

**MEDICARE-MEDICAID  
CAPITATED FINANCIAL ALIGNMENT MODEL  
REPORTING REQUIREMENTS:  
MASSACHUSETTS-SPECIFIC REPORTING  
REQUIREMENTS**

Issued February 28, 2025

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## MASSACHUSETTS-SPECIFIC REPORTING REQUIREMENTS APPENDIX

### Introduction

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

<https://www.cms.gov/medicare/medicaid-coordination/plans/mmp-reporting-requirements>

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<sup>®1</sup> and HOS. CMS and the state will also track key utilization measures, which are not included in this document, using encounter and claims data. The quantitative measures are part of broader oversight, monitoring, and performance improvement processes that include several other components and data sources not described in this document.

MMPs should contact the MA HelpDesk at [MAHelpDesk@norc.org](mailto:MAHelpDesk@norc.org) and the state contacts with any questions about the Massachusetts state-specific appendix or the data submission process.

### Definitions

All definitions for terms defined in this section and throughout this Reporting Requirements document apply whenever the term is used, unless otherwise noted.

Calendar Quarter: All quarterly measures are reported on calendar quarters. The four calendar quarters of each calendar year will be as follows: January 1 to March 31, April 1 to June 30, July 1 to September 30, and October 1 to December 31.

Calendar Year: All annual measures are reported on a calendar year basis. For example, Calendar Year (CY) 2025 represents January 1, 2025 through December 31, 2025.

Implementation Period: The initial months of the demonstration during which MMPs report to CMS and the state on a more intensive reporting schedule. For One Care MMPs that began operating on October 1, 2013, the Implementation Period was from January 1 through June 30, 2014. For the One Care MMP that began operating on January 1, 2022, the Implementation Period was from January 1 through June 30, 2022.

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

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<sup>1</sup> HEDIS<sup>®</sup> is a registered trademark of the National Committee for Quality Assurance (NCQA).

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.

Primary Care Provider: Nurse practitioners, physician assistants, or physicians who are board certified or eligible for certification in one of the following specialties: family practice, internal medicine, general practice, obstetrics/gynecology, or geriatrics.

### **Variations from the Core Reporting Requirements Document**

For the following measures, the specifications for One Care MMP reporting will differ from the core requirement:

#### Core Measure 5.3

For One Care MMPs, this is defined as the initial holding of a board meeting that includes consumers within 90 days of the first effective enrollment date for the demonstration; and on an ongoing basis, as the holding of a board meeting that includes consumers at least quarterly.

During the implementation period, MMPs must submit within 150 days of the first demonstration passive enrollment effective date the meeting minutes for the first board meeting that includes consumers and that is held within 90 days of the first effective enrollment date. During the ongoing reporting period, MMPs must annually submit meeting minutes for board meetings that include consumers and that are held at least quarterly. For the first year, MMPs are required to report both the first meeting minutes during the implementation reporting phase, and subsequent meeting minutes as part of annual reporting for the ongoing reporting phase.

#### Core Measure 9.2

The following section provides additional guidance about identifying individuals enrolled in the One Care MMP as “nursing home certifiable,” or meeting the nursing facility level of care, for the purposes of reporting Core 9.2.

Within Core 9.2, “nursing home certifiable” members are defined as “members living in the community, but requiring an institutional level of care” (see the Core Reporting Requirements for more information). For One Care MMPs, this definition includes the following types of members:

- Members classified in the C3A or C3B rating category.
- Members who have a claims history which illustrates nursing facility level of care.

According to the measure specifications, in order for members to be included in data element B, they must have been classified as nursing home certifiable for more than 100 days during the previous reporting period and must not have resided in a nursing facility for more than 100 continuous days during the previous reporting period.

- A small subset of these identified members could potentially be categorized as F1 at a point in time throughout the measurement year.
- F1 members are considered individuals who were at a facility for 90 days or more, therefore, a F1 individual could stay at a nursing facility anywhere between

90 and 100 days, without exceeding the 100 continuous day mark described above. These individuals should be included in data element B.

### **Quality Withhold Measures**

CMS and the state established a set of quality withhold measures, and MMPs are required to meet established thresholds. Throughout this document, Demonstration Year 1 and Demonstration Year 9 state-specific quality withhold measures are marked with the following symbol: (i). Demonstration Year 10 through 12 state-specific quality withhold measures are marked with the following symbol: (ii). Additional state-specific quality withhold measures for Demonstration Years 2 through 12 are reported separately through the Core Reporting Requirements and HEDIS. For more information about the state-specific quality withhold measures, refer to the Quality Withhold Technical Notes (DY 1): Massachusetts-Specific Measures and the Quality Withhold Technical Notes (DY 2-12): Massachusetts-Specific Measures at <https://www.cms.gov/medicare/medicaid-coordination/plans/mmp-quality-withhold-methodology-technical-notes>.

### **Guidance on Assessments and Care Plans for Members with a Break in Coverage**

#### **Comprehensive Assessments**

If an MMP already completed an assessment for a member who was previously enrolled in that MMP (either through passive or opt-in enrollment), the MMP is not necessarily required to conduct a new assessment if the member rejoins the same MMP within one year of their most recent assessment. Instead, the MMP can:

1. Confirm that the prior assessment results are recorded in the Centralized Enrollee Record (CER);
2. Perform any risk stratification, claims data review, or other analyses as required by the three-way contract to detect any changes in the member's condition since the assessment was conducted; and
3. Ask the member (or the member's authorized representative) over the phone or in person if there has been a change in the member's health status or needs since the assessment was conducted. If there are no changes identified, ask if the member consents to use the prior assessment results going forward.

The MMP must document any risk stratification, claims data review, or other analyses that are performed to detect any changes in the member's condition. The MMP must also document its outreach attempts and the discussion(s) with the member (or the member's authorized representative) to determine if there was a change in the member's health status or needs, and if no changes are identified, that the member consents to use the prior assessment results going forward. The discussion(s) should be documented in the CER.

If a change is identified, the MMP must conduct a new assessment within the timeframe prescribed by the three-way contract for a new enrollment. If there are no changes, the MMP is not required to conduct a new assessment unless requested by the member (or

the member's authorized representative). Please note, if the MMP prefers to conduct assessments on all re-enrollees regardless of status, it may continue to do so.

Once the MMP has conducted a new assessment as needed or confirmed that the prior assessment is still accurate, the MMP can mark the assessment as complete for the member's current enrollment. The MMP would then report that completion according to the specifications for Core 2.1 and Core 2.2. When reporting these core measures, the MMP should count the 90 days from the member's most recent enrollment effective date and should report the assessment based on the date the prior assessment was either confirmed to be accurate or a new assessment was completed. Additionally, in certain circumstances a new assessment that has been completed for a member upon reenrollment may also be reported in Core 2.3.

If the MMP is unable to reach a re-enrolled member to determine if there was a change in health status, then the MMP may report that member as unable to be reached so long as the MMP made the requisite number of outreach attempts. If a re-enrolled member refuses to discuss their health status with the MMP, then the MMP may report that member as unwilling to participate in the assessment.

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

#### Individualized Care Plans

If the MMP conducts a new assessment for the re-enrolled member, the MMP must revise the Individualized Care Plan (ICP) accordingly within the timeframe prescribed by the three-way contract. Once the ICP is revised, the MMP may mark the ICP as complete for the member's current enrollment. If the MMP determines that the prior assessment is still accurate and, therefore, no updates are required to the previously developed ICP, the MMP may mark the ICP as complete for the current enrollment at the same time that the assessment is marked complete. The MMP would then follow the Core 3.2 and MA1.2 measure specifications for reporting the completion. Please note, for purposes of reporting, the ICP for the re-enrolled member should be classified as an *initial* ICP.

