MEDICARE-MEDICAID CAPITATED FINANCIAL ALIGNMENT MODEL REPORTING REQUIREMENTS: SOUTH CAROLINA-SPECIFIC REPORTING REQUIREMENTS

Effective as of February 1, 2015, Issued August 13, 2015

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South Carolina-Specific Reporting Requirements Appendix

Introduction

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

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

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

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

MMPs should contact the SC Help Desk at SCHelpDesk@norc.org with any question about the South Carolina state-specific appendix or the data submission process.

Definitions

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

Calendar Year (CY): All annual measures are reported on a calendar year basis. Calendar year 2015 will begin on January 1, 2015 and end on December 31, 2015.

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

Demonstration Year (DY): The unit of time used in calculating savings percentages and quality withhold percentages:

Demonstration Year 1: February 1, 2015 - December 31, 2016
Demonstration Year 2: January 1, 2017 - December 31, 2017
Demonstration Year 3: January 1, 2018 - December 31, 2018

HCBS: Waiver-specific services provided to individuals enrolled in the CLTC waiver programs. Services are listed at: https://www.scdhhs.gov/historic/insideDHHS/Bureaus/BureauofLongTermCareServices/CLTCOverview.html

HCBS-like Services: Services typically provided only under the CLTC waiver programs. When these services are provided to individuals who do not meet the level of care requirements to receive these services as part of the waiver, the services are considered "HCBS-like" services. Services are listed at: https://www.scdhhs.gov/historic/insideDHHS/Bureaus/BureauofLongTermCareServices/CLTCOverview.html

Implementation Period: The period of time starting with the first effective enrollment date until December 31, 2015.

Long Term Services and Supports (LTSS): A variety of services and supports that help elderly individuals and/or individuals with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities.

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.

Quality Withhold Measures

CMS and the state will establish a set of quality withhold measures, and MMPs will be required to meet established thresholds. Throughout this document, these measures are marked with the following symbol: (ⁱ). This document contains only Demonstration Year 1 (DY1) quality withhold measures. CMS and the state will update the quality withhold measures for subsequent demonstration years closer to the start of Demonstration Year 2 (DY2). Additional information on the withhold methodology and benchmarks will be provided at a later time.

Reporting on Disenrolled and Retro-disenrolled Members

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

Reporting on Comprehensive Assessments and ICPs Completed Prior To First Effective Enrollment Date

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

For purposes of reporting data on assessments (Core 2.1, Core 2.2 and state-specific measures SC1.1 and SC1.2), MMPs should report assessments completed prior to the first effective enrollment date as if they were completed on the first effective enrollment date. For example, if a member's first effective enrollment date was June 1 and the assessment for that member was completed on May 25, the MMP should report the assessment as if it were completed on June 1.

MMPs should refer to the Core reporting requirements for detailed specifications for reporting Core 2.1 and Core 2.2 and to the state-specific reporting requirements for specifications on reporting SC1.1 and SC1.2. For example, Core 2.1 should only include members whose 90th day of enrollment occurred during the reporting period. Members enrolled into the MMP on March 1, 2015, would reach their 90th day (i.e., three full months) on May 31, 2015. Therefore, these members would be reported in the data submission for the May monthly

reporting period, even if their assessment was marked as complete on the first effective enrollment date (i.e., March 1).

MMPs must comply with contractually specified timelines regarding completion of Individualized Care Plans (ICPs) within 90 days of enrollment. In the event that an ICP is also finalized prior to the first effective enrollment date, MMPs should report completion of the ICP (for measures SC2.1 and SC2.2) as if they were completed on the first effective enrollment date. For example, if a member's first effective enrollment date was June 1 and the ICP for that member was completed on May 27, the MMP should report the ICP as if it were completed on June 1.

Guidance on Comprehensive Assessments and ICPs for Members with a Break in Coverage

Comprehensive Assessments

To determine if an assessment should be conducted for a member that re-enrolled in the same or a different MMP, the MMP should first review the member's Phoenix case management record to determine if the member previously received an assessment from any MMP in the Healthy Connections Prime program. If the member did receive an assessment that is included in Phoenix, and it was completed within one year of his/her most recent enrollment date, then the MMP is not necessarily required to conduct a new assessment. Instead, the MMP can:

1. 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

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

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 his/her authorized representative) to determine if there was a change in the member's health status or needs.

If a change is identified, the MMP must conduct a new assessment within the timeframe prescribed by the contract. If there are no changes, the MMP is not required to conduct a new assessment unless requested by the member (or his/her 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 (and the applicable state-specific measures). When reporting these measures, the MMP should count the number of enrollment 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.

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 his/her health status with the MMP, then the MMP may report that member as unwilling to participate in the assessment.

If an assessment was not completed for the re-enrolled member during his/her prior enrollment period in Healthy Connections Prime, 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 contract. The MMP must make the requisite number of attempts to reach the member (at minimum) after his/her most recent enrollment effective date, even if the MMP reported that the member was unable to be reached during his/her prior enrollment. Similarly, members that 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 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 applicable state-specific 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 an ICP was not completed and loaded into Phoenix for the re-enrolled member during his/her prior enrollment period in Healthy Connections Prime, 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 contract. The MMP must also follow the above guidance regarding reaching out to members that previously refused to participate or were not reached.

Annual Reassessments and ICP Updates

The MMP must follow contract requirements 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 assessment was actually completed, even if that date was during the member's prior enrollment period.

