 60 days of enrollment, then the assessment should not be considered completed and, therefore, would not be counted in data elements B, C or D. However, this Participant would be included in data element A.

F. Data Submission - how FIDA Plans will submit data collected to CMS and the State.

- FIDA Plans will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

Section NYII. Care Coordination

NY2.1 Participants with Person-Centered Service Plans (PCSPs) completed within 30 days of initial assessment and each re-assessment.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
NY2. Care Coordination	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the second month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
NY2. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 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 Participants with an initial assessment or reassessment completed during the reporting period.	Total number of Participants with an initial assessment or reassessment completed during the reporting period who were continuously enrolled for 30 days following the completion of the initial assessment or reassessment.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of Participants who were documented as unwilling to participate in the PCSP development within 30 days after the completion of the initial assessment or reassessment.	Of the total reported in A, the number of Participants who were documented as unwilling to participate in the PCSP development within 30 days after the completion of the initial assessment or reassessment	Field Type: Numeric Note: Is a subset of A.
C.	Total number of Participants the FIDA Plan was unable to locate, following no fewer than three documented attempts within 30 days after the completion of the initial assessment or reassessment.	Of the total reported in A, the number of Participants the FIDA Plan was unable to locate, following no fewer than three documented attempts within 30 days the initial assessment or reassessment.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of Participants with a PCSP completed within 30 days of an initial assessment or reassessment.	Of the total reported in A, the number of Participants with a PCSP completed within 30 days of an initial assessment or reassessment.	Field Type: Numeric Note: Is a subset of A.

A. 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 FIDA Plans over time, CMS and the State will apply threshold checks.

B. Edits and Validation checks – validation checks that should be performed by each FIDA Plan prior to data submission.
    - Confirm those data elements listed above as subsets of other elements.
    - FIDA Plans 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.

C. 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 Participants who:
    - Were unable to be located to have a PCSP completed within 30 days after the completion of the initial assessment or reassessment.

- Refused to have a PCSP completed within 30 days after the completion of the initial assessment or reassessment.
- Had a PCSP completed within 30 days after the completion of the initial assessment or reassessment.
- Were willing to participate, who could be located, and who had a PCSP completed within 30 days after the completion of the initial assessment or reassessment.

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

- FIDA Plans should include all Participants regardless of whether the Participant was enrolled through passive enrollment or opt-in enrollment. Medicaid-only Participants should not be included.
- FIDA Plans should include all Participants who meet the criteria outlined in Element A, regardless if they are slated for disenrollment as of the end of the reporting period (i.e., include all Participants whose 30th day of coverage after the assessment or reassessment falls within the reporting period even if the 30th day is his/her last effective day of coverage). If a Participant is enrolled for fewer than 30 days after the completion of the assessment or reassessment, he/she should not be included.
- Participants need to be continuously enrolled for 30 days from the date of the initial assessment or reassessment completion to be included in this measure.
- FIDA Plans should refer to NY's IDT Policy, and the Three-Way Contract for specific requirements pertaining to a PCSP and initial assessment or reassessment.
- For data element B, FIDA Plans should report the number of Participants who were unwilling to participate in the development of the PCSP if a Participant (or his or her authorized representative):
    1. Affirmatively declines to participate in the PCSP. Participant communicates this refusal by phone, mail, fax, or in person.
    2. Expresses willingness to complete the PCSP but asks for it to be conducted after 30 days following the completion of the assessment (despite being offered a reasonable opportunity to complete the PCSP within 30 days). Discussions with the Participant must be documented by the FIDA Plan.
    3. Expresses willingness to complete the PCSP, but reschedules or is a no-show and then is subsequently non-responsive. Attempts to contact the Participant must be documented by the FIDA Plan.
    4. Initially agrees to complete the PCSP, but then declines to participate in the PCSP.
- For data element C, FIDA Plans should report the number of Participants the FIDA Plan was unable to locate after three attempts to contact the Participant. FIDA Plans should refer to the NY three-way contract or state guidance for any specific requirements pertaining to the method of outreach to Participants. FIDA Plans must document each attempt to locate the Participant, including the method of the attempt

(i.e. phone, mail, or email), as CMS and the State may validate this number. There may be instances when the FIDA Plan has a high degree of confidence that a Participant's contact information is correct, yet that Participant is not responsive to the FIDA Plan's outreach efforts. So long as the FIDA Plan follows the guidance regarding outreach attempts, these Participants may be included in the count for this data element.

- There may be certain circumstances that make it impossible or inappropriate to complete a PCSP within 30 days of the assessment. For example, a Participant may become medically unable to respond and have no authorized representative to do so on their behalf, or a Participant may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for a PCSP. However, FIDA plans should not include such Participants in the counts for data elements B and C.
- The initial assessment or re-assessment must be completed within the reporting period, but the PCSP may not be in the same reporting period. For example, if the initial assessment or re-assessment is completed less than 30 days before the end of the reporting period (e.g., March 15), look up to 30 days past the end of the reporting period to identify if a PCSP was completed.
- If a PCSP was started but not completed within 30 days of the initial assessment or reassessment, then the PCSP should not be considered completed and, therefore, would not be counted in data elements B, C or D. However, this Participant would be included in data element A if the initial assessment or re-assessment was completed within the reporting period.

E. Data Submission – how FIDA Plans will submit data collected to CMS and the State.

- FIDA Plans will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

NY2.2 Participants with documented discussions of care goals.[i]

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
NY2. Care Coordination	Monthly	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**
NY2. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 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 Participants with an initial PCSP developed.	Total number of Participants with an initial PCSP developed during the reporting period.	Field Type: Numeric
B.	Total number of Participants with at least one documented discussion of care goals in the initial PCSP.	Of the total reported in A, the number of Participants with at least one documented discussion of care goals in the initial PCSP.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of existing PCSPs revised.	Total number of existing PCSPs revised during the reporting period.	Field Type: Numeric
D.	Total number of revised PCSPs with at least one documented discussion of new or existing care goals.	Of the total reported in C, the number of revised PCSPs with at least one documented discussion of new or existing care goals.	Field Type: Numeric Note: Is a subset of C.

