MEDICARE-MEDICAID
CAPITATED FINANCIAL ALIGNMENT MODEL
QUALITY WITHHOLD TECHNICAL NOTES (DY 2 – 8): NEW YORK FIDA-IDD-SPECIFIC MEASURES

Effective as of January 1, 2018; Issued October 29, 2018;
Updated November 30, 2023

Attachment D
New York FIDA-IDD Quality Withhold Measure Technical Notes: Demonstration Years 2 through 8

Introduction

The measures in this attachment are quality withhold measures for the Medicare-Medicaid Plan (MMP) in the New York Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) Demonstration for Demonstration Years (DY) 2 through 8. These state-specific measures directly supplement the Medicare-Medicaid Capitated Financial Alignment Model CMS Core Quality Withhold Technical Notes for DY 2 through 12.

DY 2 through 8 in the New York FIDA-IDD Demonstration are defined as follows:

Year	Dates Covered
DY 2	January 1, 2018 – December 31, 2018
DY 3	January 1, 2019 – December 31, 2019
DY 4	January 1, 2020 – December 31, 2020
DY 5	January 1, 2021 – December 31, 2021
DY 6	January 1, 2022 – December 31, 2022
DY 7	January 1, 2023 – December 31, 2023
DY 8	January 1, 2024 – December 31, 2024

Information about the applicable demonstration years for each state-specific measure, as well as benchmarks and other details, can be found in the measure descriptions below. Note that CMS and the State may elect to adjust the benchmarks or other details based on additional analysis or changes in specifications. Stakeholders will have the opportunity to comment on any substantive changes prior to finalization.

Variation from the CMS Core Quality Withhold Technical Notes

Because of the six month continuous enrollment requirement and sampling timeframe associated with CAHPS, the MMP in the New York FIDA-IDD Demonstration was unable to report CMS core quality withhold measures CW3 and CW5 for DY 1. The MMP was also unable to report these measures for DY 2. As a result, these measures were included as part of the quality withhold analysis for DY 3. The details and benchmarks for these measures are provided in the CMS Core Quality Withhold Technical Notes for DY 1, and also reiterated on pages 3 through 5 of this document.

Applicability of the Gap Closure Target to the State-Specific Quality Withhold Measures

The gap closure target methodology as described in the CMS Core Quality Withhold Technical Notes for DY 2 through 12 **will** apply to the state-specific measures contained in this attachment, unless otherwise noted in the measure descriptions below.

New York FIDA-IDD-Specific Measures: Demonstration Years 2 through 8

Measure: IDDW3 – Annual Dental Visit

Description: Percent of Participants who had one or more dental visits with a dental practitioner during the measurement year

Metric:	Measure IDD4.3 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: New York FIDA-IDD-Specific Reporting Requirements
Measure Steward/ Data Source:	State-defined measure
CMIT #:	N/A
Applicable Years:	DY 3 through 8
Utilizes Gap Closure:	Yes
Benchmarks:	DY 3: 79% DY 4 through 8: 82%
Notes:	For quality withhold purposes, this measure will be calculated by the State as follows: Denominator: The total number of Participants who were continuously enrolled in the MMP during the measurement year, with no more than a one-month enrollment gap. Numerator: The total number of Participants who had at least one dental procedure code during the measurement year. This measure will be removed from the quality withhold analysis if fewer than 30 Participants qualify for the denominator.

Measure: IDDW4 – Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) Diversion

Description:	Reporting of the number of Participants who lived outside the ICF-IID during the current measurement year as a proportion of all Participants who lived outside the ICF-IID during the previous year
Metric:	Measure IDD2.3 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: New York FIDA-IDD-Specific Reporting Requirements
Measure Steward/ Data Source:	State-defined measure
CMIT #:	N/A
Applicable Years:	DY 2 through 8
Utilizes Gap Closure:	No
Benchmark:	Timely and accurate reporting according to the IDD2.3 measure specifications

Measure: IDDW5 – Glycemic Status Assessment for Patients With Diabetes

Description:	Percent of Participants with diabetes whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) showed their average blood sugar is under control.
Measure Steward/ Data Source:	NCQA/HEDIS (the MMP should follow the version of the HEDIS Technical Specifications that is referenced in the HEDIS Reporting Requirements HPMS memorandum issued for the relevant reporting year)

HEDIS Labels:	DY 5: Comprehensive Diabetes Care (CDC) – HbA1c Poor Control (>9.0%) DY 6 and 7: Hemoglobin A1c Control for Patients with Diabetes (HBD) – HbA1c Poor Control (>9.0%) DY 8: Glycemic Status Assessment for Patients with Diabetes (GSD) – Glycemic Status >9.0%
CMIT #:	204
Applicable Years:	DY 5 through 8
Utilizes Gap Closure:	Yes
Benchmark:	65%
Notes:	The Glycemic Status metric will be reverse scored for purposes of the quality withhold analysis, such that a higher rate indicates better performance. To calculate the reverse score, the MMP's reported Glycemic Status >9.0% rate will be subtracted from 100%. This measure will be removed from the quality withhold analysis if the MMP has fewer than 1,000 enrollees as of July of the measurement year. It will also be removed if the MMP's HEDIS audit designation is "NA", which indicates that the denominator is too small (<30) to report a valid rate.

Measure: IDDW6 – Care for Older Adults: Medication Review

Description:	Percent of Participants 66 years and older who received at least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record
Measure Steward/ Data Source:	NCQA/HEDIS (the MMP should follow the version of the HEDIS Technical Specifications that is referenced in the HEDIS Reporting Requirements HPMS memorandum issued for the relevant reporting year)
HEDIS Label:	Care for Older Adults (COA) – Medication Review
CMIT #:	110
Applicable Years:	DY 5 through 8
Utilizes Gap Closure:	Yes
Benchmark:	75%
Notes:	This measure will be removed from the quality withhold analysis if the MMP has fewer than 1,000 enrollees as of July of the measurement year. It will also be removed if the MMP's HEDIS audit designation is "NA", which indicates that the denominator is too small (<30) to report a valid rate.

<u>Additional CMS Core Measures for New York FIDA-IDD: Demonstration Year 3 Only</u>

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 – Current Version)
CMIT #:	181
Applicable Year:	DY 3
Utilizes Gap Closure:	No
Benchmark:	86%
Minimum Enrollment:	600
Continuous Enrollment Requirement:	Yes, 6 months
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. 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.

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 needed? • In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as 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 – Current Version)
CMIT #:	292
Applicable Year:	DY 3
Utilizes Gap Closure:	No
Benchmark:	74%

Minimum Enrollment:	600
Continuous Enrollment Requirement:	Yes, 6 months
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.