If the MMP did not complete an ICP for the re-enrolled member during their prior enrollment period, or if it has been more than one year since the member's ICP was completed, the MMP is required to develop an ICP for the member within the timeframe prescribed by the three-way contract. The MMP must also follow the above guidance regarding reaching out to members who previously refused to participate or were not reached.

### Continuity of Care

Continuity of Care provisions remain in effect at least until contact is made with the member. Please refer to the three-way contract requirements about applicability after contact is made with the member.

### Annual Reassessments and ICP Updates

The MMP must follow the three-way contract requirements and any additional state-specific guidance regarding the completion of annual reassessments and updates to ICPs. If the MMP determined that an assessment/ICP from a member's prior enrollment was accurate and marked that assessment/ICP as complete for the member's current enrollment, the MMP should count continuously from the date that the assessment/ICP was completed in the prior enrollment period to determine the due date for the annual reassessment and ICP update. For example, when reporting Core 2.3, the MMP should count 365 days from the date when the most recent assessment was actually completed, even if that date was during the member's prior enrollment period.

### **Reporting on Passively Enrolled and Opt-In Enrolled Members**

When reporting all Massachusetts state-specific measures, MMPs should include all members who meet the criteria for inclusion in the measure regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.

### **Reporting on Disenrolled and Retro-disenrolled Members**

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

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

### **Hybrid Sampling**

Some demonstration-specific measures may allow medical record/supplemental documentation review (i.e., manual abstraction of data) to identify the numerator. In these instances, the sample size should be 411, plus additional records should be

oversampled 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) using claim header level information.
- Step 2:** Determine the final sample size. The final sample size will be 411 unless the eligible population is less than 411. If the eligible population is less than 411, follow Step 5 to determine the final sample size.
- Step 3:** Determine the oversample which should include 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 oversample.
- Step 4:** If the eligible population exceeds the final sample size as determined in Step 2, proceed to Step 6. If the eligible population is less than or equal to the final sample size as determined in Step 2, proceed to Step 5.
- Step 5:** 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:

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

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 6:** 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, 2018, 2020, 2022, and 2024 and from Z to A in 2015, 2017, 2019, 2021, 2023, and 2025).

**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 7:** 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 5, for instances in which the eligible population was less than or equal to the number derived from Step 2.

**Step 8:** 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 9:** Select every *Kth* record thereafter until the selection of the sample size is completed.

### Value Sets

The measure specifications in this document refer to code value sets that must be used to determine and report measure data element values. A value set is the complete set of codes used to identify a service or condition included in a measure. The Massachusetts-Specific Value Sets Workbook includes all value sets and codes needed to report certain measures included in the Massachusetts-Specific Reporting Requirements and is intended to be used in conjunction with the measure specifications outlined in this document. The Massachusetts-Specific Value Sets Workbook can be found on the CMS website at the following address:

<https://www.cms.gov/medicare/medicaid-coordination/plans/mmp-reporting-requirements>

### Massachusetts' Implementation, Ongoing, and Continuous Reporting Periods

Phase		Dates	Explanation
<b>Demonstration Year 1</b>			
Continuous Reporting	Implementation Period	1-1-14 through 6-30-14	From January 1 through June 30, 2014.
	Ongoing Period	1-1-14 through 12-31-14	From January 1 through December 31, 2014.
<b>Demonstration Year 2</b>			
Continuous Reporting	Ongoing Period	1-1-15 through 12-31-15	From January 1, 2015 through the end of the second demonstration year.
<b>Demonstration Year 3</b>			
Continuous Reporting	Ongoing Period	1-1-16 through 12-31-16	From January 1, 2016 through the end of the third demonstration year.

Phase		Dates	Explanation
<b>Demonstration Year 4</b>			
Continuous Reporting	Ongoing Period	1-1-17 through 12-31-17	From January 1, 2017 through the end of the fourth demonstration year.
<b>Demonstration Year 5</b>			
Continuous Reporting	Ongoing Period	1-1-18 through 12-31-18	From January 1, 2018 through the end of the fifth demonstration year.
<b>Demonstration Year 6</b>			
Continuous Reporting	Ongoing Period	1-1-19 through 12-31-19	From January 1, 2019 through the end of the sixth demonstration year.
<b>Demonstration Year 7</b>			
Continuous Reporting	Ongoing Period	1-1-20 through 12-31-20	From January 1, 2020 through the end of the seventh demonstration year.
<b>Demonstration Year 8</b>			
Continuous Reporting	Ongoing Period	1-1-21 through 12-31-21	From January 1, 2021 through the end of the eighth demonstration year.
<b>Demonstration Year 9</b>			
Continuous Reporting	Implementation Period (New MMP Only)	1-1-22 through 6-30-22	From January 1 through June 30, 2022.
	Ongoing Period	1-1-22 through 12-31-22	From January 1, 2022 through the end of the ninth demonstration year.
<b>Demonstration Year 10</b>			
Continuous Reporting	Ongoing Period	1-1-23 through 12-31-23	From January 1, 2023 through the end of the tenth demonstration year.
<b>Demonstration Year 11</b>			
Continuous Reporting	Ongoing Period	1-1-24 through 12-31-24	From January 1, 2024 through the end of the eleventh demonstration year.

Phase		Dates	Explanation
<b>Demonstration Year 12</b>			
Continuous Reporting	Ongoing Period	1-1-25 through 12-31-25	From January 1, 2025 through the end of the twelfth demonstration year.

### Data Submission

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

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

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

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

### Resubmission of Data

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

1. Email the MA HelpDesk ([MAHelpDesk@norc.org](mailto:MAHelpDesk@norc.org)) and state contact to request resubmission.
  - a. Specify in the email which measure(s) need resubmission;
  - b. Specify for which reporting period(s) the resubmission is needed; and
  - c. Provide a brief explanation for why the data need to be resubmitted.
2. After review of the request, the MA HelpDesk will notify the MMP once the FAI DCS and/or HPMS has been re-opened.
3. Resubmit data through the applicable reporting system.
4. Notify the MA HelpDesk and state contact again after resubmission has been completed.

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

**Section MAI. Care Coordination**

MA1.1 Members with care plans within 90 days of enrollment. – **Retired**

MA1.2 Members with documented discussions of care goals.<sup>i</sup>

<b>IMPLEMENTATION</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
MA1. Care Coordination	Monthly	Contract	Current Month Ex: 1/1-1/31	By the end of the month following the last day of the reporting period
<b>ONGOING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Periods</b>	<b>Due Date</b>
MA1. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

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

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of members with an initial care plan completed.	Total number of members with an initial care plan completed during the reporting period.	Field Type: Numeric
B.	Total number of members with at least one documented discussion of care goals in the initial care plan.	Of the total reported in A, the number of members with at least one documented discussion of care goals in the initial care plan.	Field Type: Numeric  Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of existing care plans revised.	Total number of existing care plans revised during the reporting period.	Field Type: Numeric
D.	Total number of revised care plans with at least one documented discussion of new or existing care goals.	Of the total reported in C, the number of revised care plans with at least one documented discussion of new or existing care goals.	Field Type: Numeric  Note: Is a subset of C.

- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- 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.
- 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.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of:
- Members who had an initial care plan completed during the reporting period who had at least one documented discussion of care goals in the initial care plan.
    - $\text{Percentage} = (B / A) * 100$
  - Existing care plans revised during the reporting period that had at least one documented discussion of new or existing care goals.
    - $\text{Percentage} = (D / C) * 100$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

#### Data Element A

- MMPs should include all members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).