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 FIDA Plan prior to data submission.
    - Confirm those data elements above as subsets of other elements.
    - FIDA Plans should validate that data element B is less than or equal to data element A.
    - FIDA Plans should validate that data element D is less than or equal to data 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:
    - Participants with an initial PCSP developed in the reporting period who had at least one documented discussion of care goals in the initial PCSP.
    - PCSPs revised during the reporting period that had at least one documented discussion of new or existing care goals.

E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
    - FIDA Plans should include all Participants regardless of whether the Participant was enrolled through passive enrollment or opt-in enrollment. Medicaid-only Participants should not be included.
    - FIDA Plans should include all Participants who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all Participants regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
    - FIDA Plans should include all PCSPs that meet the criteria outlined in data element C, regardless of whether the Participants are disenrolled as of the end of the reporting period (i.e., include all PCSPs regardless of whether the Participants are currently enrolled or disenrolled as of the last day of the reporting period).
    - Data element A should include all Participants whose PCSP was created for the first time during the reporting period (i.e., the Participant did not previously have a PCSP developed prior to the start of the reporting period). There can be no more than one initial PCSP per Participant.
    - FIDA Plans should only include Participants in data element B when the discussion of care goals is clearly documented in the Participant's initial PCSP.
    - Data element C should include all existing PCSPs that were revised during the reporting period. FIDA Plans should refer to the three-way contract for specific requirements pertaining to updating the PCSP.
    - FIDA Plans should only include PCSPs in data element D when a new or previously documented care goal is discussed and is clearly documented in the Participant's revised PCSP. If the initial PCSP clearly

documented the discussion of care goals, but those existing care goals were not revised or discussed, or new care goals are not discussed and documented during the revision of the PCSP, then that PCSP should not be reported in data element D.

- If a Participant has an initial PCSP completed during the reporting period, and has their PCSP revised during the same reporting period, they should be reported in data element A and the Participant's revised PCSP should be reported in data element C.
- If a Participant's PCSP is revised multiple times during the same reporting period, each revision should be reported in data element C. For example, if a Participant's PCSP is revised twice during the same reporting period, two PCSPs should be counted in data element C.

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

- FIDA Plans will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

NY2.3 Participants with first follow-up visit within 30 days of hospital discharge.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
NY2. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the fourth 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 hospital discharges.	Total number of hospital discharges during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge from the hospital.	Of the total reported in A, the number of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge from the hospital.	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 FIDA Plans over time, CMS and the State will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each FIDA Plan prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- FIDA Plans 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 hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of the discharge from the hospital.

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

- FIDA Plans should include all Participants regardless of whether the Participant was enrolled through passive enrollment or opt-in enrollment. Medicaid-only Participants should not be included.
- FIDA Plans should include all hospital discharges for Participants who meet the criteria outlined in Element A and who were continuously enrolled from the date of the hospital discharge through 30 days after the hospital discharge, regardless if they are disenrolled as of the end of the reporting period (i.e., include all Participants regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The date of discharge must occur within the reporting period, but the follow-up visit may not be in the same reporting period. For example, if a discharge occurs during the last month of the reporting period, look to the first month of the following reporting period to identify the follow-up visit.

- The Participant needs to be enrolled from the date of the hospital discharge through 30 days after the hospital discharge, with no gaps in enrollment.
- A follow-up visit is defined as an ambulatory care follow-up visit to assess the Participant's health following a hospitalization. Codes to identify follow-up visits are provided in Table NY-1.
- Codes to identify inpatient discharges are provided in Table NY-2.
- Exclude discharges in which the patient was readmitted within 30 days after discharge to an acute or non-acute facility.
- Exclude discharges due to death. Codes to identify patients who have expired are provided in Table NY-3.

Table NY-1: Codes to Identify Ambulatory Health Services

Description	CPT	HCPCS	ICD-9-CM Diagnosis	UB Revenue
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245			051x, 0520-0523, 0526-0529, 0982, 0983
Home services	99341-99345, 99347-99350			
Nursing facility care	99304-99310, 99315, 99316, 99318			0524, 0525
Domiciliary, rest home or custodial care services	99324-99328, 99334-99337			
Preventive medicine	99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429	G0344, G0402, G0438, G0439		
Ophthalmology and optometry	92002, 92004, 92012, 92014			
General medical examination			V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	

Table NY-2: Codes to Identify Inpatient Discharges

Principal ICD-9-CM Diagnosis		MS-DRG
001-289, 317-999, V01-V29, V40-V90	***OR***	001-013, 020-042, 052-103, 113-117, 121-125, 129-139, 146-159, 163-168, 175-208, 215-264, 280-316, 326-358, 368-395, 405-425, 432-446, 453-517, 533-566, 573-585, 592-607, 614-630, 637-645, 652-675, 682-700, 707-718, 722-730, 734-750, 754-761, 765-770, 774-782, 789-795, 799-804, 808-816, 820-830, 834-849, 853-858, 862-872, 901-909, 913-923, 927-929, 933-935, 939-941, 947-951, 955-959, 963-965, 969-970, 974-977, 981-989, 998, 999

WITH

UB Type of Bill		
11x, 12x, 41x, 84x	***OR***	Any acute inpatient facility code

Table NY-3: Codes to Identify Patients who Expired
Discharge Status Code
20

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

- FIDA Plans will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org.

Section NYIII. Long Term Care Quality

NY3.1 Long Term Care Overall Balance.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
NY3. Long Term Care Quality	Annually	Contract	Calendar 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 Participants continuously enrolled in the FIDA Plan.	Total number of Participants continuously enrolled in the FIDA Plan during the reporting period.	Field Type: Numeric
B.	Total number of Participants who did not reside in a nursing facility at the time of enrollment.	Of the total reported in A, the number of Participants who did not reside in a nursing facility at the time of enrollment.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of Participants who did not reside in a nursing facility (NF) for a long stay.	Of the total reported in B, the number of Participants who did not reside in a NF for a long stay during the reporting period.	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 FIDA Plans over time, CMS and the State will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each FIDA Plan prior to data submission.
   - Confirm those data elements above as subsets of other elements.
   - FIDA Plans should validate that data element B is less than or equal to data element A.
   - FIDA Plans 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 Participants who did not reside in a nursing facility at the time of enrollment who did not reside in a NF for a long stay during the reporting period.

