

**MEDICARE-MEDICAID
CAPITATED FINANCIAL ALIGNMENT MODEL
QUALITY WITHHOLD TECHNICAL NOTES (DY 2 – 9):
MASSACHUSETTS-SPECIFIC MEASURES**

Effective as of January 1, 2015; Issued April 29, 2016;
Updated January 24, 2022

Attachment D
Massachusetts Quality Withhold Measure Technical Notes: Demonstration Years 2 through 9

Introduction

The measures in this attachment are quality withhold measures for all Medicare-Medicaid Plans (MMPs) in the Massachusetts One Care Demonstration for Demonstration Years (DY) 2 through 9. 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 9 in the Massachusetts One Care Demonstration are defined as follows:

| Year | Dates Covered |
|-------------|-------------------------------------|
| DY 2 | January 1, 2015 – December 31, 2015 |
| DY 3 | January 1, 2016 – December 31, 2016 |
| DY 4 | January 1, 2017 – December 31, 2017 |
| DY 5 | January 1, 2018 – December 31, 2018 |
| DY 6 | January 1, 2019 – December 31, 2019 |
| DY 7 | January 1, 2020 – December 31, 2020 |
| DY 8 | January 1, 2021 – December 31, 2021 |
| DY 9 | January 1, 2022 – December 31, 2022 |

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.

Variations from the CMS Core Quality Withhold Technical Notes

Because of the six-month continuous enrollment requirement and sampling timeframe associated with CAHPS, Massachusetts 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 Massachusetts 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 6 through 7 of this document.

Additionally, the applicable demonstration years are modified for the following measures in the CMS Core Quality Withhold Technical Notes for DY 2 through 9:

- CMS core quality withhold measure CW10 is not applicable for Massachusetts MMPs for any DY.¹
- CMS core quality withhold measure CW12 is not applicable for Massachusetts MMPs as of DY 9.
- CMS core quality withhold measure CW13 is not applicable for Massachusetts MMPs for DY 2, but does apply as of DY 3.

¹ As noted in the CMS Core Quality Withhold Technical Notes for DY 2 through 9, this measure is currently suspended from the quality withhold analysis for MMPs in all demonstrations. Should the measure be reinstated in the future, it will continue to be excluded for Massachusetts MMPs.

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** apply to the state-specific measures contained in this attachment.

Modification to the Methodology for New Entrants in the Demonstration

For MMPs that are new entrants in the Massachusetts One Care Demonstration, the quality withhold methodology will be modified for the new MMP's first year of operation, given that the new MMP will not have prior year data available in order to calculate gap closure targets as applicable. For measures that normally utilize the gap closure target methodology, the new MMP will earn a "met" designation based on meeting either the benchmark less ten percentage points or the highest performing MMP's rate less ten percentage points. However, if subtracting ten percentage points results in more than a 25% reduction to the benchmark and/or the highest performing MMP's rate, then the new MMP will instead be evaluated against the benchmark less 25% and/or the highest performing MMP's rate less 25%.

As noted, this revised approach does not apply to measures that do not utilize the gap closure target methodology (i.e., new MMPs will be evaluated according to the standard approach for CMS core quality withhold measures CW6 and CW13).

Massachusetts-Specific Measures: Demonstration Years 2 through 9

Measure: MA4 – Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

| | |
|----------------------------------|--|
| Description: | Percent of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported: <ul style="list-style-type: none">• Initiation of SUD Treatment. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days.• Engagement of SUD Treatment. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation. |
| 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: | Initiation and Engagement of Substance Use Disorder Treatment (IET) |
| NQF #: | 0004 |
| Applicable Years: | DY 2 through 9 |
| Utilizes Gap Closure: | Yes |
| Benchmarks: | Initiation of SUD Treatment: 43% Engagement of SUD Treatment DY 2 through 8: 9% Engagement of SUD Treatment DY 9: 12% |
| Notes: | The MMP must meet or exceed the benchmark or gap closure target for both metrics 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.

