

**MEDICARE-MEDICAID
CAPITATED FINANCIAL ALIGNMENT MODEL
QUALITY WITHHOLD TECHNICAL NOTES (DY 2 – 12):
MASSACHUSETTS-SPECIFIC MEASURES**

DRAFT

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Updated XXXXXX

Attachment D

Massachusetts Quality Withhold Measure Technical Notes: Demonstration Years 2 through 12

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 12. These state-specific measures directly supplement the [Medicare-Medicaid Capitated Financial Alignment Model CMS Core Quality Withhold Technical Notes for DY 2 through 12](#).

DY 2 through 12 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
DY 10	January 1, 2023 – December 31, 2023
DY 11	January 1, 2024 – December 31, 2024
DY 12	January 1, 2025 – December 31, 2025

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 7 through 8 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 12:

- 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 12, 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 12 **will** apply to the state-specific measures contained in this attachment, unless otherwise noted in the measure descriptions below.

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 (e.g., 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 12

Measure: MA4 – Initiation and Engagement of Substance Use Disorder 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)
CMIT #:	394
Applicable Years:	DY 2 through 12, excluding DY 9 and 10 ²
Utilizes Gap Closure:	Yes
Benchmarks:	Initiation of SUD Treatment: 43% Engagement of SUD Treatment: 9%

² Due to significant specification changes as of the 2022 measurement year, this measure is temporarily suspended from the quality withhold analysis for DY 9 (CY 2022) and DY 10 (CY 2023).

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)

CMIT #: 36

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 – Glycemic Status Assessment for Patients With Diabetes

Description: Percent of members with diabetes whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) 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: DY 9 and 10: Hemoglobin A1c Control for Patients with Diabetes (HBD) – HbA1c Poor Control (>9.0%)
DY 11 and 12: Glycemic Status Assessment for Patients with Diabetes (GSD) – Glycemic Status >9.0%

CMIT #: 204

Applicable Years: DY 9 through 12

Utilizes Gap Closure: Yes

Benchmark: 74%

Notes: The Glycemic Status 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 Glycemic Status >9.0% 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.

Measure: MA7 – Timely Assessment

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
CMIT #:	N/A
Applicable Years:	DY 9 through 12
Utilizes Gap Closure:	Yes
Benchmark:	DY 9 and 10: 90% DY 11 and 12: 93%
Notes:	For quality withhold purposes, this measure is calculated as follows: 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. Numerator: The total number of members with an assessment completed 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.

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
CMIT #:	N/A
Applicable Years:	DY 9 through 12
Utilizes Gap Closure:	Yes

Benchmark: 85%

Notes: For quality withhold purposes, this measure is calculated as follows:

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).

Numerator: The total number of members whose race/ethnicity/primary language/homelessness/disability type/LGBTQ identity data are collected 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

CMIT #: N/A

Applicable Year: DY 9

Utilizes Gap Closure: Yes

Benchmark: 95%

Notes: For quality withhold purposes, this measure is calculated as follows:

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.

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.

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

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

CMIT #: N/A
 Applicable Year: DY 9
 Utilizes Gap Closure: Yes
 Benchmark: 95%
 Notes: For quality withhold purposes, this measure is calculated as follows:
 Denominator: The total number of members identified with LTSS needs within 90 days of enrollment, excluding the total number of members with 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.

Measure: MA11 – Breast Cancer Screening

Description: Percent of female members age 50 to 74 who had a mammogram to screen for breast cancer
 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: Breast Cancer Screening (BCS-E)
 CMIT #: 93
 Applicable Year: DY 10 through 12
 Utilizes Gap Closure: Yes
 Benchmark: 68%
 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: MA12 – Minimizing Facility Length of Stay

Description: The ratio of the MMP’s observed performance rate to the MMP’s expected performance rate. The performance rate is based on the proportion of admissions to a facility that result in successful discharge to the community within 100 days of admission.
 Metric: Core Measure 9.3 of the Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements
 Measure Steward/
 Data Source: CMS-defined measure

CMIT #: 968
 Applicable Year: DY 10 through 12
 Utilizes Gap Closure: No
 Benchmark: DY 10: 1.00
 DY 11 and 12: 1.25
 Notes: The analysis for this measure is based on the MMP's observed-to-expected (O/E) ratio, which compares the actual performance rate to the performance rate that the MMP is expected to have given its case mix. The observed rate and expected rate are calculated as follows:

1. The observed rate equals the total number of discharges from a facility to the community that occurred within 100 days or less of admission (Data Element B) divided by the total number of admissions to a facility (Data Element A).
2. The expected rate equals the total number of expected discharges to the community (Data Element C) divided by the total number of admissions to a facility (Data Element A).

Note that a higher O/E ratio indicates better performance (i.e., the MMP's O/E ratio must be greater than or equal to 1.00 to receive a "met" designation). An O/E ratio that is greater than 1.00 signifies a higher than expected rate of successful discharges.

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)
 CMIT #: 181
 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)

CMIT #: 292

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.