MEDICARE-MEDICAID
CAPITATED FINANCIAL ALIGNMENT MODEL
QUALITY WITHHOLD TECHNICAL NOTES (DY 2 – 8): SOUTH CAROLINA-SPECIFIC MEASURES

Effective as of January 1, 2017; Issued May 2, 2018;
Updated December 3, 2021

Attachment D
South Carolina Quality Withhold Measure Technical Notes: Demonstration Years 2 through 8

Introduction

The measures in this attachment are quality withhold measures for all Medicare-Medicaid Plans (MMPs) in the South Carolina Healthy Connections Prime 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 9.

DY 2 through 8 in the South Carolina Healthy Connections Prime demonstration are defined as follows:

Year	Dates Covered
DY 2	January 1, 2017 – December 31, 2017
DY 3	January 1, 2018 – December 31, 2018
DY 4	January 1, 2019 – December 31, 2019
DY 5	January 1, 2020 – December 31, 2020
DY 6	January 1, 2021 – December 31, 2021
DY 7	January 1, 2022 – December 31, 2022
DY 8	January 1, 2023 – December 31, 2023

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, South Carolina MMPs were unable to report CMS core quality withhold measures CW3 and CW5 for DY 1. As a result, these measures were included as part of the withhold analysis for DY 2 for South Carolina MMPs. 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 4 through 6 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 9 **will not** apply to the state-specific measures for DY 2 and 3, but **will** apply to the state-specific measures for DY 4 through 8.

South Carolina-Specific Measures: Demonstration Years 2 and 3

Measure: SCW4 – Management of Hospital, Nursing Facility, and Community Transitions

Description:	Percent of enrollees who transitioned to and from hospitals, nursing facilities, and the community
Metric:	Measure SC2.6 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: South Carolina-Specific Reporting Requirements

Measure Steward/ Data Source:	State-defined measure
NQF #:	N/A
Applicable Years:	DY 2 and 3
Utilizes Gap Closure:	No
Benchmark:	Timely and accurate reporting according to the SC2.6 measure specifications

Measure: SCW5 – Adjudicated Claims

Description:	Percent of adjudicated claims submitted to MMPs that were paid within the timely filing requirements
Metric:	Measure SC5.1 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: South Carolina-Specific Reporting Requirements
Measure Steward/ Data Source:	State-defined measure
NQF #:	N/A
Applicable Years:	DY 2 and 3
Utilizes Gap Closure:	No
Benchmarks:	90% of all clean claims paid within 30 days of the date of receipt 99% of all clean claims paid within 90 days of the date of receipt
Notes:	The MMP must meet or exceed the benchmark for both metrics in order to pass the measure as a whole. The first metric (i.e., percent of clean claims paid within 30 days) is calculated as follows: Denominator: The total number of clean, non-duplicated claims for services other than HCBS, adjudicated and approved during the reporting period (Data Element A) summed over four quarters. Numerator: The total number of adjudicated and approved non-HCBS claims paid using the correct rate and within 30 days (Data Element B) summed over four quarters. The second metric (i.e., percent of clean claims paid within 90 days) is calculated as follows: Denominator: The total number of clean, non-duplicated claims for services other than HCBS, adjudicated and approved during the reporting period (Data Element A) summed over four quarters. Numerator: The total number of adjudicated and approved non-HCBS claims paid using the correct rate and within 90 days (Data Element C) summed over four quarters. By summing the denominators and numerators before calculating the rates, the final calculations are adjusted for volume.

