

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

Issued February 28, 2023

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## OHIO-SPECIFIC REPORTING REQUIREMENTS APPENDIX

### Introduction

The measures in this appendix are required reporting for all MMPs in the Ohio MyCare 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:

<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.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<sup>®1</sup> and HOS. CMS and the state will also track key utilization measures, which are not included in this document, using encounter and claims data. The quantitative measures are part of broader oversight, monitoring, and performance improvement processes that include several other components and data sources not described in this document.

MMPs should contact the OH HelpDesk at [OHHelpDesk@norc.org](mailto:OHHelpDesk@norc.org) with any questions about the Core Reporting Requirements, Ohio state-specific appendix, or the data submission process.

### Definitions

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

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

**Calendar Year:** All annual measures are reported on a calendar year basis. For example, Calendar Year (CY) 2023 represents January 1, 2023 through December 31, 2023.

**Implementation Period:** The initial months of the demonstration during which MMPs reported to CMS and the state on a more intensive reporting schedule. The Implementation Period started on the first effective enrollment date and continued until the end of the first 2015 calendar year quarter (May 1, 2014 – March 31, 2015).

**Long Term Services and Supports (LTSS):** A range of home and community based services designed to meet a beneficiary's need as an alternative to long-term nursing facility care to enable a person to live as independently as possible. Examples include

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

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.

Primary Care Provider (PCP): Primary care physicians licensed by the state of Ohio and board certified in family practice, internal medicine, general practice, obstetrics/gynecology, or geriatrics, state licensed physician assistants, or a physician extender who is a registered nurse practitioner or advanced practice nurse or advanced practice nurse group practice within an acceptable specialty as required under state regulation.

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

### Core 2.1, 2.2, and 2.3

As described under Section 2.5.3.2.1 of the three-way contract, the scope and depth of the assessment may vary based on the beneficiary's assigned risk level. Beneficiaries assigned to the low and monitoring risk levels can receive a Health Risk Assessment, while beneficiaries assigned to the intensive, high, and medium risk levels and all waiver beneficiaries must receive a Comprehensive Assessment (note that MMPs may opt to administer a Comprehensive Assessment in lieu of a Health Risk Assessment for the low and monitoring risk levels). For purposes of reporting assessment completions under the applicable core measures (i.e., Core 2.1, 2.2, and 2.3), MMPs should include members who received either a Health Risk Assessment or a Comprehensive Assessment. If an MMP completed both a Health Risk Assessment and a Comprehensive Assessment for a given member, that member should be counted only once when reporting the core measures.

### Core 5.3

The following section provides additional guidance on the naming convention of the files submitted for Core 5.3. Files submitted should use the following naming convention:

(STATEABBREVIATION)\_(CONTRACTID)\_(REPORTINGPERIOD)\_(MEETINGDATE)  
\_(REGION).docx

The individual elements of the file name should be replaced as follows:

- (STATEABBREVIATION) with the two-character state abbreviation (i.e., Ohio is OH).
- (CONTRACTID) with the reporting MMP's Contract ID.
- (REPORTINGPERIOD) with the year of the reporting period in YYYY format (e.g., 2023).
- (MEETINGDATE) with the year, month, and date of the meeting in YYYYMMDD format (e.g., March 31, 2023 is 20230331).
- (REGION) with the region for which the meeting was conducted (e.g., Northwest, Central, etc.).

### Core 9.2

The following section provides additional guidance about identifying individuals enrolled in the MMP that are "nursing home certifiable," or meeting the nursing facility level of care (NF LOC), for the purposes of reporting Core 9.2.

Within Core 9.2, “nursing home certifiable” members are defined as “members living in the community but requiring an institutional level of care” (see the Core Reporting Requirements for more information). Ohio MMPs should consider any members who are enrolled in the MyCare Waiver and who are also in the Medicare-Medicaid product to be considered nursing home certifiable. As with all measures, members enrolled in the Medicaid-only product are not eligible to be reported in Core 9.2. MMPs should refer to the benefit plan code on the enrollment file to identify members who are enrolled in the MyCare Waiver.

