DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTERS FOR MEDICARE & MEDICAID SERVICES

DATE: April 21, 2016

TO: Medicare-Medicaid Plans in Illinois

FROM: Lindsay Barnette
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SUBJECT: Revised Illinois-Specific Reporting Requirements

The purpose of this memorandum is to announce the release of the revised Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: Illinois-Specific Reporting Requirements. The document is designed to provide updated guidance and technical specifications for the state-specific measures that Illinois Medicare-Medicaid Plans (MMPs) are required to collect and report under the demonstration.

Please see below for a high-level summary of the changes that were made to the Illinois-Specific Reporting Requirements. In addition to the changes listed below, the following measures are suspended from future MMP reporting effective immediately: IL1.1, IL2.1, IL3.3, IL3.5, IL6.1 – IL6.7, IL7.1, IL7.2, and IL7.5 – IL7.7. These measures were removed as part of the Illinois Department of Healthcare and Family Services' recent restructuring and alignment of its quality strategy across all state programs. However, please note that MMP performance in a number of these measurement areas will continue to be monitored via other required reporting mechanisms (e.g. HEDIS).

Illinois MMPs must use the updated Illinois-Specific Reporting Requirements for all measures due on or after May 31, 2016. Should you have any questions, please contact the Medicare-Medicaid Coordination Office at mmcocapsreporting@cms.hhs.gov.

SUMMARY OF CHANGES

Introduction

- In the "Quality Withhold Measures" section, added information about quality withhold measures for DY 2 and 3. Also added the DY 2 and 3 quality withhold designation to the relevant measure within the document.

- Added a "Reporting on Screenings, Assessments, and Care Plans Completed Prior to First Effective Enrollment Date" section. Note that this guidance was previously released via the NORC IL HelpDesk on October 6, 2015.
- In the "Guidance on Screenings, Assessments, and Care Plans for Members with a Break in Coverage" section, revised the timeframe in which MMPs are not required to conduct a new screening/assessment for a re-enrolled member. The timeframe was changed from one year to 90 days.
- In the "Guidance on Adopting Screenings and Assessments Completed Previously by an Affiliated Plan" section, clarified that screenings/assessments may also be adopted when a member joins the MMP from an affiliated Managed Long Term Services and Supports (MLTSS) plan.
- Added a "Value Sets" section that provides information about the separate Illinois State-Specific Value Sets Workbook, which contains all codes needed to report certain measures (including updated codes due to the ICD-10 conversion effective October 1, 2015). The Illinois State-Specific Value Sets Workbook is also included with this memorandum.

Measure IL2.2

- Clarified that members reported in data elements B, C and D must also be reported in data element A, while members reported in data elements F, G and H must also be reported in data element E. Since the data elements that are subsets of A and E must be mutually exclusive, added guidance about how to classify members that could meet the criteria for multiple data elements.

Measure IL3.1

- Clarified that members reported in data elements B, C, and D must also be reported in data element A. Since data elements B, C, and D must be mutually exclusive, added guidance about how to classify members that could meet the criteria for multiple data elements.

Measure IL3.2

- Clarified that the care plan must be <u>completed</u> in order for the member to be counted under data element A.

Measure IL3.4

- Revised the follow-up timeframe from 14 days to 30 days.
- Modified the reporting period and frequency from annually to quarterly. This change is effective as of the Q1 2016 reporting period. For CY 2015 reporting, MMPs should use the updated measure specifications, but will still report on a calendar year basis (note that this CY 2015 annual submission will be due on June 30, 2016).

- In the Notes section, updated the guidance to align with the revised follow-up timeframe, changed the code table references since applicable codes are now provided separately in the Illinois State-Specific Value Sets Workbook, removed several exclusions, and provided various other reporting clarifications.

Measure IL3.6

- Substantial revisions were made to this measure, including modifying the data captured under data elements B through F, and removing data elements G through R. Due to these changes, the Edits and Validation Checks, Analysis, and Notes sections were also revised accordingly. Note that these changes were made to align with updated state-specific quality withhold requirements, as communicated in a letter dated December 30, 2015 from the Illinois Department of Healthcare and Family Services.
- MMPs should carefully review the revised specifications for this measure. Should you have any questions or comments, contact the Medicare-Medicaid Coordination Office at mmcocapsreporting@cms.hhs.gov by April 28, 2016.

Appendix A

- Removed this code table appendix since applicable codes are now provided separately in the Illinois State-Specific Value Sets Workbook.