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

Effective as of April 1, 2014, Issued September 23, 2014

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# California-Specific Reporting Requirements Appendix

## *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, MMPs will be requested to submit data at the contract level. However, there are some measures (CA1.6 – CA1.8; CA4.2) that will be reported at the country level. Additional information regarding the Data Submission process is provided on page CA-7.

## *Definitions*

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

Calendar Year: All annual measures are reported on a calendar year basis. Calendar year 2014 (CY1) will be an abbreviated year. For MMPs with a first

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

effective enrollment date of April 1, 2014, data for annual CY1 measures will be reported for the time period beginning April 1, 2014 and ending December 31, 2014. For MMPs with a first effective enrollment date of July 1, 2014, data for annual CY1 measures will be reported for the time period beginning July 1, 2014 and ending December 31, 2014. Calendar year 2015 (CY2) will represent January 1, 2015 through December 31, 2015.

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.

In-Home Supportive Services (IHSS): Pursuant to Article 7 of California WIC (commencing with Section 12300) of Chapter 3, and Sections 14132.95, 14132.952, and 14132.956.), this is a 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 first full quarter following the third wave of passive enrollment (therefore, all plans would have a minimum of 6 months implementation period). For MMPs adding a county in 2015, the implementation period continues for a full quarter following the first effective date of enrollment.

For example, for a plan which began both opt-in and passive enrollment on April 1, 2014, the implementation period would start on April 1, 2014 and end on September 30, 2014. For a plan which began opt-in enrollment on April 1, 2014 and began passive enrollment on May 1, 2014, the implementation period would start on April 1, 2014 and end on December 31, 2014. For a plan which began opt-in enrollment on April 1, 2014 began passive enrollment on July 1, 2015, the implementation period would start on April 1, 2014 and end on December 31, 2014. For a plan which began both opt-in and passive enrollment on July 1, 2014, the implementation period would start on July 1, 2014 and end on December 31, 2014. For a plan which begins both opt-in and passive enrollment on January 1, 2015, the implementation period would start on January 1, 2015 and end on June 30, 2015. For any plan that begins passive enrollment in a new county in 2015, the implementation period for that plan would extend for a full quarter following the first wave of passive enrollment for that county.

For MMPs with less than 3 waves of passive enrollment, the implementation period will end September 30, 2014.

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.

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; and
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 (IHSS) that are in excess of the statutory maximum.

### *Quality Withhold Measures*

CMS and the state will 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.

### *Hybrid Sampling*

Some demonstration-specific measures may allow 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.

**California Implementation, Ongoing, and Continuous Reporting Periods**

| Demonstration Year 1 | | | |
|---|---|---|---|
| **Phase** | | **Dates** | **Explanation** |
| Continuous Reporting | Implementation Period | Varies | The period of time starting with the first effective enrollment date until the end of the first full quarter following the third wave of passive enrollment. For MMPs adding a county in 2015, the implementation period continues for a full quarter following the first effective date enrollment. |
| | Ongoing Period | Varies | From the first effective enrollment date through the end of the first full calendar year of the demonstration. |
| **Demonstration Year 2** | | | |
| Continuous Reporting | Ongoing Period | 1-1-16 through 12-31-16 | From January 1st through the end of the second full calendar year of the demonstration. |
| **Demonstration Year 3** | | | |
| Continuous Reporting | Ongoing Period | 1-1-17 through 12-31-17 | From January 1st through the end of the third full calendar year of the demonstration. |

***Data Submission***

All MMPs will submit data through an Excel template on a secure transmission site. All data submissions must be submitted to this site by 5:00p.m. ET on the applicable due date. This site can be accessed at the following web address: https://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) with the year, month, and date of the submission in YYYYMMDD format (e.g., March 31, 2014 would be 20140331).