### **Quality Withhold Measures**

CMS and the state established a set of quality withhold measures, and MMPs are required to meet established thresholds. Throughout this document, state-specific quality withhold measures are marked with the following symbol for Demonstration Year 1: (!) and the following symbol for Demonstration Years 2 through 5: (ii). The state-specific quality withhold measures for Demonstration Years 6 through 9 are reported separately through the Core Reporting Requirements and HEDIS. For more information about the state-specific quality withhold measures, refer to the Quality Withhold Technical Notes (DY 1): Ohio-Specific Measures and the Quality Withhold Technical Notes (DY 2-9): Ohio-Specific Measures at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPQualityWithholdMethodologyandTechnicalNotes.html>

### **Ohio MyCare Demonstration Reporting Population**

Because some members receive Medicare and Medicaid coverage through MyCare Ohio while others receive only their Medicaid benefits through MyCare Ohio, the distinction between these members for reporting purposes is clarified as follows.

For the purpose of all core and state-specific reporting, Ohio MMPs are to report only on members enrolled to receive both Medicare and Medicaid benefits through the MMP. MMPs should not include members who are enrolled in the Medicaid-only portion of MyCare. Of note, passive enrollment for the Medicare-Medicaid MyCare Demonstration in Ohio began in January 2015. Data reported after passive enrollment should include both Medicare-Medicaid members who opt in<sup>2</sup> and Medicare-Medicaid members who are passively enrolled into the MMP at any point. MMPs can identify this information on the enrollment file using the enrollment source codes in the CMS DTRR file. Code J represents state-submitted passive enrollment and Code L represents the opt-in population or MMP beneficiary election. Reporting of both core measures in the Health Plan Management System (HPMS) and state-specific measures via the Financial Alignment Initiative Data Collection System should exclude data for members who are Medicaid-only and should only include Medicare-Medicaid dual enrollees.

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<sup>2</sup> In this context, “opt-in” specifically refers to Medicare-Medicaid members who choose to actively enroll in an MMP at any point during the demonstration. Passive enrollment does not include members who are automatically enrolled into a Medicaid-only program with an affiliated MMP.

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

### Assessments

To determine if an assessment should be conducted for a member who enrolls (or re-enrolls) in the MMP, the MMP should first determine if the member previously received an assessment from any plan in the MyCare Ohio program (including both Medicaid-only products and Medicare-Medicaid products). If the member did receive an assessment and it was completed within one year of their 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 the member's 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 the member's 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 update the prior assessment accordingly or conduct a new assessment within the timeframe prescribed by the three-way contract. If there are no changes, the MMP is not required to revise or conduct the assessment unless requested by the member (or the member's authorized representative or provider). 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 revised or conducted the assessment as needed or confirmed that the prior assessment is still accurate, the MMP can mark the assessment as complete for the member's current enrollment. The MMP would then report that completion according to the specifications for Core 2.1 and Core 2.2. When reporting these core measures, the MMP should count the 90 days from the member's most recent enrollment effective date and should report the assessment based on the date the prior assessment was either confirmed to be accurate or a new assessment was completed. Additionally, in certain circumstances a new assessment that has been completed for a member upon reenrollment may also be reported in Core 2.3.

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

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

#### Individualized Care Plans

If the MMP updates the prior assessment or conducts a new assessment for the re-enrolled member, the MMP must revise the Individualized Care Plan (ICP) accordingly within the timeframe prescribed by the three-way contract. Once the ICP is revised, the MMP may mark the ICP as complete for the member's current enrollment. If the MMP determines that no updates are required to the previously developed ICP, the MMP may mark the ICP as complete for the current enrollment at the same time that the assessment is marked complete. The MMP would then follow the Core 3.2 and OH1.2 measure specifications for reporting the completion. Please note, for purposes of reporting, the ICP for the re-enrolled member should be classified as an *initial* ICP.

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

#### Annual Reassessments and ICP Updates

The MMP must follow the three-way 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.