- Data element A should include all members whose care plan was completed for the first time during the reporting period (i.e., the member did not previously have a care plan completed prior to the start of the reporting period). There can be no more than one initial care plan completed per member.
- Only care plans that included participation from the member (or the member's authorized representative) in the completion of the care plan should be reported.

#### Data Element B

- MMPs should only include members in data element B when the discussion of care goals with the member (or the member's authorized representative) is clearly documented in the member's initial care plan.

#### Data Element C

- MMPs should include all care plans that meet the criteria outlined in data element C, regardless of whether the member is disenrolled as of the end of the reporting period (i.e., include all care plans regardless of whether the member is currently enrolled or disenrolled as of the last day of the reporting period).
- Data element C should include all existing care plans that were revised during the reporting period. MMPs should refer to the Massachusetts three-way contract for specific requirements pertaining to updating the care plan.
- Only care plans that included participation from the member (or the member's authorized representative) in the revision to the care plan should be reported.
- If a member's care plan is revised multiple times during the same reporting period, each revision should be reported in data element C.
  - For example, if a member's care plan is revised twice during the same reporting period, two care plans should be counted in data element C.

#### Data Element D

- MMPs should only include care plans in data element D when a new or previously documented care goal is discussed with the member (or member's authorized representative) and is clearly documented in the member's revised care plan.
- If the initial care plan clearly documented the discussion of care goals, but those existing care goals were not revised or discussed, or new care goals are not discussed and documented during the revision of the care plan, then that care plan should not be reported in data element D.

#### General Guidance

- If a member has an initial care plan completed during the reporting period, and has their care plan revised during the same reporting period, then the member's initial care plan should be reported in data element A and the member's revised care plan should be reported in data element C.

## 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 collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>

MA1.3 Members with LTSS needs who have a referral to an LTS Coordinator.<sup>i</sup>

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Periods	Due Date
MA1. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members enrolled whose 90th day of enrollment occurred within the reporting period.	Total number of members enrolled whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric
B.	Total number of members identified with LTSS needs within 90 days of enrollment.	Of the total reported in A, the number of members identified with LTSS needs within 90 days of enrollment.	Field Type: Numeric  Note: Is a subset of A.
C.	Total number of members with LTSS needs who refused an LTS Coordinator within 90 days of enrollment.	Of the total reported in B, the number of members with LTSS needs who refused an LTS Coordinator within 90 days of enrollment.	Field Type: Numeric  Note: Is a subset of B.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
D.	Total number of members with LTSS needs who have a referral to an LTS Coordinator within 90 days of enrollment.	Of the total reported in B, the number of members with LTSS needs who have a referral to an LTS Coordinator within 90 days of enrollment.	Field Type: Numeric  Note: Is a subset of B.
E.	Total number of members with LTSS needs who are in the C3 and F1 rating categories.	Of the total reported in B, the number of members with LTSS needs who are in the C3 and F1 rating categories.	Field Type: Numeric  Note: Is a subset of B.
F.	Total number of members with LTSS needs who are in the C3 and F1 rating categories who refused an LTS Coordinator within 90 days of enrollment.	Of the total reported in E, the number of members with LTSS needs who are in the C3 and F1 rating categories who refused an LTS Coordinator within 90 days of enrollment.	Field Type: Numeric  Note: Is a subset of E.
G.	Total number of members with LTSS needs who are in the C3 and F1 rating categories who have a referral to an LTS Coordinator within 90 days of enrollment.	Of the total reported in E, the number of members with LTSS needs who are in the C3 and F1 rating categories who have a referral to an LTS Coordinator within 90 days of enrollment.	Field Type: Numeric  Note: Is a subset of E.
H.	Total number of members with LTSS needs who are in the C3 and F1 rating categories who have met with an LTS Coordinator within 90 days of enrollment.	Of the total reported in E, the number of members with LTSS needs who are in the C3 and F1 rating categories who have met with an LTS Coordinator within 90 days of enrollment.	Field Type: Numeric  Note: Is a subset of E.

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.
- 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.
  - MMPs should validate that data elements F, G, and H are less than or equal to data element E.
- D. Analysis – how CMS will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of members whose 90th day of enrollment occurred within the reporting period:
- Who were identified with LTSS needs within 90 days of enrollment.
    - $\text{Percentage} = (B / A) * 100$

CMS and the state will evaluate the percentage of members with LTSS needs whose 90th day of enrollment occurred within the reporting period:

- Who refused an LTS Coordinator within 90 days of enrollment.
    - $\text{Percentage} = (C / B) * 100$
  - Who have a referral to an LTS Coordinator within 90 days of enrollment.
    - $\text{Percentage} = (D / B) * 100$
  - Who are in the C3 and F1 rating categories.
    - $\text{Percentage} = (E / B) * 100$
  - Who are in the C3 and F1 rating categories who refused an LTS Coordinator within 90 days of enrollment.
    - $\text{Percentage} = (F / E) * 100$
  - Who are in the C3 and F1 rating categories who have a referral to an LTS Coordinator within 90 days of enrollment.
    - $\text{Percentage} = (G / E) * 100$
  - Who are in the C3 and F1 rating categories who have met with an LTS Coordinator within 90 days of enrollment.
    - $\text{Percentage} = (H / E) * 100$
  - Who are in the C3 and F1 rating categories who did not refuse an LTS Coordinator who have met with an LTS Coordinator within 90 days of enrollment.
    - $\text{Percentage} = (H / E - F) * 100$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

#### Definitions

- LTS Coordinator refers to long term services and supports coordinator.
- F1 refers to facility-based care individuals identified as having a long-term facility stay of more than 90 days.

- C3 refers to community tier 3 – high community need individuals. Individuals who have a daily skilled need; limitations on two or more activities of daily living (ADL) and three days of skilled nursing need; and individuals with four or more ADL limitations.
- Identified LTSS members refers to members who were identified during the reporting period as having LTSS needs.
- Meeting with Coordinator refers to a meeting with an LTS Coordinator that is, at the member's request, either a face-to-face meeting or through other technological means and documented in the member record.
- Refuse refers to anyone who refuses an LTS Coordinator.

#### Data Element A

- MMPs should include all members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- The 90th day of enrollment should be based on each member's most recent effective date of enrollment in the MMP. Members must be continuously enrolled from the most recent effective enrollment date through 90 days of enrollment with no gaps in enrollment.
- For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months.

#### General Guidance

- MMPs should refer to the Massachusetts MOU and three-way contract for specific requirements pertaining to an LTS Coordinator.

#### 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 collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>

**Section MAII. Enrollee Protections**

MA2.1 The number of critical incident and abuse reports for members receiving LTSS.

<b>IMPLEMENTATION</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
MA2. Enrollee Protections	Monthly	Contract	Current Month Ex: 1/1-1/31	By the end of the month following the last day of the reporting period
<b>ONGOING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Periods</b>	<b>Due Date</b>
MA2. Enrollee Protections	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

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

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of members receiving LTSS.	Total number of members receiving LTSS during the reporting period.	Field Type: Numeric
B.	Total number of critical incident and abuse reports.	Of the total reported in A, the number of critical incident and abuse reports during the reporting period.	Field Type: Numeric

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.
- N/A.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the:
- Number of critical incident and abuse reports per 1,000 members receiving LTSS during the current reporting period.
    - $\text{Rate} = (B / A) * 1,000$
  - Average number of critical incident and abuse reports for members receiving LTSS during the prior four reporting periods (i.e., rolling year).
    - $\text{Average number} = \text{Sum of B for prior four reporting periods} / 4$
  - Weighted average number of critical incident and abuse reports per 1,000 members receiving LTSS during the prior four reporting periods.
    - $\text{Rate} = (\text{Sum of B for prior four reporting periods} / \text{Sum of A for prior four reporting periods}) * 1,000$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

#### Definitions

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

#### Data Element A

- MMPs should include all members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).