South Carolina-Specific Measures: Demonstration Years 4 through 8

Measure: SCW6 – Comprehensive Diabetes Care

Description:	The percentage of members up to 75 years of age with diabetes (type 1 and type 2) who had each of the following: • Hemoglobin A1c (HbA1c) Testing • HbA1c Poor Control (>9.0%) • Eye Exam (Retinal) Performed • Medical Attention for Nephropathy
Measure Steward/ Data Source:	NCQA/HEDIS (MMPs 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:	Comprehensive Diabetes Care (CDC)
NQF #:	0731
Applicable Years:	DY 4 through 6
Utilizes Gap Closure:	Yes
Benchmarks:	HbA1c Testing: 93% Blood Sugar Controlled (Reverse of HbA1c Poor Control): 68% (DY 4-5 only) Eye Exam (Retinal) Performed: 64% Medical Attention for Nephropathy: 87%
Notes:	The HbA1c Testing, Eye Exam (Retinal) Performed, and Medical Attention for Nephropathy metrics apply for DY 4 through 6. The Blood Sugar Controlled metric applies for DY 4 and 5 only. The MMP must meet or exceed the benchmark or gap closure target for all applicable metrics for a given year in order to pass the measure as a whole. 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. As noted above, the Blood Sugar Controlled metric is based on the reverse score of HbA1c Poor Control, such that a higher rate indicates better performance. To calculate the reverse score, the MMP's reported HbA1c Poor Control rate will be subtracted from 100%.

Measure: SCW7 – Follow-Up Visit After Inpatient Hospital Discharge

Description:	Percent of acute inpatient hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of the discharge from the inpatient hospital stay
Metric:	Measure SC2.4 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: South Carolina-Specific Reporting Requirements
Measure Steward/ Data Source:	State-defined measure

NQF #:	N/A
Applicable Years:	DY 4 through 8
Utilizes Gap Closure:	Yes
Benchmark:	85%
Notes:	For quality withhold purposes, this measure is calculated as follows: Denominator: Total number of acute inpatient hospital discharges (Data Element A). Numerator: Total number of acute inpatient hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge from the inpatient hospital stay (Data Element B).

Measure: SCW8 – Eye Exam for Members with Diabetes

Description:	The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam
Measure Steward/ Data Source:	NCQA/HEDIS (MMPs 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:	Eye Exam for Patients with Diabetes (EED)
NQF #:	0055
Applicable Years:	DY 7 and 8
Utilizes Gap Closure:	Yes
Benchmark:	64%
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 South Carolina MMPs: Demonstration Year 2 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)

NQF #:	0006
Applicable Year:	DY 2
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)
NQF #:	0006
Applicable Year:	DY 2
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.

Attachment E
Additional CMS Withhold Measure Technical Notes: Demonstration Years 6 through 8

Introduction

This attachment provides information about the additional CMS measure that serves as the basis for the separate 1% quality withhold that applies to the Medicare A/B rate component starting in DY 6. The applicable benchmark and other details can be found in the measure description below. Note that CMS may elect to adjust the benchmark or other details based on further analysis or changes in specifications. Stakeholders will have the opportunity to comment on any substantive changes prior to finalization.

Applicability of the Gap Closure Target to the Additional CMS Measure

The gap closure target methodology as described in the CMS Core Quality Withhold Technical Notes **will** apply to the additional CMS measure, but with a 33% improvement percentage.

Alternative Withhold Measure if an MMP is Unable to Report the Additional CMS Measure

If an MMP is unable to report the additional CMS measure in a given year due to low enrollment or inability to meet other reporting criteria, an alternative measure will be used for the MMP. In such cases, the Colorectal Cancer Screening (COL) HEDIS measure will apply using a 70% benchmark and a 33% improvement percentage. Note that the COL measure would apply only to the specific year(s) for which the MMP is unable to report the additional CMS measure.

Additional CMS Measure for South Carolina MMPs: Demonstration Years 6 through 8

Measure: SCCW1 – Diabetes Care: Blood Sugar Controlled

Description:	Percent of members with diabetes who had an A1C lab test during the year that showed their average blood sugar is under control
Measure Steward/ Data Source:	NCQA/HEDIS (MMPs 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 6: Comprehensive Diabetes Care (CDC) – HbA1c Poor Control (>9.0%) DY 7 and 8: Hemoglobin A1c Control for Patients with Diabetes (HBD) – HbA1c Poor Control (>9.0%)
NQF #:	0059
Applicable Years:	DY 6 through 8
Utilizes Gap Closure:	Yes, with a 33% improvement percentage
Benchmark:	74%
Notes:	The HbA1c Poor Control 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 HbA1c Poor Control 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.