## Section CAI. Care Coordination

CA1.1 High 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 75 days | Contract | Current Month<br>Ex:<br>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** |
| CA1. Care Coordination | Quarterly | Contract | Current Calendar Quarter<br>Ex:<br>1/1-3/31<br>4/1-6/30<br>7/1-9/30<br>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 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<br><br>Note: Is a subset of A. |

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| 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<br><br>Note: Is a subset of B. |
| 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<br><br>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<br><br>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.
- 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 MMPs 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.
- Since the 75th day of enrollment falls in the middle of a month, the first report for the first reporting period is due at the end of the first FULL month after the 75th day. For example, for MMPs beginning the demonstration on April 1, 2014, the 75th day will occur on June 15, 2014. Therefore, the first report reflecting the reporting period of June 1, 2014 to June 30, 2014 will be due July 31, 2014, and monthly thereafter for the remainder of the Implementation period.
- MMPs should refer to CA's three-way contract for specific requirements pertaining to ICPs and HRAs.
- High risk members are members who are at increased risk for having an adverse health outcome or worsening of his or her health status if he or she does not receive initial contact within 45 calendar days after their effective enrollment date.
- 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 | Contract | Current Month<br>Ex:<br>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** |
| CA1. Care Coordination | Quarterly | Contract | Current Calendar Quarter<br>Ex:<br>1/1-3/31<br>4/1-6/30<br>7/1-9/30<br>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, 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<br><br>Note: Is a subset of A. |

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| 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<br><br>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<br><br>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<br><br>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 low risk 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 MMPs 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.
- The first report for the first reporting period is due at the end of the first FULL month after the 120th day. For example, MMPs beginning the demonstration on April 1, 2014, the 120th day will occur on July 30, 2014. Therefore, the first report reflecting the reporting period of July 1, 2014 to July 31, 2014 will be due September 2, 2014 (as August 31, 2014 falls on a weekend and September 1, 2014 is a holiday) and monthly thereafter for the remainder of the Implementation period. The first quarterly report will consist of data from July 1, 2014 to September 30, 2014 and will be due December 1, 2014 (as November 30, 2014 falls on a weekend).
- MMPs should refer to CA's three-way contract for specific requirements pertaining to ICPs and HRAs.
- Low risk members are members who do not meet the minimum requirements of a high risk member.
- 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 an ICP completed.

| IMPLEMENTATION | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Period** | **Due Date** |
| CA1. Care Coordination | Monthly, beginning after 75 days | Contract | Current Month<br>Ex:<br>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** |
| CA1. Care Coordination | Quarterly | Contract | Current Calendar Quarter<br>Ex:<br>1/1-3/31<br>4/1-6/30<br>7/1-9/30<br>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, including examples, methods for calculations, and how various data elements are associated.

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| A. | Total number of high risk members enrolled for 75 days or longer as of the end of the reporting period. | Total number of high risk members enrolled for 75 days or longer as of the end of the reporting period. | Field Type: Numeric |
| B. | Total number of high risk members who had an ICP completed. | Of the total reported in A, the number of high risk members who had an ICP completed as of the end of the reporting period. | Field Type: Numeric<br><br>Note: Is a subset of A. |
| C. | Total number of low risk members enrolled for 120 days or longer as of the end of the reporting period. | Total number of low risk members enrolled for 120 days or longer as of the end of the reporting period. | Field Type: Numeric<br><br>Note: This data element should not be reported until after 120 days of Implementation. |

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| D. | Total number of low risk members who had an ICP completed. | Of the total reported in C, the number of low risk members who had an ICP completed as of the end of the reporting period. | Field Type: Numeric<br><br>Note: Is a subset of C.<br><br>Note: This data element should not be reported until after 120 days of 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 B is less than or equal to data element A.
- MMPs should validate that data element D is less than or equal to data element C.
- All data elements should be positive values.

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

- High risk members enrolled for 75 days or longer who had an ICP completed as of the end of the reporting period.
- Low risk members enrolled for 120 days or longer who had an ICP completed as of the end of 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 75th day and the 120th day of enrollment should be based on each member's effective enrollment date.
- 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.