#### Data Element B

- For data element B, MMPs should include all new critical incident and abuse cases that are reported during the reporting period, regardless of whether the case status is open or closed as of the last day of the reporting period.

- Critical incident and abuse reports could be reported by the MMP or any provider and are not limited to only those providers defined as LTSS providers.
- 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.

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 collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>

**Section MAIII. Organizational Structure and Staffing**

MA3.1 Care coordinator training for supporting self-direction under the demonstration.

<b>CONTINUOUS REPORTING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
MA3. Organizational Structure and Staffing	Annually	Contract	Calendar Year, beginning CY 2015	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.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of newly hired full-time and part-time care coordinators (or those newly assigned to the MMP).	Total number of newly hired full-time and part-time care coordinators (or those newly assigned to the MMP) during the reporting period.	Field Type: Numeric
B.	Total number of newly hired care coordinators (or those newly assigned to the MMP) who have undergone state-based training for supporting self-direction under the demonstration.	Of the total reported in A, the number of newly hired care coordinators (or those newly assigned to the MMP) who 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.
- MMPs should validate that data element B is less than or equal to data element A.
- 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 newly hired full-time and part-time care coordinators who have undergone state-based training for supporting self-direction.
    - $\text{Percentage} = (B / A) * 100$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should refer to the Massachusetts three-way contract for specific requirements pertaining to a care coordinator and to training for supporting self-direction.
- 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 collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>

**Section MAIV. Performance and Quality Improvement**MA4.1 Mental Health Recovery Measure (MHRM®). – **Retired**

MA4.2 Screening and brief counseling for unhealthy alcohol use.

<b>CONTINUOUS REPORTING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
MA4. Performance and Quality Improvement	Annually	Contract	Two years	By the end of the sixth 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.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of members who were continuously enrolled in the MMP during the current two-year reporting period who had at least one outpatient visit, telephonic evaluation, or e-visit or virtual check-in during the current two-year reporting period.	Total number of members who were continuously enrolled in the MMP between January 1 of the first year and December 31 of the second year in the current two-year reporting period who had at least one outpatient visit, telephonic evaluation, or e-visit or virtual check-in during the current two-year reporting period.	Field Type: Numeric
B.	Total number of members sampled that met inclusion criteria.	Of the total reported in A, the number of members sampled that met inclusion criteria.	Field type: Numeric  Note: Is a subset of A.



Element Letter	Element Name	Definition	Allowable Values
C.	Total number of members who were screened for unhealthy alcohol use at least once using a systematic screening method during the current two-year reporting period.	Of the total reported in B, the number of members who were screened for unhealthy alcohol use at least once using a systematic screening method during the current two-year reporting period.	Field Type: Numeric  Note: Is a subset of B.
D.	Total number of members who were positively identified as an unhealthy alcohol user during the current two-year reporting period.	Of the total reported in C, the number of members who were positively identified as an unhealthy alcohol user based on the results of the systematic screening method during the current two-year reporting period.	Field Type: Numeric  Note: Is a subset of C.
E.	Total number of members who received brief counseling or other follow-up care at least once within 30 days of the positive finding during the current two-year reporting period.	Of the total reported in D, the number of members who received brief counseling or other follow-up care at least once within 30 days of the positive finding during the current two-year reporting period.	Field Type: Numeric  Note: Is a subset of D.

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.

- 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.

- MMPs should validate that data element D is less than or equal to data element C.
  - MMPs should validate that data element E is less than or equal to data element D.
- 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:
- Continuously enrolled in the MMP during the current two-year reporting period with at least one outpatient visit, telephonic evaluation, or e-visit or virtual check-in during the current two-year reporting period who were screened for unhealthy alcohol use at least once using a systematic screening method.
    - $\text{Percentage} = (C / B) * 100$
  - Identified as an unhealthy alcohol user who received brief counseling or other follow-up care at least once within 30 days of the positive finding during the current two-year reporting period.
    - $\text{Percentage} = (E / D) * 100$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

#### Definitions

- Unhealthy alcohol use is defined as the consumption of alcohol associated with health risks or consequences. It covers the full spectrum of alcohol use associated with consequences and, therefore, includes amounts known to be associated with increased risk (e.g., 5 or more standard drinks on an occasion for men, 4 for women, or >14 (men) or >7 (women) drinks per week on average, as defined by the National Institute on Alcohol Abuse and Alcoholism [NIAAA]), drinking in certain circumstances (e.g., while pregnant or taking a medication that interacts with alcohol), drinking already associated with a problem or consequence but not meeting criteria for an alcohol use disorder, and the alcohol use disorders, alcohol abuse and dependence.
- Systematic screening method is defined as:
  - Asking the patient about their weekly use (alcoholic drinks per week);
  - Asking the patient about their per occasion use (alcoholic drinks per drinking day);
  - Using a standardized tool such as AUDIT, AUDIT-C, or CAGE; or
  - Using another standardized tool.
- Brief counseling refers to one or more counseling sessions, a minimum of 5-15 minutes, which may include at least one of the following:
  - Feedback on alcohol use and harms;
  - Identification of high-risk situations for drinking and coping strategies;
  - or
  - Increase the motivation to reduce drinking.
- Other follow-up care is defined as:
  - Follow-up visit to the same provider for unhealthy alcohol use;
  - Referral to other services for unhealthy alcohol use; or

- Visit with another provider for unhealthy alcohol use.
- A terminal illness is a progressive disease that cannot be cured or adequately treated, and where death as a consequence of that disease can be reasonably expected within six months.
  - Common examples include:
    - End stage heart disease
    - End stage lung disease
    - End stage liver disease
    - ALS (Lou Gehrig's disease)
    - Stroke/CVA
    - End stage renal disease
    - End stage HIV/AIDS
    - End stage Alzheimer's disease
- Standardized screening tools include:
  - AUDIT
  - CAGE
  - AUDIT-C
  - MDS7
  - LIFESTYLE (Drinking/Smoking) (Code for drinking or smoking)
  - Alcohol Dependence Scale (ADS)
  - Alcohol, Smoking, and Substance Abuse Involvement Screening Test (ASSIST)
  - MacAndrew Alcoholism Scale (MAC – MAC-R)
  - Michigan Alcoholism Screening Test (MAST)
  - NIAAA Alcohol Consumption Questions
  - Fast Alcohol Screening Test (FAST)
  - Composite International Diagnostic Interview (CIDI)
  - Impaired Control Scale (ICS)

#### Data Element A

- MMPs should include all members aged 21 years and older as of January 1 of the first year of the reporting period.
- MMPs should only include members who were continuously enrolled in the MMP between January 1st of the first year and December 31st of the second year in the current two-year reporting period, with no more than one gap in enrollment of up to 45 days during each year of the two-year reporting period (e.g., a member can have no more than one gap in enrollment between January 1 – December 31, 2023 and no more than one gap in enrollment between January 1 – December 31, 2024).
- To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for two months [60 days] is not considered continuously enrolled).
- For data element A, MMPs should use the Outpatient #1 value set to identify members with at least one outpatient visit during the reporting period. MMPs should use a designated field within the CER or the Telephone Visits value set to capture telephonic evaluations that occurred during the reporting period

and the Online Assessments value set to capture e-visits and virtual check-ins that occurred during the reporting period.

#### Data Element B

- For reporting, medical record review is required. For further instructions on using hybrid sampling, please see page MA-8 of this document.