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

    - FIDA Plans should include all Participants regardless of whether the Participant was enrolled through passive enrollment or opt-in enrollment. Medicaid-only Participants should not be included.
    - Continuous enrollment is defined as no more than one gap in enrollment of up to 30 days during each year of continuous enrollment (i.e., the reporting period). To determine continuous enrollment for a Participant for whom enrollment is verified monthly, the Participant may not have more than a 1-month gap in coverage (i.e., a Participant whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
    - A long stay is an episode with cumulative days in facility greater than or equal to 101 days.
    - When determining a long stay, if a Participant is transferred from the nursing facility and then is readmitted to the same nursing facility within 30 days, the transfer and subsequent readmission does not disrupt the count of cumulative days. For example, if a Participant is transferred from the nursing facility to the hospital on day 93 and is subsequently readmitted to the same nursing facility 24 days later, this will be counted as the same long stay episode. The Participant's first day back in the nursing facility (i.e., the day the Participant is readmitted to the nursing facility) will count as day 94 for that episode, not as day 1.
    - When determining a long stay, if a Participant is transferred from the nursing facility and then is readmitted to any nursing facility after 30 days, the date of readmission is the start of a new episode in the nursing facility and will count as day 1 towards the Participant's cumulative days in facility.
    - A readmission or admission to a different facility ends the episode for the Participant at the original facility.
    - Codes to identify a discharge or transfer are provided in Table NY-4.
    - Nursing facility services are provided by Medicaid, Medicare, or other State agencies certified nursing homes and primarily provide three types of services:
        1. Skilled nursing or medical care and related services;
        2. Rehabilitation needed due to injury, disability, or illness;
        3. Long term care – health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition.

Table NY-4: Codes to Identify Discharges/Transfers
Discharge Status Code
02, 03, 04, 05, 30, 43, 61, 62, 63, 64, 65, 66, 69, 70

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

- FIDA Plans will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

NY3.2 Community Reintegration.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
NY3. Long Term Care Quality	Annually	Contract	Calendar Year, beginning in CY2	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 Participants who resided in a nursing facility (NF) for a long stay during the previous reporting period.	Total number of Participants who resided in a NF for a long stay during the previous reporting period and who were continuously enrolled during the previous and current reporting period.	Field Type: Numeric
B.	Total number of Participants discharged to a community setting during the previous or current reporting period who did not return to the NF for a long stay.	Of the total reported in A, the number of Participants discharged to a community setting during the previous or current reporting period who did not return to the NF for a long stay 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.
    - CMS and the State will perform an outlier analysis.
    - As data are received from FIDA Plans over time, CMS and the State will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each FIDA Plan prior to data submission.
    - Confirm those data elements above as subsets of other elements.
    - FIDA Plans 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 NF residents who resided in a NF for a long stay during the previous reporting period who were discharged to a community setting during the previous or current reporting period who did not return to the NF for a long stay during the current reporting period.

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

    - FIDA Plan should include all Participants regardless of whether the Participant was enrolled through passive enrollment or opt-in enrollment. Medicaid-only Participants should not be included.
    - Continuous enrollment is defined as no more than one gap in enrollment of up to 30 days during each year of continuous enrollment (i.e., the reporting period). To determine continuous enrollment for a Participant for whom enrollment is verified monthly, the Participant may not have more than a 1-month gap in coverage (i.e., a Participant whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
    - A long stay is an episode with cumulative days in facility greater than or equal to 101 days.
    - When determining a long stay, if a Participant is transferred from the nursing facility and then is readmitted to the same nursing facility within 30 days, the transfer and subsequent readmission does not disrupt the count of cumulative days. For example, if a Participant is transferred from the nursing facility to the hospital on day 93 and is subsequently readmitted to the same nursing facility 24 days later, this will be counted as the same long stay episode. The Participant's first day back in the nursing facility (i.e., the day the Participant is readmitted to the nursing facility) will count as day 94 for that episode, not as day 1.
    - A readmission or admission to a different facility ends the episode for the Participant at the original facility.
    - When determining a long stay, if a Participant is transferred from the nursing facility and then is readmitted to any nursing facility after 30 days, the date of readmission is the start of a new episode in the nursing

facility and will count as day 1 towards the Participant's cumulative days in facility.

- The discharge to community could have occurred during either the previous reporting period or the current reporting period.
- Codes to identify a discharge or transfer are provided in Table NY-5.
- Codes to identify a discharge to a community setting are provided in Table NY-6.
- A community based setting is defined as a private home, apartment, board and care, assisted living facility, or group home.
- This measure will not be reported until Calendar Year 2.

Table NY-5: Codes to Identify Discharges/Transfers
Discharge Status Code
02, 03, 04, 05, 30, 43, 61, 62, 63, 64, 65, 66, 69, 70

Table NY-6: Codes to Identify Discharges to the Community
Discharge Status Code
01, 06

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

- FIDA Plans will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

Section NYIV. Enrollee Protections

NY4.1 The number of critical incident and abuse reports for Participants receiving LTSS.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
NY4. Enrollee Protections	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the second month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
NY4. 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. 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 Participants receiving LTSS.	Total number of Participants receiving LTSS during the reporting period.	Field Type: Numeric
B.	Total number of critical incident and abuse reports.	Of the total reported in A, the number of critical incident and abuse reports during the reporting period.	Field Type: Numeric
C.	Name of individual or entity	The name of the individual or entity that committed the abuse reported	Field Type: Text Note: File will be uploaded to FTP site in an Excel template.

