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MEDICARE-MEDICAID CAPITATED FINANCIAL ALIGNMENT MODEL REPORTING REQUIREMENTS

Effective as of January 1, 2015

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Introduction

The Medicare-Medicaid Financial Alignment Initiative is designed to test innovative models to better align Medicare and Medicaid financing and the services provided to Medicare-Medicaid enrollees.

The purpose of this document is to provide Medicare-Medicaid Plans (MMPs) with the reporting requirements for the capitated financial alignment model. It provides technical specifications to help assure a common understanding of the data to be reported by MMPs, to assist MMPs in preparing and submitting datasets, to ensure a high level of accuracy in the data reported to the Centers for Medicare & Medicaid Services (CMS) and the states, and to reduce the need for MMPs to correct and resubmit data.

The reporting requirements document is divided into three sections. The first section consists of all Medicare Part C reporting requirements the MMPs are responsible for submitting via the Health Plan Management System (HPMS). The second section consists of all Medicare Part D reporting requirements the MMPs are responsible for submitting via HPMS. These requirements are consistent with the Medicare Parts C and D plan reporting requirements. Accordingly, these measures must be validated in accordance with Part C and Part D data validation requirements. The third section consists of the core requirements for the capitated financial alignment model, which include some modified Part C and D measures. Specifications for these demonstration measures will indicate their reporting frequency and due dates.

Unmodified Part C and Part D measures, as described in the first two sections, will continue to be reported using existing processes and specifications. For Part D measures, an extra data element, letter “F”, has been added to the specifications to clarify that these measures are reported using HPMS. MMPs will be responsible for submitting data collected for the capitated financial alignment model through a secure transmission site that was developed specifically for the demonstrations. This site can be accessed at the following web address:

https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx.

Measures should be reported at the contract level, unless otherwise indicated.

The following terms are used throughout the document:

Medicare-Medicaid Plan (MMP): An MMP is a managed care plan that has entered into a three-way contract with CMS and the state in which the plan will operate. Note: some demonstrations might use different terms to refer to their plans, such as One Care plans in Massachusetts.

State: The state with which the MMP has contracted.

Health Plan Management System (HPMS): The CMS centralized information system used by MMPs to submit Part C and Part D measure data.

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.

Passive Enrollment and Stopping Enrollment

Under the capitated financial alignment model, demonstrations may allow for passive enrollment. During passive enrollment, MMPs must demonstrate adequate performance across a range of measures to remain eligible to receive passive enrollment of beneficiaries. Failure to adequately meet any single measure or set of measures may result in CMS and the state ceasing enrollment. CMS and each state, through the Contract Management Team (CMT), will have the option to discontinue passive enrollment for MMPs for various reasons, including for MMPs failing to completely and accurately report measures or to adequately meet performance standards.

Quality Withhold Measures

CMS and each state will also establish a set of quality withhold measures, and MMPs will be required to meet established thresholds. Throughout this document, these measures are marked with the following symbol for Demonstration Year 1 quality withhold measures: (i) and the following symbol for Demonstration Year 2 measures: (ii). MMPs may have state-specific exceptions to the quality withhold measure outlined in this document. Exceptions, and definitions of Demonstration Years, are noted in the state-specific appendices. Additional information on the withhold methodology can be found at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html.

Reporting on Disenrolled and Retro-disenrolled Members

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

CMS understands that due to retro-disenrollment of members, there may be instances where there is a lag between a member's effective disenrollment date and the date on

which the MMP is informed about that disenrollment. This time lag might create occasional data inaccuracies if an MMP includes members in reports who had in fact disenrolled before the start of the reporting period. If MMPs are aware at the time of reporting that a member 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 MMPs may exclude that member from reporting. Please note that MMPs are *not* required to re-submit corrected data should you be informed of a retro-disenrollment subsequent to a reporting deadline. MMPs should act upon your best and most current knowledge at the time of reporting regarding each member's enrollment status.

Medicare Part C Reporting Requirements

Part C Section V. Grievances

Reporting section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
5. Grievances	05 – MMP	1/Year Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31 (2/28 reporting will include each quarter)	2/28 of following year

Data elements to be reported under this section are:

Grievance Category	Total number of Grievances	Number of grievances in which timely notification was given
Total Grievances	**(5.1)**	**(5.12)**
Number of Expedited Grievances	**(5.2)**	**(5.13)**
Enrollment/Disenrollment	**(5.3)**	**(5.14)**
Benefit Package Grievances	**(5.4)**	**(5.15)**
Access Grievances	**(5.5)**	**(5.16)**
Marketing Grievances	**(5.6)**	**(5.17)**
Customer Service Grievances	**(5.7)**	**(5.18)**
Organization determination and reconsideration process grievances	**(5.8)**	**(5.19)**
Quality Of Care Grievances	**(5.9)**	**(5.20)**
Grievances related to “CMS Issues”	**(5.10)**	**(5.21)**
Other Grievances	**(5.11)**	**(5.22)**

* Timely notification of grievances means grievances for which the member is notified of decision according to the following timelines:

- For standard grievances: no later than 30 days after receipt of grievance.
- For standard grievances with an extension taken: no later than 44 calendar days after receipt of grievance.
- For expedited grievances: no later than 24 hours after receipt of grievance.

Notes

This reporting section requires upload into HPMS.

In cases where a purported representative files a grievance on behalf of a beneficiary without an Appointment of Representative (AOR) form, the timeliness calculation ("clock") starts upon receipt of the AOR form. This is a contrast to grievances filed by a beneficiary, in which cases the clock starts upon receipt of the grievance.

For an explanation of Medicare Part C grievance procedures, refer to CMS regulations and guidance: 42 CFR Part 422, Subpart M, and Chapter 13 of the Medicare Managed Care Manual and the CMS website hhtp://www.cms.gov/MMCAG/. For an explanation of grievance procedures for MMPs, refer to the three-way contracts.

CMS requires plans to use one of 22 categories described in this section to report grievances to CMS (Elements 5.1 – 5.22). For purposes of Reporting Section 5:

- A grievance is defined in Chapter 13 of the Medicare Managed Care Manual as "Any complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. An enrollee or their representative may make the complaint or dispute, either orally or in writing, to a Medicare health plan, provider, or facility. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame. In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care."

- For Part C reporting, grievances are defined as those grievances completed (i.e., plan has notified enrollee of its decision) during the reporting period, regardless of when the request was received; and include grievances filed by the enrollee or his or her representative.

The category, "Grievances Related to CMS Issues" involves grievances that primarily involve complaints concerning CMS' policies, processes, or operations; the grievance is not directed against the health plan or providers. The new grievance category is meant to identify those grievances that are due to CMS issues, and are related to issues outside of the Plan's direct control. This same type of categorization is used in the Complaint Tracking Module (CTM) and allows CMS to exclude those grievances that are outside of the Plan's direct control, from the total number of grievances filed against the contract.

Reporting Inclusions:

Report:

- Only those grievances processed in accordance with the plan grievance procedures outlined in 42 CFR Part 422, Subpart M (i.e., Part C grievances).

- Report grievances involving multiple issues under each applicable category.

- Report grievances if the member is ineligible on the date of the call to the plan but was eligible previously.

Reporting Exclusions:

Do not report:

- Enrollee complaints only made through the CMS Complaints Tracking Module (CTM). CTM complaints are addressed through a process that is separate and distinct from the plan's procedures for handling enrollee grievances. Therefore, plans should not report their CTM records to CMS as their grievance logs.

- Withdrawn grievances.

- Enrollee grievances processed in accordance with the grievance procedures described under 42 C.F.R., Part 423, Subpart M (i.e., Part D grievances).

Additional Guidance

- See CY2014 Part C Plan Reporting Module for specific guidance concerning reporting grievances.

- In cases where an extension is requested after the required decision making timeframe has elapsed, the plan is to report the decision as non-timely. For example: Plan receives grievance on 1/1/2014 at 04:00pm. An extension is requested at 1/31/2014 04:05pm. Plan completes investigation and provides notification on 2/5/2014 04:00pm (35 calendar days after receipt). This grievance is not considered timely for reporting as the decision was rendered more than 30 calendar days after receipt.

- If an enrollee files a grievance and then files a subsequent grievance on the same issue *prior to* the organization's decision or deadline for decision notification (whichever is earlier), then the issue is counted as one grievance.

- If an enrollee files a grievance and then files a subsequent grievance on the same issue *after* the organization's decision or deadline for decision notification (whichever is earlier), then the issue is counted as a separate grievance.

- *For MA-PD contracts:* Include only grievances that apply to the Part C benefit. (If a clear distinction cannot be made for an MA-PD, cases are reported as Part C grievances.)

For additional details concerning Reporting Section 5 reporting requirements, see the Part C Reporting Module and Appendix 1: FAQs: Reporting Sections 5 & 6.

Part C Section VI. Organization Determinations/Reconsiderations

Reporting section	Organization Types Required to Report	Report Freq./ Level	Report Period (s)	Data Due date (s)
6. Organization Determinations/ Reconsiderations	05 – MMP	1/Year Contract	1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31 (2/28 reporting will include each quarter)	2/28 of following

Element Number	Data Elements for Organization Determinations/Reconsiderations
6.1	Total Number of Organization Determinations Made in Reporting Time Period Above
6.2	Of the Total Number of Organization Determinations in 6.1, Number Processed Timely
6.3	Number of Organization Determinations – Fully Favorable (Services)
6.4	Number of Organization Determinations – Fully Favorable (Claims)
6.5	Number of Organization Determinations – Partially Favorable (Services)
6.6	Number of Organization Determinations – Partially Favorable (Claims)
6.7	Number of Organization Determinations – Adverse (Services)
6.8	Number of Organization Determinations – Adverse (Claims)
6.9	Number of Requests for Organization Determinations - Withdrawn
6.10	Total number of Reconsiderations Made in Reporting Time Period Above
6.11	Of the Total Number of Reconsiderations in 6.10, Number Processed Timely
6.12	Number of Reconsiderations – Fully Favorable (Services)
6.13	Number of Reconsiderations – Fully Favorable (Claims)
6.14	Number of Reconsiderations – Partially Favorable (Services)
6.15	Number of Reconsiderations – Partially Favorable (Claims)
6.16	Number of Reconsiderations – Adverse (Services)
6.17	Number of Reconsiderations – Adverse (Claims)
6.18	Number of Requests for Reconsiderations - Withdrawn
6.19	Total number of reopened (revised) decisions, for any reason, in Time Period Above
For each case that was reopened, the following information will be uploaded in a data file:	

Element Number	Data Elements for Organization Determinations/Reconsiderations
6.20	Contract Number
6.21	Plan ID
6.22	Case ID
6.23	Date of original disposition
6.24	Original disposition (Fully Favorable; Partially Favorable or Adverse)
6.25	Case level (Organization Determination or Reconsideration)
6.26	Date case was reopened
6.27	Reason(s) for reopening (Clerical Error, New and Material Evidence, or Other)
6.28	Date of reopening disposition (revised decision)
6.29	Reopening disposition (Fully Favorable; Partially Favorable, Adverse, or pending)

Notes

This reporting section requires direct data entry into HPMS.

For an explanation of Part C organization determination and reconsideration procedures, refer to CMS regulations and guidance: 42 CFR Part 422, Subpart M, and Chapter 13 of the Medicare Managed Care Manual, and the CMS website: http://www.cms.gov/MMCAG/. For an explanation of reconsideration procedures for MMPs, refer to the three-way contract.

All plan types listed in the table at the beginning of this section are required to report: organization determinations and reconsiderations, as described in this guidance, regardless of whether the request was filed by an enrollee, the enrollee's representative, a physician or a non-contract provider who signed a Waiver of Liability.