South Carolina's Implementation, Ongoing, and Continuous Reporting Periods

Demonstration Year 1			
Phase		**Dates**	**Explanation**
Continuous Reporting	Implementation Period	2-1-15 through 12-31-15	From the first effective enrollment date through December 31, 2015.
	Ongoing Period	2-1-15 through 12-31-16	From the first effective enrollment date through the end of the first demonstration year.
Demonstration Year 2			
Continuous Reporting	Ongoing Period	1-1-17 through 12-31-17	From January 1st through the end of the second demonstration year.
Demonstration Year 3			
Continuous Reporting	Ongoing Period	1-1-18 through 12-31-18	From January 1st through the end of the third demonstration year.

Data Submission

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

(Note: Prior to the first use of the system, all MMPs will receive an email notification with the username and password that has been assigned to their

plan. This information will be used to log in to the FAI system and complete the data submission.)

All 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 SC HelpDesk (SCHelpDesk@norc.org) to request resubmission.
   - Specify in the email which measures need resubmission;
   - Specify for which reporting period(s) the resubmission is needed; and
   - Provide a brief explanation for why the data need to be resubmitted.

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

3. Resubmit data through the applicable reporting system.

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

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

Section SCI. Assessment

SC1.1 Low-risk members with a comprehensive assessment completed within 90 days of enrollment.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
SC1. Assessment	Monthly, beginning after 90 days	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period.
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
SC1. Assessment	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of low-risk members enrolled whose 90th day of enrollment occurred within the reporting period.	Total number of low-risk members enrolled whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric
B.	Total number of low-risk members who are documented as unwilling to participate in the comprehensive assessment within 90 days of enrollment.	Of the total reported in A, the number of low-risk members who are documented as unwilling to participate in the comprehensive assessment within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of low-risk members the MMP was unable to reach, following three documented attempts within 90 days of enrollment.	Of the total reported in A, the number of low-risk members the MMP was unable to reach, following three documented attempts within 90 days of enrollment.	Field type: Numeric Note: Is a subset of A.
D.	The number of low-risk members with a comprehensive assessment completed within 90 days of enrollment.	Of the total reported in A, the number of low-risk members with a comprehensive assessment completed within 90 days of enrollment.	Field type: Numeric Note: Is a subset of A.

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

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

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

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data elements B, C, and D are less than or equal to data element A.
- All data elements should be positive values.

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

- Were unable to be reached following three documented attempts to have their comprehensive assessment completed within 90 days of enrollment.
- Were unwilling to participate in a comprehensive assessment within 90 days of enrollment.
- Had a comprehensive assessment completed within 90 days of enrollment.
- Were willing to participate and who could be reached who had a comprehensive assessment completed within 90 days of enrollment.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The 90th day of enrollment should be based on each member's effective date. For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months.
- The effective date of enrollment is the first date of the member's coverage through the MMP.
- MMPs should refer to the South Carolina three-way contract for specific requirements pertaining to criteria for identifying low-risk members.
- MMPs should refer to the South Carolina three-way contract for specific requirements pertaining to a comprehensive assessment.
- For data element B, MMPs should report the number of members who were unwilling to participate in the comprehensive assessment if a member (or his or her authorized representative):
    - Affirmatively declines to participate in the assessment. Member communicates this refusal by phone, mail, fax, or in person.
    - Expresses willingness to complete the assessment but asks for it to be conducted after 90 days (despite being offered a reasonable opportunity to complete the assessment within 90 days). Discussions with the members must be documented by the MMP.
    - Expresses willingness to complete the assessment, but reschedules or is a no-show and then is subsequently non-responsive. Attempts to contact the member must be documented by the MMP.
    - Initially agrees to complete the assessment, but then declines to answer a majority of the questions in the assessment.
- For data element C, MMPs should report the number of members the MMP was unable to reach after three attempts to contact the member. MMPs should refer to the SC three-way contract or state guidance for any specific requirements pertaining to the method of outreach to members. MMPs must document each attempt to reach the member, including the method of the attempt (i.e., phone, mail, or email), as CMS and the state may validate this number. There may be instances when the MMP has a high degree of confidence

that a members contact information is correct, yet that member is not responsive to the MMPs outreach efforts. So long as the MMP follows the guidance regarding outreach attempts, these members may be included in the count for this data element.

- There may be certain circumstances that make it impossible or inappropriate to complete an assessment within 90 days of enrollment. For example, a member may be medically unable to respond and have no authorized representative to do so on their behalf, or a member may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for an assessment. However, MMPs should not include such members in the counts for data elements B and C.
- If a member's assessment was started but not completed within 90 days of enrollment, then the assessment should not be considered completed and, therefore, would not be counted in data elements B, C, or D. However, this member would be included in data element A.

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

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

SC1.2 Moderate and high-risk members with a comprehensive assessment completed within 60 days of enrollment.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
SC1. Assessment	Monthly, beginning after 60 days	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period.
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
SC1. Assessment	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of moderate and high-risk members enrolled whose 60th day of enrollment occurred within the reporting period.	Total number of moderate and high-risk members enrolled whose 60th day of enrollment occurred within the reporting period.	Field Type: Numeric
B.	Total number of moderate and high - risk members who are documented as unwilling to participate in the comprehensive assessment within 60 days of enrollment.	Of the total reported in A, the number of moderate and high - risk members who are documented as unwilling to participate in the comprehensive assessment within 60 days of enrollment.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of moderate and high - risk members the MMP was unable to reach, following three documented attempts within 60 days of enrollment.	Of the total reported in A, the number of moderate and high - risk members the MMP was unable to reach, following three documented attempts within 60 days of enrollment.	Field type: Numeric Note: Is a subset of A.
D.	The number of moderate and high - risk members with a comprehensive assessment completed within 60 days of enrollment.	Of the total reported in A, the number of moderate and high - risk members with a comprehensive assessment completed within 60 days of enrollment.	Field type: Numeric Note: Is a subset of A.

