

**MEDICARE-MEDICAID
CAPITATED FINANCIAL ALIGNMENT MODEL
REPORTING REQUIREMENTS:
MICHIGAN-SPECIFIC REPORTING
REQUIREMENTS**

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Table of Contents

Michigan-Specific Reporting Requirements Appendix.....MI-3

IntroductionMI-3

Definitions.....MI-3

Variations from the Core Document.....MI-4

Quality Withhold MeasuresMI-5

Reporting on Disenrolled and Retro-disenrolled Members.....MI-6

Reporting on Assessments and IICSPs Completed Prior to First Effective Enrollment Date.....MI-6

Guidance on Adopted Level II Assessments.....MI-7

Guidance on Assessments and IICSPs for Members with a Break in Coverage.....MI-8

Hybrid Sampling.....MI-10

Value SetsMI-11

Michigan’s Implementation, Ongoing, and Continuous Reporting Periods.....MI-12

Data SubmissionMI-13

Resubmission of Data.....MI-13

Section MI I. Assessment.....MI-14

Section MI II. Care Coordination.....MI-14

Section MI III. Enrollee ProtectionsMI-26

Section MI IV. Organizational Structure and StaffingMI-28

Section MI V. Performance and Quality Improvement.....MI-30

Section MI VI. Systems.....MI-45

Section MI VII. UtilizationMI-45

Michigan-Specific Reporting Requirements Appendix

Introduction

The measures in this appendix are required reporting for all MMPs in Michigan's MI Health Link Demonstration. CMS and the state reserve the right to update the measures in this document for subsequent demonstration years. These state-specific measures directly supplement the Medicare-Medicaid Capitated Financial Alignment: Core Reporting Requirements, which can be found at the following web address:

<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html>

MMPs should refer to the core document for additional details regarding Demonstration-wide definitions, reporting phases and timelines, and sampling methodology, except as otherwise specified in this document.

The core and state-specific measures supplement existing Part C and Part D reporting requirements, as well as measures that MMPs report via other vehicles or venues, such as HEDIS^{®1} and HOS. CMS and the state will also track key utilization measures, which are not included in this document, using encounter and claims data. The quantitative measures are part of broader oversight, monitoring, and performance improvement processes that include several other components and data sources not described in this document. MMPs should refer to the three-way contract and subsequent amendments for other reporting submissions to the Michigan Department of Health and Human Services (MDHHS). Additionally, revisions to the Reporting Requirements may periodically follow.

MMPs should contact the MI HelpDesk at MIHelpDesk@norc.org with any questions about the Michigan state-specific appendix or the data submission process.

Definitions

Calendar Quarter: All quarterly measures are reported on calendar quarters. The four calendar quarters of each calendar year will be as follows: 1/1 – 3/31, 4/1 – 6/30, 7/1 – 9/30, and 10/1 – 12/31.

Calendar Year: All annual measures are reported on a calendar year basis.

Implementation Period: The initial months of the demonstration during which MMPs will report to CMS and the state on a more intensive reporting schedule. The Implementation period is as follows:

¹ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

- For the three MMPs that implement during Phase I on March 1, 2015, the implementation period begins on March 1, 2015 and continues until September 30, 2015.
- For the remaining MMPs that implement during Phase II on May 1, 2015, the implementation period begins on May 1, 2015 and continues until December 31, 2015.
- For any MMP in both Phase I and Phase II, the implementation period begins on March 1, 2015 and continues until September 30, 2015.

Long Term Supports and Services (LTSS): A variety of supports and services that help elderly individuals and/or individuals with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing, and other basic activities of daily living and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. Please refer to the rules and regulations that further define specialty populations (mental illness, intellectual and developmental disabilities, and substance use disorders).

Primary Care Provider (PCP): Practitioner of primary care selected by the Enrollee or assigned to the Enrollee by the Integrated Care Organization (ICO) and responsible for providing and coordinating the Enrollee's health care needs, including the initiation and monitoring of referrals for specialty services when required. Primary Care Providers may be nurse practitioners, physician assistants or board-certified physicians, or a specialist selected by an Enrollee.

Variations from the Core Document

Core 3.2

For reporting Core 3.2, Michigan MMPs are required to comport with all requirements outlined in Appendix 6 of the Minimum Operating Standards document, which can be found at www.michigan.gov/mihealthlink. Specifically, data element D should only count members with a complete IICSP that includes the requisite member signature or proxy for the signature.

Core 9.2

The following section provides additional guidance about identifying individuals enrolled in the MMP as “nursing home certifiable,” or meeting the Michigan Medicaid Nursing Facility Level of Care Determination (NFLOCD), for the purposes of reporting Core 9.2.

Core 9.2 focuses on “nursing home certifiable” members, defined as “members living in the community, but requiring an institutional level of care” (see the Core Reporting Requirements for more information). Nursing facility residents may be considered nursing home certifiable if they meet all other criteria for the measure elements and

have resided in the nursing facility for 100 or fewer continuous days. All waiver members can be categorized as nursing home certifiable provided they meet all other criteria for the measure elements.

Michigan MMPs should use assessment results from the NFLOCD and/or the Personal Care Assessment (PCA) supplemented by claims and enrollment data to categorize members as nursing home certifiable. MMPs should use the following non-exclusive sources of data to supplement and confirm this information, specifically (an individual member may meet one or more of the following criteria but should be counted only once):

- Claims data or rate cells to identify individuals using nursing facility services or waiver services
- Level of Care (LOC) code 03 in CHAMPS to identify individuals using waiver services
- Level of Care (LOC) code 05 or 15 in CHAMPS to identify individuals using nursing facility services (provided they have resided in the nursing facility for 100 or fewer continuous days)
- PCA results for enrollees receiving or eligible for personal care services for one of the following Activities of Daily Living:
 - Eating scored at 4 or above
 - Toileting scored at 3 or above
 - Transferring scored at 3 or above

Note: An individual member may have a completed LOCD and a PCA or they may have only a LOCD or only a PCA. MMPs must utilize both sources of data (supplemented by claims and enrollment data) and not rely on one or the other in determining nursing home certifiable status.