- The ICPs reported in elements B and D could have been completed at any time after enrollment, not necessarily during the reporting period.
- Since the 75th day of enrollment falls in the middle of a month, the first monthly report for the first reporting period is due at the end of the first FULL month after the 75th day. For example, for MMPs beginning the demonstration on April 1, 2014, the 75th day will occur on June 15, 2014. Therefore, the first report reflecting the reporting period of June 1, 2014 to June 30, 2014 will be due July 31, 2014, and monthly thereafter for the remainder of the Implementation period.
- The first monthly report for the first reporting period is due at the end of the first FULL month after the 120th day. For example, for MMPs beginning the demonstration on April 1, 2014, the 120th day will occur on July 30, 2014. Therefore, the first report reflecting the reporting period of July 1, 2014 to July 31, 2014 will be due September 2, 2014 (as August 31, 2014 falls on a weekend and September 1, 2014 is a holiday) and monthly thereafter for the remainder of the Implementation period.
- High risk members are members who are at increased risk for having an adverse health outcome or worsening of his or her health status if he or she does not receive initial contact within 45 calendar days after their effective enrollment date.
- Low risk members are members who do not meet the minimum requirements of a high risk member.

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

CA1.4 Members with documented discussions of care goals.[i]

| CONTINUOUS REPORTING | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Period** | **Due Date** |
| CA1. 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 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 sampled that met the inclusion criteria. | Of the total reported in A, the number of members sampled that met inclusion criteria. | Field type: Numeric<br><br>Note: Is a subset of A. |
| C. | Total number of members with evidence of creation of at least one care goal documented in the ICP. | Of the total reported in B, the number of members with evidence of creation of at least one care goal documented in the ICP. | Field Type: Numeric<br><br>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.

- 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.
- 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 evaluate the percentage of members with an ICP developed in the reporting period who had evidence of creation of at least one care goal documented 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. A subset of all members that are eligible will be included in the sample.
- For reporting, the MMPs may elect to sample since this measure requires documentation review to identify the numerator. Sampling should be systematic to ensure all eligible individuals have an equal chance of inclusion.
- Care goal discussions can be completed as part of the initial development of the care plan. When care goals are discussed as part of the development of the care plan, the MMP should only count members in C when discussion of the care goal is clearly documented in the member's care plan.

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 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 | Contract | Calendar Year | By the end of the fourth month following the last day of the reporting period |

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

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| A. | Total number of 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 Cal MediConnect MMP for at least five months during the reporting period. | Field Type: Numeric |
| 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<br><br>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 ICP includes all of the following:

    1. The name and contact information of the primary county or county-contracted behavioral health provider,
    2. Attestation[2] that 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 MMPs 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

CA1.6 Unmet Need in IHSS.

Please note: No MMP reporting is required for this measure; CMS and the state will receive data from California Department of Social Services (CDSS). MMPs are required to assist CDSS with the process, and more detail will be provided.

Subsequent to establishing the methodology for this measure, this appendix will be updated to include the measure specifications.

| CONTINUOUS REPORTING | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Period** | **Due Date** |
| CA1. Care Coordination | Annually | County | Calendar Year | CMS and state will receive data |

[2] 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.

| | | | | |
|---|---|---|---|---|
| | | | | from CDSS |

CA1.7 IHSS case manager contact with member

Please note: No MMP reporting is required for this measure; CMS and the state will receive data from CDSS. MMPs are required to assist CDSS with the process, and more detail will be provided.

Subsequent to establishing the methodology for this measure, this appendix will be updated to include the measure specifications.

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

CA1.8 Satisfaction with IHSS case manager, home workers, personal care.

Please note: No MMP reporting is required for this measure; CMS and the state will receive data from CDSS. MMPs are required to assist CDSS with the process, and more detail will be provided.

Subsequent to establishing the methodology for this measure, this appendix will be updated to include the measure specifications.