In cases where a purported representative files an appeal on behalf of a beneficiary without an Appointment of Representative (AOR) form, the timeliness calculation ("clock") starts upon receipt of the AOR form. This is a contrast to appeals filed by a beneficiary, in which cases the clock starts upon receipt of the appeal.

For instances when the organization approves an initial request for an item or service (e.g., physical therapy services) and the organization approves a separate additional request to extend or continue coverage of the same item or service, include the decision to extend or continue coverage of the same item or service as another, separate, fully favorable organization determination.

Plans are to report encounter data, whereby an encounter took place under a capitation arrangement, as an organization determination. That is, we want plans to report capitated providers' encounters in lieu of actual claims data.

CMS requires plans to report requests for organization determinations and reconsiderations submitted to the plan. For purposes of Reporting Section 6:

- An **organization determination** is a plan's response to a request for coverage (payment or provision) of an item or service – including auto-adjudicated claims, prior authorization requests, and requests to continue previously authorized ongoing courses of treatment. It includes requests from both contract and non-contract providers.

- Reconsideration is a plan's review of an adverse or partially favorable organization determination.

- A **Fully Favorable** decision means an item or service was covered in whole.

- A **Partially Favorable** decision means an item or service was partially covered. For example, if a claim has multiple line items, some of which were paid and some of which were denied, it would be considered partially favorable. Also, if a pre-service request for 10 therapy services was processed, but only 5 were authorized, this would be considered partially favorable.

- An **Adverse** decision means an item or service was denied in whole.

- In contrast to claims (payment decisions), **service authorizations** include all service-related decisions, including pre-authorizations, concurrent authorizations and post-authorizations.

- A **reopening** is a remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record. (See CY2014 Part C Plan Reporting Module and below "Notes" for additional guidance concerning reopenings.)

- A **withdrawn** organization determination or reconsideration is one that is, upon request, removed from the plan's review process. This category excludes appeals that are dismissed.

If a provider (e.g., a physician) declines to provide coverage an enrollee has requested or offers alternative services, the provider is making a treatment decision, not an organization determination on behalf of the plan. In this situation, if the enrollee disagrees with the provider's decision, and still wishes to obtain coverage of the service or item, the enrollee must contact the Medicare health plan to request an organization determination or the provider may request the organization determination on the enrollee's behalf.

Reporting Inclusion

Organization Determinations:

- All fully favorable payment (claims) and service-related organization determinations for contract and non-contract providers/suppliers.

- All partially favorable payment (claims) and service-related organization determination for contract and non-contract providers/suppliers.

- All adverse payment (claims) and service-related organization determinations for contract and non-contract providers/suppliers.

Reconsiderations:

- All fully favorable payment (claims) and service-related reconsideration determinations for contract and non-contract providers/suppliers.

- All partially favorable payment (claims) and service-related reconsideration determinations for contract and non-contract providers/suppliers.

- All adverse payment (claims) and service-related reconsideration determinations for contract and non-contract providers/suppliers.

Reopenings:

- All Fully Favorable, Partially Favorable, Adverse or Pending Reopenings of Organization Determinations and Reconsiderations, as described in the preceding sections.

- See *CY2014 Part C Plan Reporting Module* for additional guidance concerning reopenings.

Additional Guidance

See CY2014 Part C Plan Reporting Module for additional guidance concerning reopenings.

Report:

- **Completed organization determinations and reconsiderations** (i.e., plan has notified enrollee of its decision concerning a requested item or service or adjudicated a claim) during the reporting period, regardless of when the request was received. Plans are to report organization determination or reconsideration where a substantive decision has been made, as described in this section and processed in accordance with the organization determination and reconsideration procedures described under 42 C.F.R. Part 422, Subpart M.

- All Part B drug claims processed and paid by the plan's PBM are reported as organization determinations or reconsiderations.

- **Reopenings** that are in a reopening status across multiple reporting periods are to be reported in each applicable reporting period. For example, if a plan reopened an organization determination on 3/15/2014 and sent the notice of the revised decision on 4/22/2014, that case should be reported as "pending" in the Q1 data file and then as resolved in Q2 (either Fully Favorable, Partially Favorable or Adverse). See CY2014 Part C Plan Reporting Module for detailed guidance concerning reporting reopenings.

- **Claims with multiple line items** at the "summary level."

- A **request for payment** as a separate and distinct organization determination, even if a pre-service request for that same item or service was also processed.

- A denial of **Medicare payment** for item or service as either partially favorable or adverse, regardless of whether Medicaid payment ultimately is provided, in whole or in part, for that item or service.

- Report denials based on exhaustion of Medicare benefits.

- In cases where an **extension** is requested after the required decision making timeframe has elapsed, the plan is to report the decision as non-timely. For example: Plan receives standard pre-service reconsideration request on 1/1/2014 at 04:00pm. An extension is requested at 1/31/2014 04:05pm. Plan completes reconsideration and provides notification on 2/5/2014 04:00pm (35 calendar days after receipt). This reconsideration is not considered timely for reporting as the decision was rendered more than 30 calendar days after receipt.

Do not report:

- Dismissals.

- Independent Review Entity (IRE) decisions.

- Duplicate payment requests concerning the same service or item.

- Payment requests returned to a provider/supplier in which a substantive decision (fully favorable, partially favorable or adverse) has not been made– e.g., payment requests or forms are incomplete, invalid or do not meet the requirements for a Medicare claim (e.g., due to a clerical error).

- A Quality Improvement Organization (QIO) review of an individual's request to continue Medicare-covered services (e.g., a SNF stay) and any related claims/requests to pay for continued coverage based on such QIO decision.

- Enrollee complaints only made through the CMS Complaints Tracking Module (CTM).

NOTE: For purposes of this current reporting effort, plans are not required to distinguish between standard and expedited organization determinations or standard and expedited reconsiderations.

For additional details concerning the Reporting Section 6 reporting requirements, see the CY2014 Part C Plan Reporting Module and Appendix 1: FAQs: Reporting Sections 5 & 6.

Part C Appendix 1: FAQs: Reporting Sections 5 & 6:

Grievances, Organization Determinations, & Reconsiderations

	Plan Inquires	CMS Responses
1.	Should plans report informal complaints as Grievances under the Part C reporting requirements? For example: During the course of a home visit, a member expresses dissatisfaction regarding a particular issue. The member does not contact the plan directly to file a complaint, but the plan representative determines the member is not happy and logs the issue for Quality Improvement tracking.	Plans are to report any grievances filed directly with the plan and processed in accordance with the plan grievance procedures outlined under 42 CFR Part 422, Subpart M. Plans are not to report complaints made to providers, such as the complaint in the example provided, that are not filed with the plan.
2.	Should plans report all Dual Eligible member grievances to CMS?	No. Plans are only to report Dual Eligible member grievances processed in accordance with the plan grievance procedures outlined under 42 CFR Part 422, Subpart M. For example, plans will not report grievances filed under the state Medicaid process, but not filed with the plan and addressed under the plan's Subpart M grievance process.
3.	Is a plan to report a grievance, organization determination or reconsideration to CMS when the plan makes the final decision or when the request is received?	Plans are to report grievances, organization determinations and reconsiderations that were completed (i.e., plan has notified enrollee of its decision or provided or paid for a service, if applicable) during the reporting period, regardless of when the request was received.

	Plan Inquires	CMS Responses
4.	Are plans to report only those organization determinations defined under 42 C.F.R. 422.566?	CMS requires plans to report requests for payment and services, as described in the Part C Technical Specifications, Reporting section 6. Plans are to report requests for payment and services consistent with CMS regulations at 42 C.F.R. Part 422, Subpart M as "organization determinations." For example, plans are to include adjudicated claims in the reportable data for Organization Determinations.
5.	We are seeking information on how we should report pre-service requests and claims requests for this category. Do you want fully favorable, partially favorable, and adverse for both pre-service requests and claims requests?	Yes. Plans are to report fully favorable, partially favorable, and adverse pre-service and claims requests (organization determinations and reconsiderations), as described in this guidance.
6.	If we have a prior authorization request and a claim for the same service - is that considered a duplicate or should we report both?	Plans are to report both a prior authorization request and a claim for the same service; this is not considered a duplicate.
7.	Is a request for a predetermination to be counted as an organization determination? Does it matter who requests the predetermination – contracted provider, non-contracted provider or member? If so, should they also be counted as partially and fully unfavorable?	Organization determinations include a request for a pre-service ("predetermination") decision submitted to the plan, regardless of who makes the pre-service request – e.g., a contracted provider, non-contracted provider or member. Plans are to report partially favorable, adverse and fully favorable pre-service organization determinations, as described in this guidance.
8.	Should plans report determinations made by delegated entities or only decisions that are made directly by the plan – e.g., should plans report decisions made by contracted radiology or dental groups?	Yes. Plans are to report decisions made by delegated entities – such as an external, contracted entity responsible for organization determinations (e.g., claims processing and pre-service decisions) or reconsiderations.

	Plan Inquires	CMS Responses
9.	The Tech Specs advise plans to exclude certain duplicate/edits when reporting on the claim denial requirement. Is the intent to exclude duplicates or is it to exclude "billing" errors or both? For example, if a claim is denied because the provider didn't submit the claim with the required modifier, should that be excluded from the count?	Plans should exclude duplicate claim submissions (e.g., a request for payment concerning the same service) and claims returned to a provider/supplier due to error (e.g., claim submissions or forms that are incomplete, invalid or do not meet the requirements for a Medicare claim).
10.	Do we have to include lab claims for this reporting section? Do we need to report the ones which involve no pre-service as well as the ones that involve pre-service?	Yes. Plans are to report lab claims. Even in the absence of a pre-service request, a request for payment (claim) is a reportable organization determination.
11.	Enrollee is hospitalized for heart surgery, no prior authorization is required and the claim is paid timely in accordance with full benefit coverage. Our reading of the Medicare Managed Care Manual reveals that the organization is only required to notify the enrollee of Partially Favorable or Adverse decisions. There is no requirement to notify enrollees of Fully Favorable decisions. Is this an organization determination?	Prior authorization is not required to consider a decision an organization determination. A submitted claim is a request for an organization determination. All paid claims are reportable (fully favorable) organization determinations. Timeframe and notification requirements for Fully Favorable determinations are described under 42 C.F.R 422.568(b) and (c). Written notice is required for Partially Favorable, and Adverse determinations.
12.	Enrollee obtains a rhinoplasty for purely cosmetic reasons, which is a clear exclusion on the policy. Enrollee and provider both know this is likely not covered but they submit the claim. Claim is denied as an exclusion/ noncovered service. Neither the enrollee nor the provider pursues it any further. Is this an organization determination?	The plan is to report this denial as an organization determination. A request for payment (claim) is a reportable organization determination.