Quality Withhold Measures

CMS and the state will establish a set of quality withhold measures, and MMPs will be required to meet established thresholds. Throughout this document, state-specific quality withhold measures are marked with the following symbol for Demonstration Year 1: (i) and the following symbol for Demonstration Years 2 through 5: (ii). Note that an additional DY 1 state-specific quality withhold measure is reported separately through HEDIS[®].² For more information about the state-specific quality withhold measures for Demonstration Year 1, refer to the Quality Withhold Technical Notes (DY 1): Michigan-Specific Measures at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPQualityWithholdMethodologyandTechnicalNotes.html>. Additional information on the withhold methodology and benchmarks for Demonstration Years 2 through 5 will be provided at a later time.

² HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

Reporting on Disenrolled and Retro-disenrolled Members

Unless otherwise indicated in the reporting requirements, MMPs should report on all members enrolled in the demonstration who meet the definition of the data elements, regardless of whether that member was subsequently disenrolled from the MMP. Measure-specific guidance on how to report on disenrolled members is provided under the Notes section of each state-specific measure.

Due to retro-disenrollment of members, there may be instances where there is a lag between a member's effective disenrollment date and the date on which the MMP is informed about that disenrollment. This time lag might create occasional data inaccuracies if an MMP includes members in reports who had in fact disenrolled before the start of the reporting period. If MMPs are aware at the time of reporting that a member has been retro-disenrolled with a disenrollment effective date prior to the reporting period (and therefore was not enrolled during the reporting period in question), then MMPs may exclude that member from reporting. Please note that MMPs are *not* required to resubmit corrected data should they be informed of a retro-disenrollment subsequent to a reporting deadline. MMPs should act upon their best and most current knowledge at the time of reporting regarding each member's enrollment status.

Reporting on Assessments and IICSPs Completed Prior to First Effective Enrollment Date

MMPs may complete Level I and Level II Assessments prior to individuals' effective date of enrollment, provided that the MMP meets the requirements as articulated in the National MMP Enrollment and Disenrollment Guidance. Note that for individuals who are passively enrolled, the MMP may reach out to complete Level I and Level II Assessments no sooner than 20 days before the individual's effective date of the passive enrollment.

For purposes of reporting data on Level I Assessments (Core 2.1 and Core 2.2), MMPs should report any Level I Assessments completed prior to the first effective enrollment date as if they were completed on the first effective enrollment date. For example, if a member's first effective enrollment date was June 1 and the Level I Assessment for that member was completed on May 25, the MMP should report the Level I Assessment as if it were completed on June 1.

MMPs should refer to the Core reporting requirements for detailed specifications for reporting Core 2.1 and Core 2.2. For example, Core 2.1 should only include members whose 90th day of enrollment occurred during the reporting period. Members enrolled into the MMP on June 1 would reach their 90th day (three full calendar months) on August 31. Therefore these members would be reported in the data submission for the Quarter 3 reporting period, even if their Level I Assessment was marked as complete on the first effective enrollment date (i.e., June 1).

MMPs must comply with contractually-specified timelines regarding completion of a Level II Assessment, where indicated, following the Level I Assessment. In the event that both a Level I and a Level II Assessment are finalized prior to the first effective enrollment date, MMPs would report completion of the Level II Assessment (for measures MI1.1 and MI1.2, which are currently suspended) as if the Level I Assessment were completed on the first effective enrollment date. For example, using an effective enrollment date of June 1, if the Level I Assessment was completed on May 25 and the Level II Assessment was completed on May 27 (a difference of two days), the MMP would report the Level I Assessment as if it were completed on June 1 and the Level II Assessment as if it were completed on June 3 (again, a difference of two days). If the Level I Assessment is completed prior to the effective date of coverage but the Level II Assessment is not, the MMP would still report the Level II Assessment as if the Level I Assessment was completed on the first effective enrollment date. For example, using an effective enrollment date of June 1, if the Level I Assessment is completed on May 25 and the Level II Assessment is completed on June 24 (a difference of 30 days), the MMP would report the Level I Assessment as if it were completed on June 1 and the Level II Assessment as if it were completed on July 1 (again, a difference of 30 days).

MMPs must also comply with contractually-specified timelines regarding completion of Individual Integrated Care and Supports Plans (IICSPs) within 90 days of enrollment. In the event that an IICSP is also finalized prior to the first effective enrollment date, MMPs should report completion of the IICSP (for measures Core 3.2, MI2.2, and MI2.3) as if it were completed on the first effective enrollment date. For example, if a member's first effective enrollment date was June 1 and the IICSP for that member was completed on May 27, the MMP should report the IICSP as if it were completed on June 1.

Guidance on Adopted Level II Assessments

According to the Michigan three-way contract, a Level II Assessment that was completed while a member was enrolled in a different product or program may be adopted by the MMP if it is not past the reassessment date. However, the adopted Level II Assessment must be reviewed to determine if it is complete, accurate, and appropriate for the member's current status. Since the member's current status should be ascertained through the results of the Level I Assessment, the MMP may not report the adopted Level II Assessment as complete until the Level I Assessment is complete and the MMP has determined that the adopted Level II Assessment is still appropriate for the member.

For purposes of reporting measures MI1.1 and MI1.2 (which are currently suspended), MMPs would mark the adopted Level II Assessment as complete for the member's current enrollment as of the day the MMP has completed the Level I Assessment and confirmed that the Level II Assessment is still appropriate for the member.

Guidance on Assessments and IICSPs for Members with a Break in Coverage

Level I Assessments

If a MMP already completed a Level I Assessment for a member who was previously enrolled, the MMP is not necessarily required to conduct a new Level I Assessment if the member rejoins the same MMP within one year of his/her most recent Level I Assessment. Instead, the MMP can do the following:

1. Perform any risk stratification, claims data review, or other analyses as required by the three-way contract to detect any changes in the member's condition since the Level I Assessment was conducted; and
2. Ask the member (or his/her authorized representative) if there has been a change in the member's health status or needs since the Level I Assessment was conducted.

The MMP must document any risk stratification, claims data review, or other analyses that are performed to detect any changes in the member's condition. The MMP must also document its outreach attempts and the discussion(s) with the member (or his/her authorized representative) to determine if there was a change in the member's health status or needs.