Element Letter	Element Name	Definition	Allowable Values
D.	Source	The source that identified the abuse reported;	Field Type: Text Note: File will be uploaded to FTP site in an Excel template.
E.	Provider, entity, or organization types	The type of provider, individual, entity, or organization that committed the abuse reported	Field Type: Text Note: File will be uploaded to FTP site in an Excel template.
F.	Description of the abuse	A description of the abuse reported	Field Type: Text Note: File will be uploaded to FTP site in an Excel template.
G.	Action taken by the plan	A description of action/follow-up to the reported abuse taken by the FIDA plan	Field Type: Text Note: File will be uploaded to FTP site in an Excel template.
H.	Case disposition	The legal and administrative disposition of the case including actions taken by law enforcement officials or adult protective services to whom the case has been referred	Field Type: Text Note: File will be uploaded to FTP site in an Excel template.

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 FIDA Plans over time, CMS and the State will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each FIDA Plan prior to data submission.

- Confirm those data elements above as subsets of other elements.
- FIDA Plans should validate that data element B is less than or equal to data element A.

- All numeric data elements should be positive values.
- Text fields should include explanation if information is unavailable.

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 number of critical incident and abuse reports per 1,000 Participants receiving LTSS.

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

- FIDA Plans should provide a written report for each reporting period including the information addressing elements C through H for each reported event in element B. A template for reporting elements C through H is available on the CMS Financial Alignment website at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html
- FIDA Plans should include all Participants regardless of whether the Participant was enrolled through passive enrollment or opt-in enrollment. Medicaid-only Participants should not be included.
- FIDA Plans should include all Participants who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all Participants regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- It is possible for Participants to have more than one critical incident and/or abuse report during the reporting period. All critical incident and abuse reports during the reporting period should be counted.
- Critical incident refers to any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a Participant including, neglect, financial exploitation, and mandated reporting requirements called for under the Three-Way Contract, and under New York State and Federal requirements for reporting on incidents and residents of Nursing Facilities.
- Abuse refers to any of the following:
    1. Willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish;
    2. Knowing, reckless, or intentional acts or failures to act which cause injury or death to an individual or which places that individual at risk of injury or death;
    3. Rape or sexual assault;
    4. Corporal punishment or striking of an individual;
    5. Unauthorized use or the use of excessive force in the placement of bodily restraints on an individual; and
    6. Use of bodily or chemical restraints on an individual which is not in compliance with Federal or State laws and administrative regulations.

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

- FIDA Plans will submit data collected for elements A and B of 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://Financial-Alignment-Initiative.NORC.org.
- FIDA Plans will submit supporting documentation for elements C through H via 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 NYV. Utilization

NY5.1 Participants directing their own services through the consumer-directed personal assistance option.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
NY5. Utilization	Annually	Contract	Calendar 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 Participants enrolled in the FIDA plan.	Total number of Participants continuously enrolled in the FIDA plan during the reporting period.	Field Type: Numeric
B.	Total number of Participants who were directing their own services through the consumer-directed personal assistance option.	Of the total reported in A, the number of Participants who were directing their own services through the consumer-directed personal assistance option 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 FIDA Plans over time, CMS and the State will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each FIDA Plan prior to data submission.
   - Confirm those data elements above as subsets of other elements.
   - FIDA Plans 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 Participants continuously enrolled in the FIDA Plan who were directing their own services through the consumer-directed personal assistance option during the reporting period.

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

- FIDA Plans should include all Participants regardless of whether the Participant was enrolled through passive enrollment or opt-in enrollment. Medicaid-only Participants should not be included.
- FIDA Plans should include all Participants who meet the criteria outlined in Element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all Participants regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- Continuous enrollment is defined as no more than one gap in enrollment of up to 1-month during each year of continuous enrollment (i.e., the reporting period). To determine continuous enrollment for a Participant for whom enrollment is verified monthly, the Participant may not have more than a 1-month gap in coverage (i.e., a Participant whose coverage lapses for 2 months (consecutively or non-consecutively) is not considered continuously enrolled).
- Consumer-directed personal assistance is a personal care program that empowers self-directing seniors and people with disabilities to recruit, hire, train, supervise and terminate their choice of personal assistant home care worker.

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

- FIDA Plans will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: https://Financial-Alignment-Initiative.NORC.org

Section NYVI. Participant-Level File

The New York Office of Quality and Patient Safety (OQPS) will be evaluating measures using the Medicaid Encounter Data System (MEDS), the Uniform Assessment System (UAS-NY) and Participant-level data. The State will conduct ongoing research on Participants' personal experiences in FIDA and on potential relationship of these experiences with Participants' health outcomes.

The following table provides instructions on the submission of Participant-level data on a subset of measures FIDA Plans are reporting at the plan-level and a number of IDT-related performance measures. This table does not provide any additional measures; it only provides guidance on the subset of measures for which CMS/NYSDOH require Participant-level data. Please see the source of each measure for the technical specifications for each. In particular:

- Columns 17-48 provide instructions on reporting Participant level data on HEDIS measures.
- Columns 49-54 provide instructions on some of the NY-Specific measures defined elsewhere within this appendix.
- Columns 55-62 refer to MMP Specific Core Measures available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2015CoreReportingRequirements.pdf
- Columns 63-367 provide instructions on reporting Participant level data on IDT activities. As noted for each element, some of the IDT requirements are specified within this appendix while others are specified within the final IDT policy. CMS and NYSDOH may establish thresholds and conduct outlier analysis based on this data.

Questions from FIDA Plans regarding these measures or the data submission process should be directed to NYSDOH.

