MEDICARE-MEDICAID CAPITATED FINANCIAL ALIGNMENT MODEL REPORTING REQUIREMENTS: CALIFORNIA-SPECIFIC REPORTING REQUIREMENTS

Effective as of _____, 2014, Issued _____, 2014

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Appendix 3. California-Specific Reporting Requirements

Appendix 3. California-Specific Reporting Requirements

Introduction

The measures within this appendix are required reporting for all MMPs in the California Capitated Demonstration. CMS reserves the right to update the measures in this appendix for subsequent demonstration years. These state-specific measures directly supplement the Medicare-Medicaid Capitated Financial Alignment: Core Reporting Requirements, which can be found at the following web address:

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

MMPs should refer to the core document for additional details regarding Demonstration-wide definitions, reporting phases and timelines, and sampling methodology.

The core and state-specific measures supplement existing Part C and Part D reporting requirements, as well as measures that MMPs report via other vehicles or venues, such as HEDIS®[1] and HOS. CMS and the states will also track key utilization measures, which are not included in this document, using encounter and claims data. The quantitative measures are part of broader oversight, monitoring, and performance improvement processes that include several other components and data sources not described in this document.

For the measures contained within the California state-specific appendix, plans will be requested to submit data at the county-level. Please refer to the Data Submission section on page CA-6 for additional information.

Definitions

Case Management, Information and Payrolling System II (CMIPS II): A system that tracks case information and processes payments for the California Department of Social Services In-Home Supportive Services Program, enabling nearly 400,000 qualified aged, blind, and disabled individuals in California to remain in their own homes and avoid institutionalization.

Individualized Care Plan (ICP or Care Plan): The plan of care developed by an Enrollee and/or an Enrollee's Interdisciplinary Care Team or health plan.

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

IHSS: Pursuant to Article 7 of California WIC (commencing with Section 12300) of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956.), California program that provides in-home care for people who cannot safely remain in their own homes without assistance. To qualify for IHSS, an Enrollee must be aged, blind, or disabled and, in most cases, have income below the level to qualify for the Supplemental Security Income/State Supplementary Program. IHSS includes the Community First Choice Option (CFCO), Personal Care Services Program (PCSP), and IHSS-Plus Option (IPO).

Implementation Period: The period of time starting with the first effective enrollment date until the end of the twelfth month of the demonstration.
Long Term Services and Supports (LTSS): A wide variety of services and supports that help people with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in California Welfare and Institutions Code section 14186.1, Medi-Cal covered LTSS includes all of the following:

1) In-Home Supportive Services (IHSS) provided pursuant to Article 7 of California Welfare and Institutions Code (commencing with Section 12300) of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956.)
2) Community-Based Adult Services (CBAS)
3) Multipurpose Senior Services Program (MSSP) services
4) Skilled nursing facility services and subacute care services

Primary Care Provider (PCP): A person responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining the continuity of patient care. A PCP may be a physician or non-physician medical practitioner.

Unmet Need: Documented unmet need is a recipient's total hours for non-Protective Supervision In-Home Supportive Services that are in excess of the statutory maximum.

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: ([i]). This document contains only Demonstration Year 1 (DY1) quality withhold measures. CMS will update the quality withhold measures for subsequent demonstration years closer to the start of Demonstration Year 2 (DY2). Additional information on the withhold methodology and benchmarks will be provided at a later time.

California Implementation, Ongoing, and Continuous Reporting Periods

Demonstration Year 1			
Phase		**Dates**	**Explanation**
Continuous Reporting	Implementation Period	4-1-14 through 3-31-15	From the first effective enrollment date through the end of the twelfth month of the demonstration.
	Ongoing Period	4-1-14 through 12-31-15	From the first effective enrollment date through the end of the first demonstration year.
Demonstration Year 2			
Continuous Reporting	Ongoing Period	1-1-16 through 12-31-16	From January 1st through the end of the second demonstration year.
Demonstration Year 3			
Continuous Reporting	Ongoing Period	1-1-17 through 12-31-17	From January 1st through the end of the third demonstration year.