	Plan Inquires	CMS Responses
13.	Enrollee is out of area and in need of urgent care. Provider is out of area / network. The enrollee calls plan and requests a coverage determination for this service. Health Plan approves use of out of area services. Claim is submitted and paid in full. Is this counted as one event (i.e., pre-auth and claim not counted as two events)?	In this example, both the pre-service decision and claim are counted as two, separate fully favorable organization determinations. A claim submitted for payment is an organization determination request. Claims paid in full are reportable (fully favorable) organization determinations.
14.	When an organization determination is extended into the future does that extension count in the reporting of org determinations (e.g. on-going approval for services approved in the initial decision)?	Yes. Plans generally are to count an initial request for an organization determination (request for an ongoing course of treatment) as separate from any additional requests to extend the coverage. For example, plans are to count an initial approved request for physical therapy services as one organization determination. If the plan, later, approves a subsequent request to continue the ongoing services, the plan should count the decision to extend physical therapy services as another, separate organization determination.
15.	Our interpretation is that the term “contracted provider” means “contracted with the health plan” not “contracted with Medicare.”	Yes. For purposes of Part C Reporting Section 6 reporting requirements, “contracted provider” means “contracted with the health plan” not “contracted” (or participating) with Medicare.”
16.	When we make an adverse determination that is sent to the QIO for review and later our adverse determination is overturned, should we count and report the initial Adverse determination that goes to the QIO? We understand that QIO determinations are excluded from our reporting.	Yes. Regardless of whether a QIO overturns an Adverse organization determination, plans are to report the initial adverse or partially favorable organization determination.

	Plan Inquires	CMS Responses
17.	Should cases forwarded to the Part C IRE be counted once in the reporting section, i.e., as the Partially Favorable or adverse decision prior to sending to the IRE?	When a plan upholds its adverse or partially favorable organization determination at the reconsideration level, the plan generally must report both the adverse or partially favorable organization determination and reconsideration. Exceptions: Plans are not to report: 1.) Dismissed cases, or 2.) QIO determinations concerning an inpatient hospital, skilled nursing facility, home health and comprehensive outpatient rehabilitation facility services terminations.
18.	Should supplemental benefit data be excluded from the Part C Reporting?	As described in this guidance, a plan's response to a request for coverage (payment or provision) of an item or service is a reportable organization determination. Thus, requests for coverage of a supplemental benefit (e.g., a non-Medicare covered item/service) are reportable under this effort.

Medicare Part D Reporting Requirements

Part D Section II. Retail, Home Infusion, and Long-Term Care Pharmacy Access

As outlined in §423.120, Part D Sponsors are required to maintain a pharmacy network sufficient for ensuring access to Medicare beneficiaries residing in their service areas. Part D Sponsors must ensure that they provide convenient access to retail pharmacies, as provided in §423.120(a)(1); adequate access to home infusion (HI) pharmacies, as provided in §423.120(a)(4); and convenient access to long-term care (LTC) pharmacies, as provided in §423.120(a)(5). After their initial pharmacy access submissions are approved at the time of application, Part D Sponsors are responsible for notifying CMS of any substantive changes in their pharmacy network that may impact their ability to maintain a Part D pharmacy network that meets our requirements, as described in section 50 of Chapter 5 of the Prescription Drug Benefit Manual.

Part D Sponsors will be required to submit certain data elements on an annual basis that will allow CMS to evaluate Part D Sponsors' continued compliance with pharmacy access requirements. For purposes of evaluating compliance with the retail pharmacy access standards, Part D Sponsors should use the CMS reference file that provides counts of Medicare beneficiaries by State, region, and ZIP code. This reference file is provided by CMS for the Part D applications and will be posted on the Prescription Drug Contracting, Application Guidance section of CMS' website in January(http://www.cms.hhs.gov/PrescriptionDrugCovContra/04_RxContracting_ApplicationGuidance.asp#TopOfPage). Note that this file contains total Medicare beneficiary counts, not plan enrollee counts, and that the total Medicare beneficiary count is the appropriate number to use for purposes of ensuring compliance with the standards for convenient access to retail pharmacies as provided in §423.120(a)(1), and adequate access to home infusion pharmacies as provided in §423.120(a)(4).

For purposes of evaluating compliance with the LTC and home infusion pharmacy access standards, CMS will use data elements submitted by Part D Sponsors, as well as information from CMS reference files containing counts of nursing home beds and Medicare beneficiaries by State, region, and ZIP code, as detailed in sections 50.4 and 50.5.1 of Chapter 5 of the Prescription Drug Benefit Manual.
Submission of supporting documentation with the data elements below is not required; however, CMS reserves the right to request appropriate documentation to support a Part D Sponsor's submitted pharmacy networks. CMS evaluation of compliance with pharmacy access standards will be conducted based on point-in-time information about pharmacy networks submitted by Part D Sponsors once per year.

Reporting timeline for Section 1 only:

	Period 1
Reporting Period	January 1 - March 31
Data due to CMS/HPMS	May 31

Data files to be uploaded through the HPMS at the Contract level, following templates provided in HPMS.

1. **Network Pharmacy data files, as of the last day of the reporting period specified above:**
    1. A list of contracted network retail pharmacies, including preferred/non-preferred status as applicable to network design;
    2. A list of contracted Home Infusion pharmacies, and
    3. A list of contracted Long-term Care pharmacies.

Please note that contracts will be required to submit pharmacy data using only the NPI number.

Reporting timeline for Sections 2 and 3 only:

	YTD
Reporting Period	January 1 – December 31
Data due to CMS/HPMS	February 28

Part D Section III. Medication Therapy Management Programs

The requirements stipulating that Part D Sponsors provide Medication Therapy Management (MTM) programs are described in Title I, Part 423, Subpart D, § 423.153. For monitoring purposes, Part D Sponsors will be responsible for reporting several data elements related to their MTM program. Data will be uploaded in a data file.

Reporting timeline:

	YTD
Reporting Period	January 1 - December 31
Data due to CMS/HPMS	February 28

Sponsors are required to target beneficiaries for the MTM program who meet specific criteria as specified by CMS in § 423.153(d). Some Sponsors also offer enrollment in the MTM program to other members who do not meet the specific CMS targeting criteria.

The following information will be collected for each beneficiary identified as being eligible for the Part D MTM program, whether based on CMS' specifications or other plan-specific targeting criteria within the reporting period. Regardless of this designation, the corresponding MTM services delivered to each beneficiary (such as targeted medication review or comprehensive medication review) must meet CMS definitions. The reported beneficiaries must receive MTM services that meet or exceed CMS' MTM program requirements.

A. Contract Number.
B. HICN or RRB Number.
C. Beneficiary first name.
D. Beneficiary middle initial.
E. Beneficiary last name.
F. Beneficiary date of birth.
G. Met the specified targeting criteria per CMS – Part D requirements. (Y (yes) or N (no)).
H. Beneficiary identified as cognitively impaired at time of comprehensive medication review (CMR) offer or delivery of CMR. (Y (yes), N (no), or U (unknown)).
I. Date of MTM program enrollment.
J. Date met the specified targeting criteria per CMS – Part D requirements. Required if met the specified targeting criteria per CMS – Part D requirements. (May be same as Date of MTM program enrollment)
K. Date of MTM program opt-out.
L. Reason participant opted-out of MTM program (Death; Disenrollment from Plan; Request by beneficiary; or Other). Required if Date of MTM program opt-out is applicable.

M. Offered annual CMR. (Y (yes) or N (no)). Required if met the specified targeting criteria per CMS – Part D requirements.
N. If offered, date of (initial) offer.
O. Received annual CMR with written summary in CMS standardized format. (Y (yes) or N (no)). Required if offered annual CMR.
P. Number of CMRs received with written summary in CMS standardized format. Required if received annual CMR.
Q. Date(s) of CMR(s) with written summary in CMS standardized format. (If more than 1 CMR is received, up to 5 dates will be allowed.) Required if received annual CMR.
R. Method of delivery for the annual CMR. (Face-to-face; Telephone; Telehealth consultation; or Other). (If more than 1 CMR is received, report the method of delivery for the initial CMR). Required if received annual CMR.
S. Qualified Provider who performed the initial CMR. (Physician; Registered Nurse; Licensed Practical Nurse; Nurse Practitioner; Physician's Assistant; Local Pharmacist; LTC Consultant Pharmacist; Plan Sponsor Pharmacist; Plan Benefit Manager (PBM) Pharmacist; MTM Vendor Local Pharmacist; MTM Vendor In-house Pharmacist; Hospital Pharmacist; Pharmacist – Other; or Other). Required if received annual CMR.
T. Recipient of CMR. (Beneficiary, Beneficiary's prescriber; Caregiver; or Other authorized individual). Required if received annual CMR.
U. Number of targeted medication reviews. Required if met the specified targeting criteria per CMS – Part D requirements.
V. Number of drug therapy problem recommendations made to beneficiary's prescriber(s) as a result of MTM services. (For reporting purposes, a recommendation is defined as a suggestion to take a specific course of action related to the beneficiary's drug therapy. If the same recommendation is made to multiple prescribers or repeated on multiple dates, then that recommendation should only be counted and reported once. Examples include, **but are not limited to**: Needs additional therapy; Unnecessary drug therapy; Dosage too high; Dosage too low; More effective drug available; Adverse drug reaction; or Medication Non-compliance/Non-adherence).
W. Number of drug therapy problem resolutions resulting from recommendations made to beneficiary's prescriber(s) as a result of MTM recommendations. (For reporting purposes, a resolution is defined as a change or variation from the beneficiary's previous drug therapy. Examples include, **but are not limited to**: Initiate drug; Change drug (such as product in different therapeutic class, dose, dosage form, quantity, or interval); Discontinue or substitute drug (such as discontinue drug, generic substitution, therapeutic substitution, or formulary substitution); Medication compliance/adherence).
X. Topics discussed with the beneficiary during the CMR, including the medication or care issue to be resolved or behavior to be encouraged. (If more than 1 topic discussed, up to 5 topics will be allowed to be reported.) These are the descriptions of the topics listed on the beneficiary's written summary in CMS standardized format in the Medication Action Plan under '*What we talked about*'. Required if received annual CMR.

Part D Section V. Grievances

According to MMA statute, a grievance is any complaint or dispute, other than a coverage determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Part D organization, regardless of whether remedial action is requested. Part D Sponsors are required to notify enrollees of their decision no later than 30 days after receiving their grievance. An extension up to 14 days is allowed if it is requested by the enrollee, or if the Part D Sponsor needs additional information and documents that this extension is in the interest of the enrollee. An expedited grievance that involves refusal by a Part D Sponsor to process an expedited coverage determination or redetermination requires a response from the Part D Sponsor within 24 hours.

When categorizing grievances into core categories, Sponsors may report based on their investigations subsequent to the enrollees' filing of the grievances.

For reporting, Sponsors should:

- Report data based on the date the grievance decision was made.
- Track multiple grievances by a single complainant and report as separate grievances.

For reporting, Sponsors should not:

- Report requests for coverage determinations, exceptions, or redeterminations inappropriately as grievances.
- Only base grievances reporting on CTM data.
- Report general inquiries or questions as grievances.
- Dismiss or exclude any grievances filed by beneficiaries or their appointed representatives from this reporting section.

Sponsors will report quarterly data on an annual basis.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Reporting Period	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	February 28 (reporting for all quarters due on this date)			

Data to be reported at the Contract level:

	Total number of grievances	Number of grievances in which timely notification was given
Total Grievances		
Number of Expedited Grievances		
Enrollment/Disenrollment Grievances		
Plan Benefit Grievances		
Pharmacy Access Grievances		
Marketing Grievances		
Customer Service Grievances		
Coverage Determination and Redetermination Process Grievances		
Quality of Care Grievances		
Grievances related to “CMS Issues”		
Other Grievances		

Part D Section VI. Coverage Determinations and Redeterminations

Title I, Part 423, Subpart M describes Part D Sponsors' requirements for coverage determinations (including formulary and tier exceptions, and exceptions to established drug utilization management programs) and redeterminations, including timeframes for standard and expedited requests. Part B vs. Part D coverage determinations and redeterminations should be included in this reporting. Sponsors should report data based on the date the coverage determination or redetermination decision is made. A Sponsor's complete decision includes making the determination, appropriately notifying the enrollee of the determination, and authorizing coverage or sending payment, where applicable.