#### Data Element B Exclusions

- MMPs should exclude members:
  - Diagnosed with a terminal illness.
  - Who refuse to participate in the alcohol use screening.
  - In an urgent or emergent situation due to a medical reason where time is of the essence and to delay treatment would jeopardize the member's health status.
  - Whose functional capacity or motivation to improve may impact the accuracy of the results of the standardized assessment (e.g., certain court appointed cases of cases of delirium).

#### Data Element C

- For data element C, documentation in the medical record must include both a note indicating the date when the screening for unhealthy alcohol use was performed and the result or finding.
- Documentation in a member's social history alone, *without* documentation of a qualifying systematic screening method in the medical record, does not meet criteria for data element C.

#### Data Element D

- For data element D, documentation in the medical record must include both a note indicating the date when the screening for unhealthy alcohol use was performed and the result or finding indicating the member screened positive for unhealthy alcohol use.
- If more than one screening occurred during the current two-year reporting period, use the most recent screening.
- Documentation in a member's social history alone, *without* documentation of a qualifying systematic screening method in the medical record, does not meet criteria for data element D.

#### Data Element E

- For data element E, MMPs should use the most recent documented unhealthy alcohol use screening with positive results including the encounter date. Documentation should indicate that brief counseling or other follow-up care was offered to the member within 30 days of the positive finding, including the encounter date.
- The following does not meet criteria for brief counseling or other appropriate follow-up:
  - No assessment, counseling, or education about the risks of unhealthy alcohol use;

- Assessment or counseling prior to or after the reporting period;
- Notation of “health education” or “anticipatory guidance” without any mention of specifics indicating that unhealthy alcohol use was addressed.

#### General Guidance

- The reporting period for this measure is two years, but reporting will occur on an annual basis. For example, the submission due in 2025 will consist of data from CY 2023 and CY 2024, and the submission due in 2026 will consist of data from CY 2024 and CY 2025.
- The CER may be used to identify numerator events and exclusions.
- The date of the positive identification as an unhealthy alcohol user must occur within the reporting period, but the brief counseling or other follow-up care may or may not occur within the same reporting period.
  - For example, if a member is positively identified as an unhealthy alcohol user during the last month of the reporting period, look to the first month of the following reporting period to determine if the member received brief counseling or other follow-up care within 30 days of the positive finding. If so, the member should be counted in data element E.

#### 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 collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>

#### MA4.3 Tobacco use: screening and cessation.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
MA4. Performance and Quality Improvement	Annually	Contract	Two years	By the end of the sixth 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 were continuously enrolled in the MMP during the current two-year reporting period who had at least one outpatient visit, telephonic evaluation, or e-visit or virtual check-in during the current two-year reporting period.	Total number of members who were continuously enrolled in the MMP between January 1 of the first year and December 31 of the second year in the current two-year reporting period who had at least one outpatient visit, telephonic evaluation, or e-visit or virtual check-in during the current two-year reporting period.	Field Type: Numeric
B.	Total number of members sampled that met inclusion criteria.	Of the total reported in A, the number of members sampled that met inclusion criteria.	Field type: Numeric Note: Is a subset of A.
C.	Total number of members who were screened for tobacco use at least once during the current two-year reporting period.	Of the total reported in B, the number of members who were screened for tobacco use at least once during the current two-year reporting period.	Field Type: Numeric Note: Is a subset of B.
D.	Total number of members who were positively identified as a tobacco user during the current two-year reporting period.	Of the total reported in C, the number of members who were positively identified as a tobacco user based on results of the tobacco screening during the current two-year reporting period.	Field Type: Numeric Note: Is a subset of C.

Element Letter	Element Name	Definition	Allowable Values
E.	Total number of members who received a tobacco use cessation intervention within 30 days of the positive finding during the current two-year reporting period.	Of the total reported in D, the number of members who received a tobacco use cessation intervention within 30 days of the positive finding during the current two-year reporting period.	Field Type: Numeric  Note: Is a subset of D.

- 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.
- 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.
  - MMPs should validate that data element D is less than or equal to data element C.
  - MMPs should validate that data element E is less than or equal to data element D.
- 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:
- Continuously enrolled in the MMP during the current two-year reporting period with at least one outpatient visit, telephonic evaluation, or e-visit or virtual check-in during the current two-year reporting period who were screened for tobacco use at least once.
    - $\text{Percentage} = (C / B) * 100$
  - Identified as a tobacco user who received a tobacco use cessation intervention within 30 days of the positive finding during the current two-year reporting period.
    - $\text{Percentage} = (E / D) * 100$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

#### Definitions

- Types of tobacco include, but are not limited to:

- Cigarettes,
  - Cigars,
  - Pipe smoking, and
  - Smokeless tobacco.
- Tobacco use status is any documentation of active or current use of tobacco products, including smoking. Tobacco use status can be identified by any of the following criteria:
  - Documentation stating that the patient has been asked if they are one of the following during the reporting period:
    - Current tobacco user
    - Former tobacco user
    - Non-tobacco user
  - Documentation indicating that tobacco use was verified (for example, a Yes/No flag during the reporting period regardless of status of tobacco use)
- Cessation counseling intervention includes counseling or pharmacotherapy, combined counseling and pharmacotherapy, or referral to a tobacco use cessation program.
- A terminal illness is a progressive disease that cannot be cured or adequately treated, and where death as a consequence of that disease can be reasonably expected within six months.
  - Common examples include:
    - End stage heart disease
    - End stage lung disease
    - End stage liver disease
    - ALS (Lou Gehrig's disease)
    - Stroke/CVA
    - End stage renal disease
    - End stage HIV/AIDS
    - End stage Alzheimer's disease

#### Data Element A

- MMPs should include all members aged 21 years and older as of January 1 of the first year of the current reporting period.
- MMPs should only include members who were continuously enrolled in the MMP between January 1st of the first year and December 31st of the second year in the current two-year reporting period, with no more than one gap in enrollment of up to 45 days during each year of the two-year reporting period (e.g., a member can have no more than one gap in enrollment between January 1 – December 31, 2023 and no more than one gap in enrollment between January 1 – December 31, 2024).
- To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for two months [60 days] is not considered continuously enrolled).



- For data element A, MMPs should use the Outpatient #1 value set to identify members with at least one outpatient visit during the reporting period. MMPs should use a designated field within the CER or the Telephone Visits value set to capture telephonic evaluations that occurred during the reporting period and the Online Assessments value set to capture e-visits and virtual check-ins that occurred during the reporting period.

#### Data Element B

- For reporting, medical record review is required. For further instructions on using hybrid sampling, please see page MA-8 of this document.

#### Data Element B Exclusions

- MMPs should exclude members:
  - Diagnosed with a terminal illness.
  - Who refuse to participate in the tobacco use screening.
  - In an urgent or emergent situation due to a medical reason where time is of the essence and to delay treatment would jeopardize the member's health status.
  - Whose functional capacity or motivation to improve may impact the accuracy of the results of the standardized assessment (e.g., certain court appointed cases or cases of delirium).

#### Data Element C

- For data element C, documentation in the medical record must include both a note indicating the date when the tobacco use screening was performed and the result or finding. Any of the following meets criteria:
  - Notation about current or past behavior regarding tobacco use
  - Use of a checklist that tobacco use was addressed
- Any of the following do not meet criteria for data element C:
  - No assessment about the risks of tobacco usage
  - Assessment prior to or after the reporting period
  - Notation of "health education" or "anticipatory guidance" without any mention of specifics indicating that tobacco use was addressed.
  - Documentation in a member's social history alone, *without* documentation indicating the date when the tobacco use screening was performed and the result or finding.