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

When reporting all Ohio state-specific measures, MMPs should include all members who meet the criteria for inclusion in the measure regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.<sup>3</sup> Medicaid-only members should not be included.

## Reporting on Disenrolled and Retro-disenrolled Members

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

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

## Value Sets

The measure specifications in this document refer to code value sets that must be used to determine and report measure data element values. A value set is the complete set of codes used to identify a service or condition included in a measure. The Ohio-Specific Value Sets Workbook includes all value sets and codes needed to report certain measures included in the Ohio-Specific Reporting Requirements and is intended to be used in conjunction with the measure specifications outlined in this document. The Ohio-Specific Value Sets Workbook can be found on the CMS website at the following address: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html>

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<sup>3</sup> In this context, "opt-in" specifically refers to Medicare-Medicaid members who choose to actively enroll in an MMP at any point during the demonstration. Passive enrollment does not include members who are automatically enrolled into a Medicaid-only program with an affiliated MMP.

**Ohio's Implementation, Ongoing, and Continuous Reporting Periods**

<b>Phase</b>		<b>Dates</b>	<b>Explanation</b>
<b>Demonstration Year 1</b>			
Continuous Reporting	Implementation Period	5-1-14 through 3-31-15	From the first effective enrollment date through the end of the first quarter of 2015.
	Ongoing Period	5-1-14 through 12-31-15	From the first effective enrollment date through the end of the first demonstration year.
<b>Demonstration Year 2</b>			
Continuous Reporting	Ongoing Period	1-1-16 through 12-31-16	From January 1, 2016 through the end of the second demonstration year.
<b>Demonstration Year 3</b>			
Continuous Reporting	Ongoing Period	1-1-17 through 12-31-17	From January 1, 2017 through the end of the third demonstration year.
<b>Demonstration Year 4</b>			
Continuous Reporting	Ongoing Period	1-1-18 through 12-31-18	From January 1, 2018 through the end of the fourth demonstration year.
<b>Demonstration Year 5</b>			
Continuous Reporting	Ongoing Period	1-1-19 through 12-31-19	From January 1, 2019 through the end of the fifth demonstration year.
<b>Demonstration Year 6</b>			
Continuous Reporting	Ongoing Period	1-1-20 through 12-31-20	From January 1, 2020 through the end of the sixth full calendar year of the demonstration.
<b>Demonstration Year 7</b>			
Continuous Reporting	Ongoing Period	1-1-21 through 12-31-21	From January 1, 2021 through the end of the seventh full calendar year of the demonstration.

Phase		Dates	Explanation
<b>Demonstration Year 8</b>			
Continuous Reporting	Ongoing Period	1-1-22 through 12-31-22	From January 1, 2022 through the end of the eighth full calendar year of the demonstration.
<b>Demonstration Year 9</b>			
Continuous Reporting	Ongoing Period	1-1-23 through 12-31-23	From January 1, 2023 through the end of the ninth full calendar year of the demonstration.

### Data Submission

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

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

All MMPs will submit core measure data in accordance with the Core Reporting Requirements. Submission requirements vary by measure, but most core measures are reported through 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 OH HelpDesk ([OHHelpDesk@norc.org](mailto:OHHelpDesk@norc.org)) to request resubmission.
  - a. Specify in the email which measure(s) need resubmission;
  - b. Specify for which reporting period(s) the resubmission is needed; and
  - c. Provide a brief explanation for why the data need to be resubmitted.
2. After review of the request, the OH HelpDesk will notify the MMP once the FAI DCS and/or HPMS has been re-opened.
3. Resubmit data through the applicable reporting system.
4. Notify the OH 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 OHI. Care Coordination**OH1.1 Members with care plans within 90 days of enrollment. – **Retired**

OH1.2 Members with documented discussions of care goals.