NY6.1 Participant-Level File

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
NY6 Participant-Level Measures	Annually	Contract	Calendar Year	By June 15 of the calendar year following the reporting period

A. File Format definitions – details for each data element reported to CMS and the State.

Column Placement	Name	Direction	Allowed Values
Instructions for Participant Identification			
Column 1-8	MMIS ID	Enter the Plan's numeric eight-digit ID.	########
Column 9–16	Medicaid CIN	A Participant's client identification number. The field should be continuous without any spaces or hyphens. The field is alpha- numeric and should be treated as a text field. The CIN entered in this field should be for the CIN for the measurement period. For example, CINs for 2013 should be used.	**Dual eligible individuals only**
Instructions for Participant-level data on HEDIS Measures			
Column 17	Denominator for Antidepressant Medication Management (AMM)	Enter a '1' if the Participant is in the denominator of the Antidepressant Medication Management measures, '0' if the Participant is not in the denominator.	1 = Yes 0 = No
Column 18	Numerator for Antidepressant Medication Management – Effective Acute Phase Treatment (AMM)	Enter a '1' if the Participant is in the numerator of the Antidepressant Medication Management – Effective Acute Phase Treatment measure, '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 19	Numerator for Antidepressant Medication Management– Effective Continuation Phase Treatment (AMM)	Enter a '1' if the Participant is in the numerator of the Antidepressant Medication Management – Effective Continuation Phase Treatment measure, '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 20	Denominator for Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET): 18+ years	Enter: '1' if the Participant is in the denominator of the Initiation and Engagement of AOD Treatment, 18+ years measure '0' if the Participant is not in the denominator of this measure	1 = Yes 0 = No

Column Placement	Name	Direction	Allowed Values
Column 21	Numerator for Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET): Initiation of AOD Treatment—18+ years	Enter: '1' if the Participant is in the numerator of the Initiation and Engagement of AOD Treatment—Initiation of AOD Treatment, 18+ years measure '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 22	Numerator for Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET): Engagement of AOD Treatment—18+ years	Enter: '1' if the Participant is in the numerator of the Initiation and Engagement of AOD Treatment—Engagement of AOD Treatment, 18+ years measure '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 23-24	Denominator for Follow-Up After Hospitalization for Mental Illness (FUH)	Enter the number of times the Participant appears in the denominator of the Follow-Up After Hospitalization for Mental Illness; '0' if the Participant is not in the denominator.	0-98
Column 25-26	Numerator 1 for Follow-Up After Hospitalization for Mental Illness, 7 days after discharge (FUH)	Enter the number of times the Participant appears in numerator 1 of the Follow-Up After Hospitalization for Mental Illness, 7 days after discharge. '0' if the Participant is not in the numerator or the information is missing.	0-98
Column 27-28	Numerator 2 for Follow-Up After Hospitalization for Mental Illness, 30 days after discharge (FUH)	Enter the number of times the Participant appears in numerator 2 of the Follow-Up After Hospitalization for Mental Illness, 30 days after discharge. '0' if the Participant is not in the numerator or the information is missing.	0-98
Column 29-30	Denominator for Medication Reconciliation After Discharge from Inpatient Facility (MRP)	Enter the number of times the Participant appears in the denominator of the Medication Reconciliation After Discharge from Inpatient Facility	00-98
Column 31-32	Numerator for Medication Reconciliation After Discharge from Inpatient Facility (MRP)	Enter the number of times the Participant appears in numerator of the Medication Reconciliation After Discharge from Inpatient Facility	00-98

Column Placement	Name	Direction	Allowed Values
Column 33	Denominator for the Care for Older Adults (COA)	Enter a '1' if the Participant is in the denominator of the Care for Older Adults measure, '0' if the Participant is not in the denominator.	1 = Yes 0 = No
Column 34	Numerator for Care for Older Adults – Medication Review (COA)	Enter a '1' if the Participant is in the numerator of the Care for Older Adults Medication Review measure, '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 35	Numerator for Care for Older Adults – Functional Status Assessment (COA)	Enter a '1' if the Participant is in the numerator of the Care for Older Adults Functional Status Assessment, '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 36	Numerator for Care for Older Adults – Pain Screening (COA)	Enter a '1' if the Participant is in the numerator of the Care for Older Adults Pain Screening, '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 37	Denominator for Comprehensive Diabetes Care (CDC)	Enter a '1' if the Participant is in the denominator of the CDC measures, '0' if the Participant is not in the denominator.	1 = Yes 0 = No
Column 38	Numerator for CDC – Eye Exam	Enter a '1' if the Participant is in the numerator of the CDC Eye Exam measure, '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 39	Numerator for CDC – Nephropathy Monitor	Enter a '1' if the Participant is in the numerator of the CDC Nephropathy Monitor measure, '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 40	Numerator for CDC – HbA1c Control (<8.0%)	Enter a '1' if the Participant is in the numerator of the CDC HbA1c Control (<8.0%) measure, '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 41	Denominator for Disease Modifying Anti-Rheumatic Drug Therapy (DMARD)	Enter a '1' if the Participant is in the denominator of the DMARD measure, '0' if the Participant is not in the denominator.	1 = Yes 0 = No

Column Placement	Name	Direction	Allowed Values
Column 42	Numerator for Disease Modifying Anti-Rheumatic Drug Therapy (DMARD)	Enter a '1' if the Participant is in the numerator of the DMARD measure, '0' if the Participant is not in the numerator or the information is missing. .	1 = Yes 0 = No
Column 43	Denominator for Controlling High Blood Pressure (CBP)	Enter a '1' if the Participant is in the denominator of the Controlling High Blood Pressure measure, '0' if the Participant is not in the denominator.	1 = Yes 0 = No
Column 44	Numerator for Controlling High Blood Pressure (CBP)	Enter a '1' if the Participant is in the numerator of the Controlling High Blood Pressure measure, '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 45	Denominator for Breast Cancer Screening (BCS)	Enter a '1' if the Participant is in the denominator of the Breast Cancer Screening measure, '0' if the Participant is not in the denominator.	1 = Yes 0 = No
Column 46	Numerator for Breast Cancer Screening (BCS)	Enter a '1' if the Participant is in the numerator of the Breast Cancer Screening measure, '0' if the participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 47	Denominator for Colorectal Cancer Screening (COL)	Enter a '1' if the Participant is in the denominator of the Colorectal Cancer Screening measure, '0' if the Participant is not in the denominator.	1 = Yes 0 = No
Column 48	Numerator for Colorectal Cancer Screening (COL)	Enter a '1' if the Participant is in the numerator of the Colorectal Cancer Screening measure, '0' if the Participant is not in the numerator of this measure.	1 = Yes 0 = No
Instructions for Participant Level Data on NY Specific Measures			
Column 49	Denominator for NY3.1 Long Term Care Overall Balance	Enter a '1' if the Participant is in the denominator of the NY3.1 Long Term Care Overall Balance measure, '0' if the Participant is not in the denominator.	1 = Yes 0 = No
Column 50	Numerator for NY3.1 Long Term Care Overall Balance	Enter a '1' if the Participant is in the numerator of the NY3.1 Long Term Care Overall Balance measure, '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No