Data Submission

All MMPs will submit data through an Excel template on a secure transmission site. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx.

The template is available for download at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html

MMPs should follow the instructions below on how to properly name each data file submitted:

- Required File Format is Microsoft Excel File.
- The file name extension should be ".xls"
- File name= CA_(CONTRACTID)_(REPORTING PERIOD)_(SUBMISSIONDATE).xls.

- Replace (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), and (SUBMISSIONDATE) the year, month, and date of the submission in YYYYMMDD format (e.g., March 30, 2014 would be 20140330).

Section CAI. Care Coordination

CA1.1 High risk members with an Individualized Care Plans (ICP) within 30 days after the completion of the Health Risk Assessment (HRA).

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA1. Care Coordination	Monthly, beginning after 75 days	County	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA1. Care Coordination	Quarterly	County	Current Quarter Ex: 1/1-3/31	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 high risk members enrolled whose 75th day of enrollment occurred within the reporting period.	Total number of high risk members enrolled whose 75th day of enrollment occurred within the reporting period.	Field Type: Numeric
B.	Total number of high risk members with a HRA completed.	Of the total reported in A, the number of high risk members with a HRA completed.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of high risk members who are documented as unwilling to complete an ICP within 30 days after the completion of the HRA.	Of the total reported in B, the number of high risk members who are documented as unwilling to complete an ICP within 30 days after the completion of the HRA.	Field Type: Numeric Note: Is a subset of B.

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of high risk members the MMP was unable to locate, following three documented attempts within 30 days after the completion of the HRA.	Of the total reported in B, the number of high risk members the MMP was unable to locate, following three documented attempts within 30 days after the completion of the HRA.	Field Type: Numeric Note: Is a subset of B.
E.	Total number of high risk members with an ICP completed within 30 days after the completion of the HRA	Of the total reported in B, the number of high risk members with an ICP completed within 30 days after the completion of the HRA.	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 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.
- MMPs should validate that data elements C, D, and E are less than or equal to data element B.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of high risk members who:

- Were unable to be located to have an ICP completed within 30 days after the completion of the HRA.
- Refused to have an ICP completed within 30 days after the completion of the HRA.
- Had an ICP completed within 30 days after the completion of the HRA.
- Were willing to participate and who could be located who had an ICP completed within 30 days after the completion of the HRA.

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.
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- The 75th day of enrollment should be based on each member's effective enrollment date. The 75 days reflect the 45 day requirement to complete the HRA for high risk members, plus the 30 day timeframe in which plans are required to complete the care plan for high risk members.
- The effective date of enrollment is the first date of the member's coverage through the MMP.
- MMPs should refer to CA's three-way contract for specific requirements pertaining to ICPs and HRAs.
- Failed attempts to contact members to complete an ICP must be documented and CMS and the state may validate this number.

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

CA1.2 Low risk members with an Individualized Care Plan (ICP) within 30 days after the completion of the Health Risk Assessment (HRA).

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA1. Care Coordination	Monthly, beginning after 120 days	County	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA1. Care Coordination	Quarterly	County	Current Quarter Ex: 1/1-3/31	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, including examples, methods for calculations, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of low risk members enrolled whose 120th day of enrollment occurred within the reporting period.	Total number of low risk members enrolled whose 120th day of enrollment occurred within the reporting period.	Field Type: Numeric
B.	Total number of low risk members with a HRA completed.	Of the total reported in A, the number of low risk members with a HRA completed.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of low risk members who are documented as unwilling to complete an ICP within 30 days after the completion of the HRA.	Of the total reported in B, the number of low risk members who are documented as unwilling to complete an ICP within 30 days after the completion of the HRA.	Field Type: Numeric Note: Is a subset of B.
D.	Total number of low risk members the MMP was unable to locate, following three documented attempts within 30 days after the completion of the HRA.	Of the total reported in B, the number of low risk members the MMP was unable to locate, following three documented attempts within 30 days after the completion of the HRA.	Field Type: Numeric Note: Is a subset of B.
E.	Total number of low risk members with an ICP completed within 30 days after the completion of the HRA.	Of the total reported in B, the number of low risk members with an ICP completed within 30 days after the completion of the HRA.	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 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.
- MMPs should validate that data elements C, D and E are less than or equal to data element B.
- All data elements should be positive values.