<b>IMPLEMENTATION</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
OH1. Care Coordination	Monthly	Contract	Current Month Ex: 1/1-1/31	By the end of the month following the last day of the reporting period
<b>ONGOING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Periods</b>	<b>Due Date</b>
OH1. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	By the end of the second month following the last day of the reporting period

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

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

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

- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will perform an outlier analysis.
  - As data are received from MMPs over time, CMS and the state will apply threshold checks.
- C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.
- MMPs should validate that data element B is less than or equal to data element A.
  - MMPs should validate that data element D is less than or equal to data element C.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of:
- Members with an initial ICP completed during the reporting period who had at least one documented discussion of care goals in the initial ICP.
    - Percentage =  $(B / A) * 100$
  - Existing ICPs revised during the reporting period that had at least one documented discussion of new or existing care goals.
    - Percentage =  $(D / C) * 100$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

#### Data Element A

- MMPs should include all members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- Data element A should include all members whose ICP was completed for the first time during the reporting period (i.e., the member did not previously have an ICP completed prior to the start of the reporting period). There can be no more than one initial ICP completed per member.

- Only ICPs that included participation from the member (or the member's authorized representative) in the completion of the ICP should be reported.

#### Data Element B

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

#### Data Element C

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

#### Data Element D

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

#### General Guidance

- For Medicare-Medicaid members who were formerly Medicaid-only members prior to enrollment into the Medicare-Medicaid benefit plan, MMPs are still required to contact enrollees to ensure that there are no changes to health status or additional needs as a result of expanded coverage. MMPs must make necessary updates to the ICP accordingly.
- If a member has an initial ICP completed during the reporting period, and has their ICP revised during the same reporting period, then the member's initial ICP should be reported in data element A and the member's revised ICP should be reported in data element C.

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

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

OH1.3 Members with first follow-up visit within 30 days of inpatient hospital discharge.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
OH1. Care Coordination	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of acute inpatient hospital discharges.	Total number of acute inpatient hospital discharges that occurred during the reporting period for members who were continuously enrolled from the date of the inpatient hospital discharge through 30 days after the inpatient hospital discharge, with no gaps in enrollment.	Field Type: Numeric
B.	Total number of acute inpatient hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge from the inpatient hospital stay.	Of the total reported in A, the number of acute inpatient hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge from the inpatient hospital stay.	Field Type: Numeric  Note: Is a subset of A.

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

- CMS and the state will perform an outlier analysis.

- As data are received from MMPs over time, CMS and the state will apply threshold checks.
- C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.
- MMPs should validate that data element B is less than or equal to data element A.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will:
- Evaluate the percentage of acute inpatient hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of the discharge from the inpatient hospital stay.
    - $\text{Percentage} = (B / A) * 100$
  - Use enrollment data to evaluate the total number of acute inpatient hospital discharges per 10,000 member months during the reporting period.
    - $\text{Rate} = (A / \text{Total Member Months}) * 10,000$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

#### Data Element A

- MMPs should include all acute inpatient hospital discharges for members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period.
- The denominator for this measure is based on acute inpatient hospital discharges, not members.
- To identify all acute inpatient hospital discharges during the reporting period:
  - Identify all acute and nonacute inpatient stays (Inpatient Stay value set).
  - Exclude nonacute inpatient stays (Nonacute Inpatient Stay value set).
  - Identify the discharge date for the stay. The date of discharge must be within the reporting period.
  - Report all inpatient stays identified with discharges within the reporting period, including denied and pended claims.

Additionally, MMPs should use UB Type of Bill codes 11x, 12x, 41x, and 84x or any acute inpatient facility code to identify discharges from an inpatient hospital stay.

- If the discharge is followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period, count only the last discharge for reporting in data element A. To identify readmissions and direct transfers to an acute inpatient care setting:
  - Identify all acute and nonacute inpatient stays (Inpatient Stay value set).
  - Exclude nonacute inpatient stays (Nonacute Inpatient Stay value set).
  - Identify the admission date for the stay.

#### Data Element A Exclusions

- Exclude discharges for members who use hospice services or elect to use a hospice benefit at any time between the hospital discharge date and 30 days

following the hospital discharge. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record, claims/encounter data (Hospice Encounter value set; Hospice Intervention value set), or supplemental data.