Coverage decisions (both coverage determinations and redeterminations) may result in a partially favorable decision.

- Example of a fully favorable decision: Non-formulary exception request approved for drug and quantity prescribed.
- Example of a partially favorable decision: Non-formulary exception request approved for drug, but full quantity prescribed not approved.

Sponsors should also include reopened coverage determination and redetermination data in this reporting, based on the date the revised decision is made. Reopening includes any revision to a binding determination for any reason, including but not limited to clerical errors and new and material evidence not available or known at the time of the determination.

Sponsors will report quarterly data on an annual basis. All data elements to be entered into the HPMS at the Contract level, except reopenings data in element B to be uploaded in a data file.

Reporting timeline:

	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
Reporting Period	January 1 - March 31	April 1 - June 30	July 1 - September 30	October 1 - December 31
Data due to CMS/HPMS	February 28 (reporting for all quarters due on this date)			

1. Coverage Determinations and Exceptions

Data elements to be entered into the HPMS at the Contract level:

A. The total number of pharmacy transactions in the time period above.
B. Of the total reported in A, the number of pharmacy transactions rejected due to non-formulary status.
C. Of the total reported in A, the number of pharmacy transactions rejected due to prior authorization (PA) requirements.

D. Of the total reported in A, the number of pharmacy transactions rejected due to step therapy requirements.
E. Of the total reported in A, the number of pharmacy transactions rejected due to quantity limits (QL) requirements based on CMS approved formulary. Safety edits and rejections due to early refills should be excluded.
F. Did the plan have high cost edits for compounds in place during the time period above? ((Y (yes) or N (no)).
G. If yes to element F, the cost threshold used.
H. Did the plan have high cost edits for non-compounds in place during the time period above? ((Y (yes) or N (no)).
I. If yes to element H, the cost threshold used.
J. Of the total reported in A, the total number of claims rejected due to high cost edits for compounds.
K. Of the total reported in A, the total number of claims rejected due to high cost edits for non-compounds.
L. The total number of coverage determinations decisions made in the reporting time period above.
M. Of the number reported in element L, the total number of exception decisions made in the reporting time period above.
N. Of the number reported in element L, the number processed timely.
O. Of the number reported in element L, the number that were fully favorable.
P. Of the number reported in element L, the number that were partially favorable.
Q. Of the number reported in element L, the number that were adverse.
R. The total number of requests for coverage determinations that were withdrawn in the reporting time period above.
S. The total number of requests for coverage determinations that were dismissed in the reporting time period above.

2. Redeterminations

Data elements to be entered into the HPMS at the Contract level:

A. The total number of redeterminations made in the reporting time period above.
B. Of the number reported in element A, the number processed timely.
C. Of the number reported in element A, the number that were fully favorable.
D. Of the number reported in element A, the number that were partially favorable.
E. Of the number reported in element A, the number that were adverse.
F. The total number of requests for redeterminations that were withdrawn in the reporting time period above.
G. The total number of requests for redeterminations that were dismissed in the reporting time period above.

3. Reopenings

Data elements to be uploaded in a data file at the Contract level:

A. The total number of reopened (revised) decisions, for any reason, in the time period above.
B. For each case that was reopened, the following information will be uploaded in a data file:
    1. Contract Number;
    2. Plan ID;
    3. Case ID;
    4. Date of original disposition;
    5. Original disposition (Fully Favorable; Partially Favorable or Adverse);
    6. Case level (Coverage Determination or Redetermination);
    7. Date case was reopened;
    8. Reason(s) for reopening (Clerical Error, New and Material Evidence, Fraud or Similar Fault, or Other)
    9. Date of reopening disposition (revised decision);
    10. Reopening disposition (Fully Favorable; Partially Favorable, Adverse, or Pending).

Part D Section VII. Long-Term Care (LTC) Utilization

LTC network pharmacies receive access/performance rebates that may create financial incentives that conflict with Part D Sponsors' formularies or drug utilization management (DUM) programs. These incentives can negatively impact formulary adherence as well as overall drug costs associated with beneficiaries served by LTC pharmacies. CMS will collect data for LTC pharmacies' formulary and non-formulary cost and utilization, for comparison to retail pharmacies' cost and utilization patterns.

Sponsors will report the number of 31-day equivalent prescriptions dispensed by each LTC pharmacy, and the aggregate number of 30-day equivalent prescriptions dispensed by network retail pharmacies. These are calculated by summing days supply of all covered Part D prescriptions dispensed by the respective pharmacy or group of pharmacies, and then dividing by either 31 or 30 days. Prescription cost is defined as the sum of ingredient cost, dispensing fee, and sales tax; the ingredient cost should reflect the Sponsor's negotiated price. A network LTC pharmacy is a network pharmacy owned by or under contract with a LTC facility to provide prescription drugs to the facility's residents.

Reporting timeline:

	Period 1	**Period 2**
Reporting Period	January 1 - June 30	July 1 – December 31
Data due to CMS/HPMS	August 31	February 28

Data elements to be entered or uploaded into the HPMS at the Contract level:

Data file to be uploaded through the HPMS at the Contract level as specified below:

A. The total number of network LTC pharmacies in the service area.
B. The total number of network retail pharmacies in the service area.
C. The total number of beneficiaries in LTC facilities for whom Part D drugs have been provided under the Contract.
D. For each network LTC pharmacy in the service area:
    1. LTC pharmacy name;
    2. LTC pharmacy NPI number;
    3. Contract entity name of LTC pharmacy;
    4. Chain code of LTC pharmacy;
    5. Number of 31-day equivalent formulary prescriptions dispensed;
    6. Number of 31-day equivalent non-formulary prescriptions dispensed;
    7. Cost of formulary prescriptions;
    8. Cost of non-formulary prescriptions.
E. In aggregate, for all retail pharmacies in the service area:
    1. Number of 30-day equivalent formulary prescriptions dispensed;
    2. Number of 30-day equivalent non-formulary prescriptions dispensed;
    3. Cost of formulary prescriptions;
    4. Cost of non-formulary prescriptions.

MMP Specific Core Reporting Requirements – Calendar Year 2015

Introduction

The core reporting requirements section consists of measures developed for all capitated financial alignment demonstrations, including some modified Part C and D measures. State-specific appendices capture the reporting requirements specific to each state's demonstration. The core and state-specific measures supplement existing Medicare Part C and Part D reporting requirements, as well as measures that MMPs report via other vehicles or venues, such as HEDIS®, HOS, CAHPS® and state Medicaid agencies.[1,2] In addition, CMS and the states will 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.

Passive Enrollment and Stopping Enrollment

Under the capitated financial alignment model, demonstrations may allow for passive enrollment. During passive enrollment, MMPs must demonstrate adequate performance across a range of measures to remain eligible to receive passive enrollment of beneficiaries. Failure to adequately meet any single measure or set of measures may result in CMS and the state ceasing enrollment. CMS and each state, through the Contract Management Team (CMT), will have the option to discontinue passive enrollment for MMPs for various reasons, including for MMPs failing to completely and accurately report measures or to adequately meet performance standards.

Quality Withhold Measures

CMS and each state will also establish a set of quality withhold measures, and MMPs will be required to meet established thresholds. Throughout this document, these measures are marked with the following symbol for Demonstration Year 1 quality withhold measures: ([i]) and the following symbol for Demonstration Year 2 measures: ([ii]). MMPs may have state-specific exceptions to the quality withhold measure outlined in this document. Exceptions, and definitions of Demonstration Years, are noted in the state-specific appendices. Additional information on the withhold methodology can be found at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html.

[1] HEDIS® is a registered trademark of the National Committee of Quality Assurance (NCQA).
[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Reporting Phases

There are three distinct types of reporting phases for demonstration measures: "Implementation," "Ongoing," and "Continuous Reporting."

The Implementation phase corresponds with the initial months of the demonstration and will be further defined in the Introduction section of each state-specific appendix. Monitoring will be more intensive during this phase to allow CMS and the state to quickly become aware of any performance or access issues. MMPs will report measures on the Implementation reporting timeline only during the Implementation phase.

The Ongoing phase begins at the inception of the demonstration and continues for the life of the demonstration. MMPs will report measures on the Ongoing reporting timeline during the Ongoing phase. Note: Measures that have both an Implementation and Ongoing phase should be reported concurrently (e.g., Measure 2.1, Members with an assessment completed within 90 days of enrollment). MMPs will cease reporting on the Implementation reporting timeline once the Implementation phase is complete. Some measures do not include an Ongoing phase, meaning data are collected only during the Implementation phase.

Continuous Reporting measures will be reported at the same frequency for the duration of the demonstration. The first reporting period for these measures coincides with the first reporting period of the Ongoing and Implementation phases.

Reporting timelines are defined in terms of calendar days, not business days. If a reporting due date for any core measure falls on a weekend or a federal holiday, plans may submit data on the following business day, except for Part C or D required measures. Table 1 and Table 2 below are examples of reporting timelines that will be found throughout this document. The introduction of each state-specific appendix provides tables describing each state's Implementation, Ongoing, and Continuous Reporting periods.

Table 1. Sample Implementation and Ongoing reporting timeline

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
Example	Monthly, beginning after 90 days	Contract	Current Calendar 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**
Example	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

Table 2. Sample Continuous Reporting timeline

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
Example	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

Measure Specifications

Each measure specification includes information regarding the following subjects:

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.

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.

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

D. Analysis - how CMS will evaluate reported data, as well as how other data sources may be monitored.

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

F. Data Submission - how MMPs will submit data collected to CMS and the state.

Hybrid Sampling

Some demonstration-specific measures may require medical record/supplemental documentation review to identify the numerator. In these instances, the sample size should be 411, plus additional records to allow for substitution. Sampling should be systematic to ensure that all individuals eligible for a measure have an equal chance of inclusion.

MMPs should complete the following steps for each measure that requires medical record review:

Step 1: Determine the eligible population. Create a list of eligible members, including full name, date of birth, and event (if applicable).

Step 2: Determine the final sample size. The final sample size will be 411 plus an adequate number of additional records to make substitutions. Oversample only enough to guarantee that the targeted sample size of 411 is met. The following oversampling rates are acceptable: 5 percent, 10 percent, 15 percent, or 20 percent. If oversampling, round up to the next whole number when determining the final sample size.

Step 3: If the eligible population exceeds the final sample size as determined in Step 2, proceed to Step 5. If the eligible population is less than or equal to the final sample size as determined in Step 2, proceed to Step 4.

Step 4: If the eligible population is less than or equal to the final sample size as determined in Step 2, the sample size can be reduced from 411 cases to a reduced final sample size by using the following formula:

$$Reduced\ Final\ Sample\ Size = \frac{\text{Original Final Sample Size}}{1 + \left(\frac{Original\ Final\ Sample\ Size}{Eligible\ Population}\right)}$$

Where the *Original Final Sample Size* is the number derived from Step 2, and the *Eligible Population* is the number derived from Step 1.

Step 5: Sort the list of eligible members in alphabetical order by last name, first name, date of birth and event (if applicable). Sort this list by last name from A to Z during even reporting periods and from Z to A in odd reporting periods (i.e., name will be sorted from A to Z in 2014, 2016, and 2018 and from Z to A in 2015, 2017, and 2019.
Note: Sort order applies to all components. For example, for reporting period 2014, the last name, first name, date of birth, and events will be ascending.