If a change is identified, the MMP must conduct a new Level I Assessment within the timeframe prescribed by the contract. If there are no changes, the MMP is not required to conduct a new Level I Assessment unless requested by the member (or his/her authorized representative). Please note, if the MMP prefers to conduct Level I Assessments on all re-enrollees regardless of status, it may continue to do so.

Once the MMP has conducted a new Level I Assessment as needed or confirmed that the prior Level I Assessment is still accurate, the MMP can mark the Level I Assessment as complete for the member's current enrollment. The MMP would then report that completion according to the specifications for Core 2.1 and Core 2.2. When reporting these measures, the MMP should count the number of enrollment days from the member's most recent enrollment effective date, and should report the Level I Assessment based on the date the prior Level I Assessment was either confirmed to be accurate or a new Level I Assessment was completed.

If the MMP is unable to reach a re-enrolled member to determine if there was a change in health status, then the MMP may report that member as unable to be reached so long as the MMP made the requisite number of outreach attempts. If a re-enrolled member refuses to discuss his/her health status with the MMP, then the MMP may report that member as unwilling to participate in the Level I Assessment.

If the MMP did not complete a Level I Assessment for the re-enrolled member during his/her prior enrollment period, or if it has been more than one year since the member's Level I Assessment was completed, the MMP is required to conduct a Level I Assessment for the member within the timeframe prescribed by the contract.

The MMP must make the requisite number of attempts to reach the member (at minimum) after his/her most recent enrollment effective date, even if the MMP reported that the member was unable to be reached during his/her prior enrollment. Similarly, members who refused the Level I Assessment during their prior enrollment must be asked again to participate (i.e., the MMP may not carry over a refusal from one enrollment period to the next).

Level II Assessments

If the re-enrolled member previously received a Level II Assessment, and the MMP confirms through the steps outlined above that there has been no change in the member's health status or needs, then the MMP is not required to conduct a new Level II Assessment, unless requested by the member (or his/her authorized representative), provided that the reassessment timeframe specified by the selected Level II Assessment tool (as outlined in Section 2.6.1.4.3 of the three-way contract) has not lapsed. If changes in health status or needs are identified, the MMP must conduct a Level II Assessment within the timeframe prescribed by Section 2.6.1.4.6 of the contract.

If the re-enrolled member did not previously receive a Level II Assessment, but upon re-enrollment demonstrates a need for LTSS or behavioral health services, then the MMP is required to conduct a Level II Assessment as prescribed in Section 2.6.1.4.6 of the three-way contract.

Once the MMP has conducted a new Level II Assessment as needed or confirmed that any prior Level II Assessment is still accurate, the MMP can mark the Level II Assessment as complete for the member's current enrollment. The MMP would then report that completion under MI1.1 or MI1.2; however, those measures are currently suspended.

Individual Integrated Care and Supports Plans

If the MMP conducts a new Level I Assessment (or Level II Assessment if required) for the re-enrolled member, the MMP must revise the Individual Integrated Care and Supports Plan (IICSP) accordingly within the timeframe prescribed by the contract. Once the IICSP is revised, the MMP may mark the IICSP as complete for the member's current enrollment. If the MMP determines that the prior assessment(s) are still accurate and therefore no updates are required to the previously developed IICSP, the MMP may mark the IICSP as complete for the current enrollment at the same time that the Level I Assessment is marked complete. The MMP would then follow the Core 3.2, MI2.2, and MI2.3 measure specifications for reporting the completion. Please note, for purposes of reporting, the IICSP for the re-enrolled member should be classified as an *initial* IICSP.

If the MMP did not complete an IICSP for the re-enrolled member during his/her prior enrollment period, or if it has been more than one year since the member's IICSP was completed, the MMP is required to develop an IICSP for the member within the

timeframe prescribed by the contract. The MMP must also follow the above guidance regarding outreach to members who previously refused to participate or were not reached.

Annual Reassessments and IICSP Updates

The MMP must follow contract requirements regarding the completion of annual Level I reassessments and updates to IICSPs. If the MMP determined that the assessment/IICSP from a member's prior enrollment was accurate and marked that assessment/IICSP as complete for the member's current enrollment, the MMP should count continuously from the date that the assessment/IICSP was completed in the prior enrollment period to determine the due date for the annual reassessment and IICSP update. For example, when reporting Core 2.3, the MMP should count 365 days from the date when the Level I Assessment was actually completed, even if that date was during the member's prior enrollment period.

Hybrid Sampling

Some demonstration-specific measures may allow medical record/supplemental documentation review to identify the numerator. In these instances, the sample size should be 411, plus additional records to allow for substitution. Sampling should be systematic to ensure that all individuals eligible for a measure have an equal chance of inclusion.

MMPs should complete the following steps for each measure that requires medical record review:

- Step 1:** Determine the eligible population. Create a list of eligible members, including full name, date of birth, and event (if applicable).
- Step 2:** Determine the final sample size. The final sample size will be 411 plus an adequate number of additional records to make substitutions. Oversample only enough to guarantee that the targeted sample size of 411 is met. The following oversampling rates are acceptable: 5 percent, 10 percent, 15 percent, or 20 percent. If oversampling, round up to the next whole number when determining the final sample size.
- Step 3:** If the eligible population exceeds the final sample size as determined in Step 2, proceed to Step 5. If the eligible population is less than or equal to the final sample size as determined in Step 2, proceed to Step 4.
- Step 4:** If the eligible population is less than or equal to the final sample size as determined in Step 2, the sample size can be reduced from 411 cases to a reduced final sample size by using the following formula:

$$\text{Reduced Final Sample Size} = \frac{\text{Original Final Sample Size}}{1 + \left(\frac{\text{Original Final Sample Size}}{\text{Eligible Population}} \right)}$$

Where the *Original Final Sample Size* is the number derived from Step 2, and the *Eligible Population* is the number derived from Step 1.