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

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

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

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data elements B, C, and D are less than or equal to data element A.
- All data elements should be positive values.

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

- Were unable to be reached to have their comprehensive assessment completed within 60 days of enrollment.
- Were unwilling to participate in a comprehensive assessment within 60 days of enrollment.
- Had a comprehensive assessment completed within 60 days of enrollment.
- Were willing to participate and who could be reached who had a comprehensive assessment completed within 60 days of enrollment.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The 60th day of enrollment should be based on each member's effective date. For the purposes of reporting this measure, 60 days of enrollment will be equivalent to two full calendar months.
- The effective date of enrollment is the first date of the member's coverage through the MMP.
- MMPs should refer to the South Carolina three-way contract for specific requirements pertaining to criteria for identifying moderate and high-risk members.
- MMPs should refer to the South Carolina three-way contract for specific requirements pertaining to a comprehensive assessment.
- For data element B, MMPs should report the number of members who were unwilling to participate in the comprehensive assessment if a member (or his or her authorized representative):
    - Affirmatively declines to participate in the assessment. Member communicates this refusal by phone, mail, fax, or in person.
    - Expresses willingness to complete the assessment but asks for it to be conducted after 60 days (despite being offered a reasonable opportunity to complete the assessment within 60 days). Discussions with the member must be documented by the MMP.
    - Expresses willingness to complete the assessment, but reschedules or is a no-show and then is subsequently non-responsive. Attempts to contact the member must be documented by the MMP.
    - Initially agrees to complete the assessment, but then declines to answer a majority of the questions in the assessment.
- For data element C, MMPs should report the number of members the MMP was unable to reach after three attempts to contact the member. MMPs should refer to the SC three-way contract or state guidance for any specific requirements pertaining to the method of outreach to members. MMPs must document each attempt to reach the member, including the method of the attempt (i.e., phone, mail, or email), as CMS and the state may validate this number. There may be instances when the MMP has a high degree of confidence

that a members contact information is correct, yet that member is not responsive to the MMPs outreach efforts. So long as the MMP follows the guidance regarding outreach attempts, these members may be included in the count for this data element.

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

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

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

SC1.3 Suicide risk assessment (PCPI Measure #2, Adult Major Depressive Disorder set).

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
SC1. Assessment	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members aged 21 years and older with a diagnosis of new or recurrent episode of major depressive disorder.	Total number of members aged 21 years and older with a diagnosis of new or recurrent episode of major depressive disorder during the reporting period.	Field Type: Numeric
B.	Total number of members sampled that met inclusion criteria.	Of the total reported in A, the number of members sampled that met inclusion criteria.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members with a suicide risk assessment completed during the visit in which a diagnosis of new or recurrent episode was identified.	Of the total reported in B, the number of members with a suicide risk assessment completed during the visit in which a diagnosis of new or recurrent episode was identified.	Field Type: Numeric Note: Is a subset of B.

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

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

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

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A and greater than or equal to data element C.
- MMPs should validate that data element C is less than or equal to data element B.
- All data elements should be positive values.

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

- CMS and the state will evaluate the percentage of members aged 21 years and older with a suicide risk assessment completed during the visit in which a diagnosis of new or recurrent episode of major depressive disorder was identified.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. A subset of members that are eligible will be included in the sample. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- For reporting, the MMPs may elect to sample since this measure requires documentation review to identify the numerator. Sampling should be systematic to ensure all eligible individuals have an equal chance of inclusion. The sample size should be 411, plus oversample to allow for substitution. For further instructions on selecting the sample size, please see pages 34-35 of the Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements on CMS' Web site: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans
- If MMPs do not elect to sample, data element B should be equal to data element A.
- The visit in which a diagnosis of new or recurrent episode was identified can include any Ambulatory Care (Primary Care, Mental Health, Day Treatment).
- The suicide risk assessment must include questions about the following:
    - Suicidal ideation
    - Member's intent of initiating a suicide attempt

  And, if either of these are present, questions about:
    - Member's plans for a suicide attempt
    - Whether the member has means for completing suicide
- Codes to identify a single episode or recurrent episode of major depressive disorder are provided in Table SC-1.
- Codes to identify a member encounter/visit during the reporting period are provided in Table SC-2.
- Codes to identify members with a suicide risk assessment completed are provided in Table SC-3.

Table SC-1: Codes to Identify Major Depressive Disorder
ICD-9-CM Diagnosis
296.20 – 296.26, 296.31- 296.31, 296.33 – 296.36

Table SC-2: Codes to Identify Patient Encounter
CPT
90791, 90792, 90832, 90834, 90837, 90845, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285

Table SC-3: Codes to Identify Suicide Risk Assessment
G8932

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 SCII. Care Coordination

SC2.1 Low, moderate, and high-risk members with an Individualized Care Plan (ICP) completed within 90 days of enrollment.[i]

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
SC2. Care Coordination	Monthly, beginning after 90 days	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
SC2. 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 low-risk members enrolled whose 90th day of enrollment occurred within the reporting period.	Total number of low-risk members enrolled whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric
B.	Total number of low-risk members who are documented as unwilling to complete an ICP within 90 days of enrollment.	Of the total reported in A, the number of low-risk members who are documented as unwilling to complete an ICP within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of low-risk members the MMP was unable to reach, following three documented attempts within 90 days of enrollment.	Of the total reported in A, the number of low-risk members the MMP was unable to reach, following three documented attempts within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of low-risk members with an ICP completed within 90 days of enrollment.	Of the total reported in A, the number of low-risk members with an ICP completed within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of A.
E.	Total number of moderate-risk members enrolled whose 90th day of enrollment occurred within the reporting period.	Total number of moderate-risk members enrolled whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric
F.	Total number of moderate-risk members who are documented as unwilling to complete an ICP within 90 days of enrollment.	Of the total reported in E, the number of moderate-risk members who are documented as unwilling to complete an ICP within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of E.
G.	Total number of moderate-risk members the MMP was unable to reach, following three documented attempts within 90 days of enrollment.	Of the total reported in E, the number of moderate-risk members the MMP was unable to reach, following three documented attempts within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of E.
H.	Total number of moderate-risk members with an ICP completed within 90 days of enrollment.	Of the total reported in E, the number of moderate-risk members with an ICP completed within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of E.

