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Quality Withhold Reimbursement Methodology for MMPs under the Medicare-Medicaid Capitated Financial Alignment Model
DRAFT FOR COMMENT

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 benchmarks. These benchmarks are based on 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 payment under Medicare.

The purpose of this document is to provide MMPs with additional detail regarding the reimbursement methodology associated with the quality withhold payments and benchmarks associated with the core 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 requirements, including long-term supports and service measures, will be made available on a rolling basis as they are developed.

The overall methodology for DY 1 is below. 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 core measures can be found in subsequent attachments.

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 each MMP passes. If one or measures cannot be calculated for the MMP because of timing constraints or enrollment requirements, 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 future technical guidance. 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.

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 note 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%. In states where there are more than 10 plans the benchmark would be based on the 85thpercentile plan minus 10%.
Note:	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.

Comment [A1]: CMS seeks input on both the concept of a credibility threshold and possible threshold for this measure.

Measure: CW2-Consumer Governance Board

Description:	Establishment of consumer advisory board or inclusion of consumer 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?

Metric:	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 uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each contract earned.
Measure Steward/ Data Source:	AHRQ/CAHPS
NQF #:	0006
Benchmark:	86%
Timing:	For MMPs starting in January- July 2014, CAHPS will be reported in 2015 for DY 1. For MMPs starting in August-December 2014 or January-April 2015, CAHPS will be reported in 2016 for DY 1. For MMPs starting in 2013, CAHPS measures will be deferred to DY 2.
Minimum Enrollment:	600

Measure: CW4-Encounter Data

Description:	Encounter data submitted timely and completely in compliance with contract requirements.
Measure Steward/ Data Source:	MMP Encounter Data
NQF #:	N/A
Benchmark:	99% timely and complete unless otherwise specified in three-way contract.

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?

Metric:	This case-mix adjusted composite measure is used to assess how quickly the member was able to get appointments and care. The CAHPS score uses the mean of the distribution of responses converted to a scale from 0 to 100. The score shown is the percentage of the best possible score each plan earned.
Measure Steward/ Data Source:	CAHPS
NQF #:	0006
Benchmark:	74%
Timing:	For MMPs starting in January- July 2014, CAHPS will be reported in 2015 for DY 1. For MMPs starting in August-December 2014 or January-April 2015, CAHPS will be reported in 2016 for DY 1. For MMPs starting in 2013, CAHPS measures will be deferred to DY 2.
Minimum Enrollment:	600

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Attachment X

State-Specific Withhold Measure Technical Notes: Demonstration Year 1

WILL BE ISSUED SEPARATELY FOR EACH STATE