

**MEDICARE-MEDICAID
CAPITATED FINANCIAL ALIGNMENT MODEL
QUALITY WITHHOLD TECHNICAL NOTES (DY 2 & 3):
SOUTH CAROLINA-SPECIFIC MEASURES**

Effective as of January 1, 2017; Issued May 2, 2018

Attachment D
South Carolina Quality Withhold Measure Technical Notes: Demonstration Years 2 and 3

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 and 3. These state-specific measures directly supplement the Medicare-Medicaid Capitated Financial Alignment Model CMS Core Quality Withhold Technical Notes for DY 2 through 5, which can be found at the following address: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/QualityWithholdGuidanceDY2-503142018.pdf>.

DY 2 in the South Carolina Healthy Connections Prime demonstration is defined as January 1, 2017 through December 31, 2017. DY 3 is defined as January 1, 2018 through December 31, 2018.

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 will be 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 2 through 3 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 5 **will not** apply to the state-specific measures contained in this attachment.

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
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
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
Note:	<p>The MMP must meet or exceed the benchmark for both metrics in order to pass the measure as a whole.</p> <p>The first metric (i.e., percent of clean claims paid within 30 days) is calculated as follows:</p> <p>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.</p> <p>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.</p> <p>The second metric (i.e., percent of clean claims paid within 90 days) is calculated as follows:</p> <p>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.</p> <p>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.</p> <p>By summing the denominators and numerators before calculating the rates, the final calculations are adjusted for volume.</p>

Additional CMS Core Measures for South Carolina MMPs: Demonstration Year 2 Only

Measure: CW3 – Customer Service

Description:	<p>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:</p> <ul style="list-style-type: none"> • 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
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

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.