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

CA1.9 Members with first follow-up visit within 30 days after hospital discharge.

| CONTINUOUS REPORTING | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Periods** | **Due Date** |
| CA1. Care Coordination | Quarterly | Contract | Current Calendar Quarter<br>Ex:<br>1/1-3/31<br>4/1-6/30<br>7/1-9/30<br>10/1-12/31 | By the end of the fourth month following the last day of the reporting period |

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

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| A. | Total number of hospital discharges. | Total number of hospital discharges during the reporting period. | Field Type: Numeric |
| B. | Total number of hospital 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 hospital discharges that resulted in an ambulatory care follow-up visit within 30 days after discharge from the hospital. | Field Type: Numeric<br><br>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 hospital 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 or may not occur 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 | | | |
| 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** | ***OR*** | Any acute inpatient facility code |
|---|---|---|
| 11x, 12x, 41x, 84x | | |

| 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

CA1.10 Members who have a case manager and have at least one care team contact during the reporting period.[i]

| CONTINUOUS REPORTING | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Period** | **Due Date** |
| CA1. 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 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 or other care team contact. | Of the total reported in A, the number of members who had at least one case manager or other care team contact. | Field Type: Numeric<br><br>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 a case manager who had at least one case manager or other care team 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 contact can be from the case manager or another member of the care team, depending on the member's needs.
- MMPs should refer to CA's three-way contract for specific requirements pertaining to the care team.

- To be included in this measure, 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

CA2.1The number of critical incident and abuse reports for members receiving LTSS.

| IMPLEMENTATION | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Period** | **Due Date** |
| CA2. Enrollee Protections | Monthly | Contract | Current Month<br>Ex:<br>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** |
| CA2. Enrollee Protections | Quarterly | Contract | Current Calendar Quarter<br>Ex:<br>1/1-3/31<br>4/1-6/30<br>7/1-9/30<br>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 receiving IHSS. | Total number of members receiving IHSS during the reporting period. | Field Type: Numeric |
| B. | Total number of members receiving CBAS services. | Total number of members receiving CBAS services during the reporting period. | Field Type: Numeric |
| C. | Total number of members receiving MSSP services. | Total number of members receiving MSSP services during the reporting period. | Field Type: Numeric |
| D. | Total number of members receiving nursing facility (NF) services. | Total number of members receiving NF services during the reporting period. | Field Type: Numeric |

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| E. | Total number of critical incident and abuse reports among members receiving IHSS. | Of the total reported in A, the number of critical incident and abuse reports during the reporting period. | Field Type: Numeric |
| F. | Total number of critical incident and abuse reports among members receiving CBAS. | Of the total reported in B, the number of critical incident and abuse reports during the reporting period. | Field Type: Numeric |
| G. | Total number of critical incident and abuse reports among members receiving MSSP services. | Of the total reported in C, the number of critical incident and abuse reports during the reporting period. | Field Type: Numeric |
| H. | Total number of critical incident and abuse reports among members receiving NF services. | Of the total reported in D, the number of critical incident and abuse reports 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.

- 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 critical incident and abuse reports per 100 members receiving IHSS during the reporting period.
- CMS and the state will evaluate the number of critical incident and abuse reports per 100 members receiving CBAS services during the reporting period.
- CMS and the state will evaluate the number of critical incident and abuse reports per 100 members receiving MSSP services during the reporting period.

- CMS and the state will evaluate the number of critical incident and abuse reports per 100 members receiving NF services 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.
- It is possible for members to have more than one critical incident and/or abuse report during the reporting period. All critical incident and abuse reports during the reporting period should be counted.
- Critical incident refers to any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a member.
- Abuse refers to:

  1. Willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish;
  2. Knowing, reckless, or intentional acts or failures to act which cause injury or death to an individual or which places that individual at risk of injury or death;
  3. Rape or sexual assault;
  4. Corporal punishment or striking of an individual;
  5. Unauthorized use or the use of excessive force in the placement of bodily restraints on an individual; and
  6. Use of bodily or chemical restraints on an individual which is not in compliance with federal or state laws and administrative regulations.

- Community Based Adult Services (CBAS) is an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, and transportation to eligible Medi-Cal beneficiaries, aged 18 years and older, blind, or disabled.
- Multi-Purpose Senior Services Program (MSSP) is a California-specific program, the 1915(c) Home and Community-Based services waiver that provides HCBS to Medi-Cal eligible individuals who are 65 years or older with disabilities as an alternative to nursing facility placement.