#### Data Element D

- For data element D, documentation in the medical record must include both a note indicating the date when the tobacco use screening was performed and the result or finding indicating that the member is a tobacco user.
- If more than one screening occurred during the current two-year reporting period, use the most recent screening.
- Documentation in a member's social history alone, *without* documentation indicating the date when the tobacco use screening was performed and the result or finding indicating that the member is a tobacco user in the medical record, does not meet criteria for data element D.

### Data Element E

- For data element E, documentation in the medical record must include one of the following:
  - A note indicating the date of tobacco cessation counseling or treatment
  - A note indicating the date of prescription of smoking cessation medication(s)
  - A note indicating the date of distribution of educational materials pertaining to tobacco use cessation
  - A note indicating the date of “anticipatory guidance” for tobacco use
- Any of the following do not meet criteria for data element E:
  - No assessment or counseling about the risks of tobacco usage
  - Assessment or counseling prior to or after the reporting period
  - Prescription or dispensing of medications that have uses beyond cessation (such as antidepressants) without any of the above documentation
  - Notation of “health education” or “anticipatory guidance” without any mention of specifics indicating that tobacco use was addressed

### General Guidance

- The reporting period for this measure is two years, but reporting will occur on an annual basis. For example, the submission due in 2025 will consist of data from CY 2023 and CY 2024, and the submission due in 2026 will consist of data from CY 2024 and CY 2025.
- The CER may be used to identify numerator events and exclusions.
- The date of the positive identification as a tobacco user must occur within the reporting period, but the tobacco use cessation intervention may or may not occur within the same reporting period.
  - For example, if a member is positively identified as a tobacco user during the last month of the reporting period, look to the first month of the following reporting period to determine if the member received a tobacco use cessation intervention within 30 days of the positive finding. If so, the member should be counted in data element E.

#### 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 collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>

#### MA4.4 Medication reconciliation post-discharge. – **Retired**

## MA4.5 Care for Adults.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
MA4. Performance and Quality Improvement	Annually	Contract	Calendar Year	By the end of the sixth 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 numbers of members continuously enrolled who were currently enrolled on December 31 of the reporting period.	Total numbers of members who were continuously enrolled in the MMP during the reporting period, and who were currently enrolled on December 31 of the reporting period.	Field type: Numeric
B.	Total number of members sampled who met inclusion criteria.	Of the total reported in A, the number of members sampled who met inclusion criteria.	Field type: Numeric Note: Is a subset of A
C.	Total number of members who had at least one medication review conducted by a prescribing practitioner or clinical pharmacist during the reporting period and the presence of a medication list in the medical record.	Of the total reported in B, the number of members who had at least one medication review conducted by a prescribing practitioner or clinical pharmacist during the reporting period and the presence of a medication list in the medical record.	Field Type: Numeric Note: Is a subset of B.

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of members who had at least one functional status assessment completed during the reporting period.	Of the total reported in B, the number of members who had at least one functional status assessment completed during the reporting period.	Field Type: Numeric  Note: Is a subset of B.
E.	Total number of members who had at least one pain screening or pain management plan completed during the reporting period.	Of the total reported in B, the number of members who had at least one pain screening or pain management plan completed during the reporting period.	Field Type: Numeric  Note: Is a subset of B.

- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will perform an outlier analysis.
  - As data are received from 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.
- 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.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of members who had each of the following completed during the reporting period:
- Medication review.
    - $\text{Percentage} = (C / B) * 100$
  - Functional status assessment.
    - $\text{Percentage} = (D / B) * 100$
  - Pain assessment.
    - $\text{Percentage} = (E / B) * 100$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

#### Definitions

- A medication list is a list of the member's medications in the medical record. The medication list may include medication names only or may include

medication names, dosages and frequency, over-the-counter (OTC) medications, and herbal or supplemental therapies.

- A medication review is a review of all a member's medications, including prescription medications, OTC medications, and herbal or supplemental therapies.
- A standardized tool is a set of structured questions that elicit member information. May include person-reported outcome measures, screening or assessment tools, or standardized questionnaires developed by the MMP to assess risks and needs.
- A clinical pharmacist is a pharmacist with extensive education in the biomedical, pharmaceutical, sociobehavioral, and clinical sciences. Clinical pharmacists are experts in the therapeutic use of medications and are a primary source of scientifically valid information and advice regarding the safe, appropriate, and cost-effective use of medications. Most clinical pharmacists have a Doctor of Pharmacy (PharmD) degree, and many have completed one or more years of post-graduate training (e.g., a general and/or specialty pharmacy residency). In some states, clinical pharmacists have prescriptive authority.
- A prescribing practitioner is a practitioner with prescribing privileges, including nurse practitioners, physician assistants, and other non-MDs who have the authority to prescribe medications.

#### Data Element A

- MMPs should include all members aged 21 years and older.<sup>2</sup>
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during the reporting period (i.e., January through December). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for two months [60 days] is not considered continuously enrolled).
- MMPs should only include those members who are currently enrolled as of the last day of the reporting period, including deceased members who were enrolled through the end of the reporting period. The last day of the reporting period is the anchor date, or the date on which all reported members must be enrolled in the MMP.

#### Data Element A Exclusions

- Exclude members who use hospice services or elect to use a hospice benefit at any time during the reporting period from the eligible population, regardless of when the services began. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record, claims/encounter data (Hospice Encounter value set; Hospice Intervention value set), or supplemental data.

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<sup>2</sup> The HEDIS eligible population for this measure is limited to individuals 66 years of age and older. The Massachusetts Demonstration population includes individuals ages 21 through 64 at the time of enrollment; therefore, this measure has been modified to apply to this population.

- Exclude members who die any time during the reporting period. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record, claims/encounter data, or supplemental data.

#### Data Element B

- MMPs may elect to use medical record review or supplemental documentation to identify the numerator (i.e., hybrid sampling). For further instructions on hybrid sampling, please see page MA-8 of this document.
- If an MMP does not elect to sample, data element B should be equal to data element A.

#### Data Element C

##### *Administrative Specifications*

- If the MMP elects to only use administrative data to identify members with a medication review completed, either of the following meet criteria:
  - Both of the following during the same visit during the reporting period where the provider type is a prescribing practitioner or clinical pharmacist. Exclude codes with a modifier (CPT CAT II Modifier value set):
    - At least one medication review (Medication Review value set)
    - The presence of a medication list in the medical record (Medication List value set)
  - Transitional care management services (Transitional Care Management Services value set) during the reporting period.
- Exclude services provided in an acute inpatient setting (Acute Inpatient value set; Acute Inpatient POS value set).

##### *Hybrid Specifications*

- A medication list, signed and dated during the reporting period by the appropriate practitioner type (prescribing practitioner or clinical pharmacist), meets criteria (the practitioner's signature is considered evidence that the medications were reviewed).
- When reviewing a member's medical record, documentation must come from the same medical record and must include one of the following:
  - A medication list in the medical record, **and** evidence of a medication review by a prescribing practitioner or clinical pharmacist and the date when it was performed.
  - Notation that the member is not taking any medication and the date when it was noted.
- A review of side effects for a single medication at the time of prescription alone is not sufficient.
- An outpatient visit is not required to meet criteria.
- Do not include medication lists or medication reviews performed in an acute inpatient setting.
- A medication review performed without the member present meets criteria.

## Data Element D

### *Administrative Specifications*

- If the MMP elects to only use administrative data to identify members with at least one functional status assessment completed, please refer to the Functional Status Assessment value set to identify numerator positive hits when using administrative data.
- Exclude services provided in an acute inpatient setting (Acute Inpatient value set; Acute Inpatient POS value set).
- Exclude codes with a modifier (CPT CAT II Modifier value set).