Element Letter	Element Name	Definition	Allowable Values
I.	Total number of high-risk members enrolled whose 90th day of enrollment occurred within the reporting period.	Total number of high-risk members enrolled whose 90th day of enrollment occurred within the reporting period.	Field Type: Numeric
J.	Total number of high-risk members who are documented as unwilling to complete an ICP within 90 days of enrollment.	Of the total reported in I, the number of high-risk members who are documented as unwilling to complete an ICP within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of I.
K.	Total number of high-risk members the MMP was unable to reach, following three documented attempts within 90 days of enrollment.	Of the total reported in I, the number of high-risk members the MMP was unable to reach, following three documented attempts within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of I.
L.	Total number of high-risk members with an ICP completed within 90 days of enrollment.	Of the total reported in I, the number of high-risk members with an ICP completed within 90 days of enrollment.	Field Type: Numeric Note: Is a subset of I.

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

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

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

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data elements B, C, and D are less than or equal to data element A.
- MMPs should validate that data elements F, G, and H are less than or equal to data element E.
- MMPs should validate that data elements J, K, and L are less than or equal to data element I.
- All data elements should be positive values.

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

- Low-risk members who were unable to be reached to have an ICP completed within 90 days of enrollment.
- Low-risk members who refused to have an ICP completed within 90 days of enrollment.
- Low-risk members who had an ICP completed within 90 days of enrollment.
- Low-risk members who were willing to participate and who could be reached who had an ICP completed within 90 days of enrollment.
- Moderate-risk members who were unable to be reached to have an ICP completed within 90 days of enrollment.
- Moderate-risk members who refused to have an ICP completed within 90 days of enrollment.
- Moderate-risk members who had an ICP completed within 90 days of enrollment.
- Moderate-risk members who were willing to participate and who could be reached who had an ICP completed within 90 days of enrollment.
- High-risk members who were unable to be reached to have a ICP completed within 90 days of enrollment.
- High-risk members who refused to have an ICP completed within 90 days of enrollment.
- High-risk members who had an ICP completed within 90 days of enrollment.
- High-risk members who were willing to participate and who could be reached who had an ICP completed within 90 days of enrollment.

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

- MMPs should include all low, moderate, and high-risk members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Element A, E, and I regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The 90th day of enrollment should be based on each member's effective date. For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months.
- The effective date of enrollment is the first date of the member's coverage through the MMP.

- MMPs should refer to the South Carolina three-way contract for specific requirements to identify low, moderate, and high-risk members.
- MMPs should refer to the South Carolina three-way contract for specific requirements pertaining to an ICP.
- Low, moderate, and high-risk members should be classified based off of the risk category determined during the health risk screen.
- For data elements B, F, and J, MMPs should report the number of members who were unwilling to participate in the development of the ICP if a member (or his or her authorized representative):
    - Affirmatively declines to participate in the ICP. Member communicates this refusal by phone, mail, fax, or in person.
    - Expresses willingness to complete the ICP but asks for it to be conducted after 90 days following the completion of the assessment (despite being offered a reasonable opportunity to complete the ICP within 90 days). Discussions with the member must be documented by the MMP.
    - Expresses willingness to complete the ICP, but reschedules or is a no-show and then is subsequently non-responsive. Attempts to contact the member must be documented by the MMP.
    - Initially agrees to complete the ICP, but then declines to answer a majority of the questions in the ICP.
- For data elements C, G, and K, MMPs should report the number of members the MMP was unable to reach after three attempts to contact the member. MMPs should refer to the SC three-way contract or state guidance for any specific requirements pertaining to the method of outreach to members. MMPs must document each attempt to reach the member, including the method of the attempt (i.e., phone, mail, or email), as CMS and the state may validate this number. There may be instances when the MMP has a high degree of confidence that a member's contact information is correct, yet that member is not responsive to the MMP's outreach efforts. So long as the MMP follows the guidance regarding outreach attempts, these members may be included in the count for this data element.
- There may be certain circumstances that make it impossible or inappropriate to complete a ICP within 90 days of enrollment. For example, a member may become medically unable to respond and have no authorized representative to do so on their behalf, or a member may be experiencing an acute medical or behavioral health crisis that requires immediate attention and outweighs the need for a ICP. However, MMPs should not include such members in the counts for data elements B, C, F, G, J, or K.

- If a ICP was started but not completed within 90 days of enrollment, then the ICP should not be considered completed and, therefore, would not be counted in data elements B, C, D, F, G, H, J, K, or L. However, this member would be included in data elements A, E, and I.
- Low-risk members will have their ICP continuously monitored and reviewed every 120 days.
- Moderate-risk members will have their ICP continuously monitored and reviewed every 90 days.
- High-risk members will have their ICP continuously monitored and reviewed every 30 days.

