DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTERS FOR MEDICARE & MEDICAID SERVICES

DATE: August 10, 2016

TO: Medicare-Medicaid Plans

FROM: Lindsay Barnette
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Medicare-Medicaid Coordination Office

SUBJECT: Update to CY 2016 Core Reporting Requirements for Medicare-Medicaid Plans

The purpose of this memorandum is to announce the release of the updated Calendar Year (CY) 2016 Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements and Value Sets Workbook. Medicare-Medicaid Plans (MMPs) should follow the revised requirements for future submissions of all reporting periods that commence on or after January 1, 2016.

Please see below for a summary of the substantive changes that were made as compared to the CY 2016 reporting requirements document that was previously released on January 8, 2016.

Should you have any questions, please contact the Medicare-Medicaid Coordination Office at mmcocapsreporting@cms.hhs.gov.

SUMMARY OF CHANGES

Part C and Part D Reporting Sections

The Part C and Part D sections were revised to reflect recent updates to the corresponding reporting requirements, including:

- Revisions to the Part C Organization Determinations and Reconsiderations reporting section to clarify withdrawals, dismissals, and denials. For more information about Part C reporting, please see the following link: https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/ReportingRequirements.html.
- Revision to the Part D MTM section to reflect an update to the reporting deadline. For more information about Part D reporting, please see the following link: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxContracting_ReportingOversight.html.

Note that MMPs are required to report only the Part C and Part D measures that are included in the CY 2016 Core Reporting Requirements.

MMP-Specific Reporting Section

CMS has decided to temporarily suspend the collection of Core Measure 3.1, which evaluates the percentage of members discharged from an inpatient facility for whom a transition record was transmitted within 24 hours of discharge to the provider designated for follow-up care.

Core Measure 3.1 is based on a measure developed by the AMA-convened Physician Consortium for Performance Improvement (PCPI) and endorsed by the National Quality Forum (NQF #0648). According to PCPI, the measure was designed for use at the practitioner or system level in order to promote greater communication that may result in improved continuity of care and decreased risk of hospital readmissions.[1]

In adapting this measure for use in the capitated model demonstrations, our goal was to encourage MMPs to participate in discharge planning and potentially receive or track transition records as part of their broader care coordination efforts. However, this measure has presented significant data collection challenges in its application at the payer level.

As a result, we are temporarily suspending the reporting of Core Measure 3.1 as of the CY 2016 measurement period.[2] Since we expect to reinstate the measure at a later date, we strongly encourage MMPs to work with their provider network to develop infrastructure that would facilitate greater communication in the discharge process between the inpatient facility, MMP, and follow-up provider. We recognize that many MMPs have already made significant strides in this area, and we urge all MMPs to continue to invest resources in this important component of effective care coordination. Over the next several months, the Contract Management Teams will follow up with MMPs to inquire about their progress. Additionally, we will also continue to closely monitor related outcome measures – such as all-cause hospital readmissions – that capture some of the ultimate impacts of successful or unsuccessful care transitions and other care coordination activities.

Also note that in November 2015, CMS released a Notice of Proposed Rulemaking that would revise the Medicare hospital, critical access hospital, and home health agency Conditions of Participation for discharge planning.[3] The proposed regulation includes requirements regarding communication between healthcare providers and facilities during inpatient stays, as well as when discharged to home. Once the discharge planning regulations are finalized, we will reevaluate Core Measure 3.1 accordingly.

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[1] See the American Medical Association's Care Transitions Performance Measurement Set available at: http://www.ama-assn.org/apps/listserv/x-check/qmeasure.cgi?submit=PCPI

[2] The suspension of Core Measure 3.1 does not apply to Michigan MMPs since this measure is designated as a state-specific quality withhold. Additional guidance for Michigan MMPs will be forthcoming.

[3] See 80 Fed. Reg. 68,126