DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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MEDICARE-MEDICAID COORDINATION OFFICE

DATE: February 28, 2019

TO: Medicare-Medicaid Plans in Ohio

FROM: Lindsay P. Barnette
Director, Models, Demonstrations and Analysis Group

SUBJECT: Revised Ohio-Specific Reporting Requirements and Value Sets Workbook

The purpose of this memorandum is to announce the release of the revised Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: Ohio-Specific Reporting Requirements and corresponding Ohio-Specific Value Sets Workbook. These documents provide updated guidance, technical specifications, and applicable codes for the state-specific measures that Ohio Medicare-Medicaid Plans (MMPs) are required to collect and report under the demonstration. As with prior annual update cycles, revisions were made in an effort to streamline and clarify reporting expectations for Ohio MMPs.

Please see below for a summary of the substantive changes to the Ohio-Specific Reporting Requirements. Note that the Ohio-Specific Value Sets Workbook also includes changes; Ohio MMPs should carefully review and incorporate the updated value sets, particularly for measure OH1.3.

Ohio MMPs must use the updated specifications and value sets for measures due on or after May 31, 2019. Should you have any questions, please contact the Medicare-Medicaid Coordination Office at mmcocapsreporting@cms.hhs.gov.

SUMMARY OF CHANGES

Introduction

- Revised the "Guidance on Assessments and Care Plans for Members with a Break or Change in Coverage" section to indicate that under certain circumstances, a new assessment that was completed for a member upon reenrollment may also be reported in Core Measure 2.3. Ohio MMPs should refer to the specifications for Core Measure 2.3 for more information.
- Added a new section titled "Reporting on Passively Enrolled and Opt-In Enrolled Members," which instructs Ohio MMPs to include all members who meet measure

criteria, regardless if the member was enrolled through passive or opt-in enrollment.[1] The section also reiterates that Medicaid-only members should not be included in any measure. Note that this guidance was previously listed in the Notes section for each measure.

General Changes to All State-Specific Measures

- For each measure, formulas were added to the Analysis section to further clarify how measure rates are calculated.
- Additionally, the Notes section for each measure was reorganized to add subheadings that group bullets by relevance for reporting each data element.

Measure OH1.3

- Revised data element A to incorporate continuous enrollment criteria that were previously included in the Notes section.
- In the Notes section, added an exclusion 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.

Measure OH2.1

- Revised data element A to clarify that full-time and part-time waiver service coordinators should be counted in the measure. This guidance was previously included in the Notes section.

Measure OH3.2

- This measure, which was originally designated as calculated by the state, is suspended effective immediately.

Measure OH5.1

- Revised data element A to incorporate continuous enrollment criteria that were previously included in the Notes section.

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