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

SC2.2 Members with an ICP completed.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
SC2. Care Coordination	Monthly, beginning after 90 days	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
SC2. 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, including examples, methods for calculations, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members enrolled for 90 days or longer as of the end of the reporting period.	Total number of members enrolled for 90 days or longer as of the end of the reporting period.	Field Type: Numeric
B.	Total number of members who had an ICP completed.	Of the total reported in A, the number of members who had an ICP completed as of the end of the reporting period.	Field Type: Numeric Note: Is a subset of A.

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

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

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

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

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

- CMS and the state will evaluate the percentage of members enrolled for 90 days or longer who had an ICP completed as of the end of the reporting period.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- The 90th day of enrollment should be based on each member's effective enrollment date. For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months.

- The effective date of enrollment is the first date of the member's coverage through the MMP.
- The ICPs reported in element B could have been completed at any time after enrollment, not necessarily during the reporting period.
- MMPs should refer to SC's three-way contract for specific requirements pertaining to ICPs.

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

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

SC2.3 Members eligible for HCBS with a waiver service plan within 90 days of enrollment.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
SC2. Care Coordination	Quarterly, beginning in CY 2016	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 determined to be newly eligible for HCBS whose 90th day of enrollment in the MMP occurred within the reporting period.	Total number of members determined to be newly eligible for HCBS whose 90th day of enrollment in the MMP occurred within the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of members newly eligible for HCBS with a waiver service plan completed within 90 days of enrollment in the MMP.	Of the total reported in A, the number of members newly eligible for HCBS with a waiver service plan completed within 90 days of enrollment in the MMP.	Field Type: Numeric Note: Is a subset of A.

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

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

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

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

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

- CMS and the state will evaluate the percentage of members eligible for HCBS with a waiver service plan completed within 90 days of enrollment.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- The 90th day of enrollment should be based on each member's effective date. For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months.
- The effective date of enrollment is the first date of the member's coverage through the MMP.

- MMPs should refer to the South Carolina three-way contract for specific requirements pertaining to a waiver service plan.
- This measure will not be collected or reported until Calendar Year 2 (2016) to correspond with Phase II of the HCBS transition plan. Calendar Year 2016 will be Calendar Year 2 for all MMPs whose demonstration effective enrollment date began in Calendar Year 2015.

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

SC2.4 Members with first follow-up visit within 30 days of hospital discharge.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
SC2. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the fourth month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of hospital discharges.	Total number of hospital discharges during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge from the hospital.	Of the total reported in A, the number of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge from the hospital.	Field Type: Numeric Note: Is a subset of A.

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

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

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

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

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

- CMS and the state will evaluate the percentage of hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of the discharge from the hospital.

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

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

- The member needs to be enrolled from the date of the hospital discharge through 30 days after the hospital discharge, with no gaps in enrollment to be included in this measure.
- A follow-up visit is defined as an ambulatory care follow-up visit to assess the member's health following a hospitalization. Codes to identify follow-up visits are provided in Table SC-4.
- Codes to identify inpatient discharges are provided in Table SC-5.
- Exclude discharges in which the patient was readmitted within 30 days after discharge to an acute or non-acute facility.
- Exclude discharges due to death. Codes to identify patients who have expired are provided in Table SC-6.

Table SC-4: Codes to Identify Ambulatory Health Services

Description	CPT	HCPCS	ICD-9-CM Diagnosis	UB Revenue
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245			051x, 0520-0523, 0526-0529, 0982, 0983
Home services	99341-99345, 99347-99350			
Nursing facility care	99304-99310, 99315, 99316, 99318			0524, 0525
Domiciliary, rest home or custodial care services	99324-99328, 99334-99337			
Preventive medicine	9938-99387, 99395-99397, 99401-99404, 99411, 99412, 99420, 99429	G0344, G0402, G0438, G0439		
Ophthalmology and optometry	92002, 92004, 92012, 92014			
General medical examination			V70.0, V70.3, V70.5, V70.6, V70.8, V70.9	

Table SC-5: Codes to Identify Inpatient Discharges

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

WITH

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

Table SC-6: Codes to Identify Patients who Expired
Discharge Status Code
20

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

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

SC2.5 MMPs with established work plan and systems in place, utilizing Phoenix as appropriate, for ensuring smooth transition to and from hospitals, nursing facilities, and the community.[i]

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
SC2. Care Coordination	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period.

A. Data element definitions

- To be determined.

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

- To be determined.

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

- To be determined.

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

- To be determined.

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

- To be determined.

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

- To be determined.

SC2.6 Transition (admissions and discharge) between hospitals, nursing facilities and the community.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
SC2. 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 member months during the reporting period.	Total number of member months during the reporting period.	Field Type: Numeric
B.	Total number of inpatient hospital discharges to nursing facilities.	The number of inpatient hospital discharges to the nursing facilities during the reporting period.	Field Type: Numeric
C.	Total number of inpatient hospital discharges to the community.	The number of inpatient hospital discharges to the community during the reporting period.	Field Type: Numeric
D.	Total number of inpatient hospital admissions from the community.	The number of inpatient hospital admissions from the community during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
E.	Total number of nursing facility admissions from the community.	The number of nursing facility admissions from the community during the reporting period.	Field Type: Numeric
F.	Total number of nursing facility discharges to the community.	The number of nursing facility discharges to the community during the reporting period.	Field Type: Numeric
G.	Total number of inpatient hospital admissions from nursing facilities.	The number of inpatient hospital admissions from nursing facilities during the reporting period.	Field Type: Numeric
H.	Number of Care transitions recorded and transmitted to CICO Care Coordinator (via Phoenix)	Of the total transitions reported in B through G, the number of transitions that were recorded and transmitted to CICO Care Coordinator via Phoenix within 30 calendar days of the transition.	Field Type: Numeric Note: Is a subset of the sum of B, C, D, E, F, and G.