Column Placement	Name	Direction	Allowed Values
Column 51	Denominator for the Participants directing their own services through the Consumer-Directed Personal Assistance Option	Enter a '1' if the Participant is in the denominator of the NY5.1 Consumer-Directed Personal Assistance Option measure above, '0' if the Participant is not in the denominator.	1 = Yes 0 = No
Column 52	Numerator for the Participants directing their own services through the Consumer-Directed Personal Assistance Option	Enter a '1' if the Participant is in the numerator of the NY5.1 Consumer-Directed Personal Assistance Option measure above, '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 53	Denominator for NY 3.2 Community Reintegration	Enter a '1' if the Participant is in the denominator of the NY 3.2 Community Reintegration measure above, '0' if the Participant is not in the denominator.	1 = Yes 0 = No
Column 54	Numerator for NY 3.2 Community Reintegration	Enter a '1' if the Participant is in the numerator of the NY 3.2 Community Reintegration measure above, '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Instructions for Participant Level Data on MMP Specific Core Reporting Requirements			
Column 55	Denominator for Screening for MMP Core Measure 6.1 Clinical Depression and Follow-up Care	Enter a '1' if the Participant is in the denominator of the MMP Core Measure 6.1 Screening for Clinical Depression and Follow-up care, '0' if the Participant is not in the denominator.	1 = Yes 0 = No
Column 56	Numerator for the MMP Core Measure 6.1 Screening for Clinical Depression and Follow-up Care	Enter a '1' if the Participant is in numerator 1 of the MMP Core Measure 6.1 Screening for Clinical Depression and Follow-up care, '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No
Column 57	Denominator for MMP Core Measure 9.2 Nursing Facility Diversion	Enter a '1' if the Participant is in the denominator of the MMP Core Measure 9.2 Nursing Facility Diversion measure, '0' if the Participant is not in the denominator.	1 = Yes 0 = No
Column 58	Numerator for MMP Core Measure 9.2 Nursing Facility Diversion	Enter a '1' if the Participant is in the numerator of the MMP Core Measure 9.2 Nursing Facility Diversion measure, '0' if the Participant is not in the numerator or the information is missing.	1 = Yes 0 = No

Column Placement	Name	Direction	Allowed Values
Column 59-60	Denominator for Care Transition Record Transmitted to Health Care Professional	Enter the number of times the Participant met the inclusion criteria for Element B of MMP Core Measure 3.1 Care Transition Record Transmitted to Health Care Professional measure, '00' if Participant does not.	00-98
Column 61-62	Numerator for Care Transition Record Transmitted to Health Care Professional	Enter the number of times the Participant the Participant met the inclusion criteria for Element C of the MMP Core Measure 3.1 Care Transition Record Transmitted to Health Care Professional measure, '00' if Participant is not in the numerator or the information is missing.	00-98
Instructions for Participant Level Data on IDT Requirements			
Column 63	Enrollment Type	Enter a '1' if the Participant is an opt-in enrollee as specified in NY1.1 above (as indicated by an appropriate code in the E file), Enter a '0' if the Participant is a Passive enrollee as specified in NY1.2 above (as indicated by an appropriate code in the E file).	1 = Voluntary 0 = Passive
Column 64-71	The date on which the Participant had his/her IDT formed	Enter the date on which the Participant's IDT was formed as specified in the final IDT policy. Leave the cell blank if the Participant did not have an IDT formed or the information is missing.	MMDDYYYY
Column 72	Did the Participant refuse to have his/her UAS-NY completed at least once in the reporting year?	Enter a '1' if the Participant refused to have his/her UAS-NY completed at least once in the reporting year as described in NY1.1 and 1.2 above, otherwise enter '0'.	1 = Yes 0 = No
Columns 73-168 (up to 12 dates for this measure)	Date(s) on which the Participant had a PCSP completed or updated	Enter the date(s) on which the Participant had their PCSP completed or updated as specified in the final IDT policy. Leave the cell blank if the Participant did not have a PSCP completed/updated or the information is missing.	MMDDYYYY

Column Placement	Name	Direction	Allowed Values
Column 169	Did the Participant refuse to have his/her PCSP completed at least once in the reporting year?	Enter a '1' if this Participant refused to have his/her PCSP completed at least once in the reporting year as specified in NY2.1 above and the final IDT policy, otherwise enter '0'.	1 = Yes 0 = No
Columns 95-106 (e.g., column 95 for date 1, column 96 for date 2, etc.; up to 12 dates for this measure)	Date(s) on which the Participant had an IDT meeting within reporting year	Enter the date(s) on which the Participant had IDT meetings as specified in the final IDT policy. Leave the cell blank if the Participant did not have any IDT meetings or the information is missing.	MMDDYYYY
Column 107	Did the Participant refuse to have an IDT meeting at least once in the reporting year?	Enter a '1' if this Participant refused to have an IDT meeting as specified in the final IDT policy at least once in the reporting year, otherwise enter '0'.	1 = Yes 0 = No
Columns 108-119 (e.g., column 108 for date 1, column 109 for date 2, etc.; up to 12 dates for this measure)	Date(s) on which the Participant Was Discharged From a Hospital Inpatient or Nursing Facility to the Community	Enter the date(s) on which the Participant was discharged from a hospital inpatient or nursing facility to the community as specified in the transition of care setting section of the final IDT policy. Leave the cell blank if the Participant was not discharged from a hospital inpatient or nursing facility to the community or the information is missing.	MMDDYYYY
Column 120	Did the Participant have Behavioral Health Specialist as a member of the IDT at least once in the reporting year?	Enter a '1' if the Participant had a Behavioral Health Specialist as a member of the IDT as specified in the final IDT policy, '0' if the Participant did not have a Behavioral Health Specialist as a member of the IDT.	1 = Yes 0 = No
Column 364	Did the Participant have an RN assessor as a member of the IDT at least once in the reporting year?	Enter a '1' if the Participant had the RN assessor as a member of the IDT as specified in the final IDT policy, '0' if the Participant did not have the RN Assessor as a member of the IDT.	1 = Yes 0 = No