Step 6: Calculate *N*, which will determine which member will start your sample. Round down to the nearest whole number.

$$N = \frac{\text{Eligible Population}}{\text{Final Sample Size}}$$

Where the *Eligible Population* is the number derived from Step 1. The *Final Sample Size* is either:

- The number derived from Step 2, for instances in which the eligible population exceeds the final sample size as determined in Step 2.
  OR
- The number derived in Step 4, for instances in which the eligible population was less than or equal to the number derived from Step 2.

Step 7: Randomly select starting point, *k*, by choosing a number between one and N using a table of random numbers or a computer-generated random number.

Step 8: Select every *kth* record thereafter until the selection of the sample size is completed.

Section I. Access

1.1 Claims (excluding pharmacy point of sale [POS]) denied during the first 90 days of enrollment with the MMP, by reason for denial. ***– Suspended for 2015***

1.2 Pharmacy point-of-sale (POS) claims denied during passive enrollment, by reason for denial.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
1. Access	Every 14 days during the first month of a wave of passive (subsequent submissions may be necessary for MMPs that meet or exceed the threshold)	Contract	14 days Ex: 12:00a.m. on January 1st through 11:59p.m. on January 14th and 12:00a.m. on January 15th through 11:59p.m. on January 28th.	5:00p.m. ET three days following the end of the reporting period Ex: Data is due by 5:00p.m. ET on January 17th for the reporting period that ends at 11:59p.m. ET on January 14th. Data is due by 5:00p.m. ET on January 31st for the reporting period that ends at 11:59p.m. ET on January 28th.

The list of pharmacy POS denied claims will be limited to claims denied for the following reasons: non-formulary, prior authorization, and step therapy. A template for providing these claims is located at the CMS Financial Alignment website:

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

A. Data elements definitions-details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

- Required file format is Microsoft Excel file.
- The file name extension should be ".xlsx"
- File name= RX_(STATEABBREVIATION)_(CONTRACTID)_(REPORTING PERIOD)_(SUBMISSIONDATE).xlsx.

- Replace (STATEABBREVIATION) with the two-character state abbreviation (e.g., Massachusetts is MA), (CONTRACTID) with the contract ID, (REPORTINGPERIOD) with the month and year of the beginning of the reporting period in YYYYMM format (e.g., February 2014 would be 201402), and (SUBMISSIONDATE) with the year, month, and day of the submission in YYYYMMDD format (e.g., March 31, 2014 would be 20140331).
- The first worksheet in the template should be named "Rejected Claims."
- The second worksheet in the template should be named "Key Acronyms."
- The third worksheet in the template should be named "Addl Reject Codes_Pharmacy Msgs."

File Layout

Field Name	Field Description	Allowable Values
HICN	Health insurance claim number (HICN) refers to the number assigned by the Social Security Administration to an individual for the purpose of identifying him/her as a Medicare beneficiary. HICN will be shown in the beneficiary's insurance card and it is on the basis of this number that a beneficiary's Medicare claims are processed.	Field Type: Alpha-numeric
Member Enrollment Date	Identifies the date that each member enrolled. Enrollment eligibility begins on the 1st of the month. If a member has a gap in coverage, provide the most recent enrollment date.	Field Type: Date in MM/DD/YYYY format
Member Disenrollment Date	Identifies the date that each member disenrolled. Eligibility continues through the last day of the month that the member disenrolls.	Field Type: Date in MM/DD/YYYY format If a member is still enrolled during the reporting period, please insert 12/31/9999 to indicate the member is currently enrolled.
Cardholder ID	Insurance ID assigned to the cardholder or identification number used by the MMP. May be the same as HICN.	Field Type: Alpha-numeric
CCN	Claim Control Number (CCN). A claim control number is a unique number given to each claim.	Field Type: Alpha-numeric
CMS Contract ID	Designation assigned by CMS that identifies a specific sponsor.	Field Type: Alpha-numeric
Plan Name	Plan Name	Field Type: Text

Field Name	Field Description	Allowable Values
NDC 11 (no hyphens)	National Drug Code Drug products are identified and reported using a unique, three-segment number, called the National Drug Code (NDC), which serves as a universal product identifier for drugs. FDA publishes the listed NDC numbers and the information submitted as part of the listing information in the NDC.	Field Type: Numeric Note: 11-digit NDC code with no hyphens
Date of Service	Identifies date the prescription was filled. This date may be outside the reporting period as long as the associated Date of Rejection is after the Date of Service.	Field Type: Date in MM/DD/YYYY Format
Date of Rejection	Identifies the date the claim was rejected. The Date of Rejection must occur during the reporting period.	Field Type: Date in MM/DD/YYYY Format
Claim Quantity	Quantity dispensed expressed in metric decimal units.	Field Type: Numeric Allowable Values: >0
Claim Days Supply	Estimated number of days the prescription will last.	Field Type: Numeric Allowable Values: >0; < 999
Compound Code	Code indicating whether or not the prescription is a compound.	Field Type: Numeric Allowable Values: 0 = not specified 1 = not a compound 2 = compound
Rejection Category (1=NF, 2=PA, 3=ST)	Rejection Category: Use category 1 if the rejection is for Non-Formulary drug. Use category 2 if the rejection is for Prior Authorization. Use category 3 if the rejection is for Step Therapy.	Field Type: Numeric Allowable Values: 1=Non-Formulary 2=Prior Authorization 3=Step Therapy
Reject Code 1	Reject code used in MMP's claim adjudication system.	Field Type: Alpha-numeric
Pharmacy Message 1	Reject Message used in MMP's claim adjudication system.	Field Type: Text
Reject Code 2	Reject code used in MMP's claim adjudication system.	Field Type: Alpha-numeric
Pharmacy Message 2	Reject Message used in MMP's claim adjudication system.	Field Type: Text
Reject Code 3	Reject code used in MMP's claim adjudication system.	Field Type: Alpha-numeric
Pharmacy Message 3	Reject Message used in MMP's claim adjudication system.	Field Type: Text

Field Name	Field Description	Allowable Values
MMP must provide all reject codes and messaging, not limited to the number of fields in the "Rejected Claims" template. Please insert columns in the "Add'l Reject Codes_Pharmacy Msgs" template as necessary.	Provide any additional reject codes and messaging.	

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.

- An audit of a sample of claims will be performed. Claims not excluded from the analysis will be flagged as "potentially inappropriate." A sample of up to 30 potentially inappropriate claims will be selected for further review, including: protected class drugs and non-protected class drugs. If at least 15 protected and 15 non-protected class drugs are submitted, 15 protected and 15 non-protected class drugs will be sampled. If fewer than 15 claims are submitted in either drug class, additional claims from the opposing drug class will be selected, until a sample of 30 is reached (e.g., 13 protected and 17 non-protected drugs). If the plan submits fewer than 30 rejected claims, the sample will consist of all submitted rejected claims. MMPs will be required to review claims and address the following:
    - Was this claim was an appropriate Rejection (Y/N).
    - Patient setting (e.g., nursing facility, acute care hospital, etc.).
    - Patient DOB.
    - Provide a brief explanation as to why the claim was appropriate or inappropriate, related to one of the three rejection categories.
    - Was the claim paid (Y/N).
    - If the claim was paid, provide the date the claims was paid for the drug in question.

C. Edits and Validation checks - validation checks that should be performed by each MMP prior to data submission. Any claims that do not pass validation will be excluded from the analysis. These checks will include the following:

- The CMS Contract ID is formatted as 5 alpha-numeric characters.
- The CMS Contract ID matches the submitting Contract ID.
- The NDC consists of 11 numeric characters.
- The NDC is a valid NDC.
- The Date of Service is in the MM/DD/YYYY format.
- The Date of Rejection is in the MM/DD/YYYY format.
- The Date of Rejection is during the reporting period.
- The Date of Rejection is on or after the Date of Service.
- The Rejection Category is 1, 2, or 3.

- The Claim Quantity is greater than zero.
- The Claim Days Supply is greater than zero.
- The Claim Days Supply is between 1 and 3 numeric characters (1-999).

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 calculate an overall score once MMPs have reviewed and provided comments.
    - For all class drugs, the number of inappropriate denials (numerator) will be divided by the total number of potentially inappropriate claims sampled (denominator) to calculate an overall rate of inappropriate denials.
    - For protected class drugs, the number of inappropriate denials (numerator) will be divided by the total number of potentially inappropriate claims for protected class drugs sampled (denominator) to calculate an overall rate of inappropriate denials.
    - For non-protected class drugs, the number of inappropriate denials (numerator) will be divided by the total number of potentially inappropriate claims for non-protected class drugs sampled (denominator) to calculate an overall rate of inappropriate denials.

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

- Reporting timelines are defined in terms of calendar days, not business days. If a reporting due date for Core measure 1.2 falls on a weekend or holiday, MMPs may submit data on the following business day.
- This measure assesses only the following three denial types: non-formulary, prior authorization, and step therapy.
    - Non-formulary drugs are drugs that are not on an MMP's formulary.
    - Prior Authorization is defined as Approval that a member must get from the MMP before filling a prescription in order for the MMP to cover the prescription. The MMP may require prior authorization for certain drugs.
    - Step Therapy is a coverage rule used by some MMPs that requires a member to try one or more similar, lower cost drugs to treat their condition before the MMP will cover the prescribed drug.
- The reporting period for this measure will begin at the start of the passive enrollment period. Once reporting begins, members should be included regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- Passive enrollment periods may vary by state. MMPs should refer to their state's three-way contract for specific requirements.
- CMS reserves the right to extend the reporting frequency after the first two waves of passive enrollment, if necessary.

- MMPs should include all denied claims including adjusted and reprocessed claims, even if repeated claims are attempted on the same day.
- Date of Rejection must occur within the reporting period, but it is acceptable if the Date of Service is outside of the reporting period as long as the Date of Rejection is after the Date of Service.
- Denials ensuing from requests for early refills should be excluded.
- Subsequent 14 day submissions may be necessary for MMPs that meet or exceed the threshold or have an insufficient sample size. MMPs will receive a MMP-specific report indicating whether a MMP passed, failed, or had an insufficient sample size following the full 28 day period. Any MMP that failed or had an insufficient sample size, must undergo another round and must submit data during the next wave of passive. For MMPs in states with monthly passive enrollment, the MMP must report the last 14 days of the next month of passive (e.g., for MMPs that start passive April 1, 2014, a subsequent submission will be May 15 – 28th). For MMPs with passive that is not month to month, the MMP must submit the first 14 days of the next wave of passive. MMPs that pass the first 28 day period will not need a subsequent round of review.

F. Data Submission - how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for 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://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

Section II. Assessment

2.1 Members with an assessment completed within 90 days of enrollment.[i]

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
2. Assessment	Monthly during the implementation period, beginning after 90 days of implementation	Contract	Current Calendar Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period Ex: Demo implementation is January 1, 2014; 90 days after enrollment is March 31, 2014; first report is due by April 30, 2014; the next report would be due May 31, 2014
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
2. 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 members whose 90th day of enrollment occurred within the reporting period.	Total number of members enrolled whose 90th day of enrollment occurred within the reporting period and who were currently enrolled at the end of the reporting period.	Field type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of members who are documented as unwilling to participate in the assessment within 90 days of enrollment.	Of the total reported in A, the number of members who are documented as unwilling to participate in the assessment and who never had an assessment completed within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members the MMP was unable to locate, following three attempts, within 90 days of enrollment.	Of the total reported in A, the number of members the MMP was unable to locate following three attempts, to participate in the assessment and who never had an assessment completed within 90 days of enrollment.	Field type: Numeric Note: Is a subset of A. Attempts must be documented and CMS and the state may validate this number.
D.	Total number of members with an assessment completed within 90 days of enrollment.	Of the total reported in A, the number of members with an assessment completed within 90 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.