D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of low risk members who:

- Were unable to be located to have an ICP completed within 30 days after the completion of the HRA.
- Refused to have an ICP completed within 30 days after the completion of the HRA.
- Had an ICP completed within 30 days after the completion of the HRA.
- Were willing to participate and who could be located who had an ICP completed within 30 days after the completion of the HRA.

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.
- The 120th day of enrollment should be based on each member's effective enrollment date. The 120 days reflect the 90 day requirement to complete the HRA for low risk members, plus the 30 day timeframe in which plans are required to complete the care plan for low risk members.
- The effective date of enrollment is the first date of the member's coverage through the MMP.
- MMPs should refer to CA's three-way contract for specific requirements pertaining to ICPs and HRAs.
- Failed attempts to contact members to complete an ICP must be documented and CMS and the state may validate this number.

F. Data Submission – how MMPs will submit data collected to CMS.

- 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

CA1.3 Members with documented discussions of care goals.[i]

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA1. Care Coordination	Annually	County	Demonstration 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 with an Individualized Care Plan (ICP) developed.	Total number of members with an ICP developed during the reporting period.	Field Type: Numeric
B.	Total number of members with at least one documented discussion of care goals in the ICP.	Of the total reported in A, the number of members with at least one documented discussion of care goals in the ICP.	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 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 with an ICP developed in the reporting period who had at least one documented discussion of care goals in the ICP.

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.
- Development of the original care plan can be counted as a discussion of care goals if goals are clearly documented in the ICP.
- Documented discussions of care goals will be recorded in a member's Individualized Care Plan (ICP).

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

CA1.4 Members receiving Medi-Cal specialty mental health and/or drug Medi-Cal services receiving coordinated care plans as indicated by having an Individualized Care Plan (ICP) with the primary behavioral health provider.[i]

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA1. Care Coordination	Annually	County	Demonstration 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 receiving Medi-Cal specialty mental health and/or Drug Medi-Cal services.	Total number of members receiving Medi-Cal specialty mental health and/or Drug Medi-Cal services who have been continuously enrolled in the same Medi-Cal MediConnect plan for at least five months during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of members that have ICPs that indicate evidence of coordinated care planning with the primary behavioral health provider.	Of the total reported in A, the number of members who have ICPs that indicate evidence of coordinated care planning with the primary behavioral health provider.	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 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 receiving Medi-Cal specialty mental health and/or Drug Medi-Cal services who have care plans that indicate evidence of coordinated care planning with the primary behavioral health provider.

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.
- Evidence of coordinated care planning will be defined in the three-way contracts to mean that the member's Individualized Care Plan (ICP) includes all of the following:

    1. The name and contact information of the primary county or county-contracted behavioral health provider, and

2. Attestation[2] that the member, the county behavioral health provider, and the primary care provider have reviewed and approved the care plan, and
3. Record of at least one case review meeting that included the county behavioral health provider and includes date of meeting, names of participants, and evidence of creation or adjustment of care goals, as described in the plans' models of care reviewed and approved by NCQA.

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

CA1.5 Unmet Need in IHSS. (Please note: No plan reporting is required for this measure; CMS and the state will receive data from California Department of Social Services (CDSS).)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA1. Care Coordination	Annually	County	Demonstration Year, beginning in DY2	CMS and state will receive data from CDSS

CA1.6 IHSS case manager contact with member.[i] (Please note: No plan reporting is required for this measure; CMS and the state will receive data from California Department of Social Services (CDSS).)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA1. Care Coordination	Annually	County	Demonstration Year	CMS and state will receive data from CDSS

[2] The plans may determine the most feasible method of attestation, such as but not necessarily an electronic signature, an attached paper signature or a checked box. To check compliance DHCS would require supporting documentation in the form of written communication.

