MEDICARE-MEDICAID
CAPITATED FINANCIAL ALIGNMENT MODEL
QUALITY WITHHOLD TECHNICAL NOTES (DY 1): TEXAS-SPECIFIC MEASURES

Effective as of March 1, 2015; Issued March 2, 2016;
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Attachment B: Texas Withhold Measure Technical Notes: Demonstration Year 1

Introduction

The measures in this attachment are quality withhold measures for all Medicare-Medicaid Plans (MMPs) in the Texas Dual Eligible Integrated Care Project for Demonstration Year (DY) 1. These state-specific measures directly supplement the Medicare-Medicaid Capitated Financial Alignment Model CMS Core Quality Withhold Technical Notes for DY 1, which can be found at the following address: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY1QualityWithholdGuidance060614.pdf.

Demonstration Year 1 and Application of the Withholds in CY 2015 and 2016

Demonstration Year 1 in the Texas Dual Eligible Integrated Care Project is defined as March 1, 2015 through December 31, 2016. As outlined in the three-way contract, because Demonstration Year 1 crosses calendar and contract years, an MMP will be evaluated to determine whether it has met quality withhold requirements at the end of both CY 2015 and CY 2016 and the withheld amounts will be repaid separately for each calendar year. However, the determination in CY 2015 will be based solely on those measures that can be appropriately calculated based on the actual enrollment volume during CY 2015. As a result, there are a few measures that are not reportable during CY 2015:

- **CAHPS:** Because of the six month continuous enrollment requirement and sampling time frame associated with CAHPS, MMPs in the Texas Dual Eligible Integrated Care Project will not be able to report CAHPS until CY 2016.
- **Annual Plan of Care Update:** Due to the timing of the start of the Texas Dual Eligible Integrated Care Project, few if any MMP members would be eligible for an annual Plan of Care update during CY 2015.

As a result, CMS core withhold measures CW3 and CW5 and state-specific withhold measures TXW1 and TXW3 will not be included as part of the withhold calculation at the end of CY 2015. MMPs in Texas will be evaluated on the full set of CMS core and Texas-specific withhold measures at the end of CY 2016.

Quality Withhold Requirements in Future Years

CMS and the state shall provide subsequent guidance and technical notes for withhold measures required for DY 2 and 3.

Texas-Specific Measures: Demonstration Year 1

Measure: TXW1 – STAR+PLUS Long-Term Services and Supports Preferences

Description:	Percent of members reporting that service coordinators asked about their STAR+PLUS long-term services and supports preferences.
Metric:	Supplemental question collected via CAHPS
Measure Steward/ Data Source:	State-defined process measure
NQF #:	N/A
Benchmark:	55% responding “usually” or “always” to the survey question (CY 2016 only)

Note:	MMPs will be instructed to add the state-defined questions listed below to their CAHPS surveys. Question three will be used to calculate the metric used under this withhold measure. The first two questions are screening questions necessary to ensure an accurate response to question three. 1. A service coordinator is the person from your STAR+PLUS health plan who helps set up and coordinate services with you. Do you currently have a service coordinator from your STAR+PLUS health plan who helps arrange your medical and other types of services? Response options: Yes, No, Don't Know 2. Long-term services and supports might include attendant care, day program services, or adaptive aids. In the last 6 months, did you speak with a service coordinator that helped arrange long-term services and supports for you? Response options: Yes, No 3. In the last 6 months, how often did your service coordinator involve you in decisions about your long-term services and supports? Response options: Never, Sometimes, Usually, Always

Measure: TXW2 – Nursing Facility Transition

Description:	Percent of members who went from community to hospital to nursing facility and remained in the nursing facility.
Metric:	Measure TX5.1 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: Texas-Specific Reporting Requirements
Measure Steward/ Data Source:	State-defined process measure
NQF #:	N/A
Benchmark:	10%
Note:	For quality withhold purposes, this measure is calculated as follows: **Denominator:** Total number of members who were admitted to the hospital from the community and who remained in the hospital for 30 days or less (Data Element A). **Numerator:** Total number of members from Data Element A who were discharged to a nursing facility and remained in the nursing facility for at least 120 continuous days (Data Element B). Note that lower rates are better for this measure.

Measure: TXW3 – Annual Plan of Care Update

Description:	Percent of enrollees whose Plan of Care was updated annually before the expiration date.

Metric:	Measure TX1.4 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: Texas-Specific Reporting Requirements
Measure Steward/ Data Source:	State-defined process measure
NQF #:	N/A
Benchmark:	86% (CY 2016 only)
Note:	For quality withhold purposes, this measure is calculated as follows: **Denominator:** Total number of members eligible for a Plan of Care annual update (Data Element A). **Numerator:** Total number of members from Data Element A whose Plan of Care was updated annually before the expiration date (Data Element B).

Texas-Specific Adjustments to CW4-Encounter Data

As noted in the Medicare-Medicaid Capitated Financial Alignment Model CMS Core Quality Withhold Technical Notes for DY 1, MMPs must begin submission of encounters within four months from first enrollment effective date or from the earliest date the MMP could submit, whichever is later, as part of the CMS core withhold measure CW4. To qualify for the quality withhold in CY 2015, the MMPs in Texas must begin submitting encounters no later than **July 1, 2015**. CMS identified this date as "the earliest the MMP could submit" based on meeting all the following criteria:

- CMS systems prepared to receive encounter data; and
- State companion guide issued to MMPs.

MMPs must also meet the requirements in the Notes with respect to frequency of submission (based on number of enrollees per contract ID), as well as timeliness of submission, i.e., 180 days from date of service.