Step 5: Sort the list of eligible members in alphabetical order by last name, first name, date of birth, and event (if applicable). Sort this list by last name from A to Z during even reporting periods and from Z to A in odd reporting periods (i.e., name will be sorted from A to Z in 2014, 2016, and 2018 and from Z to A in 2015, 2017, and 2019).

Note: Sort order applies to all components. For example, for reporting period 2014, the last name, first name, date of birth, and events will be ascending.

Step 6: Calculate N , which will determine which member will start your sample. Round down to the nearest whole number.

$$N = \frac{\text{Eligible Population}}{\text{Final Sample Size}}$$

Where the *Eligible Population* is the number derived from Step 1. The *Final Sample Size* is either of the following:

- The number derived from Step 2, for instances in which the eligible population exceeds the final sample size as determined in Step 2.
- OR
- The number derived in Step 4, for instances in which the eligible population was less than or equal to the number derived from Step 2.

Step 7: Randomly select starting point, K , by choosing a number between one and N using a table of random numbers or a computer-generated random number.

Step 8: Select every K th record thereafter until the selection of the sample size is completed.

Value Sets

The measure specifications in this document refer to code value sets that must be used to determine and report measure data element values. A value set is the complete set of codes used to identify a service or condition included in a measure. The Michigan-Specific Value Sets Workbook includes value sets and codes needed to report certain measures included in the Michigan-Specific Reporting Requirements and is intended to be used in conjunction with the measure specifications outlined in this document. The Michigan-Specific Value Sets Workbook can be found on the CMS website at the following address: <https://www.cms.gov/Medicare-Medicaid->

Data Submission

All MMPs will submit state-specific measure data through the web-based Financial Alignment Initiative Data Collection System (FAI DCS), unless otherwise specified in the measure description. All data submissions must be submitted to this site by 5:00p.m. ET on the applicable due date. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>

(Note: Prior to the first use of the system, all MMPs will receive an email notification with the username and password that has been assigned to their MMP. This information will be used to log in to the FAI DCS and complete the data submission.)

All MMPs will submit core measure data in accordance with the Core Reporting Requirements. Submission requirements vary by measure, but most core measures are reported through the Health Plan Management System (HPMS).

Please note, late submissions may result in compliance action from CMS.

Resubmission of Data

MMPs must comply with the following steps to resubmit data after an established due date:

1. Email the MI HelpDesk (MIHelpDesk@norc.org) to request resubmission.
 - Specify in the email which measures need resubmission;
 - Specify for which reporting period(s) the resubmission is needed; and
 - Provide a brief explanation for why the data need to be resubmitted.
2. After review of the request, the MI HelpDesk will notify the MMP once the FAI DCS and/or HPMS has been re-opened.
3. Resubmit data through the applicable reporting system.
4. Notify the MI HelpDesk again after resubmission has been completed.

Please note, requests for resubmission after an established due date may result in compliance action from CMS.

Section MI I. Assessment

MI1.1 Level I and Level II Assessment Completion for persons with intellectual/developmental disabilities.– **Suspended**

MI1.2 Level I and Level II Assessment Completion for persons with mental illness. – **Suspended**

Section MI II. Care Coordination

MI2.1 Members with an Individual Integrated Care and Supports Plan (IICSP) within 90 days of enrollment. – **Retired**

MI2.2 Members with IICSPs completed.

IMPLEMENTATION				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
MI2. Care Coordination	Monthly, beginning after 90 days	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	Reporting Frequency	Level	Reporting Periods	Due Date
MI2. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1 – 3/31 4/1 – 6/30 7/1 – 9/30 10/1 – 12/31	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members enrolled for 90 days or longer as of the end of the reporting period.	Total number of members enrolled for 90 days or longer as of the end of the reporting period who were currently enrolled as of the last day of the reporting period.	Field Type: Numeric
B.	Total number of members who had an initial IICSP completed as of the end of the reporting period.	Of the total reported in A, the number of members who had an initial IICSP completed as of the end of the reporting period.	Field type: Numeric Note: Is a subset of A.

- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will perform an outlier analysis.
 - As data are received from MMPs over time, CMS and the state will apply threshold checks.
- C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.
- Confirm those data elements listed above as subsets of other elements.
 - MMPs should validate that data element B is less than or equal to data element A.
 - All data elements should be positive values.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
- CMS and the state will evaluate the percentage of members enrolled for 90 days or longer who had an initial IICSP completed as of the end of the reporting period.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should include all Medicare-Medicaid members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
 - The 90th day of enrollment should be based on each member's effective enrollment date. For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months.
 - The effective enrollment date is the first date of the member's coverage through the MMP.

- For data element A, members must be enrolled on the last day of the reporting period to be included in this measure.
- For data element B, only include members with a complete IICSP that includes the requisite member signature or proxy for the signature. For reporting of this measure, MMPs are required to comport with all requirements outlined in Appendix 6 of the Minimum Operating Standards document.
- The IICSPs reported in data element B could have been completed at any time, not necessarily during the reporting period.
- MMPs should refer to the Michigan three-way contract for specific requirements pertaining to a care plan.
- MMPs should only report completed IICSPs where the member or the member’s authorized representative was involved in the development of the IICSP.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>.

MI2.3 Members with documented discussions of care goals.^{i, ii}

IMPLEMENTATION				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
MI2. Care Coordination	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	Reporting Frequency	Level	Reporting Periods	Due Date
MI2. Care Coordination	Quarterly	Contract	Current Calendar Quarter Ex: 1/1 – 3/31 4/1 – 6/30 7/1 – 9/30 10/1 – 12/31	By the end of the second month following the last day of the reporting period

- A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members with an initial IICSP completed.	Total number of members with an initial IICSP completed during the reporting period.	Field Type: Numeric
B.	Total number of members with at least one documented discussion of care goals in the initial IICSP.	Of the total reported in A, the number of members with at least one documented discussion of care goals in the initial IICSP.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of existing IICSPs revised.	Total number of existing IICSPs revised during the reporting period.	Field Type: Numeric
D.	Total number of revised IICSPs with at least one documented discussion of new or existing care goals.	Of the total reported in C, the number of revised IICSPs with at least one documented discussion of new or existing care goals.	Field Type: Numeric Note: Is a subset of C.

- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- Guidance will be forthcoming on the established benchmark for this measure for DY 2 through 5.
- C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.
- Confirm those data elements listed above as subsets of other elements.
 - MMPs should validate that data element B is less than or equal to data element A.
 - MMPs should validate that data element D is less than or equal to data element C.
 - All data elements should be positive values.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of:
- Members who had an initial IICSP completed during the reporting period who had at least one documented discussion of care goals in the initial IICSP.
 - IICSPs revised during the reporting period that had at least one documented discussion of new or existing care goals.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period (i.e., include all members regardless of whether they are currently enrolled or disenrolled as of the last day of the reporting period).
- MMPs should include all IICSPs for members that meet the criteria outlined in data element C, regardless of whether the members are disenrolled as of the end of the reporting period (i.e., include all IICSPs regardless of whether the members are currently enrolled or disenrolled as of the last day of the reporting period).
- Data element A should include all members whose IICSP was completed for the first time during the reporting period (i.e., the member did not previously have an IICSP completed prior to the start of the reporting period). There can be no more than one initial IICSP completed per member. Only IICSPs that included participation from the member (or his/her authorized representative) in the completion of the IICSP should be reported.
- MMPs should only include members in data element B when the discussion of care goals with the member (or his/her authorized representative) is clearly documented in the member's initial IICSP.
- Data element C should include all existing IICSPs that were revised during the reporting period. MMPs should refer to the Michigan three-way contract for specific requirements pertaining to updating the IICSP. Only IICSPs that included participation from the member (or his/her authorized representative) in the revision to the IICSP should be reported.
- The Michigan three-way contract section 2.6.8.6 contains guidance on what must be contained within the IICSP. Revisions to these items would require a new member signature or proxy for signature and would be counted as a revision to the IICSP reportable for measure MI2.3 data element C. Internal MMP updates via notes or documentation on established services or existing goals in the IICSP would not be included under the definition of revision, and therefore would not be included under data elements C and D.
- MMPs should only include IICSPs in data element D when a new or previously documented care goal is discussed with the member (or his/her authorized representative) and is clearly documented in the member's revised IICSP. If the initial IICSP clearly documented the discussion of care goals, but those existing care goals were not revised or discussed, or new care goals are not discussed and documented during the revision of the IICSP, then that IICSP should not be reported in data element D.

- An initial IICSP and a revised IICSP (reported in data elements A and C, respectively) must include the requisite member signature or proxy for the signature. For reporting of this measure, MMPs are required to comport with all requirements outlined in Appendix 6 of the Minimum Operating Standards document.
- If a member has an initial IICSP completed during the reporting period, and has their IICSP revised during the same reporting period, then the member’s initial IICSP should be reported in data element A and the member’s revised IICSP should be reported in data element C.
- If a member’s IICSP is revised multiple times during the same reporting period, each revision should be reported in data element C. For example, if a member’s IICSP is revised twice during the same reporting period, two IICSPs should be counted in data element C.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>.

MI2.4 Members with documented discussions of members’ rights and choices of providers. – **Retired**

MI2.5 Members with first follow-up visit within 30 days of hospital discharge.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
MI2. Care Coordination	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of acute inpatient hospital discharges.	Total number of acute inpatient hospital discharges during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of acute inpatient hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge from the inpatient hospital stay.	Of the total reported in A, the number of acute inpatient hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of discharge from the inpatient hospital stay.	Field Type: Numeric Note: Is a subset of A.

- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will perform an outlier analysis.
 - As data are received from MMPs over time, CMS and the state will apply threshold checks.
- C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.
- Confirm those data elements listed above as subsets of other elements.
 - MMPs should validate that data element B is less than or equal to data element A.
 - All data elements should be positive values.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
- CMS and the state will evaluate the percentage of acute inpatient hospital discharges that resulted in an ambulatory care follow-up visit within 30 days of the discharge from the inpatient hospital stay.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should include all inpatient hospital discharges for members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
 - MMPs should include all inpatient hospital discharges for members who meet the criteria outlined in data element A and who were continuously enrolled from the date of the inpatient hospital discharge through 30 days after the inpatient hospital discharge, regardless if they are disenrolled as of the end of the reporting period.
 - The denominator for this measure is based on inpatient hospital discharges, not members.
 - The date of discharge must occur within the reporting period, but the follow-up visit may not be in the same reporting period. For example, if a discharge occurs during the last month of the reporting period, look to

the first month of the following reporting period to identify the follow-up visit.

- The member needs to be enrolled from the date of the inpatient hospital discharge through 30 days after the inpatient hospital discharge, with no gaps in enrollment to be included in this measure.
- A follow-up visit is defined as an ambulatory care follow-up visit to assess the member's health following a hospitalization. Codes to identify follow-up visits are provided in the Ambulatory Visits value set and Other Ambulatory Visits value set. MMPs should report ambulatory care follow-up visits based on all visits identified, including denied and pended claims, and including encounter data as necessary in cases where follow-up care is included as part of a bundled payment covering the services delivered during the inpatient stay. MMPs should use all information available, including encounter data supplied by providers, to ensure complete and accurate reporting.
- To identify all acute inpatient hospital discharges during the reporting period (data element A):
 - Identify all acute and nonacute inpatient stays (Inpatient Stay value set).
 - Exclude nonacute inpatient stays (Nonacute Inpatient Stay value set).
 - Identify the discharge date for the stay. The date of discharge should be within the reporting period.

Additionally, MMPs should use UB Type of Bill codes 11x, 12x, 41x, and 84x or any acute inpatient facility code to identify discharges from an inpatient hospital stay.

- MMPs should report discharges based on all inpatient stays identified, including denied and pended claims.
- If the discharge is followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period, count only the last discharge for reporting in data element A. To identify readmissions and direct transfers to an acute inpatient care setting:
 - Identify all acute and nonacute inpatient stays (Inpatient Stay value set)
 - Exclude nonacute inpatient stays (Nonacute Inpatient Stay value set)
 - Identify the admission date for the stay
- Exclude from data element A any discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period. To identify readmissions and direct transfers to a nonacute inpatient care setting:
 - Identify all acute and nonacute inpatient stays (Inpatient Stay value set)
 - Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay value set) on the claim

- Identify the admission date for the stay

These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.