Column Placement	Name	Direction	Allowed Values
Column 365	Did the Participant have a Participant Designee on the IDT at least once in the reporting year?	Enter a '1' if the Participant had a Participant Designee as a member of the IDT as specified in the final IDT policy, '0' if the Participant did not have a Participant Designee as a member of the IDT.	1 = Yes 0 = No
Column 366	Did the Participant have a home care aid or a designee with clinical experience from the home care agency on the IDT at least once in the reporting year?	Enter a '1' if the Participant had a home care aide or a designee with clinical experience from the home care agency as a member of the IDT as specified in the final IDT policy, '0' if the Participant did not have a home care aide or a designee with clinical experience from the home care agency as a member of the IDT.	1 = Yes 0 = No
Column 367	Did the Participant have a nursing facility representative on the IDT at least once in the reporting year?	Enter a '1' if the Participant had a nursing facility representative as a member of the IDT as specified in the final IDT policy, '0' if the Participant did not have a nursing facility representative as a member of the IDT.	1 = Yes 0 = No

A. Edits and Validation checks – validation checks that should be performed by each FIDA plan prior to data submission.

- FIDA Plans should ensure that all data values are recorded in the prescribed format (see column "Allowed values").

B. Analysis – how CMS and the State will evaluate reported data, as well as how other data sources may be monitored.

- NYSDOH will use the Participant-level data to conduct ongoing research on Participants' personal experiences in the FIDA program and on potential relationship of these experiences with Participants' health outcomes.

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

- Overall format:
  - Prepare a fixed width text file in the following format.
  - Include one row for every Participant who was enrolled in the FIDA plan and who meets criteria for one or more of the specified FIDA measures for the measurement year.
  - Numeric values should be right justified and blank filled to the left of the value; text fields should be left-justified and blank filled to the right of the value.
  - The file should be named ParticipantFIDA.txt.

- The sum of the field should equal the numerator or denominator for the corresponding measure entered in the NYS submission tools for the plan-level reporting. Measures that are not applicable to the Participant should be zero-filled.
- The FIDA plan should use the continuous enrollment specifications applicable to each element as specified in HEDIS, elsewhere in this appendix, and/or the MMP-Specific Core Measures guidance.
- For the IDT performance measures, if a Participant had multiple enrollment periods within the same FIDA plan during the reporting period, include only dates for IDT formation, IDT meetings, and PCSPs, and safe discharge in the following manner:
  - If a Participant was passively enrolled, disenrolled, and then opted-back in to the same FIDA plan, include the dates for the period that relates to his/her passive enrollment.
  - If a Participant opted in to the FIDA plan, disenrolled, and then opted back in again in the same FIDA plan, include the dates for the latter period that relates to his/her second opt-in enrollment.

D. Data Submission – how FIDA Plans will submit data collected to CMS and the State.

- FIDA Plans will submit the files in the above specified format to NYSDOH via the Health Commerce System (HCS) Secure File Transfer.

Section NYVII. Other Financial Reporting Requirements

FIDA Plans shall submit financial reports, including certified annual and quarterly financial statements, and make available documents relevant to its financial condition to NYSDOH, CMS, and the State Insurance Department (SID) in a timely manner as required by State laws and regulations including, but not limited to, PHL § 4403-a,, § 4404 and § 4409, Title 10 NYCRR Part 98 and when applicable, State Insurance Law §§ 304, 305, 306, and 310. The NYSDOH may require the FIDA Plan to submit such relevant financial reports and documents related to its financial condition to the New York State Department of Health.

Questions from FIDA Plans regarding these reporting requirements or the data submission process should be directed to the NYSDOH.

NY7.1 Annual Financial Reports.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
NY7. Other Reporting Requirements	Annually	Contract	Prior Calendar Year Ex:1/1-12/31	4/1

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

- In accordance with 10 NYCRR Part 98-1.16, the Contractor shall file with NYSDOH and CMS an annual financial statement called the FIDAOR. The FIDAOR shows the financial condition of the plan at last year-end and contains the information required by PHL § 4408.
- The annual report is in addition to the quarterly financial reports, described below.
- The annual report includes audited financial statements the prior calendar year.

B. Data Submission – how FIDA Plans will submit data collected to CMS and the State.

- FIDA Plans will submit FIDAOR annual financial reports in the above specified format to the Health Commerce System.
- FIDA Plans will also submit FIDAOR annual financial reports to the New York State Department of Health.

NY7.2 Quarterly Financial Reports.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
NY7. Other Reporting Requirements	Quarterly	Contract	Current Calendar Quarter	45 days after the end of the calendar quarter

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

- In accordance with 10 NYCRR Part 98-1.16, the Contractor shall file with NYSDOH and CMS an annual financial statement called the FIDAOR. The FIDAOR shows the financial condition of the plan at last year-end and contains the information required by PHL § 4408.
- The quarterly reports are year to date through the quarter end. This means the quarterly report that is due on May 15 covers the period of January 1 - March 31; the report that is due on August 15 covers the period of January 1 - June 30; and the report that is due on November 15 covers the period of the January 1 - September 30.
- The templates and instructions for the financial reports are forthcoming.
- These financial reports are in addition to any existing reports that plans submit to other agencies.
- The NAIC Analysis of Operations exhibit: FIDA data are to be reported in “Other Health” product/column. This also applies to the rest of the exhibits.
- The NYDATA report: FIDA data are to be included in the MAP, MLTC-Partial and PACE column.