Measure: MA5 – Adults' Access to Preventive/Ambulatory Health Services

| | |
|----------------------------------|---|
| Description: | Percent of members 20 years and older who had an ambulatory or preventive care visit during the measurement year |
| 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: | Adults' Access to Preventive/Ambulatory Health Services (AAP) |
| NQF #: | N/A |
| Applicable Years: | DY 3 through 8 |
| Utilizes Gap Closure: | Yes |
| Benchmarks: | DY 3 through 6: 89% DY 7 through 8: 95% |
| 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. |

Measure: MA6 – Diabetes Care: Blood Sugar Controlled

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|----------------------------------|---|
| 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 Label: | Hemoglobin A1c Control for Patients with Diabetes (HBD) – HbA1c Poor Control (>9.0%) |
| NQF #: | 0059 |
| Applicable Year: | DY 9 |
| Utilizes Gap Closure: | Yes |
| Benchmark: | 74% |
| Notes: | <p>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%.</p> <p>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.</p> |

Measure: MA7 – Timely Assessment

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|----------------------------------|--|
| Description: | Percent of members with an initial assessment completed within 90 days of enrollment |
| Metric: | Core Measure 2.1 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements |
| Measure Steward/ Data Source: | CMS-defined measure |
| NQF #: | N/A |
| Applicable Year: | DY 9 |
| Utilizes Gap Closure: | Yes |
| Benchmark: | 90% |
| Notes: | <p>For quality withhold purposes, this measure is calculated as follows:</p> <p>Denominator: The total number of members whose 90th day of enrollment occurred within the reporting period, excluding the total number of members who were documented as unwilling to participate in the assessment within 90 days of enrollment and the total number of members the MMP was unable to reach within 90 days of enrollment (Data Element A – Data Element B – Data Element C) summed over four quarters.</p> <p>Numerator: The total number of members with an assessment completed within 90 days of enrollment (Data Element D) summed over four quarters.</p> <p>By summing the quarterly denominators and numerators before calculating the rate, the final calculation is adjusted for volume.</p> |

Measure: MA8 – Tracking of Demographic Information

| | |
|----------------------------------|---|
| Description: | Percent of members whose demographic data are collected and maintained in the MMP Centralized Enrollee Record |
| Metric: | Measure MA5.1 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: Massachusetts-Specific Reporting Requirements |
| Measure Steward/ Data Source: | State-defined measure |
| NQF #: | N/A |
| Applicable Year: | DY 9 |
| Utilizes Gap Closure: | Yes |
| Benchmark: | 85% |
| Notes: | <p>For quality withhold purposes, this measure is calculated as follows:</p> <p>Denominator: The total number of members enrolled at the end of the reporting period multiplied by six (six is the number of data elements included in the measure).</p> <p>Numerator: The total number of members whose race/ethnicity/primary language/homelessness/disability type/LGBTQ identity data are collected</p> |

and maintained in the MMP Centralized Enrollee Record (Data Element A + Data Element B + Data Element C + Data Element D + Data Element E + Data Element F).

Measure: MA9 – Documentation of Care Goals

| | |
|----------------------------------|---|
| Description: | Percent of members with documented discussions of care goals |
| Metric: | Measure MA1.2 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: Massachusetts-Specific Reporting Requirements |
| Measure Steward/ Data Source: | State-defined measure |
| NQF #: | N/A |
| Applicable Year: | DY 9 |
| Utilizes Gap Closure: | Yes |
| Benchmark: | 95% |
| Notes: | <p>For quality withhold purposes, this measure is calculated as follows:</p> <p>Denominator: The total number of members with an initial care plan completed during the reporting period plus the total number of existing care plans revised during the reporting period (Data Element A + Data Element C) summed over four quarters.</p> <p>Numerator: The total number of members with at least one documented discussion of care goals in the initial care plan plus the total number of revised care plans with at least one documented discussion of new or existing care goals (Data Element B + Data Element D) summed over four quarters.</p> <p>By summing the quarterly denominators and numerators before calculating the rate, the final calculation is adjusted for volume.</p> |

Measure: MA10 – Access to LTS Coordinator

| | |
|----------------------------------|--|
| Description: | Percent of members with LTSS needs who have a referral to an LTS Coordinator within 90 days of enrollment |
| Metric: | Measure MA1.3 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: Massachusetts-Specific Reporting Requirements |
| Measure Steward/ Data Source: | State-defined measure |
| NQF #: | N/A |
| Applicable Year: | DY 9 |
| Utilizes Gap Closure: | Yes |
| Benchmark: | 95% |
| Notes: | <p>For quality withhold purposes, this measure is calculated as follows:</p> <p>Denominator: The total number of members identified with LTSS needs within 90 days of enrollment, excluding the total number of members with</p> |

LTSS needs who refused an LTS Coordinator within 90 days of enrollment (Data Element B – Data Element C) summed over four quarters.

Numerator: The total number of members with LTSS needs who have a referral to an LTS Coordinator within 90 days of enrollment (Data Element D) summed over four quarters.

By summing the quarterly denominators and numerators before calculating the rate, the final calculation is adjusted for volume.

Additional CMS Core Measures for Massachusetts MMPs: Demonstration Year 2 Only

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 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 – 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.