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

CA2.2 Policies and procedures attached to the MOU with county BH agency(ies) around assessments, referrals, coordinated care planning, and information sharing.[i]

| CONTINUOUS REPORTING | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Period** | **Due Date** |
| CA2. Enrollee Protections | 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. | Policies and procedures attached to the MOU with county BH agency(ies) around assessments, referrals, coordinated care planning, and information sharing | Policies and procedures attached to the MOU with county BH agency(ies) around assessments, referrals, coordinated care planning, and information sharing | Field Type: N/A<br><br>Note: File will be emailed to the State; additional information will be forthcoming |

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.

- Data will be submitted directly to the state; additional information will be provided.

## 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]

| CONTINUOUS REPORTING | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Period** | **Due Date** |
| CA3. 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. | Established Work Plan. | Established Work Plan. | Field Type: N/A<br><br>Note: File will be uploaded to FTP site as a separate attachment. |
| B. | Identification of the individual responsible for physical access compliance. | A document that identifies the individual responsible for physical access compliance. | Field Type: N/A<br><br>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 31, 2014 would be 20140331), 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 | 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 care coordinators who have been employed by the MMP for at least 30 days. | Total number of care coordinators who have been employed by the MMP for at least 30 days at any point during the reporting period. | Field Type: Numeric |
| B. | Total number of care coordinators that have undergone training for supporting self-direction under the demonstration within the reporting period. | Of the total reported in A, the number of care coordinators that have undergone training for supporting self-direction under the demonstration within the reporting period. | Field Type: Numeric<br><br>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 who have undergone training for supporting self-direction within the reporting period.

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.
- 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 30 days at any point 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 (ED) use for seriously mentally ill and substance use disorder (SUD) members.

(Note: This will become a quality withhold for Demonstration Year 2 and Demonstration Year 3).

| CONTINUOUS REPORTING | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Period** | **Due Date** |
| CA4. Utilization | Annually | Contract | Calendar Year, beginning in CY2 | By the end of the fourth month following the last day of the reporting period |

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

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| A. | Total number of members enrolled for at least five months, with an indication of either mental illness or substance use disorders (SUD). | Total number of members continuously enrolled for at least five months during reporting period, with an indication of either serious mental 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.

- 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.

- 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 for members with an indication of either serious mental illness or SUD problems during the 12 months prior to the reporting period 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 or observation stay. 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 MMP as of 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 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 MMP reporting is required for this measure; CMS and the state will receive data from California Department of Social Services (CDSS). MMPs are required to assist CDSS with the process, and more detail will be provided.

Subsequent to establishing the methodology for this measure, this appendix will be updated to include the measure specifications.

| CONTINUOUS REPORTING | | | | |
|---|---|---|---|---|
| **Reporting Section** | **Reporting Frequency** | **Level** | **Reporting Period** | **Due Date** |
| CA4. Utilization | Annually | County | Calendar 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 | Contract | Calendar Year | By the end of the fourth month following the last day of the reporting period |

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

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

| Element Letter | Element Name | Definition | Allowable Values |
|---|---|---|---|
| F. | Total number of short-term stay NF residents with COPD transferred from the NF and admitted 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 and admitted to an acute care hospital for COPD and who were subsequently discharged back to the NF during the reporting period. | Field Type: Numeric<br><br>Note: Is a subset of C.<br><br>(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<br><br>Note: Is a subset of G. |
| 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<br><br>Note: Is a subset of G. |
| J. | Total number of long-term stay NF residents transferred from the NF and admitted 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 and admitted 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<br><br>Note: Is a subset of G. |

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

**Long-Term Stay Analysis**

- CMS and the state will evaluate the percentage of long-term stay NF residents who were transferred from the NF and admitted to an acute care hospital for any medical diagnosis and who were 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 and admitted to an acute care hospital for diabetes and who were 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 COPD who were transferred from the NF and admitted to an acute care hospital for COPD and who were subsequently discharged back to the NF 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.
- 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.
- 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.
- The transfer from the NF to the acute care hospital and the discharge from the acute care hospital back to the NF must both occur during the reporting period.
- If a member was transferred to a hospital but only had an ER visit or observation stay then returned to the nursing facility, then the transfer is not counted as a readmission back to the nursing facility. A member must be admitted to the hospital to be considered a numerator positive event.
- 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