CA1.7 Satisfaction with case manager, home workers, personal care. (Please note: No plan reporting is required for this measure; CMS and the state will receive data from California Department of Social Services (CDSS).)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA1. Care Coordination	Annually	County	Demonstration Year, beginning in DY2	CMS and state will receive data from CDSS

CA1.8 Members with first follow-up visit within 30 days after discharge.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA1. Care Coordination	Quarterly	County	Current Quarter Ex: 1/1-3/31	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 hospital discharges.	Total number of hospital discharges during the reporting period.	Field Type: Numeric
B.	Total number of discharges that resulted in an ambulatory care follow-up visit within 30 days after discharge from the hospital.	Of the total reported in A, the number of discharges that resulted in an ambulatory care follow-up visit within 30 days after discharge from the hospital.	Field Type: Numeric Note: Is a subset of A.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from 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 discharges that resulted in an ambulatory care follow-up visit within 30 days after discharge from the hospital.

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.
- The date of discharge must occur within the reporting period, but the follow-up visit may not be in the same reporting period.
- If a discharge occurs during the last month of the reporting period, look 30 days past the last day of the reporting period to identify the follow-up visit.
- A follow-up visit is defined as an ambulatory care follow-up visit to assess the member's health following a hospitalization. Codes to identify follow-up visits are provided in Table CA-1.
- Codes to identify inpatient discharges are provided in Table CA-2.
- Exclude discharges in which the patient was readmitted within 30 days after discharge to an acute or non-acute facility.
- Exclude discharges due to death. Codes to identify patients who have expired are provided in Table CA-3.

Table CA-1: Codes to Identify Ambulatory Health Services

Description	CPT	HCPCS	ICD-9-CM Diagnosis	UB Revenue
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245			051x, 0520-0523, 0526-0529, 0982, 0983
Home services	99341-99345, 99347-99350			
Nursing facility care	99304-99310, 99315, 99316, 99318			0524, 0525
Domiciliary, rest home or custodial care services	99324-99328, 99334-99337			

Table CA-1: Codes to Identify Ambulatory Health Services				
Description	**CPT**	**HCPCS**	**ICD-9-CM Diagnosis**	**UB Revenue**
Preventive medicine	99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429	G0344, G0402, G0438, G0439		
Ophthalmology and optometry	92002, 92004, 92012, 92014			
General medical examination			V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	

Table CA-2: Codes to Identify Inpatient Discharges		
Principal ICD-9-CM Diagnosis		**MS-DRG**
001-289, 317-999, V01-V29, V40-V90	***OR***	001-013, 020-042, 052-103, 113-117, 121-125, 129-139, 146-159, 163-168, 175-208, 215-264, 280-316, 326-358, 368-395, 405-425, 432-446, 453-517, 533-566, 573-585, 592-607, 614-630, 637-645, 652-675, 682-700, 707-718, 722-730, 734-750, 754-761, 765-770, 774-782, 789-795, 799-804, 808-816, 820-830, 834-849, 853-858, 862-872, 901-909, 913-923, 927-929, 933-935, 939-941, 947-951, 955-959, 963-965, 969-970, 974-977, 981-989, 998, 999

WITH

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

Table CA-3: 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 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

CA1.9 Members who have a case manager and have at least one case manager contact during the reporting period.[i]

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA1. Care Coordination	Annually	County	Demonstration 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 who have/had a case manager.	Total number of members who have/had a case manager during the reporting period.	Field Type: Numeric
B.	Total number of members who had at least one case manager contact.	Of the total reported in A, the number of members who had at least one case manager contact.	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 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.
- 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 with a case manager who had at least one case manager contact 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.
- The member needs to be continuously enrolled for six months during the reporting period, with no gaps in enrollment.

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 CAII. Enrollee Protections

CA2.1 The number of critical incident and abuse reports for members receiving LTSS. (Please note: No plan reporting is required for this measure; CMS and the state will receive data from California Department of Social Services (CDSS).)