B. Data Submission – how FIDA Plans will submit data collected to CMS and the State.

- FIDA Plans will submit FIDAOR quarterly financial reports in the above specified format to the Health Commerce System.
- FIDA Plans will also submit FIDAOR quarterly financial reports to the New York State Department of Health.

Section NYVIII. Other Fraud, Abuse, and Excluded Provider Reporting Requirements

In addition to the reporting requirements specified below, FIDA plans must comply with the following requirements and report to NYSDOH and CMS the following ad-hoc information:

The FIDA Plan will certify to the NYSDOH and CMS initially and immediately upon changed circumstances from the last such certification that it does not knowingly have an individual who has been debarred or suspended by the Federal, State or local government, or otherwise excluded from participating in procurement activities:

- As a director, officer, partner or person with beneficial ownership of more than five percent (5%) of the FIDA Plan's equity; or
- As a party to an employment, consulting or other agreement with the FIDA Plan for the provision of items and services that are significant and material to the FIDA Plan's obligations in the Medicaid managed care program, consistent with requirements of SSA § 1932 (d)(1).

Pursuant to 42 CFR 455.101, the FIDA Plan is required to check against the Medicaid excluded Provider list any employee in the capacity of general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day to day operations at initial hiring and periodically thereafter.

The US Department of Health and Human Services Office of Inspector General has the authority to exclude individuals and entities from Federally funded health care programs pursuant to sections 1128 and 1156 of the Social Security Act and maintains a list of all currently excluded individuals and entities called the List of Excluded Individuals and Entities (LEIE). Similarly, the New York Office of the Medicaid Inspector General also has the authority to exclude, for good reason, medical professionals from participating in the New York Medicaid program. FIDA Plans are required to check both the List of Excluded Individuals and Entities (LEIE) (available at: http://exclusions.oig.hhs.gov/) and the Restricted, Terminated or Excluded Individuals or Entities List (available at: http://www.omig.ny.gov/component/content/article/29-fraud/fraud-abuse/372-restricted-terminated-or-excluded-individuals-or-entities) on a monthly basis to ensure that none of their staff, Participating Providers, or other contracted entities are excluded. The FIDA plan must comply with applicable guidance on the treatment of excluded individuals and entities and notify CMS/NYSDOH immediately if the plan has discovered an excluded individual or entity. Additional guidance on the effects of an exclusion is provided in the Special Advisory Bulletin on the Effect of Exclusions from Participation in Federal Health Programs, available at: https://oig.hhs.gov/exclusions/files/sab-05092013.pdf.

The FIDA Plan shall report to NYSDOH and CMS documentation of the identity of and financial statements of person(s) or corporation(s) with an ownership or contract interest in the FIDA Plan, or with any subcontract(s) in which the FIDA Plan has a five

percent (5%) or more ownership interest, consistent with requirements of SSA § 1903 (m)(2)(a)(viii) and 42 CFR 455.100 through 455.104.

Pursuant to 42 CFR 455.106, the FIDA Plan will disclose any criminal convictions of managing employees related to Medicare, Medicaid, or Title XX programs at the time the FIDA Plan applies or renews an application for participation in the Medicaid managed care program or Family Health Plus program or at any time on request. NYSDOH is required to notify the HHS-Office of Inspector General (HHS-OIG) whenever such disclosures are made.

Pursuant to 42 CFR 455.106, the FIDA Plan will require Providers to disclose health care related criminal conviction information from all parties affiliated with the Provider. Upon entering into an initial agreement or renewal of any agreement between the FIDA Plan and its Providers, the FIDA Plan must disclose any conviction of a criminal offense related to that Provider or Provider's managing employee involvement in any program under Medicare, Medicaid, or Title XX services program.

NY8.1 Fraud and Abuse Reporting Requirements.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
NY8. Other Reporting Requirements	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.	Name of individual or entity	The name of the individual or entity that committed the fraud or abuse	Field Type: Text
B.	Source	The source that identified the fraud or abuse;	Field Type: Text
C.	Provider, entity, or organization types	The type of provider, entity or organization that committed the fraud or abuse	Field Type: Text
D.	Description of the fraud	A description of the fraud	Field Type: Text

Element Letter	Element Name	Definition	Allowable Values
E.	Dollar amount	The approximate dollar amount of the fraud or abuse	Field Type: Numeric, dollars Note: use specific number if known. If not, provide a range.
F	Action taken by the plan	A description of action/follow-up taken by the FIDA plan	Field Type: Text
G.	Case disposition	The legal and administrative disposition of the case including actions taken by law enforcement officials to whom the case has been referred	Field Type: Text

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

- Reports shall be submitted when cases of fraud or abuse are confirmed and reports have been filed with the Federal and State authority with primary fraud and abuse reporting responsibility.
- These reports to not impact the FIDA plan's Federal and State fraud and abuse reporting requirements described above.
- Reports shall be reviewed and signed by a senior member of the Medicare Compliance team of the FIDA Plan.
- For the purposes of this Section, criminal fraud includes cases of fraud through grievances, organizational monitoring, contractors, subcontractors, providers, Participants, etc. related to Medicare or Medicaid services. This includes submitting claims for services not rendered, providing unnecessary services, or possessing forged documents including prescriptions.

C. Data Submission – how FIDA Plans will submit data collected to CMS and the State.

- FIDA Plans will submit fraud and abuse reports to CMS and NYSDOH plan managers by email in the above specified format and in the template referenced below for each report filed according to the FIDA plan's fraud and abuse policies and procedures called for under the Three-Way Contract.
- A template for reporting elements A through G is available on the CMS Financial Alignment website at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html