- Guidance will be forthcoming on the established threshold for this measure.

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

- Confirm those data elements listed above as subsets of other elements.
- MMPs 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:

- Members who were unwilling to participate in the assessment and who never had an assessment completed within 90 days of enrollment.
- Members the MMP was unable to locate, following three attempts, to participate in the assessment and who never had an assessment completed within 90 days of enrollment.
- Members who had an assessment completed within 90 days of enrollment.

- Members that were willing to participate and who could be located who had an assessment completed within 90 days of enrollment (i.e., data element A minus data elements B and C will serve as the denominator).

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should only include those members who are currently enrolled as of the last day of the reporting period.
- The 90th day of enrollment should be based on each member's effective date of enrollment. For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months.
- The effective date of enrollment is the first date of the member's coverage through the MMP.
- If a member's assessment is in progress, but is not completed by the end of the reporting period, then the assessment should not be considered completed and, therefore, would not be counted in any data element during the reporting period.
- If the MMP makes only one or two attempts to contact a member to complete an assessment, and no assessment is completed by the end of the reporting period, then these attempts should not be included in data element C.
- The assessment for this measure should be the comprehensive health risk assessment. Some states may require an initial screen or assessment; these are not the focus of this measure.
- The specific requirements pertaining to an assessment may vary by state. MMPs should refer to their three-way contract for specific requirements.

F. Data Submission - how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

2.2 Members with an assessment completed.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
2. Assessment	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the 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 members with an assessment completed within the reporting period.	Total number of members with an assessment completed within the reporting period.	Field Type: Numeric
B.	Total number of members enrolled for 90 days or longer as of the last day of the reporting period.	Total number of members enrolled for 90 days or longer as of the last day of the reporting period.	Field type: Numeric Note: This data element should not be reported until 90 days after implementation.
C.	Total number of members enrolled for 90 days or longer who had an assessment completed.	Of the total reported in B, the number of members enrolled for 90 days or longer who had an assessment completed.	Field type: Numeric Note: Is a subset of B. Note: This data element should not be reported until 90 days after implementation.

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 MMPs over time, CMS and the state will apply threshold checks.

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

- Confirm those data elements listed above as subsets of other elements.
- MMPs 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 obtain enrollment data to evaluate the percentage of members:

- Who had an assessment completed within the reporting period.
- Enrolled for 90 days or longer as of the last day of the reporting period who had an assessment completed.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members 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 members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The 90th days of enrollment should be based on each member's effective date of enrollment. For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months.
- The effective date of enrollment is the first date of the member's coverage through the MMP.
- The specific requirements pertaining to an assessment may vary by state. MMPs should refer to their three-way contract for specific requirements.
- The assessment for this measure should be the comprehensive health risk assessment. Some states may require an initial screen or assessment; these are not the focus of this measure.
- Data element A will be reported after the first month following the beginning of the Implementation period, whereas data elements B and C will not be reported until after 90 days.
- The assessments reported in element C could have been completed at any time, not necessarily during the reporting period.

F. Data Submission - how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

2.3 Members with an annual reassessment.

CONTINUOUS				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
2. 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 members eligible for an annual health risk reassessment (HRA).	Total number of members eligible for an annual HRA during the reporting period.	Field Type: Numeric
B.	Total number of annual reassessments completed.	Of the total reported in A, the number of annual reassessments completed 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 MMPs over time, CMS and the state will apply threshold checks.

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

- Confirm those data elements listed above as subsets of other elements.
- MMPs 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 obtain enrollment data to evaluate the percentage of members who had a reassessment completed during the reporting period.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Section A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The effective date of enrollment is the first date of the member's coverage through the MMP.
- The specific requirements pertaining to an assessment may vary by state. MMPs should refer to their three-way contract for specific requirements.
- The assessment for this measure should be the comprehensive health risk assessment. Some states may require an initial screen or assessment; these are not the focus of this measure.
- For reporting data element A, report all members in the same MMP who:
    - Received a reassessment HRA within 365 days of their last HRA (initial or reassessment).
    - Were enrolled for 365 days continuously after their initial HRA or their last reassessment HRA and did not receive a reassessment HRA within 365 days
    - Did not receive an initial HRA within 90 days of enrollment and reached the threshold of 365 days of continuous enrollment after initial enrollment without receiving a reassessment HRA.
- Exclusions:
    - Members with a documented initial HRA under that plan prior to the measurement year. Excludes new members who disenrolled from the plan within 90 days of enrollment, if they did not receive an initial HRA prior to disenrolling.
- For reporting data element B, include reassessments completed within 365 days of last HRA (initial or reassessment HRA) for eligible members. Data element B also includes "first time" assessments occurring within 365 days of initial enrollment on members continuously enrolled up to 365 days from enrollment date without having received an initial HRA.

F. Data Submission - how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

Section III. Care Coordination

3.1 Members, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted within 24 hours of discharge to the facility or primary care provider or other health care professional designated for follow-up care. (modified from NQF #0648)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
3. Care Coordination	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 members, regardless of age, discharged from an inpatient facility to home/self-care or any other sites of care.	Total number of members, regardless of age, discharged from an inpatient facility (hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home/self-care or any other sites of care during the reporting period.	Field Type: Numeric
B.	Total number of members sampled that met inclusion criteria.	Of the total reported in A, the number of members sampled that met inclusion criteria.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.	Of the total reported in B, the number of members for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.	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 MMPs over time, CMS and the state will apply threshold checks.

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

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A and greater than or equal to 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 members, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Section A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The primary care provider (PCP) or other health care professional designated for follow-up care may be the designated primary care physician, medical specialist, or other physician or health care professional.
- Transition record may be transmitted to the facility or physician or other health care professional designated for follow-up care via fax, secure e-mail, or mutual access to an electronic health record (EHR).
- A transition record is defined as a core, standardized set of data elements related to patient's diagnosis, treatment, and care plan that is discussed with and provided to patient in printed or electronic format at each transition of care, and transmitted to the facility/physician/other health care professional providing follow-up care. Electronic format may be provided only if acceptable to patient.
- MMPs may use sampling for this measure since documentation review is required to identify the numerator. Sampling should be systematic to

ensure all eligible individuals have an equal chance of inclusion. The sample size should be 411, plus oversample to allow for substitution.

- Refer to the codes provided in Table 1 to identify total members discharged from an inpatient facility. To determine the numerator, MMPs may need to obtain medical records from the discharge facility for each member within the sample to verify if a transition record was transmitted. However, MMPs could also consider tracking or receiving transition records. MMPs have a contractual and financial interest in ensuring that transitions are performed appropriately. The intent of using this measure and modifying it to apply to MMPs was not to have health plans audit its facilities, but rather to encourage MMPs to participate in the transition and discharge planning and potentially receive the transition plan as part of its care coordination efforts. In contrast to the original 2014 reporting specification, this measure has been revised to be reported annually to reduce auditing burdens for those MMPs that still need to audit; however, MMPs should consider mechanisms for tracking beneficiaries' transitions such that they also receive the transition plan or confirmation that the transition plan was sent.
- If MMPs do not elect to sample, data element B should be equal to data element A.
- MMP should exclude patients who died and patients who left against medical advice or discontinued care. Codes to identify exclusions are provided in Table 2.
- If a discharge occurs on the last day of the report period, look 1 day past the end of the reporting period to identify if a transition record was transmitted within 24 hours.

Table 1: Codes to Identify Members Discharged from an Inpatient Facility

Type of Bill Codes		Discharge Status		Revenue Code
0111, 0121, 0114, 0124, 0211, 0214, 0221, 0224, 0281, 0284	***AND***	01, 02, 03, 04, 05, 06, 43, 50, 51, 61, 62, 63, 64, 65, 66, 70		
0131, 0134	***AND***	01, 02, 03, 04, 05, 06, 43, 50, 51, 61, 62, 63, 64, 65, 66, 70	***AND***	0762, 0490, 0499

Table 2: Codes to Identify Exclusions

UB-04
07, 20, 40, 41, 42

F. Data Submission - how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

Section IV. Enrollee Protections

4.1 Part D appeals. – ***Suspended for 2015***; See Part D Reporting Requirements Section VI – Coverage Determinations and Redeterminations for required reporting.

4.2 Grievances and Appeals.

IMPLEMENTATION					
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**	**Data Elements**
4. Enrollee Protections	Monthly	Contract	Current Calendar Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period	A1-B2
ONGOING					
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**	**Data Elements**
4. Enrollee Protections	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	A1-L3

Note: Plans should report all non-Part D (i.e., Part C and Medicaid) grievances and appeals for data elements A-L, in addition to reporting the already required Medicare Part C and D appeals and grievances as follows:

- Part D grievances are reported according to Part D reporting requirements (see Part D Section V Grievances on page 26 above);
  Part C grievances are also reported through Part C reporting requirements (see Section V Grievances on page 7 above); and Plans will continue to report appeals data consistent with Medicare Part C Reporting Requirements (see Part C Section VI Organization Determinations/Reconsiderations on page 11 above).

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.

Grievances

Element Letter	Element Name	Definition	Allowable Values
A1.	Inability to get an appointment with a primary care provider (PCP) – Total number of grievances.	The number of grievances related to an inability to get an appointment with a PCP.	Field Type: Numeric Is based on the date the decision was made.
A2.	Inability to get an appointment with a primary care provider (PCP) – Number of grievances for which the MMP provided timely notification of its decision.	The number of grievances related to an inability to get an appointment with a PCP that resulted in timely notification of decision.	Field Type: Numeric. Is a subset of A1. See Part C reporting requirements on page 6 above for definition of timely grievance notification.
B1.	Inability to get an appointment with a specialist – Total number of grievances.	The number of grievances related to an inability to get an appointment with a specialist.	Field Type: Numeric Is based on the date the decision was made.
B2.	Inability to get an appointment with a specialist – Number of grievances for which the MMP provided timely notification of its decision.	The number of grievances related to an inability to get an appointment with a specialist that resulted in timely notification of decision.	Field Type: Numeric. Is a subset of B1. See Part C reporting requirements on page 6 above for definition of timely grievance notification.
C1.	Excessive wait time to get an appointment with a PCP – Total number of grievances.	The number of grievances related to excessive wait time to get an appointment with a PCP.	Field Type: Numeric Is based on the date the decision was made.

Element Letter	Element Name	Definition	Allowable Values
C2.	Excessive wait time to get an appointment with a PCP – Number of grievances for which the MMP provided timely notification of its decision.	The number of grievances related to excessive wait time to get an appointment with a PCP that resulted in timely notification of decision.	Field Type: Numeric. Is a subset of C1. See Part C reporting requirements on page 6 above for definition of timely grievance notification.
D1.	Excessive wait time to get an appointment with a specialist – Total number of grievances.	The number of grievances related to excessive wait time to get an appointment with a specialist.	Field Type: Numeric Is based on the date the decision was made.
D2.	Excessive wait time to get an appointment with a specialist – Number of grievances for which the MMP provided timely notification of its decision.	The number of grievances related to excessive wait time to get an appointment with a specialist that resulted in timely notification of decision.	Field Type: Numeric. Is a subset of D2. See Part C reporting requirements on page 6 above for definition of timely grievance notification.
E1.	Other grievances related to areas not mentioned above – Total number of grievances.	The number of grievances related to other grievances related to areas not mentioned above.	Field Type: Numeric Is based on the date the decision was made.
E2.	Other grievances related to areas not mentioned above – Number of grievances for which the MMP provided timely notification of its decision.	The number of grievances related to other grievances related to areas not mentioned above that resulted in timely notification of decision.	Field Type: Numeric. Is a subset of E1. See Part C reporting requirements on page 6 above for definition of timely grievance notification.