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

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

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

- All data elements should be positive values.
- MMPs should validate that data element H is less than or equal to the sum of data elements B through G.

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:

- Inpatient hospital discharges to nursing facilities during the reporting period per 1,000 member months.

- Inpatient hospital discharges to the community during the reporting period per 1,000 member months.
- Inpatient hospital admissions from the community during the reporting period per 1,000 member months.
- Nursing facility admissions from the community during the reporting period per 1,000 member months.
- Nursing facility discharges to the community during the reporting period per 1,000 member months.
- Inpatient hospital admissions from nursing facilities during the reporting period per 1,000 member months.
- Care transitions recorded and transmitted to CICO Care Coordinator (via Phoenix) within 30 calendar days of the transition.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all member months for members who meet the criteria outlined in Element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- A transition is the movement (i.e., admission or discharge) of a member from one care setting to another as the member's health status changes; for example, moving from home to a hospital as the result of an exacerbation of a chronic condition or moving from the hospital to a rehabilitation facility after surgery.
- Inpatient hospital admissions and discharges are based on the CMS 2 midnight rule. The 2 midnight rule requires members to be admitted to the hospital for a minimum of 2 midnights to be considered an inpatient hospital admission. For further guidance on applying the 2 midnight rule, please review the FAQ posted on CMS' website: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/Questions_andAnswersRelatingtoPatientStatusReviewsforPosting_31214.pdf

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 SCIII. Enrollee Protections

SC3.1 The number of critical incident and abuse reports for members receiving LTSS.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
SC3. 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
ONGOING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
SC3. 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.

Element Letter	Element Name	Definition	Allowable Values
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.

- All data elements should be positive values.

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

- CMS and the state will evaluate the number of critical incident and abuse reports per 1,000 members receiving LTSS.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- It is possible for members to have more than one critical incident and/or abuse report during the reporting period. All critical incident and abuse reports during the reporting period should be counted.
- Critical incident refers to any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or well-being of a member.
- Abuse refers to:

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

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 SCIV. Organizational Structure and Staffing

SC4.1 Care coordinator training for supporting self-direction under the demonstration.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
SC4. Organizational Structure and Staffing	Annually	Contract	Calendar Year	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of new care coordinators.	Total number of new care coordinators employed by the MMP for at least 3 months during the reporting period.	Field Type: Numeric
B.	Total number of new care coordinators that have undergone training for supporting self-direction under the demonstration.	Of the total reported in A, the number of new care coordinators that have undergone training for supporting self-direction under the demonstration.	Field Type: Numeric Note: Is a subset of A.

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

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

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

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

- MMPs should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

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

- CMS and the state will evaluate the percentage of new care coordinators that have undergone training for supporting self-direction.

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

- MMPs should refer to SC's three-way contract for specific requirements pertaining to a care coordinator.
- MMPs should refer to SC's three-way contract for specific requirements pertaining to training for supporting self-direction.
- A care coordinator includes all full-time and part-time staff.
- If a care coordinator was not currently with the MMP at the end of the reporting period, but was with the MMP for at least 3 months during the reporting period, they should be included in this measure.

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 SCV. Performance and Quality Improvement

SC5.1 Adjudicated claims.[i]

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
SC5. Performance and Quality Improvement	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 clean, non-duplicated claims for services other than HCBS, adjudicated and approved.	Total number of clean, non-duplicated claims for services other than HCBS, adjudicated and approved during the reporting period.	Field Type: Numeric
B.	Total number of adjudicated and approved non-HCBS claims paid using the correct rate and within 30 days.	Of the total reported in A, the number of adjudicated and approved non-HCBS claims paid using the correct rate and within 30 days.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of adjudicated and approved non-HCBS claims paid using the correct rate and within 90 days.	Of the total reported in A, the number of adjudicated and approved non-HCBS claims paid using the correct rate and within 90 days.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of clean, non-duplicated claims for HCBS services, adjudicated and approved.	Total number of clean, non-duplicated claims for HCBS services, adjudicated and approved during the reporting period.	Field Type: Numeric
E.	Total number of adjudicated and approved non-duplicated HCBS claims paid using the correct rate and within 7 days.	Of the total reported in D, the number of adjudicated and approved non-duplicated HCBS claims paid using the correct rate and within 7 days.	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.

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

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

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data elements B and C are less than or equal to data element A.
- MMPs should validate that data element E is less than or equal to data element D.
- All data elements should be positive values.

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

- Adjudicated and approved clean, non-duplicated, non-HCBS claims paid within 30 days.
- Adjudicated and approved clean, non-duplicated, non-HCBS claims paid within 90 days.
- Adjudicated and approved clean, non-duplicated, HCBS claims paid within 7 days.

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

- Claims adjudication refers to the process in which MMPs verify that the services provided are covered benefits, certify admission where

appropriate, conduct prepayment utilization screening, and authorize payment for those claims.
- Clean claims are those which can be processed without obtaining additional information from the physician or from a third party.
- In the case of duplicated claims, only the first claim should be included when reporting this measure.

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

SC5.2 Diabetes: foot exam (modified from NQF #0056)

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
SC5. Performance and Quality Improvement	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members with a diagnosis of diabetes.	Total number of members with a diagnosis of diabetes (type 1 or type 2) who were continuously enrolled in the MMP during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of members who received a foot exam.	Of the total reported in A, the number of members who received a foot exam (visual inspection with either a sensory exam or pulse exam) during the reporting period.	Field Type: Numeric Note: Is a subset of A.

