DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
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CENTER FOR MEDICARE & MEDICAID SERVICES

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TO: Medicare -Medicaid Plans

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SUBJECT: Update to the Contract Year 2014 Massachusetts State Specific Reporting Requirements Appendix

In November 2013, CMS released the Medicare-Medicaid Capitated Financial Alignment Model and the Massachusetts State Specific Reporting Requirements Appendix reporting requirements. The purpose of this memorandum is to provide an update to the state-specific reporting requirements appendix for the Commonwealth of Massachusetts. The reporting requirements document provides guidance and technical specification for the state-specific measures that MMPs participating in Massachusetts One Care Demonstration will be required to collect and report under the demonstration. Updated guidance for the Medicare-Medicaid Capitated Financial Alignment Model will be released in a separate memorandum. The updates found in this memorandum incorporate feedback from the Commonwealth of Massachusetts, the Centers for Medicare and Medicaid Services and MMP's participating in the Massachusetts One Care Demonstration.

Below is a brief description of the changes that have been made along with a rationale for those changes.

Massachusetts Measures

MA Introduction

Description of Changes: Added language to indicate that measures may change or be updated in subsequent demonstration years for the MA appendix.

Rationale: Language was added to indicate the MA Appendix may change in subsequent demonstration years.

MA Introduction, Definitions Section

Description of Changes: Edited language to reflect that the first reporting period will start on the first day of passive enrollment rather than opt-in enrollment. Edited language to reflect that the implementation period will end after the second wave of passive enrollment.

Rationale: To clarify the definition of the implementation period.

MA Introduction, Variation from the Core Document

Description of Changes: Added section to introduction explaining variances to core requirements that One Care MMP's will have to follow.

Rationale: MMP's in MA have variances in the contract for certain core measures.

MA Introduction, Quality Withhold Measures

Description of Changes: Added sections to introduction explaining that certain measures in the core document will be quality withhold measures in MA.

Rationale: MMP's in MA will have quality withhold measures that are not listed as quality withhold measures in the core document.

MA Introduction, Data Submission Section

Description of Changes: Added language to direct users to the CMS website for access to the data reporting tool and removed the embedded document link.

Rationale: To have all data collection templates available from the CMS website.

MA3.1

Description of changes: Measure 3.1, Americans with Disabilities Act (ADA) compliance has been deleted.

Rationale: Measure is being evaluated during readiness review.

MA3.2

Description of changes: Renumbered as MA3.1

Rationale: Measure MA3.1 was deleted.

MA4.1

Description of changes: Measure is identified with a [1] and is a quality withhold measure.

Rationale: Measure MA4.1 is a quality withhold measure.

MA4.2 and MA4.3

Description of changes:

- Removed Data Elements C (Total number of members identified as an unhealthy alcohol user or tobacco user) and D (Total number of members who received counseling).
- Modified Data Element B description and analysis sections accordingly.
- Added language about the two-year reporting period to the reporting timeline table, Data Element A, Data Element B, and Section E of the measure specifications.

Rationale: Data elements were removed to align with measure steward's definition of numerator. The administrative codes in these measures cannot be used to generate data for Data Elements C and D. In order for plans to report to that level of granularity, medical record review would be required. Language regarding the two-year reporting period was added to further clarify the reporting cycle for these measures.

MA4.4 and MA4.5

Description of changes: Extended the due date to be the end of the sixth month following the last day of the reporting period to allow plans sufficient time to conduct medical record review.

Rationale: To align with HEDIS requirements.

MA 6.1

Description of changes:

- Changed measure name to Chronic Obstructive Pulmonary Disease (COPD) or asthma in older adults admission rate.
- Changed Data Element A from "Total number of non-maternal discharges with an ICD-9-CM principal diagnosis code for COPD," to "Total number of member months for members age 40 and older."
- Added Data Element B "Total number of non-maternal discharges with an ICD-9-CM principal diagnosis code for COPD or asthma for members age 40 and older."
- Added a note under Allowable Values for Data Element B stating, "Select codes appearing in the primary diagnosis position must be accompanied by a secondary diagnosis of COPD."
- Under the "Analysis" section, changed language from "CMS and the state will obtain enrollment data from CMS' Web site to evaluate the number of discharges with a primary diagnosis of COPD per 1,000 members," to "CMS and the state will evaluate the number of discharges with a primary diagnosis of COPD or asthma per 100,000 member months for members age 40 and older."
- Under the "Notes" section, added definition for member months and language that age is based on date of admission. A link the 2013 Addendum to the Medicaid Adult Core Set Specifications was also added.

Rationale: To align with the 2013 Addendum to the Medicaid Adult Core Set Specifications.

MA 6.2

Description of changes:

- Changed Data Element A from "Total number of non-maternal discharges with an ICD-9-CM principal diagnosis code for CHF," to "Total number of member months."
- Added Data Element B "Total number of non-maternal discharges with an ICD-9-CM principal diagnosis code for CHF."
- Under the "Analysis" section, changed language from "CMS and the state will obtain enrollment data from CMS' Web site to evaluate the number of discharges with a primary diagnosis of CHF per 1,000 members," to "CMS and the state will evaluate the number of discharges with a primary diagnosis of CHF per 100,000 member months."
- Under the "Notes" section, added definition for member months and language that age is based on date of admission.
- A link the 2013 Addendum to the Medicaid Adult Core Set Specifications was also added.

Rationale: To align with the 2013 Addendum to the Medicaid Adult Core Set Specification.

Tool Updates

All data collection tools were updated to reflect changes described above.

Please contact the Medicare-Medicaid Coordination Office at mmcocapsmodel@cms.hhs.gov if you have any questions.