MEDICARE-MEDICAID
CAPITATED FINANCIAL ALIGNMENT MODEL
QUALITY WITHHOLD TECHNICAL NOTES (DY 2 & 3)

Effective as of January 1, 2015, Issued April 29, 2016

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 withhold 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 for the quality withhold analysis associated with the CMS and state-specific withhold measures in Demonstration Years (DY) 2 and 3. 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 core and state-specific reporting requirements can be found at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html.

The overall methodology is described below and is applicable to both the CMS and state-specific measures for DY 2 and 3. Details and benchmarks for CMS core measures are in Attachment A; these are applicable to all MMPs unless otherwise noted in subsequent state-specific attachments. Details and benchmarks regarding state-specific measures can also be found in the state-specific attachments; stakeholders will have an opportunity to comment on state requirements prior to finalization.

Please note that DY 2 and 3 vary from state to state and are defined in each state's three-way contract and referenced in the state-specific attachments. Also note that the quality withhold analysis will be conducted separately for DY 2 and 3 (i.e., an MMP will be evaluated to determine whether it has met quality withhold requirements for each year and the withheld amounts will be repaid separately).

Methodology

MMPs will receive a "pass" or "fail" score for each withhold measure. For DY 2 and 3, MMPs have two ways in which to pass a particular core measure:

1. If the MMP meets the established benchmark for the measure, or
2. If the MMP meets the established goal for closing the gap between its performance in the calendar year prior to the performance period and the established benchmark by a stipulated percentage.[1]

If the MMP meets the established benchmark or the gap closure target, it will receive a "pass" for that core measure. If the MMP does not meet the benchmark or the gap closure target, it will receive a "fail" for that core measure. For state-specific measures, states have the discretion to determine whether the gap closure target methodology applies. Refer to the state-specific attachments for more information.

Note that plans may also be required to participate in performance measure validation for any core or state-specific quality withhold measure. If issues are identified that impact the accuracy of the data

[1] The gap closure target methodology does not apply to CMS core measure CW13.

reported by the MMP, CMS and the state may request that the MMP resubmit the measure and/or determine that the MMP failed the measure for purposes of the quality withhold analysis. Additional information regarding performance measure validation will be provided at a later date. Note that any such validation would only apply to measures that do not already have a data accuracy process incorporated into the reporting protocol (e.g., HEDIS and CAHPS measures would not be subject to this additional validation).

Quality withhold payments will be determined based on the percentage of all withhold measures, including CMS core and state-specific measures, each MMP passes. All measures will be weighted equally, with no distinction made between measures that earned a "pass" by meeting the benchmark and measures that earned a "pass" by meeting the gap closure target. 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. In circumstances where the removal of measures results in fewer than three measures that are eligible for inclusion, alternative measures will be added to the quality withhold analysis (for more information, see the "Minimum Number of Measures" section on the following page).

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%

Benchmarks

Benchmarks for individual measures are 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 are established using national data such that all MMPs across demonstrations are held to a consistent level of performance. For state-specific measures, benchmarks are developed by states using state-specific data, as well as national data when available/appropriate.

Technical notes, including required benchmarks for DY 2 and 3, can be found in Attachment A for CMS core measures and in subsequent attachments for state-specific measures. For DY 3, CMS may elect to adjust the benchmarks included in Attachment A based on additional analysis.

Gap Closure Targets

As indicated on the previous page, MMPs also have the opportunity to pass a measure if the MMP closes the gap between its performance in the calendar year prior to the performance period and the benchmark by a stipulated improvement percentage. For most MMPs, a standard improvement percentage of 10 percent (10%) will be used when determining the gap closure target; however, CMS may adjust this percentage in exceptional circumstances.

The gap closure target for each measure will be set at as follows:

1. Calculate the difference between the MMP's performance rate in the prior calendar year and the established benchmark level;
2. Multiply the difference identified in Step 1 by the improvement percentage (e.g. 10%);

3. Add the result from Step 2 to the MMP's performance rate in the prior calendar year and round to one decimal place.

For example, if an MMP's performance rate in CY 2015 is 78 and the benchmark is 92, then the gap closure target for CY 2016 would be 79.4 (based on a 10% improvement percentage). In other words, the MMP would need to achieve a minimum rate of 79.4 in order to pass the measure for CY 2016.

When this calculation results in improvement of less than one percentage point, the gap closure target will instead be set at the MMP's performance rate in the prior calendar year plus one percentage point.

If an MMP was unable to report a particular measure in the prior calendar year due to timing constraints or enrollment requirements, the gap closure target for that MMP will be set at the average gap closure target for other MMPs operating in the state. If an MMP failed to accurately report a measure in the prior calendar year without appropriate justification, then the MMP's performance for the current calendar year will be evaluated against the benchmark only. If the majority (i.e., more than 50 percent) of MMPs in a given state were unable to report a measure in the prior calendar year, the gap closure target will not be used for that measure (i.e., all MMPs in the state will be evaluated against the benchmark only for the current calendar year). MMPs will be notified in writing of the applicability of the gap closure target for each measure included in the quality withhold analysis.

Minimum Number of Measures

As noted on the prior page, MMPs will be evaluated on no fewer than three quality withhold measures for each performance year. If an MMP is unable to report at least three quality withhold measures (either CMS core or state-specific) for a given year due to low enrollment or inability to meet other reporting criteria, alternative measures will be used in the quality withhold analysis. These alternative measures will be aligned with measures that were previously included in the quality withhold analysis for DY 1. The alternative measures and corresponding benchmarks are listed in Attachment B.