- Exclude discharges due to death, using the Discharges due to Death value set.
- Exclude from data element A any discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period. To identify readmissions and direct transfers to a nonacute inpatient care setting:
  - Identify all acute and nonacute inpatient stays (Inpatient Stay value set).
  - Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay value set) on the claim.
  - Identify the admission date for the stay.

These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.

- For example, the following direct transfers/readmissions should be excluded from this measure:
  - An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1 (a direct transfer).
  - An inpatient discharge on June 1, followed by a readmission to a hospital on June 15 (readmission within 30 days).

#### Data Element B

- 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.
- 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 the Ambulatory Visits value set, Other Ambulatory Visits value set, and Telephone Visits value set.
- MMPs should report ambulatory care follow-up visits based on all visits identified, including denied and pended claims, and including encounter data as necessary in cases where follow-up care is included as part of a bundled payment covering the services delivered during the inpatient stay. MMPs should use all information available, including encounter data supplied by providers, to ensure complete and accurate reporting.

#### 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 OHII. Organizational Structure and Staffing

OH2.1 Waiver service coordinator training for supporting self-direction under the demonstration.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
OH2. Organizational Structure and Staffing	Annually	Contract	Calendar Year	By the end of the second month following the last day of the reporting period

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

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of full-time and part-time waiver service coordinators.	Total number of full-time and part-time waiver service coordinators employed for at least 30 days with the MMP during the reporting period.	Field Type: Numeric
B.	Total number of waiver service coordinators who have undergone MyCare Ohio Plan (MCOP) training for supporting self-direction under the demonstration.	Of the total reported in A, the number of waiver service coordinators who have undergone MCOP training for supporting self-direction under the demonstration.	Field Type: Numeric  Note: Is a subset of A.

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

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

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

- MMPs should validate that data element B is less than or equal to data element A.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
- CMS and the state will evaluate the percentage of full-time and part-time waiver service coordinators who have undergone MCOP training for supporting self-direction.
    - $\text{Percentage} = (B / A) * 100$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

#### Data Element A

- If a waiver service coordinator was not currently with the MMP at the end of the reporting period but was with the MMP for at least 30 days at any point during the reporting period, they should be included in this measure.

#### General Guidance

- MMPs should refer to the Ohio three-way contract for specific requirements pertaining to a waiver service coordinator and for specific requirements pertaining to training for supporting self-direction.
- F. Data Submission – how MMPs will submit data collected to CMS and the state.
- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>

**Section OHIII. Performance and Quality Improvement**

OH3.1 Long-term care overall balance.<sup>ii</sup> – **Retired**

OH3.2 Long-term care rebalancing. – **Retired**

OH3.3 Nursing facility residents whose need for help with Activities of Daily Living (ADLs) has increased.

Please note: No MMP reporting is required for this measure; however, MMPs must assist ODM with data collection and analysis as needed. The full specifications for this measure can be found in ODM’s MyCare MDS Quality Measures Methods document.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
OH3. Performance and Quality Improvement	Annually	Contract	Calendar Year	N/A

A. 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 rates are calculated over time, CMS and the state will apply threshold checks.

B. 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 long-stay residents whose need for help with late-loss Activities of Daily Living (ADLs) has increased when compared to the prior assessment.

OH3.4 Nursing facility residents who have/had a catheter inserted and left in their bladder.

Please note: No MMP reporting is required for this measure; however, MMPs must assist ODM with data collection and analysis as needed. The full specifications for this measure can be found in ODM’s MyCare MDS Quality Measures Methods document.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
OH3. Performance and Quality Improvement	Annually	Contract	Calendar Year	N/A

- A. 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 rates are calculated over time, CMS and the state will apply threshold checks.
- B. 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 long-stay residents who have/had an indwelling catheter in the last 7 days.

OH3.5 Nursing facility residents who were physically restrained.

Please note: No MMP reporting is required for this measure; however, MMPs must assist ODM with data collection and analysis as needed. The full specifications for this measure can be found in ODM's MyCare MDS Quality Measures Methods document.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
OH3. Performance and Quality Improvement	Annually	Contract	Calendar Year	N/A

- A. 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 rates are calculated over time, CMS and the state will apply threshold checks.
- B. 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 long-stay nursing facility residents who are physically restrained on a daily basis.

