MEDICARE-MEDICAID
CAPITATED FINANCIAL ALIGNMENT MODEL
QUALITY WITHHOLD TECHNICAL NOTES (DY 2 – 5): CALIFORNIA-SPECIFIC MEASURES

Effective as of January 1, 2016; Issued March 16, 2018

Attachment D
California Quality Withhold Measure Technical Notes: Demonstration Years 2 through 5

Introduction

The measures in this attachment are quality withhold measures for all Medicare-Medicaid Plans (MMPs) in the California Cal MediConnect Demonstration for Demonstration Years (DY) 2 through 5. 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 through 5 in the California Cal MediConnect Demonstration are defined as follows:

Year	Dates Covered
DY 2	January 1, 2016 – December 31, 2016
DY 3	January 1, 2017 – December 31, 2017
DY 4	January 1, 2018 – December 31, 2018
DY 5	January 1, 2019 – December 31, 2019

The state-specific measures within this attachment apply to all demonstration years listed above; however, CMS and the State may elect to adjust the analyses and/or benchmarks for DY 4 and 5. Stakeholders will have the opportunity to comment on any changes prior to finalization.

Variations from the CMS Core Quality Withhold Technical Notes

CMS core quality withhold measure CW13 evaluates both the frequency of encounter submissions (i.e., at least monthly) and timeliness of encounter submissions (i.e., within 180 days of the ending date of service). For California MMPs, the CW13 analysis will be modified as follows:

- For DY 2, California MMPs will be evaluated only on the frequency of Medicare encounter submissions starting with September 2016.
- For DY 3, California MMPs will be evaluated on the frequency and timeliness of Medicare encounter submissions for the full calendar year. California MMPs will also be evaluated on the frequency of Medicaid encounter submissions starting with June 2017.

California MMPs will be evaluated according to the full CW13 criteria for DY 4 and DY 5.

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** apply to the state-specific measures contained in this attachment, unless otherwise noted in the measure descriptions on the pages that follow.

California-Specific Measures: Demonstration Years 2 through 5

Measure: CAW6 – Behavioral Health Shared Accountability Process Measure

Description:	Percent of members receiving Medi-Cal specialty mental health services that received care coordination with the primary mental health provider
Metric:	Measure CA1.7 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: California-Specific Reporting Requirements
Measure Steward/ Data Source:	State-defined measure
NQF #:	N/A
Benchmark:	Performance rate achieved by the highest scoring MMP minus ten percentage points
Notes:	This measure is applicable for DY 3 only. The gap closure target methodology does not apply to this measure. For quality withhold purposes, this measure is calculated as follows: Denominator: Two times the total number of members receiving Medi-Cal specialty mental health services, excluding the total number of members for whom the MMP was unable to reach the member's county mental health provider/county clinic for the purpose of care coordination of the member's mental health needs and the total number of members the MMP was unable to reach for the purpose of care coordination of the member's mental health needs ([Data Element A x 2] – Data Element B – Data Element D). Numerator: The total number of members for whom the MMP successfully contacted the member's county mental health provider/county clinic for the purpose of care coordination of the member's mental health needs plus the total number of members the MMP successfully contacted for the purpose of care coordination of the member's mental health needs (Data Element C + Data Element E).

Measure: CAW7 – Behavioral Health Shared Accountability Outcome Measure

Description:	Reduction in emergency department use for seriously mentally ill and substance use disorder members
Metric:	Measure CA4.1 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: California-Specific Reporting Requirements
Measure Steward/ Data Source:	State-defined measure
NQF #:	N/A
Benchmark:	10% decrease in the performance rate for the measurement year compared to the performance rate for the baseline year
Notes:	For DY 2 through 5, Calendar Year (CY) 2015 will serve as the baseline year, except for MMPs that began operating in CY 2015 or added a new service area in CY 2015. For those MMPs, this measure will apply as a quality

withhold starting in DY 3, with CY 2016 serving as the baseline year for DY 3 through 5.

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

Denominator: Total number of member months for members enrolled for at least five months with an indication of either serious mental illness or substance use disorders (Data Element B).

Numerator: The total number of emergency department visits (Data Element C).

The quotient will be multiplied by 1,000 to determine the rate per 1,000 member months.

Measure: CAW8 – Documentation of Care Goals

Description:	Percent of members with documented discussions of care goals
Metric:	Measure CA1.6 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: California-Specific Reporting Requirements
Measure Steward/ Data Source:	State-defined measure
NQF #:	N/A
Benchmark:	DY 2 and 3: 55% DY 4: 60% DY 5: 65%
Notes:	For quality withhold purposes, this measure is calculated as follows: Denominator: The total number of [sampled] members with an initial Individualized Care Plan (ICP) completed during the reporting period plus the total number of [sampled] existing ICPs revised during the reporting period (Data Element B + Data Element E). Numerator: The total number of members with at least one documented discussion of care goals in the initial ICP plus the total number of revised ICPs with at least one documented discussion of new or existing care goals (Data Element C + Data Element F).

Measure: CAW9 – Interaction with Care Team

Description:	Percent of members who have a care coordinator and have at least one care team contact during the reporting period
Metric:	Measure CA1.12 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: California-Specific Reporting Requirements
Measure Steward/ Data Source:	State-defined measure
NQF #:	N/A
Benchmark:	DY 2 and 3: 78% DY 4: 83% DY 5: 88%

Notes:	For quality withhold purposes, this measure is calculated as follows: Denominator: The total number of members who have/had a care coordinator during the reporting period (Data Element A). Numerator: The total number of members who had at least one care coordinator or other care team contact (Data Element B).