Attachment A
CMS Core Withhold Measure Technical Notes: Demonstration Years 2 and 3

Measure: CW6 – Plan all-cause readmissions

Description:	Percent of plan members discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason.
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:	Plan All-Cause Readmissions (PCR)
NQF #:	1768
Benchmark:	11%
Notes:	Lower rates are better

Measure: CW7 – Annual flu vaccine

Description:	Percent of plan members who got a vaccine (flu shot) prior to flu season.
Measure Steward/ Data Source:	AHRQ/CAHPS (Medicare CAHPS – Current Version)
NQF #:	0040
Minimum Enrollment:	600
Continuous Enrollment Requirement:	Yes, 6 months
Benchmark:	69%
Notes:	If an MMP's score for this measure has very low reliability (as defined by CMS and its contractor in the MMP CAHPS report), this measure will be removed from the total number of withhold measures on which the MMP will be evaluated.

Measure: CW8 – Follow-up after hospitalization for mental illness

Description:	Percentage of discharges for plan members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days of discharge.
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:	Follow-Up After Hospitalization for Mental Illness (FUH)
NQF #:	0576
Benchmark:	56%

Measure: CW9 – Screening for clinical depression and follow-up care

Description:	Percentage of patients ages 18 years and older screened for clinical depression using a standardized tool and follow-up plan documented.
Metric:	Measure 6.1 of the Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements
Measure Steward/ Data Source:	CMS-defined process measure
NQF #:	Modified from 0418
Benchmark:	N/A
Notes:	This measure is suspended until further notice, and therefore will not be included in the quality withhold analysis (i.e., this measure is removed from the total number of withhold measures on which MMPs are evaluated). For more information, refer to the HPMS memorandum issued August 13, 2015 titled "Update to Contract Year 2015 Medicare-Medicaid Plan Reporting Requirements."

Measure: CW10 – Reducing the risk of falling

Description:	Percent of plan members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.
Measure Steward/ Data Source:	NCQA/HEDIS (Collected in HOS – MMPs should follow the NCQA HEDIS Specifications for the Medicare Health Outcomes Survey for the relevant reporting year)
HEDIS Label:	Fall Risk Management (FRM)
NQF #:	0035
Benchmark:	55%
Notes:	The National Committee for Quality Assurance is currently re-evaluating this measure to align with the most current U.S. Preventive Services Task Force guidelines. Should the technical specifications for this measure change, CMS will consider any implications for the quality withhold analysis and will update this document accordingly.

Measure: CW11 – Controlling blood pressure

Description:	Percentage of plan members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) for members 18-59 years of age and 60-85 years of age with diagnosis of diabetes or (150/90) for members 60-85 without a diagnosis of diabetes 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:	Controlling High Blood Pressure (CBP)

NQF #: 0018

Benchmark: 53%

Measure: CW12 – Medication adherence for diabetes medications

Description: Percent of plan members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.

Measure Steward/ Data Source: CMS Prescription Drug Event (PDE) Data (This measure will be calculated according to the Medicare Part C & D Star Rating Technical Notes for the relevant reporting year)

NQF #: 0541

Benchmark: 73%

Measure: CW13 – 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 on the next page):

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.
- All encounters must be submitted within 180 days of the date of service.[2]

Measure Steward/ Data Source: MMP Encounter Data

NQF #: N/A

[2] As communicated in the March 25, 2016 HPMS memo titled "Completing Submission of CY 2014-15 Encounter Data by Medicare-Medicaid Plans (MMPs)," the CY 2016 encounter analysis will not include the 180-day timeliness requirement for submission of encounters with dates of service on or before September 30, 2015. This modification may impact the DY 1, DY 2, or DY 3 encounter analysis depending on the start date of each demonstration.

Benchmark:	80% of encounters are submitted according to the criteria identified above timely, unless otherwise specified in the three-way contract and state-specific attachment. CMS and the states will monitor progress and reserve the right to revisit the benchmark as appropriate. For DY 3, completeness of the encounter submissions may be factored into the analysis. Additional information regarding this update will be provided at a later date. Stakeholders will have the opportunity to comment on the new criteria and benchmark prior to finalization.
Notes:	This metric excludes 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. The gap closure target methodology is not applicable to this measure.

Attachment B
Alternative Withhold Measure Technical Notes: Demonstration Years 2 and 3

The following measures will be included in the quality withhold analysis only if an MMP is unable to report at least three of the standard quality withhold measures (either CMS core or state-specific) for a given year. The alternative measures will be added to the analysis in the order in which they are listed below (unless low enrollment prevents reporting of the alternative measure). If a third alternative measure is required, it will be selected by CMS and the state from a DY 1 state-specific quality withhold measure and communicated to the MMPs in separate guidance.

Measure: AW1 – Annual Reassessment

Description:	Percent of plan members who received a reassessment within 365 days of the most recent assessment completed.
Metric:	Measure 2.3 of the Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements
Measure Steward/ Data Source:	CMS-defined process measure
NQF #:	N/A
Benchmark:	65%
Notes:	For quality withhold purposes, this measure will be calculated as follows: Denominator: Total number of members who had an assessment completed during the previous reporting period (Data Element B). Numerator: Total number of members with a reassessment completed within 365 days of the most recent assessment completed (Data Element D).

Measure: AW2 – Consumer Governance Board

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