OH3.6 Nursing facility residents experiencing one or more falls with a major injury.

Please note: No MMP reporting is required for this measure; however, MMPs must assist ODM with data collection and analysis as needed. The full specifications for this measure can be found in ODM's MyCare MDS Quality Measures Methods document.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
OH3. Performance and Quality Improvement	Annually	Contract	Calendar Year	N/A

A. 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 rates are calculated over time, CMS and the state will apply threshold checks.

B. 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 long-stay residents who have experienced one or more falls with major injury reported in the reporting period or look-back period.

OH3.7 Nursing facility residents with a urinary tract infection.

Please note: No MMP reporting is required for this measure; however, MMPs must assist ODM with data collection and analysis as needed. The full specifications for this measure can be found in ODM's MyCare MDS Quality Measures Methods document.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
OH3. Performance and Quality Improvement	Annually	Contract	Calendar Year	N/A

A. 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 rates are calculated over time, CMS and the state will apply threshold checks.

B. 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 long-stay residents who have a urinary tract infection.

OH3.8 Nursing facility diversion.<sup>i, ii</sup> – **Retired**

OH3.9 High-risk residents with pressure ulcers.

Please note: No MMP reporting is required for this measure; however, MMPs must assist ODM with data collection and analysis as needed. The full specifications for this measure can be found in ODM’s MyCare MDS Quality Measures Methods document.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
OH3. Performance and Quality Improvement	Annually	Contract	Calendar Year	N/A

A. 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 rates are calculated over time, CMS and the state will apply threshold checks.

B. 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 long-stay, high-risk residents with Stage II through IV pressure ulcers.

**Section OHIV. Systems**OH4.1 MyCare Centralized Enrollee Record. – **Retired****Section OHV. Utilization**

OH5.1 Unduplicated members receiving HCBS and unduplicated members receiving nursing facility services.

<b>CONTINUOUS REPORTING</b>				
<b>Reporting Section</b>	<b>Reporting Frequency</b>	<b>Level</b>	<b>Reporting Period</b>	<b>Due Date</b>
OH5. 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.

<b>Element Letter</b>	<b>Element Name</b>	<b>Definition</b>	<b>Allowable Values</b>
A.	Total number of members.	Total number of members who were continuously enrolled in the MMP for six months during the reporting period, with no gaps in enrollment.	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 nursing facility services during the reporting period.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	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 during the reporting period.	Field Type: Numeric  Note: Is a subset of A.
D.	Total number of members receiving both HCBS and nursing facility services.	Of the total reported in A, the number of members receiving both HCBS 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 apply threshold checks.
- C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.
- MMPs should validate that data elements B, C, and D are less than or equal to data element A.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of members receiving:
- HCBS during the reporting period who did not receive nursing facility services during the reporting period.
    - Percentage =  $(B / A) * 100$
  - Nursing facility services during the reporting period who did not receive HCBS during the reporting period.
    - Percentage =  $(C / A) * 100$
  - Both HCBS and nursing facility services during the reporting period.
    - Percentage =  $(D / A) * 100$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

#### Definitions

- HCBS refers to Home and Community Based Services. MMPs should refer to the MyCare Waiver Procedure Codes document shared by the state, which

contains waiver procedure codes, modifiers, and service descriptions to identify services that fall under HCBS.

- Nursing facility services include any type of nursing facility care, including skilled and custodial services.
- 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 toward members receiving nursing facility services during the reporting period (data element C).

#### Data Element A

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

#### Data Element B

- Members receiving only HCBS should be counted for data element B (unduplicated).

#### Data Element C

- Members receiving only nursing facility services should be counted for data element C (unduplicated).

#### Data Element D

- Members receiving both HCBS and nursing facility services should be counted for data element D (unduplicated).

#### General Guidance

- Include members who were receiving HCBS or nursing facility services for any length of time during the reporting period in data elements B, C, and D.
- Data elements B, C, and D are mutually exclusive.

#### 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>