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

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

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

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

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

- CMS and the state will evaluate the percentage of members with a diagnosis of diabetes (type 1 or type 2) who received a foot exam during the reporting period.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during each year of continuous enrollment (i.e., the reporting period). 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 2 months [60 days] is not considered continuously enrolled).
- A foot exam is a visual inspection with either a sensory exam or a pulse exam.
- Codes to identify members with diabetes are provided in Table SC-8.

- Codes to identify a foot exam are provided in Table SC-9.

Table SC-8: Codes to Identify Diabetes
ICD-9-CM Diagnosis
250, 357.2, 362.0, 366.41, 648.0

WITH

CPT	HCPCS
97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350,	G0270, G0271, G0402

Table SC-9: Codes to Identify Foot Exam
CPT II
2028F, 2028F with 1P, 2028F with 8P

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 SCVI. Utilization

SC6.1 HCBS members who experienced an increase or decrease in authorized hours.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
SC6. Utilization	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members receiving HCBS.	Total number of members receiving HCBS during the reporting period.	Field Type: Numeric
B.	Total number of HCBS members whose authorized personal care hours decreased.	Of the total reported in A, the number of HCBS members whose authorized personal care hours decreased during the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of HCBS members whose authorized personal care hours increased.	Of the total reported in A, the number of HCBS members whose authorized personal care hours increased during the reporting period.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of HCBS members whose authorized respite care hours decreased.	Of the total reported in A, the number of HCBS members whose authorized respite care hours decreased during the reporting period.	Field Type: Numeric Note: Is a subset of A.
E.	Total number of HCBS members whose authorized respite care hours increased.	Of the total reported in A, the number of HCBS members whose authorized respite care hours increased during the reporting period.	Field Type: Numeric Note: Is a subset of A.
F.	Total number of HCBS members whose authorized non-consumer directed HCBS services decreased.	Of the total reported in A, the number of HCBS members whose authorized non-consumer directed HCBS services decreased during the reporting period.	Field Type: Numeric Note: Is a subset of A.
G.	Total number of HCBS members whose authorized non-consumer directed HCBS services increased.	Of the total reported in A, the number of HCBS members whose authorized non-consumer directed HCBS services increased during the reporting period.	Field Type: Numeric Note: Is a subset of A.
H.	Total number of members who used consumer-directed services.	Of the total reported in A, the number of members who used consumer-directed services during the reporting period.	Field Type: Numeric Note: Is a subset of A.

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

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

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

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data elements B, C, D, E, F, G, and H are less than or equal to data element A.
- All data elements should be positive values.

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

- Whose authorized personal care hours decreased during the reporting period.
- Whose authorized personal care hours increased during the reporting period.
- Whose authorized respite care hours decreased during the reporting period.
- Whose authorized respite care hours increased during the reporting period.
- Whose authorized non-consumer directed HCBS services decreased during the reporting period.
- Whose authorized non-consumer directed HCBS services increased during the reporting period.
- Who used consumer-directed services during the reporting period.

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

- SCDHHS believes that the role of the care coordinator will serve as a catalyst for changes in HCBS, and thus believes it is important to track and compare the use of HCBS services, and HCBS-like services, and the subsequent care outcomes.
- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- The member needs to be continuously enrolled during the reporting period, with no gaps in enrollment to be included in this measure.
- For purposes of reporting this measure, MMPs may utilize claims reconciliation reports generated by SCDHHS and the service authorization reports generated in Phoenix.
- Personal care services means long-term maintenance or support services necessary to enable the individual to remain at or return home rather than enter a nursing facility. Personal care services are provided to individuals in the areas of activities of daily living, access to the community, monitoring of self-administered medications or other medical needs, and the monitoring of health status and physical condition. Where the individual requires

assistance with activities of daily living, and where specified in the plan of care, such supportive services may include assistance with instrumental activities of daily living. Services may be provided in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities.

- Respite care services means those short-term personal care services provided to individuals who are unable to care for themselves because of the absence of or need for the relief of the unpaid caregiver who normally provides the care.
- Authorized hours are service hours authorized by a county social worker. The social worker will assess the types of services the member needs and the number of hours the county will authorize for each of these services.
- Consumer-directed services are support services that are necessary to enable an individual to remain at or return home rather than enter an institution. Services may include assistance with bathing, dressing, toileting, transferring, and nutritional support necessary for consumers to remain in their own homes or in the community. Services can also include supervision, respite, and companion services.
- HCBS refers to Home and Community Based Services. Additionally, HCBS are waiver-specific services provided to individuals enrolled in the CLTC waiver programs. Services are listed at: https://www.scdhhs.gov/historic/insideDHHS/Bureaus/BureauofLongTermCareServices/CLTCOverview.html

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

SC6.2 Unduplicated members receiving HCBS, unduplicated members receiving HCBS-like services, and unduplicated members receiving nursing facility services.

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
SC6. Utilization	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members.	Total number of members who were continuously enrolled in the MMP for six months during the reporting period.	Field Type: Numeric
B.	Total number of members receiving HCBS.	Of the total reported in A, the number of members receiving HCBS during the reporting period who did not receive HCBS-like or nursing facility services during the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members receiving HCBS-like services.	Of the total reported in A, the number of members receiving HCBS-like services during the reporting period who did not receive HCBS or nursing facility services during the reporting period.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
D.	Total number of members receiving nursing facility services.	Of the total reported in A, the number of members receiving nursing facility services during the reporting period who did not receive HCBS or HCBS-like services during the reporting period.	Field Type: Numeric Note: Is a subset of A.
E.	Total number of members receiving both HCBS and nursing facility services during the reporting period.	Of the total reported in A, the number of members receiving both HCBS and nursing facility services during the reporting period who did not receive any HCBS-like services during the reporting period.	Field Type: Numeric Note: Is a subset of A.
F.	Total number of members receiving both HCBS-like and nursing facility services during the reporting period.	Of the total reported in A, the number of members receiving both HCBS-like and nursing facility services during the reporting period who did not receive any HCBS during the reporting period	Field Type: Numeric Note: Is a subset of A.
G.	Total number of members receiving both HCBS and HCBS-like services during the reporting period.	Of the total reported in A, the number of members receiving both HCBS and HCBS-like services during the reporting period who did not receive any nursing facility services during the reporting period	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
H.	Total number of members receiving HCBS, HCBS-like, and nursing facility services during the reporting period.	Of the total reported in A, the number of members receiving HCBS, HCBS-like services, and nursing facility services during the reporting period	Field Type: Numeric Note: Is a subset of A.