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA2. Enrollee Protections	Monthly	County	Current Month Ex: 1/1 – 1/31	CMS and state will receive data from CDSS
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA2. Enrollee Protections	Quarterly	County	Current Quarter Ex: 1/1-3/31	CMS and state will receive data from CDSS

Section CAIII. Organizational Structure and Staffing

CA3.1 MMPs with an established work plan and identification of an individual who is responsible for physical access compliance.[i]

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA3. Organizational Structure and Staffing	Semi-Annually	County	Ex: 1/1 – 6/30	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**
CA3. Organizational Structure and Staffing	Annually	County	Demonstration 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.	Established Work Plan.	Established Work Plan.	Field Type: N/A Note: File will be uploaded to FTP site as a separate attachment.
B.	Identification of the individual responsible for physical access compliance.	Identification of the individual responsible for physical access compliance.	Field Type: N/A Note: File will be uploaded 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.

    - To be determined.

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

    - To be determined.

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

    - To be determined.

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
    - For data submission, each data element above should be uploaded as a separate attachment.
    - Required File Format is Microsoft Word File.
    - The file name extension should be ".docx"
    - File name= CA_(CONTRACTID)_(REPORTING PERIOD)_(SUBMISSIONDATE)_(ELEMENTNAME).docx
    - Replace (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), (SUBMISSIONDATE) the year, month, and date of the submission in YYYYMMDD format (e.g., March 30, 2014 would be 20140330), and (ELEMENTNAME) with the element name listed below.
        1. For element letter "A", the (ELEMENTNAME) should be (PLAN).
        2. For element letter "B", the (ELEMENTNAME) should be (INDIVIDUAL).

CA3.2 Care coordinator training for supporting self-direction under the demonstration.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA3. Organizational Structure and Staffing	Annually	County	Demonstration 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 care coordinators.	Total number of care coordinators in the MMP during the reporting period.	Field Type: Numeric
B.	Total number of care coordinators that have undergone state-based training for supporting self-direction under the demonstration.	Of the total reported in A, the number of care coordinators that have undergone State-based training for supporting self-direction under the demonstration.	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 care coordinators that have undergone state-based training for supporting self-direction.

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

- MMPs should refer to CA's three-way contract for specific requirements pertaining to care coordinators.
- MMPs should refer to CA's three-way contract for specific requirements pertaining to training for supporting self-direction.
- Training for supporting self-direction is only required for new care coordinators who have not previously received the training.
- If a care coordinator was not currently with the MMP at the end of the reporting period, but was with the MMP for at least one quarter during the reporting period, they should be included in this measure.
- All full-time and part-time staff are included in the count of total number of care coordinators.

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 CAIV. Utilization

CA4.1 Reduction in emergency department use for seriously mentally ill and substance use disorder (SUD) members.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA4. Utilization	Annually	County	Demonstration Year, beginning in DY2	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 enrolled for at least five months, with an indication of either mental illness or substance use disorders (SUD).	Total number of members enrolled for at least five months during reporting period, with an indication of either serious smental illness or SUD problems during the 12 months prior to the reporting period.	Field Type: Numeric
B.	Total number of member months.	Of the total reported in A, the number of member months during the reporting period.	Field Type: Numeric
C.	Total number of ED visits.	Of the total reported in A, the number of ED visits 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.

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

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

- Each member should have a member month value between 5 and 12. A value greater than 12 is not acceptable.
- 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 number of ED visits per 1,000 member months.
- A 95 percent confidence interval will be set around the baseline utilization year, and future years will be compared against that 95 percent confidence interval to look for statistically significant changes:
    - Year 2 compared to baseline: Any statistically significant reduction.
    - Year 3 compared to baseline: A statistically significant reduction greater than in year 2.