- For example, the following direct transfers/readmissions should be excluded from this measure:
 - An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1 (a direct transfer)
 - An inpatient discharge on June 1, followed by a readmission to a hospital on June 15 (readmission within 30 days)
- Exclude discharges due to death, using the Discharges due to Death value set.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>.

MI2.6 Timely transmission of care transition record to health care professional.
(Modified from NQF #0648) ^{i, ii}

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
MI2. Care Coordination	Annually	Contract	Calendar Year	By the end of the sixth month following the last day of the reporting period

A. Data element definitions - details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members, regardless of age, discharged from an inpatient facility to home/self-care or any other sites of care.	Total number of members, regardless of age, discharged from an inpatient facility (hospital inpatient, skilled nursing facility, or rehabilitation facility) to home/self-care or any other sites of care during the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of members sampled that met inclusion criteria.	Of the total reported in A, the number of members sampled that met inclusion criteria.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care on the day of discharge or the following day.	Of the total reported in B, the number of members for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care on the day of discharge or the following day.	Field Type: Numeric Note: Is a subset of B.

- B. QA Checks/Thresholds - procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- Guidance will be forthcoming on the established benchmark for this measure for DY 2 through 5.
- C. Edits and Validation checks - validation checks that should be performed by each plan prior to data submission.
- Confirm those data elements listed above as subsets of other elements.
 - MMPs should validate that data element B is less than or equal to data element A.
 - MMPs should validate that data element C is less than or equal to data element B.
 - All data elements should be positive values.
- D. Analysis - how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
- CMS and the state will evaluate the percentage of members, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient, skilled nursing facility, or rehabilitation facility) to home/self-care or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care on the day of discharge or the following day.
- E. Notes - additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-

only members should not be included. A subset of all members who are eligible will be included in the sample.

- MMPs should include all members who meet the criteria outlined in data element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- For purposes of this measure, a patient can qualify for the measure multiple times during the reporting period if they have multiple inpatient discharges.
- The primary care provider (PCP) or other health care professional designated for follow-up care may be the designated primary care physician, medical specialist, or other physician or health care professional. For further definitions of a PCP please see page MI-4 and the Michigan three-way contract.
- The transition record may be transmitted to the facility or physician or other health care professional designated for follow-up care via fax, secure e-mail, or mutual access to an electronic health record (EHR).
- A transition record is defined as a core, standardized set of data elements related to the patient's diagnosis, treatment, and care plan that is discussed with and provided to the patient in printed or electronic format at each transition of care, and transmitted to the facility/physician/other health care professional providing follow-up care. Electronic format may be provided only if acceptable to patient.
- To identify members for data element A, members must have any one of the following code combinations:
 - Type of Bill #1 value set *and* Discharge Status value set
 - Type of Bill #2 value set *and* Discharge Status value set *and* Revenue Code value set
- MMPs may use sampling for this measure since documentation review may be required to identify the numerator. Sampling should be systematic to ensure all eligible individuals have an equal chance of inclusion. The sample size should be 411, plus oversample to allow for substitution. For further instructions on selecting the sample size, please see page MI-9 of this document.
- To determine the numerator, MMPs may need to obtain medical records from the discharge facility for each member within the sample to verify if a transition record was transmitted. However, MMPs could also consider tracking or receiving transition records. MMPs have a contractual and financial interest in ensuring that transitions are performed appropriately. The intent of using this measure and modifying it to apply to MMPs was not to have health plans audit its facilities, but rather to encourage MMPs to participate in the transition and discharge planning and potentially receive the transition plan as part of its care coordination efforts. MMPs should consider mechanisms for tracking

beneficiaries' transitions such that they also receive the transition plan or confirmation that the transition plan was sent.

- If MMPs do not elect to sample, data element B should be equal to data element A.
- MMP should exclude patients who died and patients who left against medical advice or discontinued care using the Inpatient Facility Discharge Exclusions value set.
- If a discharge occurs on the last day of the report period, look one day past the end of the reporting period to identify if a transition record was transmitted on the day of discharge or the following day.

F. Data Submission - how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>.

Section MI III. Enrollee Protections

MI3.1 The number of critical incident and abuse reports for members receiving LTSS.

IMPLEMENTATION				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
MI3. Enrollee Protections	Monthly	Contract	Current Month Ex: 1/1 – 1/31	By the end of the month following the last day of the reporting period
ONGOING				
Reporting Section	Reporting Frequency	Level	Reporting Periods	Due Date
MI3. Enrollee Protections	Quarterly	Contract	Current Calendar Quarter Ex: 1/1 – 3/31 4/1 – 6/30 7/1 – 9/30 10/1 – 12/31	By the end of the second month following the last day of the reporting period

A. Data element definitions - details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members receiving LTSS.	Total number of members receiving LTSS during the reporting period.	Field Type: Numeric
B.	Total number of critical incident and abuse reports.	Of the total reported in A, the number of critical incident and abuse reports during the reporting period.	Field Type: Numeric

B. QA Checks/Thresholds - procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks - validation checks that should be performed by each MMP prior to data submission.

- All data elements should be positive values.

D. Analysis - how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the number of critical incident and abuse reports per 1,000 members receiving LTSS during the reporting period.

E. Notes - additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
- MMPs should include all members who meet the criteria outlined in data element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
- It is possible for members to have more than one critical incident and/or abuse report during the reporting period. All critical incident and abuse reports during the reporting period should be counted.
- Critical incident refers to any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety, or well-being of a member.
- For data element B, MMPs should include all new critical incident and abuse cases that are reported during the reporting period, regardless if the case status is open or closed as of the last day of the reporting period.
- Critical incident and abuse reports could be reported by the MMP or any provider, and are not limited to only those providers defined as LTSS providers.
- Abuse refers to the following:
 1. Willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish;
 2. Knowing, reckless, or intentional acts or failures to act which cause injury or death to an individual or which places that individual at risk of injury or death;
 3. Rape or sexual assault;
 4. Corporal punishment or striking of an individual;
 5. Unauthorized use or the use of excessive force in the placement of bodily restraints on an individual; and
 6. Use of bodily or chemical restraints on an individual which is not in compliance with federal or state laws and administrative regulations.