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

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will consider applying threshold checks.

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

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data elements B, C, D, E, F, G, and H are less than or equal to data element A.
- All data elements should be positive values.

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

- HBCS during the reporting period who did not receive HCBS-like or nursing facility services during the reporting period.
- HCBS-like services during the reporting period who did not receive HCBS or nursing facility services during the reporting period.
- Nursing facility services during the reporting period who did not receive HCBS or HCBS-like services during the reporting period.
- Both HCBS and nursing facility services during the reporting period who did not receive HCBS-like services during the reporting period.
- Both HCBS-like services and nursing facility services during the reporting period who did not receive HBCS during the reporting period.
- Both HCBS and HCBS-like services during the reporting period who did not receive any nursing facility services during the reporting period.
- HCBS, HCBS-like services, and nursing facility services during the reporting period.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in Element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- For purposes of reporting this measure, MMPs may utilize claims reconciliation reports generated by SCDHHS and the service authorization reports generated in Phoenix.
- Members receiving HCBS should only be counted for data element B (unduplicated). Members receiving HCBS-like should only be counted for data element C (unduplicated). Members receiving nursing facility services should only be counted for data element D (unduplicated). Members receiving both HCBS and nursing facility services should only be counted for data element E (unduplicated). Members receiving both HCBS-like and nursing facility services should only be counted for data element F (unduplicated). Members receiving both HCBS and HCBS-like should only be counted for data element G (unduplicated). Members receiving HCBS, HCBS-like, and nursing facility services should only be counted for data element H (unduplicated). Data elements B, C,D, E, F, G, and H are mutually exclusive.
- Unduplicated means a member should only be counted once for the type of service they receive. For example, if a member received nursing facility services in two different facilities during the reporting period, they would only count once towards members receiving nursing facility services during the reporting period (data element C).
- Elements C, F, G, and H apply only to those MMPs offering HCBS-like benefits.
- Include members who were receiving HCBS, HCBS-like, or nursing facility services for any length of time during the reporting period.
- HCBS refers to Home and Community Based Services. Additionally, HCBS are waiver-specific services provided to individuals enrolled in the CLTC waiver programs. Services are listed at: https://www.scdhhs.gov/historic/insideDHHS/Bureaus/BureauofLongTermCareServices/CLTCOverview.html
- HCBS-like services are services typically provided only under the CLTC waiver programs. When these services are provided to individuals who do not meet the level of care requirements to receive these services as part of the waiver, the services are considered “HCBS-like” services. Services are listed at:

https://www.scdhhs.gov/historic/insideDHHS/Bureaus/BureauofLongTermCareServices/CLTCOverview.html

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

SC6.3 Palliative Care

CONTINUOUS REPORTING				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Periods**	**Due Date**
SC6. Utilization	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members enrolled and eligible to receive palliative care.	Total number of members enrolled and eligible to receive palliative care during the reporting period.	Field Type: Numeric
B.	Total number of members who began receiving palliative care.	Total number of members who receive palliative care during the reporting period.	Field Type: Numeric Note: Is a subset of A.

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

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

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

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

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

- CMS and the state will evaluate the percentage of eligible members who receive palliative care during the reporting period.

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

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- To identify individuals who are eligible for palliative care services, as outlined in South Carolina three-way contract, MMPs should include members who have a history of hospitalizations, a history of acute care utilization for pain and/or symptom management, or the recommendation of a physician or the multidisciplinary team to be eligible to receive palliative care services and at least one of the following diagnoses:

Table SC-7: Codes to Identify Individuals with Diseases Eligible for Palliative Care Treatment

ICD-9-CM Diagnosis
151.0, 151.1, 151.2, 151.3, 151.4, 151.5, 151.6, 151.8, 151.9, 152.0, 152.1, 152.2, 152.3, 152.8, 152.9, 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 154.3, 162.0, 162.2, 162.3, 162.4, 162.5, 162.8, 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 175.0, 185, 186.0, 186.9, 187.1, 187.2, 187.3, 187.4, 187.5, 187.6, 187.7, 187.8, 187.9, 196, 196.0, 196.1, 196.2, 196.3, 196.5, 196.6, 196.8, 196.9, 197, 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.8, 198.81, 198.82, 331.0, 331.1, 331.2, 332.0, 333.4, 335.20, 340, 402.01, 402.11, 402.91, 404.01, 404.11, 404.91, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 491.20, 491.21, 491.22, 492.0, 492.8, 493.20, 493.21, 493.22, 494.0, 494.1, 495.0, 495.1, 495.2, 495.3, 495.4, 495.5, 495.6, 495.7, 495.8, 495.9, 496, 571, 571.0, 571.1, 571.2, 571.3, 571.4, 571.40, 571.41, 571.42, 571.49, 571.5, 571.6, 571.8, 571.9, 585.6

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

- Palliative care provides pain and symptom control for members experiencing pain and discomfort due to a serious illness.

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