### *Hybrid Specifications*

- When reviewing a member's medical record, documentation must include evidence of a complete functional status assessment and the date when it was performed.
- Notations for a complete functional status assessment must include one of the following:
  - Notation that Activities of Daily Living (ADL) were assessed or that at least five of the following were assessed: bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking.
  - Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medications, handling finances.
  - Result of assessment using a standardized functional status assessment tool, not limited to:
    - SF-36®.
    - Assessment of Living Skills and Resources (ALSAR).
    - Barthel ADL Index Physical Self-Maintenance (ADLS) Scale®.
    - Bayer ADL (B-ADL) Scale.
    - Barthel Index®.
    - Edmonton Frail Scale®.
    - Extended ADL (EADL) Scale.
    - Groningen Frailty Index.
    - Independent Living Scale (ILS).
    - Katz Index of Independence in ADL®.
    - Kenny Self-Care Evaluation.
    - Klein-Bell ADL Scale.
    - Kohlman Evaluation of Living Skills (KELS).
    - Lawton & Brody's IADL scales®.
    - Patient Reported Outcome Measurement Information System (PROMIS) Global or Physical Function Scales®.
- A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) does not meet criteria for a comprehensive functional status assessment. The components of the

functional status assessment numerator may take place during separate visits within the reporting period.

- Do not include comprehensive functional status assessments performed in an acute inpatient setting.
- This measure does not require a specific setting. Therefore, services rendered during a telephone visit, e-visit, or virtual check-in meet criteria.

## Data Element E

### *Administrative Specifications*

- If the MMP elects to only use administrative data to identify members with at least one pain assessment completed, please refer to the Pain Assessment value set to identify numerator positive hits when using administrative data.
- Exclude services provided in an acute inpatient setting (Acute Inpatient value set; Acute Inpatient POS value set).
- Exclude codes with a modifier (CPT CAT II Modifier value set).

### *Hybrid Specifications*

- When reviewing a member's medical record, documentation in the medical record must include evidence of a pain assessment and the date when it was performed.
- Notations for a pain assessment must include one of the following:
  - Documentation that the patient was assessed for pain (which may include positive or negative findings for pain).
  - Result of assessment using a standardized pain assessment tool, not limited to:
    - Numeric rating scales (verbal or written).
    - Face, Legs, Activity, Cry Consolability (FLACC) scale®.
    - Verbal descriptor scales (5–7 Word Scales, present pain inventories).
    - Pain thermometer.
    - Pictorial Pain Scales (Faces Pain Scale®, Wong-Baker Pain Scale®).
    - Visual analogue scale.
    - Brief Pain Inventory®.
    - Chronic Pain Grade.
    - PROMIS Pain Intensity Scale®.
    - Pain Assessment in Advanced Dementia (PAINAD) Scale.
- Do not include pain assessments performed in an acute inpatient setting.
- This measure does not require a specific setting. Therefore, services rendered during a telephone visit, e-visit, or virtual check-in meet criteria.
- Notation alone of a pain management plan does not meet criteria.
- Notation alone of a pain treatment plan does not meet criteria.
- Notation alone of screening for chest pain or documentation alone of chest pain does not meet criteria.



## 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 collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>

## MA4.6 Depression screening and follow-up.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
MA4. Performance and Quality Improvement	Annually	Contract	Calendar Year	By the end of the sixth 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 were continuously enrolled in the MMP who had at least one outpatient visit, telephonic evaluation, or e-visit or virtual check-in during the reporting period.	Total number of members who were continuously enrolled in the MMP during the current reporting period who had at least one outpatient visit, telephonic evaluation, or e-visit or virtual check-in 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 Note: Is a subset of A.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
C.	Total number of members who were screened for clinical depression using an age-appropriate standardized screening tool at least once during the reporting period.	Of the total reported in B, the number of members who were screened for clinical depression using an age-appropriate standardized screening tool at least once during the reporting period.	Field Type: Numeric  Note: Is a subset of B.
D.	Total number of members who screened positive for clinical depression during the reporting period.	Of the total reported in C, the number of members who screened positive for clinical depression during the reporting period.	Field Type: Numeric  Note: Is a subset of C.
E.	Total number of members who had a follow-up plan documented within 30 days of the positive depression finding.	Of the total reported in D, the number of members who had a follow-up plan documented within 30 days of the positive depression finding.	Field Type; Numeric  Note: Is a subset of D.

- 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.
- 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.
  - MMPs should validate that data element D is less than or equal to data element C.
  - MMPs should validate that data element E is less than or equal to data element D.

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:

- Continuously enrolled in the MMP during the current reporting period with at least one outpatient visit, telephonic evaluation, or e-visit or virtual check-in during the current reporting period who were screened for clinical depression using an age-appropriate standardized screening tool at least once during the reporting period.
  - $\text{Percentage} = (C / B) * 100$
- Positively screened for clinical depression who had a follow-up plan documented within 30 days of the positive depression finding during the reporting period.
  - $\text{Percentage} = (E / D) * 100$

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

#### Definitions

- Clinical depression is not a specific term for a single diagnostic condition. Depressive disorders generally consist of major depressive disorder (MDD), dysthymia, and minor depression, but not other conditions with depressive features, such as bipolar disorder.
- Active diagnosis refers to the principal diagnosis of an episode of care and should be present at the start of the episode of care.
- A Standardized Depression Screening Tool is a normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the appropriate standardized depression screening tool utilized must be documented in the medical record.
- Standardized screening tools include:
  - Patient Health Questionnaire (PHQ-9)
  - Beck Depression Inventory (BDI or BDI-II)
  - Center for Epidemiologic Studies Depression Scale (CES-D)
  - Depression Scale (DEPS)
  - Duke Anxiety-Depression Scale (DADS)
  - Geriatric Depression Scale (GDS)
  - Cornell Scale Screening
  - PRIME MD-PHQ2
  - MDS Section E. Mood and Behavior Patterns – Scoring a Positive Depression Screen (Indicators of Depression, Anxiety, Sad Mood with a score of 1 or 2 for questions 1a, 1d, or 1h AND Mood Decline with a score of Yes or 1 on the mood decline questions)

#### Data Element A

- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during the reporting period (i.e., January through December). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in

coverage (i.e., a member whose coverage lapses for two months [60 days] is not considered continuously enrolled).

- For data element A, MMPs should use the Outpatient #2 value set to identify members with at least one outpatient visit during the reporting period. MMPs should use a designated field within the CER or the Telephone Visits value set to capture telephonic evaluations that occurred during the reporting period and the Online Assessments value set to capture e-visits and virtual check-ins that occurred during the reporting period.

#### Data Element B

- For reporting, medical record review is required. For further instructions on using hybrid sampling, please see page MA-8 of this document.

#### Data Element B Exclusions

- For data element B, MMPs should exclude members:
  - Who refuse to participate in the depression screening.
  - In an urgent or emergent situation due to a medical reason where time is of the essence and to delay treatment would jeopardize the member's health status.
  - Whose functional capacity or motivation to improve may impact the accuracy of the results of the standardized assessment (e.g., certain court appointed cases or cases of delirium).
  - With documentation of an active diagnosis of depression (Major Depression value set) or bipolar disorder (Bipolar Disorder value set and Other Bipolar Disorder value set) during the reporting period.
    - Note that a problem list alone, *without* documentation of an active diagnosis of depression or bipolar disorder during the reporting period, does not meet exclusion criteria for data element B.
  - With documentation of a depression screening conducted prior to the start of the reporting period who are undergoing treatment for depression.
  - With documentation of severe mental and/or physical incapacity where the member is unable to express themselves in a manner understood by others.
    - For example, cases such as delirium or severe cognitive impairment, where depression cannot be accurately assessed through the use of nationally recognized standardized depression assessment tools.