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.
- Members diagnosed with mental illness (MI) *and/or* substance use disorders (SUD) should be included in this measure (i.e., members with both MI and SUD diagnoses should also be included).
- MMPs should exclude ED visits that resulted in a hospital admission. Refer to Table CA-4 for codes to identify ED visits.
- Member months refers to the number of months each Medicare-Medicaid member was enrolled in the MMP in the year. Each member should have a member month value between 5 and 12. A value greater than 12 is not acceptable. Determine member months using the 15th of the month. This date must be used consistently from member to member, month to month, and from year to year. For example, if Ms. X is enrolled in the organization on January 15, Ms. X contributes one member month in January.
- A member with MI is defined as someone with the following:
    - MI diagnosis in Medicare or Medicaid claims in the 12 months prior to the reporting period (Table CA-5).
- A member with substance use disorder (SUD) is defined as someone with ANY of the following:
    - SUD diagnosis in Medicare or Medicaid claims in the 12 months prior to the reporting period (Table CA-6).

- SUD treatment or detox in Medicare of Medicaid claims in the 12 months prior to the reporting period (Table CA-7 and Table CA-8).

Table CA-4: Codes to Identify ED Visits	
CPT Codes	**UB Revenue Codes**
99281-99285	045x, 0981

Table CA-5: Codes to Identify Mental Health Diagnosis
ICD-9-CM Diagnosis Codes
293-294, 294.8-302, 306-316

Table CA-6: Codes to Identify SUD Diagnosis
ICD-9-CM Diagnosis Codes
291-291.9, 303.00-303.02, 303.90-303.92, 304.00-304.02, 304.10-304.12, 304.20-304.22, 304.30-304.32, 304.40-304.42, 304.50-304.52, 304.60-304.62, 304.70-304.72, 304.80-304.82, 304.90-304.92, 305.00-305.02, 305.20-305.22, 305.30-305.32, 305.40-305.42, 305.50-305.52, 305.60-305.62, 305.70-305.72, 305.80-305.82, 305.90-305.92, 535.3, 571.1

Table CA-7: Codes to Identify Detoxification Visits		
HCPCS	**ICD-9-CM Procedure**	**UB Revenue**
H0008-H0014	94.62, 94.65, 94.68	0116, 0126, 0136, 0146, 0156

Table CA-8: Codes to Identify SUD Procedures
ICD-9-CM Procedure Codes
94.61, 94.63, 94.64, 94.66, 94.67, 94.69

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

CA4.2 In-Home Supportive Services (IHSS) utilization. (Please note: No plan reporting is required for this measure; CMS and the state will receive data from California Department of Social Services (CDSS).)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA4. Utilization	Annually	County	Demonstration Year	CMS and state will receive data from CDSS

CA4.3 Readmissions of short- and long-stay nursing facility residents after hospitalization for diabetes, chronic obstructive pulmonary disease (COPD) or any medical diagnosis.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
CA4. Utilization	Annually	County	Demonstration 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 short-term stay nursing facility (NF) residents.	Total number of short-term stay NF residents during the reporting period.	Field Type: Numeric
B.	Total number of short-term stay NF residents with diabetes.	Of the total reported in A, the number of short-term stay NF residents with diabetes.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of short-term stay NF residents with chronic obstructive pulmonary disease (COPD).	Of the total reported in A, the number of short-term stay NF residents with COPD.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of short-term stay NF residents transferred from the NF for any medical diagnosis to an acute care hospital and subsequently discharged back to the NF.	Of the total reported in A, the number of short-term stay NF residents transferred from the NF for any medical diagnosis to an acute care hospital and subsequently discharged back to the NF during the reporting period.	Field Type: Numeric Note: Is a subset of A.
E.	Total number of short-term stay NF residents with diabetes transferred from the NF to an acute care hospital for diabetes and who were subsequently discharged back to the NF.	Of the total reported in B, the number of short-term stay NF residents with diabetes transferred from the NF to an acute care hospital for diabetes and who were subsequently discharged back to the NF during the reporting period.	Field Type: Numeric Note: Is a subset of B. (Is also a subset of D).
F.	Total number of short-term stay NF residents with COPD transferred from the NF to an acute care hospital for COPD and who were subsequently discharged back to the NF.	Of the total reported in C, the number of short-term stay NF residents with COPD transferred from the NF to an acute care hospital for COPD and who were subsequently discharged back to the NF during the reporting period.	Field Type: Numeric Note: Is a subset of C. (Is also a subset of D).
G.	Total number of long-term stay NF residents.	Total number of long-term stay NF residents during the reporting period.	Field Type: Numeric
H.	Total number of long-term stay NF residents with diabetes.	Of the total reported in G, the number of long-term stay NF residents with diabetes.	Field Type: Numeric Note: Is a subset of G.

