MEDICARE-MEDICAID
CAPITATED FINANCIAL ALIGNMENT MODEL
QUALITY WITHHOLD TECHNICAL NOTES (DY 1)

Effective as of October 1, 2013, issued June 6, 2014

Introduction

The Medicare-Medicaid Financial Alignment Initiative seeks to better serve people who are enrolled in both Medicare and Medicaid by testing a person-centered, integrated care model that provides a more easily navigable and seamless path to all Medicare and Medicaid services. In order to ensure that Medicare-Medicaid enrollees receive high quality care and to incent quality improvement (both primary goals of the overall Initiative as well as the capitated model), both Medicare and Medicaid will withhold a percentage of their respective components of the capitation rate. The withheld amounts will be repaid retrospectively subject to participating Medicare-Medicaid Plan (MMP) performance consistent with established quality requirements that include a combination of certain core quality withhold measures (across all demonstrations), as well as state-specified quality measures. Note that this methodology and related measures are separate and distinct from those used to determine a plan's Star Rating under Medicare Advantage; MMPs are not eligible for Quality Bonus Payments under Medicare.

The purpose of this document is to provide MMPs with additional detail regarding the methodology associated with the quality withhold payments and benchmarks associated with the CMS and state-specific withhold measures in Demonstration Year (DY) 1. The quality withhold measures are a subset of a larger and more comprehensive set of quality and reporting requirements that MMPs must adhere to under the demonstration—more detail on the broader set of CMS reporting requirements can be found at http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2014CoreReportingRequirements.pdf. State-specific reporting requirements, including long-term supports and service measures, will be made available on a rolling basis as they are finalized.

The overall methodology is below and is applicable to both the DY 1 CMS and state-specific measures. Details and benchmarks for CMS core measures are in Attachment A; these are applicable to all MMPs unless otherwise noted. Details and benchmarks regarding state-specific measures can be found in subsequent attachments; stakeholders will have an opportunity to comment on state-specific requirements prior to being finalized.

Please note that DY 1 varies from state to state and is defined in each state's three-way contract and referenced in the state-specific attachments.

Methodology

MMPs will receive a "pass" or "fail" score for each withhold measure. If the MMP meets the determined benchmark, it will receive a "pass" for that measure. If the MMP does not meet the benchmark, it will receive a "fail" for that measure.

Quality withhold payments will be determined based on the percentage of withhold measures, including CMS and state-specific measures, each MMP passes. All measures will be weighted equally. If one or more measures cannot be calculated for the MMP because of timing constraints or enrollment requirements (e.g., the reporting period does not fall during the applicable demonstration year, an MMP does not have sufficient enrollment to report the measure as detailed in the technical notes), it will be removed from the total number of withhold measures on which an MMP will be evaluated.

MMPs will be evaluated using the following bands:

Percent of Measures Passed	Percent of Withhold MMP Receives
0-19%	0%
20-39%	25%
40-59%	50%
60-79%	75%
80-100%	100%

Any updates to the quality withhold methodology for Demonstration Years 2 and 3 will be provided in the technical guidance described below. However, CMS does expect that in DY 2 and 3, MMPs may have two ways in which to "pass" a particular measure depending on the distribution of scores on the measure:

1. If the MMP meets the established benchmark on an individual measure, or
2. If the MMP meets the established goal for closing the gap between its performance in the 12 months prior to the performance period and the established benchmark by a stipulated percentage.

Benchmarks

Benchmarks for individual measures will be determined through an analysis of national or state-specific data depending upon the data available for each measure. In general, benchmarks for CMS core measures will be established using national data such that all MMPs across the demonstration are held to a consistent level of performance. For state-specific measures, benchmarks will be developed by states using state-specific data.

- *Demonstration Year 1:* Technical notes, including required benchmarks, can be found in Attachment A for CMS core measures and in subsequent Attachments for state-specific measures.
- *Demonstration Years 2 and 3:* Technical guidance outlining updates to the methodology and technical notes on the measures and required benchmarks will be made available in the fall preceding the start of the next Demonstration Year. A draft of this guidance will be made available for public comment prior to being finalized.