#### Data Element C

- For data element C, documentation in the medical record must include both of the following:
  - A note indicating the date when the depression screening was performed and the name of the standardized screening tool
  - The result or finding

### Data Element E

- A follow-up plan for a positive depression screening must include one or more of the following:
  - Additional evaluation for depression
  - Suicide risk assessment
  - Referral to a practitioner who is qualified to diagnose and treat depression
  - Pharmacological interventions
  - Other interventions or follow-up for the diagnosis or treatment of depression
- For data element E, documentation in the medical record must include both of the following:
  - A note indicating the date when the depression screening was performed and the positive result or finding
  - A note indicating the date and a plan for follow-up on the positive depression findings
    - Notation of counseling or referral for treatment for depression
    - Prescription of antidepressant medications or discussion of antidepressants for depression (not for off label uses such as smoking cessation)
    - Notation on counseling or symptoms of depression or where to get help
    - Notation of education on symptoms, treatment, or strategies to deal with depression
    - Distribution of educational material that may include symptoms of depression, treatment alternatives, red flag warnings, and where to get help
- The following are not positive findings for depression screening and follow-up:
  - No assessment or counseling or education on depression
  - Mental health treatment for other conditions
  - Assessment or counseling or education on depression prior to or after the reporting period
  - Use of “psychiatric” or “mental health” check boxes or global statements of “normal” without indication that depression screening specifically included
  - Use of a checklist indicating mental health was addressed, without specific reference to depression
  - Notation of assessment or counseling or education of a single symptom, such as sleep patterns, without any reference to screening for other symptoms related to depression

### General Guidance

- The CER may be used identify denominator and numerator events.
- The date of the screening must occur within the reporting period, but the follow-up plan may or may not be completed within the same reporting period.

- For example, if a screening occurs during the last month of the reporting period, look to the first month of the following reporting period to determine if a follow-up plan was documented within 30 days of the positive depression finding. If so, the member should be counted in data element E.
- For instances when more than one screening is administered to a member during the reporting period, the MMP should reference the most recent depression screening conducted for the member during the reporting period, regardless of whether the screenings were administered on different days or on the same day.
  - Note that the outcome of the depression screening does not determine which screening should be reported (e.g., do not automatically count the screening with a positive result in data element D).
- For instances when more than one screening is administered to a member on the same day during the reporting period, the MMP should reach out to the provider where the screenings were administered to understand the provider's policy for administering multiple screenings on the same day and which type of screening (e.g., PHQ-9, MDS, etc.) represents the final determination.
- Note that if the MMP is unable to obtain this information from the provider, the screening that yielded a positive result should be reported.

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 collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>

**Section MAV. Systems****MA5.1 MMP Centralized Enrollee Record.<sup>i,ii</sup>**

MMPs should refer to the MassHealth specifications for reporting this measure.

**Section MAVI. Utilization****MA6.1 Chronic obstructive pulmonary disease (COPD) or asthma in older adults admission rate. (PQI #05)**

<b>CONTINUOUS REPORTING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Periods</b>	<b>Due Date</b>
MA6. Utilization	Annually	Contract	Calendar Year	By the end of the sixth 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.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of member months for members age 40 and older.	Total number of member months during the reporting period for members age 40 and older.	Field Type: Numeric
B.	Total number of hospital discharges for members age 40 years and older with a principal ICD-10-CM diagnosis code for COPD (excluding acute bronchitis); or a principal ICD-10-CM diagnosis code for asthma.	Of the total reported in A, the number of hospital discharges for members age 40 years and older with a principal ICD-10 CM diagnosis code for COPD (excluding acute bronchitis); or a principal ICD-10-CM diagnosis code for asthma.	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 1 and 12. A value greater than 12 is not acceptable.
- 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 hospitalizations for members age 40 years and older with either a primary ICD-10-CM diagnosis code for COPD (excluding acute bronchitis); or a principal ICD-10-CM diagnosis code for asthma per 100,000 member months.
    - $\text{Rate} = (B / A) * 100,000$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

#### Data Element A

- MMPs should include all member months for members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- For data element A, use the members' age on the specified day of each month to determine the age group to which member months will be contributed.
  - For example, if an MMP tallies members on the 1st of each month and Ms. X turns 40 on April 3 and is enrolled for the entire year, then Ms. X contributes eight months to the 40 and older age group category.

#### Data Element B

- The numerator for this measure is based on hospital discharges, not members.
- To identify data element B, MMPs should include hospital discharges for members age 40 years and older with either:
  - A principal ICD-10-CM diagnosis for COPD (excluding acute bronchitis) (COPD [Excluding Acute Bronchitis] value set); or
  - A principal ICD-10-CM diagnosis for Asthma (Asthma value set)
- For data element B, age is based on the date of admission.

#### Data Element B Exclusions

- MMPs should exclude the following cases:



- With any listed ICD-10-CM diagnosis codes for cystic fibrosis and anomalies of the respiratory system (Cystic Fibrosis and Anomalies of the Respiratory System value set).
- With admission source for transferred from a different hospital or other health care facility (Admission Codes for Transfers value set).
- With a point of origin code for transfer from a hospital, a skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), or other healthcare facility (Admission Codes for Transfers value set).
- Obstetric discharges (Note: By definition, discharges with a principal diagnosis of COPD, asthma, or acute bronchitis exclude obstetric discharges, because the principal diagnosis for an obstetric discharge would identify it as obstetric, and no such diagnoses are included in the set of qualifying diagnoses).

#### General Guidance

- 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 1 and 12. A value greater than 12 is not acceptable. Determine member months using the 1st of the month. This date must be used consistent from member to member, month to month and from year to year.
  - For example, if Ms. X is enrolled in the organization on January 1, Ms. X contributes one member month in January.

#### 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 collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>

#### MA6.2 Heart failure admission rate. (PQI #08)

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Periods	Due Date
MA6. Utilization	Annually	Contract	Calendar Year	By the end of the sixth 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 member months for members age 18 and older.	Total number of member months during the reporting period for members age 18 and older.	Field Type: Numeric
B.	Total number of hospital discharges for members age 18 years and older with a principal ICD-10-CM diagnosis code for heart failure.	Of the total reported in A, the number of hospital discharges for members age 18 years and older with a principal ICD-10-CM diagnosis code for heart failure.	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 1 and 12. A value greater than 12 is not acceptable.
- 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 hospitalizations for members age 18 years and older with a principal ICD-10-CM diagnosis code for heart failure per 100,000 member months.
    - $\text{Rate} = (B / A) * 100,000$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

#### Data Element A

- MMPs should include all member months for members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).

### Data Element B

- The numerator for this measure is based on hospital discharges, not members.
- Age is based on date of admission.
- Codes to identify heart failure are provided in the Heart Failure value set.

### Data Element B Exclusions

- MMPs should exclude the following cases:
  - With any listed ICD-10-PCS procedure codes for cardiac procedure (Cardiac Procedure value set).
  - With admission source for transferred from a different hospital or other health care facility (Admission Codes for Transfers value set).
  - With a point of origin code for transfer from a hospital, a skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), or other healthcare facility (Admission Codes for Transfers value set).
  - Obstetric discharges (Note: By definition, discharges with a principal diagnosis of heart failure exclude obstetric discharges, because the principal diagnosis for an obstetric discharge would identify it as obstetric, and no such diagnoses are included in the set of qualifying diagnoses).

### General Guidance

- 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 1 and 12. A value greater than 12 is not acceptable. Determine member months using the 1st of the month. This date must be used consistent from member to member, month to month and from year to year.
  - For example, if Ms. X is enrolled in the organization on January 1, Ms. X contributes one member month in January.

#### 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 collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>