Appeals

Element Letter	Element Name	Definition	Allowable Values
F1.	Denial or limited authorization of specialty services – Fully Favorable.	The number of appeals related to denial or limited authorization of specialty services for which the MMP Coverage Decision or Reconsideration was fully favorable.	Field Type: Numeric The sum of data elements F1, F2, and F3 should equal the total number of appeals related to denial or limited authorization of specialty services.
F2.	Denial or limited authorization of specialty services – Partially Favorable.	The number of appeals related to denial or limited authorization of specialty services for which the MMP Coverage Decision or Reconsideration was partially favorable.	Field Type: Numeric
F3.	Denial or limited authorization of specialty services – Adverse.	The number of appeals related to denial or limited authorization of specialty services for which the MMP Coverage Decision or Reconsideration was adverse.	Field Type: Numeric
G1.	Denial or limited authorization of LTSS services – Fully Favorable.	The number of appeals related to denial or limited authorization of LTSS services (total) for which the MMP Coverage Decision or Reconsideration was fully favorable.	Field Type: Numeric The sum of data elements G1, G2, and G3 should equal the total number of appeals related to denial or limited authorization of LTSS services.
G2.	Denial or limited authorization of LTSS services – Partially Favorable.	The number of appeals related to denial or limited authorization of LTSS services (total) for which the MMP Coverage Decision or Reconsideration was partially favorable.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
G3.	Denial or limited authorization of LTSS services – Adverse.	The number of appeals related to denial or limited authorization of LTSS services (total) for which the MMP Coverage Decision or Reconsideration was adverse.	Field Type: Numeric
H1.	Denial or limited authorization of HCBS services – Fully Favorable.	The number of appeals related to denial or limited authorization of HCBS services for which the MMP Coverage Decision or Reconsideration was fully favorable.	Field Type: Numeric Note: Is a subset of G1. The sum of data elements H1, H2, and H3 should equal the total number of appeals related to denial or limited authorization of HCBS services.
H2.	Denial or limited authorization of HCBS services – Partially Favorable.	The number of appeals related to denial or limited authorization of HCBS services for which the MMP Coverage Decision or Reconsideration was partially favorable.	Field Type: Numeric Note: Is a subset of G2.
H3.	Denial or limited authorization of HCBS services – Adverse.	The number of appeals related to denial or limited authorization of HCBS services for which the MMP Coverage Decision or Reconsideration was adverse.	Field Type: Numeric Note: Is a subset of G3.
I1.	Denial or limited authorization of institutional services – Fully Favorable.	The number of appeals related to denial or limited authorization of institutional services for which the MMP Coverage Decision or Reconsideration was fully favorable.	Field Type: Numeric Note: Is a subset of G1. The sum of data elements I1, I2, and I3 should equal the total number of appeals related to denial or limited authorization of institutional services.

Element Letter	Element Name	Definition	Allowable Values
I2.	Denial or limited authorization of institutional services – Partially Favorable.	The number of appeals related to denial or limited authorization of institutional services for which the MMP Coverage Decision or Reconsideration was partially favorable.	Field Type: Numeric Note: Is a subset of G2.
I3.	Denial or limited authorization of institutional services – Adverse.	The number of appeals related to denial or limited authorization of institutional services for which the MMP Coverage Decision or Reconsideration was adverse.	Field Type: Numeric Note: Is a subset of G3.
J1.	Denial or limited authorization of mental health services – Fully Favorable.	The number of appeals related to denial or limited authorization of mental health services for which the MMP Coverage Decision or Reconsideration was fully favorable.	Field Type: Numeric The sum of data elements J1, J2, and J3 should equal the total number of appeals related to denial or limited authorization of mental health services.
J2.	Denial or limited authorization of mental health services – Partially Favorable.	The number of appeals related to denial or limited authorization of mental health services for which the MMP Coverage Decision or Reconsideration was partially favorable.	Field Type: Numeric
J3.	Denial or limited authorization of mental health services – Adverse.	The number of appeals related to denial or limited authorization of mental health services for which the MMP Coverage Decision or Reconsideration was adverse.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
K1.	Denial or limited authorization of substance use treatment services – Fully Favorable.	The number of appeals related to denial or limited authorization of substance use treatment services for which the MMP Coverage Decision or Reconsideration was fully favorable.	Field Type: Numeric The sum of data elements K1, K2, and K3 should equal the total number of appeals related to denial or limited authorization of substance use treatment services.
K2.	Denial or limited authorization of substance use treatment services – Partially Favorable.	The number of appeals related to denial or limited authorization of substance use treatment services for which the MMP Coverage Decision or Reconsideration was partially favorable.	Field Type: Numeric
K3.	Denial or limited authorization of substance use treatment services – Adverse.	The number of appeals related to denial or limited authorization of substance use treatment services for which the MMP Coverage Decision or Reconsideration was adverse.	Field Type: Numeric
L1.	Other appeals related to areas not mentioned above – Fully Favorable.	The number of appeals related to other appeals related to areas not mentioned above (includes all Medicare and Medicaid demonstration related appeals) for which the MMP Coverage Decision or Reconsideration was fully favorable.	Field Type: Numeric The sum of data elements L1, L2, and L3 should equal the total number of appeals related to denial or limited authorization services not mentioned above.

Element Letter	Element Name	Definition	Allowable Values
L2.	Other appeals related to areas not mentioned above – Partially Favorable.	The number of appeals related to other appeals related to areas not mentioned above (includes all Medicare and Medicaid demonstration related appeals) for which the MMP Coverage Decision or Reconsideration was partially favorable.	Field Type: Numeric
L3.	Other appeals related to areas not mentioned above – Adverse.	The number of appeals related to other appeals related to areas not mentioned above (includes all Medicare and Medicaid demonstration related appeals) for which the MMP Coverage Decision or Reconsideration was adverse.	Field Type: Numeric

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 MMPs over time, CMS and the state will apply threshold checks.

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

- CMS and the state will evaluate denial or limited authorization rates per 1,000 enrollees and will trend rates from quarter to quarter and from previous year.
- 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 obtain enrollment information and will evaluate the following:
  - Number of grievances related to:
    1) Inability to get appointment with a PCP per 1,000 members.
    2) Inability to get appointment with a PCP that resulted in timely notification of decision per 1,000 members.
    3) Inability to get an appointment with a specialist per 1,000 members.
    4) Inability to get an appointment with a specialist that resulted in timely notification of decision per 1,000 members.
    5) Excessive wait time to get an appointment with a PCP per 1,000 members.
    6) Excessive wait time to get an appointment with a PCP that resulted in timely notification of decision per 1,000 members.
    7) Excessive wait time to get an appointment with a specialist per 1,000 members.
    8) Excessive wait time to get an appointment with a specialist that resulted in timely notification of decision per 1,000 members.
    9) Other grievances related to areas not mentioned above per 1,000 members.
    10) Other grievances related to areas not mentioned above that resulted in timely notification of decision per 1,000 members.
  - Number of appeals related to denial or limited authorization of:
    1) Specialty services for which the MMP coverage decision or reconsideration was fully favorable per 1,000 members.
    2) Specialty services for which the MMP coverage decision or reconsideration was partially favorable per 1,000 members.
    3) Specialty services for which the MMP coverage decision or reconsideration was adverse per 1,000 members.
    4) LTSS services (total) for which the MMP coverage decision or reconsideration was fully favorable per 1,000 members.
    5) LTSS services (total) for which the MMP coverage decision or reconsideration was partially favorable per 1,000 members.
    6) LTSS services (total) for which the MMP coverage decision or reconsideration was adverse per 1,000 members.
    7) HCBS services for which the MMP coverage decision or reconsideration was fully favorable per 1,000 members.
    8) HCBS services for which the MMP coverage decision or reconsideration was partially favorable per 1,000 members.
    9) HCBS services for which the MMP coverage decision or reconsideration was adverse per 1,000 members.
    10) Institutional services for which the MMP coverage decision or reconsideration was fully favorable per 1,000 members.

11) Institutional services for which the MMP coverage decision or reconsideration was partially favorable per 1,000 members.
12) Institutional services for which the MMP coverage decision or reconsideration was adverse per 1,000 members.
13) Mental health services for which the MMP coverage decision or reconsideration was fully favorable per 1,000 members.
14) Mental health services for which the MMP coverage decision or reconsideration was partially favorable per 1,000 members.
15) Mental health services for which the MMP coverage decision or reconsideration was adverse per 1,000 members.
16) Substance use treatment services for which the MMP coverage decision or reconsideration was fully favorable per 1,000 members.
17) Substance use treatment services for which the MMP coverage decision or reconsideration was partially favorable per 1,000 members
18) Substance use treatment services for which the MMP coverage decision or reconsideration was adverse per 1,000 members

- Number of appeals related to areas not mentioned above for which the MMP coverage decision or reconsideration was fully favorable per 1,000 members.
- Number of appeals related to areas not mentioned above for which the MMP coverage decision or reconsideration was partially favorable per 1,000 members.
- Number of appeals related to areas not mentioned above for which the MMP coverage decision or reconsideration was adverse per 1,000 members.

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

- This measure supplements existing Part C Reporting Requirements for MMPs related to grievances and appeals.
- The date the decision was made should be used to assess which reporting period the appeal or grievance should be reported.
- MMPs should refer to the explanatory notes in the Part C Reporting Requirements on page 7 above for further reporting information, including inclusion and exclusion criteria, definitions of timeliness and category assignments.
- One grievance involving multiple issues should be reported under each applicable category.
- If a member files a grievance and then files a subsequent grievance on the same issue prior to the organization's decision or deadline for decision notification (whichever is earlier), the issue is counted as one grievance.
- If a member files a grievance and then files a subsequent grievance on the same issue after the organization's decision or deadline for decision notification (whichever is earlier), the issue is counted as a separate grievance.

- There are no minimum enrollment criteria for these measures. All grievances and appeals should be reported regardless how long a member has been enrolled in the MMP or if they have disenrolled from the MMP.
- For reporting, MMPs should exclude grievances related to supplemental benefits as these are additional benefits provided by MMPs which are outside of reporting requirements.
- Long Term Services and Supports (LTSS) will be defined in the state-specific appendix.
- Specialty services are defined as any service or medical care provided or directed by a "specialist" (as opposed to a Primary Care Provider) that would not be a service offered by a Primary Care Provider or fitting into another category above. Note: Specialty service providers should include occupational/physical/speech therapy, dental, vision, transportation, and durable medical equipment.
- Primary Care Provider (PCP) will be defined in the state-specific appendix.

F. Data Submission - how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

Section V. Organizational Structure and Staffing

5.1 Care coordinator to member ratio.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
5. Organizational Structure and Staffing	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
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
5. Organizational Structure and Staffing	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 full time equivalent (FTE) care coordinators working on the Demonstration.	Total number of FTE care coordinators working on the Demonstration as of the last day of the reporting period.	Field Type: Numeric
B.	Total FTE care coordinators assigned to care management and conducting assessments.	Of the total reported in A, the number of FTE care coordinators assigned to care management and conducting assessments.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of newly hired FTE care coordinators (or those newly assigned to the MMP).	Of the total reported in A, the number of newly hired FTE care coordinators (or those newly assigned to the MMP) during the reporting period.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of FTE care coordinators that left the MMP.	Total number of FTE care coordinators that left the MMP during the reporting period.	Field type: Numeric

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 MMPs over time, CMS and the state will apply threshold checks.

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

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data elements B and C 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.

