MEDICARE-MEDICAID
CAPITATED FINANCIAL ALIGNMENT MODEL
QUALITY WITHHOLD TECHNICAL NOTES (DY 1): SOUTH CAROLINA-SPECIFIC MEASURES

Effective as of February 1, 2015, Issued on June 9, 2016

Attachment B: South Carolina Withhold Measure Technical Notes: Demonstration Year 1

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 Year (DY) 1. These state-specific measures directly supplement the Medicare-Medicaid Capitated Financial Alignment Model CMS Core Quality Withhold Technical Notes for DY 1, which can be found at the following address: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY1QualityWithholdGuidance060614.pdf.

Demonstration Year 1 and Application of the Withholds in CY 2015 and 2016

Demonstration Year 1 in the South Carolina Healthy Connections Prime demonstration is defined as February 1, 2015 through December 31, 2016. Because Demonstration Year 1 crosses calendar and contract years, an MMP will be evaluated to determine whether it has met quality withhold requirements at the end of both CY 2015 and CY 2016 and the withheld amounts will be repaid separately for each calendar year.

Variation from the CMS Core Quality Withhold Technical Notes

Because of the six month continuous enrollment requirement and sampling timeframe associated with CAHPS, core quality withhold measures CW3 and CW5 are not included in the quality withhold analysis for South Carolina MMPs in DY 1. South Carolina MMPs will be evaluated on these measures in DY 2.

Quality Withhold Requirements in Future Years

CMS and the state shall provide subsequent guidance and technical notes for withhold measures required for DY 2 and 3.

South Carolina-Specific Measures: Demonstration Year 1

Measure: SCW1 – Individualized Care Plan

Description:	Proportion of Enrollees at each risk level (high, medium, low) with an Individualized Care Plan (ICP) developed within specified timeframes compared to total Enrollees at each risk level requiring ICPs.
Metric:	Measure SC2.1 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: South Carolina-Specific Reporting Requirements
Measure Steward/ Data Source:	State-defined process measure
NQF #:	N/A
Benchmark:	Percentage achieved by highest scoring MMP minus 10 percentage points
Note:	For quality withhold purposes, this measure is calculated as follows: **Denominator:** The total number of low, moderate, and high-risk members whose 90th day of enrollment occurred within the reporting period, excluding the total number of low, moderate, and high-risk members who were documented as unwilling to complete an ICP within 90 days of enrollment and the total number of low, moderate, and high-risk members

the MMP was unable to reach, following three documented attempts within 90 days of enrollment (Data Elements A + E + I – B – C – F – G – J – K) summed over the applicable number of quarters.

Numerator: The total number of low, moderate, and high-risk members with an ICP completed within 90 days of enrollment (Data Elements D + H + L) summed over the applicable number of quarters.

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

Measure: SCW2 – Hospital, Nursing Facility and Community Transition Planning

Description:	MMP has an established work plan and systems in place, utilizing Phoenix as appropriate, for ensuring smooth transition to and from hospitals, nursing facilities, and the community.
Metric:	Measure SC2.5 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: South Carolina-Specific Reporting Requirements
Measure Steward/ Data Source:	State-defined process measure
NQF #:	N/A
Benchmark:	100% compliance
Note:	CMS and the state will review the MMP's policies and procedures for ensuring smooth transitions of care as required in the three-way contract. Based on this review, CMS and the state will determine that the MMP's policies and procedures either meet or fail to meet the requirements. If deficiencies are identified, the MMP will be given one opportunity to resubmit. Following any necessary resubmission, MMPs determined to have met the requirements will be considered to have met the benchmark, and MMPs failing to meet the requirements will be determined to have not met the benchmark.

Measure: SCW3 – 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 process measure
NQF #:	N/A
Benchmark:	90% of all clean claims paid within 30 days of the date of receipt
Note:	For quality withhold purposes, this measure is calculated as follows:

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 the applicable number of quarters.

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 the applicable number of quarters.

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

South Carolina-Specific Adjustments to CW4-Encounter Data

As noted in the Medicare-Medicaid Capitated Financial Alignment Model CMS Core Quality Withhold Technical Notes for DY 1, MMPs must begin submission of encounters within four months from first enrollment effective date or from the earliest date the MMP could submit, whichever is later, as part of the CMS core withhold measure CW4. To qualify for the quality withhold in CY 2015, the MMPs in South Carolina must begin submitting encounters no later than **October 31, 2015**. CMS identified this date as "the earliest the MMP could submit" based on meeting all the following criteria:

- CMS systems prepared to receive encounter data; and
- State companion guide issued to MMPs.

MMPs must also meet the requirements in the Notes with respect to frequency of submission (based on number of enrollees per contract ID), as well as timeliness of submission, i.e., 180 days from date of service.[1]

[1] 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.