Element Letter	Element Name	Definition	Allowable Values
I.	Total number of long-term stay NF residents with COPD.	Of the total reported in G, the number of long-term NF residents with COPD.	Field Type: Numeric Note: Is a subset of G.
J.	Total number of long-term stay NF residents transferred from the NF to an acute care hospital for any medical diagnosis and who were subsequently discharged back to the NF.	Of the total reported in G, the number of long-term stay NF residents transferred from the NF to an acute care hospital for any medical diagnosis and who were subsequently discharged back to the NF during the reporting period.	Field Type: Numeric Note: Is a subset of G.
K.	Total number of long-term stay NF residents with diabetes transferred from the NF to an acute care hospital for diabetes and who were subsequently discharged back to the NF.	Of the total reported in H, the number of long-term stay NF residents with diabetes transferred from the NF to an acute care hospital for diabetes and who were subsequently discharged back to the NF during the reporting period.	Field Type: Numeric Note: Is a subset of H. (Is also a subset of J).
L.	Total number of long-term stay NF residents with COPD transferred from the NF to an acute care hospital for COPD and who were subsequently discharged back to the NF.	Of the total reported in I, the number of long-term stay NF residents with COPD transferred from the NF to an acute care hospital for COPD and who were subsequently discharged back to the NF during the reporting period.	Field Type: Numeric Note: Is a subset of I. (Is also a subset of J).

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 elements B, C, and D are less than or equal to data element A.
- MMPS should validate that data element E is less than or equal to data element B.
- MMPS should validate that data element F is less than or equal to data element C.
- MMPs should validate that data elements E and F are less than or equal to data element D.
- MMPs should validate that data elements H, I, and J are less than or equal to data element G.
- MMPS should validate that data element K is less than or equal to data element H.
- MMPS should validate that data element L is less than or equal to data element I.
- MMPs should validate that data elements K and L are less than or equal to data element J.
- 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.

Short-Term Stay Analysis

- CMS and the state will evaluate the percentage of short-term stay NF residents who were transferred from the NF for any medical diagnosis to an acute care hospital and subsequently discharged back to the NF during the reporting period.
- CMS and the state will evaluate the percentage of short-term stay NF residents with diabetes who were transferred from the NF to an acute care hospital for diabetes and were subsequently discharged back to the NF.
- CMS and the state will evaluate the percentage of short-term stay NF residents with COPD who were transferred from the NF to an acute care hospital for COPD and were subsequently discharged back to the NF.

Long-Term Stay Analysis

- CMS and the state will evaluate the percentage of long-term stay NF residents who were transferred from the NF to an acute care hospital for any medical diagnosis and subsequently discharged back to the NF during the reporting period.
- CMS and the state will evaluate the percentage of long-term stay NF residents with diabetes who were transferred from the NF to an

acute care hospital for diabetes and were subsequently discharged back to the NF.
- CMS and the state will evaluate the percentage of long-term stay NF residents with COPD who were transferred from the NF to an acute care hospital for COPD and were subsequently discharged back to the NF.

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.
- A long-term stay resident is defined as having resided in the nursing facility for greater than 100 cumulative days at the time of the transfer.
- A short-term stay resident is defined as having resided in the nursing facility for less than or equal to 100 cumulative days at the time of the transfer.
- To identify a diabetes-related hospital admission, refer to the primary diagnosis codes listed in Table CA-9.
- To identify a COPD-related hospital admission, refer to the primary diagnosis codes listed in Table CA-10.

Table CA-9: Codes to Identify Diabetes

ICD-9-CM
250, 357.2, 362.0, 366.41, 648.0

Table CA-10: Codes to Identify Chronic Obstructive Pulmonary Disease

ICD-9-CM
491, 492, 493.2, 496

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