Note: This measure is not adjusted for case mix, plus care coordination will vary for each demonstration and each MMP's care plan model structure. Therefore, this measure will be used solely to track care coordination investments and changes in each MMP's care coordinator to member ratio longitudinally. CMS will compare each MMP's submitted staffing plan to the reported data elements.

CMS and the state will:

- Obtain enrollment data to evaluate the number of FTE care coordinators per enrollee.
- Evaluate the percentage of FTE care coordinators who were assigned to care management and conducting assessments.
- Evaluate the percentage of FTE care coordinators that left the MMP during the reporting period.

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

- Care coordinator will be defined in the state-specific appendix. Different terms may be used in different states.
- All part-time and full-time care coordinators will be counted, regardless of whether they are subcontracted or employed directly by the MMP.
- FTE is defined as full time equivalent. To calculate this, add up all of the care coordinators' work hours during the reporting period and divide this value by the number of normal working hours that occurred during the reporting period. In instances where care coordinators support multiple

lines of business, include only the time associated with the demonstration/MMP.

F. Data Submission - how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

5.2 Annual staffing worksheets. – ***Suspended for 2015***

5.3 Establishment of consumer advisory board or inclusion of consumers on a pre-existing governance board consistent with contractual requirements.[i]

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
5. Organizational Structure and Staffing	Annually	Contract	Calendar Year	By the end of the second month following the last day of the reporting period

MMPs will be required to submit information on each consumer advisory board and/or governance board during the annual reporting period. One template per meeting should be completed and submitted. A template for providing information is located at the CMS Financial Alignment website:

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

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.	Date.	Date each meeting occurred during the annual reporting period.	Field Type: N/A Note: Date in YYYYMMDD Format Note: MMPs should upload file to FTP site as a separate attachment.
B.	Name of board members invited.	Full names of all consumer advisory board/governance board members invited to the meeting.	Field Type: N/A Note: MMPs should upload file to FTP site as a separate attachment.

Element Letter	Element Name	Definition	Allowable Values
C.	Name of board members in attendance.	Full names of all consumer advisory board/governance board members in attendance either in-person or remotely.	Field Type: N/A Note: MMPs should upload file to FTP site as a separate attachment.
D.	Name of board members invited who are actual beneficiaries or family caregivers.	Full names of board members invited who are actual beneficiaries or family caregivers. Professional advocates should not be included unless they are also members or caregivers for members of the MMP.	Field Type: N/A Note: MMPs should upload file to FTP site as a separate attachment.
E.	Name of board members who are actual beneficiaries or family caregivers in attendance.	Full names of board members who are actual beneficiaries or family caregivers in attendance either in-person or remotely. Professional advocates should not be included unless they are also members or caregivers for members of the MMP.	Field Type: N/A Note: MMPs should upload file to FTP site as a separate attachment.
F.	Agenda.	Agenda for each meeting during the annual period.	Field Type: N/A Note: MMPs should upload file to FTP site as a separate attachment.
G.	Minutes.	Minutes for each meeting held during the annual reporting period.	Field Type: N/A Note: MMPs should upload file to FTP site as a separate attachment.

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 MMP prior to data submission.

- Meeting dates are within the performance period.

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 analyze attendance and participation of MMP members in board meetings.

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

- MMPs should submit one template per meeting.

F. Data Submission - how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for 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://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx
- Required File Format is Microsoft Word File.
- The file name extension should be ".docx"
- File name= (STATEABBREVIATION)_(CONTRACTID)_(REPORTING PERIOD)_(MEETINGDATE).docx.
- Replace (STATEABBREVIATION) with the two-character state abbreviation (e.g., Massachusetts is MA), (CONTRACTID) with the contract ID, (REPORTINGPERIOD) with the year and month of the beginning of the reporting period in YYYYMM format (e.g., February 2014 would be 201402), (MEETINGDATE) with the month, date, and year of the meeting in YYYYMMDD format (e.g., March 31, 2014 would be 21140331).

Section VI. Performance and Quality Improvement

6.1 Screening for Clinical Depression and Follow-up Plan. (modified from NQF #0418)[ii]

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
6. Performance and Quality Improvement	Annually	Contract	Calendar Year	June 30th of each year

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 members age 18 and older who had an outpatient visit.	Total number of members age 18 and older who had an outpatient visit during the reporting period.	Field Type: Numeric
B.	Total number of members age 18 and older screened for clinical depression using a standardized tool with appropriate follow-up plan documented.	Of the total reported in A, total number of members who were screened for clinical depression using a standardized tool during the reporting period, and if positive, a follow-up plan is documented on the date of the positive screen.	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 MMPs over time, CMS and the state will apply threshold checks.

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

- Confirm those data elements listed above as subsets of other elements.
- MMPs 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 members age:

- CMS and the state will evaluate the percentage of members screened for clinical depression using a standardized tool AND, if positive, whose follow-up plan was documented on the date of the positive screen during the reporting period.

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

- NOTE: CMS and States are still exploring whether or not medical record review should be included and required, in compliance with the Medicaid Adult Core Set, for this measure. MMCO will provide an update following receipt of and review of 2014 data received on this measure.
- MMPs should include all members, regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Section A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The date of encounter and screening must occur on the same date of service and if a member has more than one encounter during the reporting period, the member should be counted only once
- Refer to the codes provided in Table 3 to identify outpatient visits.
- Refer to the codes provided in Table 4 to identify a Clinical Depression Screen.
- Refer to the codes provided in Table 5 to identify exclusions.
- Screening refers to the completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition.
- A standardized tool refers to an assessment tool that has been appropriately normalized and validated for the population in which it is being utilized. Please see the Medicaid Adult Core Set located at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Medicaid-Adult-Core-Set-Manual.pdf for a list of acceptable depression screening tools.
- A follow-up plan refers to the proposed outline of treatment to be conducted as a result of a clinical depression screening. Follow-up for a positive depression screening much include one (1) or more of the following:
    - Additional evaluation
    - Suicide risk assessment
    - Referral to a practitioner who is qualified to diagnose and treat depression
    - Pharmacological interventions

- Other interventions or follow-up for the diagnosis or treatment of depression.

Table 3: Codes to Identify Outpatient Visits	
CPT	**HCPCS**
90791, 90792, 90832, 90834, 90837, 90839, 92557, 92567, 92568, 92625, 92626, 96150, 96151, 97003, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215	G0101, G0402, G0438, G0439, G0444

Table 4: Codes to Identify Clinical Depression Screen	
Code	**Description**
G8431	Positive screen for clinical depression using a standardized tool and a follow-up plan documented
G8510	Negative screen for clinical depression using standardized tool, patient not eligible/appropriate for follow-up plan documented

Table 5: Codes to Identify Exclusions	
Code	**Description**
G8433	Screening for clinical depression not documented, patient not eligible/appropriate
G8940	Screening for clinical depression documented, follow-up plan not documented, patient not eligible/appropriate

F. Data Submission - how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

Section VII. Provider Network

Guidance will be forthcoming for MMPs to annually report the Medicare provider and facility networks.

Section VIII. Systems

8.1 LTSS clean claims paid within 30 days, 60 days, and 90 days.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
8. Systems	Semi-Annual	Contract	Ex: 1/1-6/30 7/1-12/31	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 LTSS clean claims paid within the reporting period.	Total number of LTSS clean claims paid within the reporting period.	Field Type: Numeric
B.	Total number of clean claims paid within 30 calendar days of receipt.	Of the total reported in A, the number of clean claims paid within 30 calendar days of receipt.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of clean claims paid within 60 calendar days of receipt.	Of the total reported in A, the number of clean claims paid within 60 calendar days of receipt.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of clean claims paid within 90 calendar days of receipt.	Of the total reported in A, the number of clean claims paid within 90 calendar days of receipt.	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 MMPs over time, CMS and the state will apply threshold checks.

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

- Confirm those data elements listed above as subsets of other elements.
- MMPs 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 LTSS clean claims that were paid within:

- 30 calendar days of receipt.
- 60 calendar days of receipt.
- 90 calendar days of receipt.

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

- Long Term Services and Supports (LTSS) will be defined in the state-specific appendix.
- A “clean” claim is one that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.
- The 30, 60, and 90-day cutoffs should be calculated using individual calendar days, unlike core measures 2.1 and 2.2 where “90 days of enrollment” is considered equivalent to three full calendar months.
- MMPs should include LTSS clean claims if they were paid during the reporting period. LTSS clean claims submitted during the reporting period, but not paid during the reporting period, should not be included.

F. Data Submission - how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

Section IX. Utilization

9.1 Emergency room behavioral health services utilization.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
9. Utilization	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 behavioral health-related ED visits with a CPT or UB Revenue code for an emergency department visit and a principal diagnosis related to behavioral health	Total number of behavioral health-related ED visits with a CPT or UB Revenue code for an emergency department visit and a principal diagnosis related to behavioral health during the reporting period.	Field Type: Numeric

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 MMPs over time, CMS and the state will apply threshold checks.

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

- Data element should be a positive value.

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 obtain enrollment information to evaluate the total number of behavioral health-related ED visits per 1,000 members during the reporting period.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- MMPs should include all behavioral health-related ED visits for members who meet the criteria outlined in Section A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- Refer to the codes provided in Table 6 to identify emergency department visits.
- Refer to the codes provided in Table 7 to identify a behavioral health diagnosis.
- MMP should exclude members if they are admitted as inpatients.

Table 6: Codes to Identify ED Visits	
CPT	**UB Revenue**
99281-99285	045x, 0981

Table 7: Codes to Identify Behavioral Health Diagnosis
ICD-9 Principal Diagnosis
290, 293-302, 306-316

F. Data Submission - how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).

9.2 Nursing Facility (NF) Diversion.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
9. Utilization	Annually	Contract	Calendar Year, beginning 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 nursing home certifiable members who did not reside in a NF for more than 100 continuous days during the previous reporting period.	Total number of nursing home certifiable members who did not reside in a NF for more than 100 continuous days during the previous reporting period.	Field Type: Numeric
B.	Total number of members who did not reside in a NF for more than 100 continuous days during the current reporting period.	Of the total reported in A, the number of members who did not reside in a NF for more than 100 continuous days 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.

   a. CMS and the state will perform an outlier analysis.
   b. As data are received from MMPs over time, CMS and the state will apply threshold checks.

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

   - Confirm those data elements listed above as subsets of other elements.
   - MMPs 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.

- For members who did not reside in a NF for more than 100 continuous days during the ***previous*** reporting period, CMS and the state will evaluate the percentage of nursing home certifiable members who did not reside in a NF for more than 100 continuous days during the ***current*** reporting period.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- MMPs should include all members who meet the criteria outlined in Section A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- Nursing home certifiable members is defined as members living in the community, but requiring an institutional level of care. This definition may not align with the MMP's applicable state definition. MMP's should refer to their state's specific definition for additional information.
- A member must be enrolled in the MMP for 11 out of 12 months during the current reporting period to be included in this measure.
- A member must be Medicaid eligible for 11 out of 12 months during the previous reporting period to be included in this measure.
- Nursing facility services are provided by Medicaid, Medicare, or other state agencies certified nursing homes.
- Exclude members who expired during the reporting period. Codes to identify patients who have expired are provided in Table 8.
- This measure will not be reported until Calendar Year 2 (e.g., Calendar Year 2015 will be Calendar Year 2 for all MMPs whose demonstration effective enrollment date began in Calendar Year 2014).

Table 8: Codes to Identify Patients who Expired

Discharge Status Code
20

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

- MMPs will submit data collected for this measure through the Health Plan Management System (HPMS).