Attachment A
CMS Core Withhold Measure Technical Notes: Demonstration Year 1

Measure: CW1- Assessments

Description:	Members with initial assessments completed within 90 days of enrollment.
Metric:	Measure 2.1 of Medicare-Medicaid Capitated Financial Alignment Demonstration Reporting Requirements (see notes below)
Measure Steward/ Data Source:	CMS-defined process measure
NQF #:	N/A
Benchmark:	Benchmark to be calculated in each state and based on the percentage achieved by the highest scoring MMP minus 10 percentage points. In states where there are more than 10 plans the benchmark would be based on the 85th percentile plan minus 10 percentage points.
Notes:	In order to calculate an annual rate for the purposes of the withhold, all reported numerators (Data Element D) and denominators (Data Element A) will be summed. In recognition of both the person-centered foundation underlying the Demonstration and the challenges associated with obtaining valid contact information for the Medicare-Medicaid enrollee population, the number of members who are documented as unwilling to participate (Data Element B) and the number of members the MMP was unable to locate following three attempts (Data Element C) will be removed from the analysis. However, CMS and the states will monitor trends and plan-specific outliers in both of these elements, and reserve the right to revisit this as appropriate. CMS may establish a credibility threshold for this measure as applied to any low-enrollment plans.

Measure: CW2-Consumer Governance Board

Description:	Establishment of consumer advisory board or inclusion of consumers on governance board consistent with contract requirements
Metric:	Measure 5.3 of Medicare-Medicaid Capitated Financial Alignment Demonstration Reporting Requirements
Measure Steward/ Data Source:	CMS-defined process measure
NQF #:	N/A
Benchmark:	100% compliance

Measure: CW3-Customer Service

Description:	Percent of the best possible score the plan earned on how easy it is for members to get information and help from the plan when needed: • In the last 6 months, how often did your health plan's customer service give you the information or help you needed? • In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect? • In the last 6 months how, often were the forms for your health plan easy to fill out?
Measure Steward/ Data Source:	AHRQ/CAHPS (Medicare CAHPS-CAHPS 4.0)
NQF #:	0006
Benchmark:	86%
Minimum Enrollment:	600
Continuous Enrollment Requirement:	Yes, 6 months
Timing:	Given that start dates vary state-to-state, the timing of MMP collection of CAHPS will be identified in the state specific attachments.
Notes:	The case-mix adjusted composite measure is used to assess how easy it was for the member to get information and help when needed. CAHPS measures are adjusted for self-reported physical and mental health status, age, education, proxy status, dual eligibility, low income subsidy eligibility, and language of survey. For a list of CAHPS case-mix coefficients, please see the Star Ratings Technical Notes at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html. CAHPS uses the mean of the distribution of responses converted to a scale from 0 to 100. The percent of the best possible score the plan earned is an average of scores for the questions within the composite.

Measure: CW4-Encounter Data

Description:	Encounter data for all services covered under the demonstration, with the exception of Prescription Drug Event (PDE) data, submitted timely in compliance with demonstration requirements.
Metric:	MMPs will be required to submit encounter data at the frequency specified according to the following tiered scale (as determined by the number of enrollees per Contract ID), with the exception of PDE data (see Notes below):

Plan Enrollment	Data Submission
Greater than 100,000	Weekly
50,000-100,000	Bi-Weekly
Less than 50,000	Monthly

Additional criteria:

- All encounters must be submitted at least monthly, consistent with the above schedule.
- The first submission of encounters must be within four months from first enrollment effective date or from the earliest date the MMP could submit, whichever is later (to be identified in the state-specific attachment).
- All encounters must be submitted within 180 days of the date of service.

Measure Steward/
Data Source: MMP Encounter Data

NQF #: N/A

Benchmark: 80% of encounters are submitted according to the criteria identified above timely, unless otherwise specified in three- way contract and state-specific attachment. CMS and the states will monitor progress and reserve the right to revisit the benchmark as appropriate.

Notes: This metric excludes Prescription Drug Event (PDE) data. MMPs are responsible for following existing PDE submission requirements.

If the submission standards cited in an MMP's three-way contract are more stringent than those described in the schedule/criteria above, MMPs will be required to adhere to their contract's standards. This will be noted in the state specific attachments, if applicable.

Measure: CW5-Getting Appointments and Care Quickly

Description: Percent of best possible score the plan earned on how quickly members get appointments and care:

- In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?
- In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?
- In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?

Measure Steward/ Data Source:	AHRQ/CAHPS (Medicare CAHPS—CAHPS 4.0)
NQF #:	0006
Benchmark:	74%
Minimum Enrollment:	600
Continuous Enrollment Requirement:	Yes, 6 months
Timing:	Given that start dates vary state-to-state, the timing of MMP collection of CAHPS will be identified in the state specific attachments.
Notes:	This case-mix adjusted composite measure is used to assess how quickly the member was able to get appointments and care. CAHPS measures are adjusted for self-reported physical and mental health status, age, education, proxy status, dual eligibility, low income subsidy eligibility, and language of survey. For a list of CAHPS case-mix coefficients, please see the Star Ratings Technical Notes at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html. The CAHPS score uses the mean of the distribution of responses converted to a scale from 0 to 100. The percentage of the best possible score each plan earned is an average of scores for the questions within the composite.