DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES

DATE: January 8, 2016

TO: Medicare-Medicaid Plans

FROM: Lindsay Barnette
Director, Models, Demonstrations and Analysis Group
Medicare-Medicaid Coordination Office

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

The purpose of this memorandum is to announce the release of the Calendar Year 2016 Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements. Medicare-Medicaid Plans (MMPs) should follow these revised requirements for 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 2015 reporting requirements document that was previously released on December 14, 2015.

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

- Revised the Part C and Part D sections to reflect updates to the corresponding reporting requirements. This includes the addition of two new Part C measures, "Rewards and Incentives Programs" and "Payments to Providers." 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.
- For more information about Part C reporting, please see the following link: https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/ReportingRequirements.html.
- For more information about Part D reporting, please see the following link: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/RxContracting_ReportingOversight.html.

MMP-Specific Reporting Section

Core Measure 2.1

- In the Data Element Definitions section, clarified that data element A should only include members who were currently enrolled at the end of the reporting period. For data elements B and C, added guidance that the member's unwillingness to participate or the member's completed assessment must be clearly documented in order for the member to be counted in the respective data element.
- In the Edits and Validation Checks section, added additional validation steps that MMPs should complete prior to the submission of data for this measure.
- Made several revisions to the Notes section, including:
    - Added clarifying language regarding the determination of the 90th day of enrollment.
    - Clarified that data elements B, C, and D should be mutually exclusive, and provided guidance on how to classify members that may meet the criteria for multiple data elements.
    - Added guidance that the assessment tool should meet any state-specific criteria and include the appropriate domains as determined by the state.
    - Added direction that MMPs should refer to their state's reporting appendix for information on reporting assessments completed by the MMP prior to a member's effective enrollment date, reporting assessments for members with a break in coverage, and reporting assessments completed previously by the MMP's affiliated product (note that applicability of this guidance varies by state).
    - Clarified that members who decline care management activities overall or refuse any contact with the MMP may be counted under data element B.

Core Measure 2.3

- In the Notes section, added guidance that the assessment tool should meet any state-specific criteria and include the appropriate domains as determined by the state.

Core Measure 7.1

- Added this measure, which provides additional detail about the required annual network submission. For further information, MMPs should refer to the MMP Medicare Network Submission Guidance that will be issued in the summer of 2016.