F. Data Submission - how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>.

Section MI IV. Organizational Structure and Staffing

MI4.1 MMPs with an established work plan and identification of an individual who is responsible for ADA compliance. – **Retired**

MI4.2 Care coordinator training for supporting self-direction under the demonstration.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
MI4. Organizational Structure and Staffing	Annually	Contract	Calendar Year	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of care coordinators.	Total number of care coordinators who have been employed by the MMP for at least 3 months at any point during the reporting period.	Field Type: Numeric
B.	Total number of care coordinators who have undergone training for supporting self-direction under the demonstration.	Of the total reported in A, the number of care coordinators who have undergone training for supporting self-direction under the demonstration.	Field Type: Numeric Note: Is a subset of A.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
- As data are received from MMPs over time, CMS and the state will apply threshold checks.

C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.
- All data elements should be positive values.

- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
- CMS and the state will evaluate the percentage of care coordinators who have undergone state-based training for supporting self-direction.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should refer to the Michigan three-way contract for specific requirements pertaining to a care coordinator.
 - MMPs should refer to the Michigan three-way contract for specific requirements pertaining to training for supporting self-direction.
 - A care coordinator includes all full-time and part-time staff.
 - If a care coordinator was not currently with the MMP at the end of the reporting period, but was with the MMP for at least 3 months, they should be included in this measure.
 - For data element B, MMPs may include care coordinators who participated in the self-determination training provided by MDHHS. MMPs may also include care coordinators who received MMP-sponsored training for supporting self-direction. Note that care coordinators should only be counted once when reporting this measure (i.e., if a care coordinator participated in both MDHHS training and MMP training, count the care coordinator only once in data element B).
- F. Data Submission – how MMPs will submit data collected to CMS and the state.
- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>.

Section MI V. Performance and Quality Improvement

MI5.1 Ambulatory care-sensitive condition hospital admission. (PQI #90)

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
MI5. Performance and Quality Improvement	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members age 21 years and older.	Total number of members age 21 years and older enrolled in the MMP during the reporting period.	Field Type: Numeric
B.	Total number of discharges for members age 21 years and older with an admission for one of the following conditions: <ol style="list-style-type: none"> 1. Diabetes with short-term complications 2. Diabetes with long-term complications 3. Uncontrolled diabetes without complications 4. Diabetes with lower-extremity amputation 5. Chronic obstructive pulmonary disease 6. Asthma 7. Hypertension 8. Heart failure 9. Dehydration 10. Bacterial pneumonia 11. Urinary tract infection 	Of the total reported in A, the number of discharges for members age 21 years and older with an admission for one of the following conditions: <ol style="list-style-type: none"> 1. Diabetes with short-term complications 2. Diabetes with long-term complications 3. Uncontrolled diabetes without complications 4. Diabetes with lower-extremity amputation 5. Chronic obstructive pulmonary disease 6. Asthma 7. Hypertension 8. Heart failure 9. Dehydration 10. Bacterial pneumonia 11. Urinary tract infection 	Field Type: Numeric

- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will perform an outlier analysis.
 - As data are received from MMPs over time, CMS and the state will apply threshold checks.
- C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.
- All data elements should be positive values.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
- CMS and the state will evaluate the number of ambulatory care-sensitive condition hospital admissions (discharges) for members age 21 years and older per 100,000 members.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
 - MMPs should include all members who meet the criteria outlined in data element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
 - The PQI overall composite measure includes admissions for one of the following conditions during the reporting period:
 - Diabetes with short-term complications (PQI #01)
 - Diabetes with long-term complications (PQI #03)
 - Chronic obstructive pulmonary disease or Asthma in Older Adults (PQI #05)
 - Hypertension (PQI #07)
 - Heart failure (PQI #08)
 - Dehydration (PQI #10)
 - Bacterial pneumonia (PQI #11)
 - Urinary tract infection (PQI #12)
 - Uncontrolled diabetes without complications (PQI #14)
 - Asthma in Younger Adults (PQI #15)
 - Diabetes with lower-extremity amputation (PQI #16)
 - Further details on technical specifications for the individual PQI measures, including inclusion and exclusion criteria and codes, are located in the Individual Measure Technical Specifications on the Agency for Healthcare Research and Quality (AHRQ) website at the following link:
https://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec_ICD10

[v70.aspx](#) Further details on the AHRQ quality indicator software used to generate results are located at the following link:

<https://www.qualityindicators.ahrq.gov/Software/Default.aspx>

- The numerator for this measure is based on inpatient discharges, not members.
- Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the above PQIs are counted only once in the composite numerator.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>.

MI5.2 Members using self-directed arrangements through a fiscal intermediary.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Periods	Due Date
MI5. Performance and Quality Improvement	Quarterly	Contract	Current Calendar Quarter Ex: 1/1 – 3/31 4/1 – 6/30 7/1 – 9/30 10/1 – 12/31	By the end of the second month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members enrolled in waiver services.	Total number of members who were continuously enrolled in waiver services during the reporting period.	Field Type: Numeric
B.	Total number of members using self-directed arrangements.	Of the total reported in A, the number of members using self-directed arrangements during the reporting period.	Field Type: Numeric Note: Is a subset of A.

B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- CMS and the state will perform an outlier analysis.
 - As data are received from MMPs over time, CMS and the state will apply threshold checks.
- C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.
- Confirm those data elements listed above as subsets of other elements.
 - MMPs should validate that data element B is less than or equal to data element A.
 - All data elements should be positive values..
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
- CMS and the state will evaluate the percentage of members using self-directed arrangements during the reporting period.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
 - Data element A includes members who have an LOC 03 in the Community Health Automated Medicaid Processing System (CHAMPS).
 - Effective January 2, 2018, Program Enrollment Type (PET) codes are required whenever LOCs are referenced. MMPs should refer to the MCC LOC to PET crosswalk document to identify applicable codes.
 - Self-directed arrangements mean the member has the authority to exercise decision making over long-term care services and supports and accepts the responsibility for taking a direct role in managing them. Arrangements that support self-determination are an alternative to provider management of services wherein a service provider has the responsibility for managing all aspects of service delivery in accordance with the service plan developed through the person-centered planning process. This measure shall include members who meet each of the following three criteria:
 - Members who have an LOC 03 in the CHAMPS at the time of service delivery
 - Members who have been approved for self-determination arrangements through the MI Health Link HCBS C-Waiver for the Fiscal Intermediary service (Waiver Services value set)
 - Members receiving at least one of the following services:
 1. Chore Services (Chore Services value set)
 2. Environmental Modifications (Environmental Modifications value set)
 3. Expanded Community Living Supports (Expanded Community Living Supports value set)

4. Non-Medical Transportation (Non-Medical Transportation value set)
5. Preventive Nursing Services (Preventive Nursing Services value set)
6. Private Duty Nursing (Private Duty Nursing value set)
7. Respite (Respite value set)

- The member must be continuously enrolled during the reporting period, with no gaps in enrollment, to be included in this measure.
- MMPs should include members who were using self-directed arrangements for any length of time during the reporting period.
- MMPs should conduct a full count of members specified for this measure, not provide an estimate based on sampling.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>.

MI5.3 Adherence to antipsychotic medications for individuals with schizophrenia.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
MI5. Performance and Quality Improvement	Annually	Contract	Calendar Year, beginning CY2	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members with schizophrenia.	Total number of members with schizophrenia, who were continuously enrolled in the MMP during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric

Element Letter	Element Name	Definition	Allowable Values
B.	Total number of members who achieved a proportion of days covered (PDC) of at least 80% for their antipsychotic medications.	Of the total reported in A, the number of members who achieved a PDC of at least 80% for their antipsychotic medications during the reporting period.	Field Type: Numeric Note: Is a subset of A.

- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will perform an outlier analysis.
 - As data are received from MMPs over time, CMS and the state will apply threshold checks.
- C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.
- Confirm those data elements listed above as subsets of other elements.
 - MMPs should validate that data element B is less than or equal to data element A.
 - All data elements should be positive values.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
- CMS and the state will evaluate the percentage of members with schizophrenia who achieved a PDC of at least 80% for their antipsychotic medications during the reporting period.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
 - IPSD is the index prescription start date. It is the earliest prescription dispensing date for any antipsychotic medication during the reporting period.
 - Treatment period is the period of time beginning on the IPSD through the last day of the reporting period.
 - PDC is the proportion of days covered. It is the number of days a member is covered by at least one antipsychotic medication prescription, divided by the number of days in the treatment period.
 - Oral medication dispensing event is one prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events.

- Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, use the prescription with the longest days supply. Use the Drug ID to determine if the prescriptions are the same or different.
- Long-acting injections dispensing event count as one dispensing event. Multiple J codes or National Drug Codes (NDCs) for the same or different medication on the same day are counted as a single dispensing event.
- Follow the instructions below to determine how to calculate the number of days covered for oral medications.
 - If multiple prescriptions for the same or different oral medications are dispensed on the same day, calculate number of days covered by an antipsychotic medication (for the numerator, data element B) using the prescription with the longest days supply.
 - If multiple prescriptions for different oral medications are dispensed on different days, count each day within the treatment period only once toward the numerator (data element B).
 - If multiple prescriptions for the same oral medication are dispensed on different days, sum the days supply and use the total to calculate the number of days covered by an antipsychotic medication (for the numerator, data element B).
 1. For example, if three antipsychotic prescriptions for the same oral medication are dispensed on different days, each with a 30-day supply; sum the days supply for a total of 90 days covered by an oral antipsychotic (even if there is overlap). Use the drug ID provided on the Medication List Directory of NDC codes to determine if the prescriptions are the same or different.
- To calculate number of days covered for long-acting injections (for data element B), use the days supply specified for the medication in the medication list or in the value set name.
 - For multiple J Codes or NDCs for the same or different medications on the same day, use the medication with the longest days supply.
 - For multiple J Codes or NDCs for the same or different medications on different days with overlapping days supply, count each day within the treatment period only once toward the numerator (data element B).
- If an oral medication and a long-acting injection are dispensed on the same day, calculate number of days covered by an antipsychotic

medication (for data element B) using the prescription with the longest days' supply.

- If an oral medication and long-acting injection are dispensed on different days, with some overlapping days of supply, count each day within the treatment period only once toward data element B.
- Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during the reporting period (i.e., January through December). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
- Due to continuous enrollment criteria, this measure will be reported beginning CY2.
- Follow the steps outlined below to identify the eligible population (data element A). Members who use hospice services or elect to use a hospice benefit at any time during the reporting period are excluded from the eligible population. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice value set).

Step 1: Identify members with schizophrenia as those who met at least one of the following criteria during the reporting period:

- At least one acute inpatient encounter with any diagnosis of schizophrenia. Either of the following code combinations meets criteria:
 - BH Stand Alone Acute Inpatient value set **with** Schizophrenia value set.
 - BH Acute Inpatient value set **with** BH Acute Inpatient POS value set **and** Schizophrenia value set.
- At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meets criteria:
 - BH Stand Alone Outpatient/PH/IOP value set **with** Schizophrenia value set.
 - BH Outpatient/PH/IOP value set **with** BH Outpatient/PH/IOP POS value set **with** Schizophrenia value set.
 - ED value set **with** Schizophrenia value set.
 - BH ED value set **with** ED POS value set **with** Schizophrenia value set.
 - BH Stand Alone Nonacute Inpatient value set **with** Schizophrenia value set.

- BH Nonacute Inpatient value set **with** BH Nonacute Inpatient POS value set **with** Schizophrenia value set.

Step 2: Identify required exclusions. Exclude members who met at least one of the following during the reporting period:

- A diagnosis of dementia (Dementia value set).
 - Did not have at least two antipsychotic medication dispensing events. There are two ways to identify dispensing events: by claim/encounter data and by pharmacy data. The MMP must use both methods to identify dispensing events, but an event need only be identified by one method to be counted.
 - Pharmacy data: Dispensed an antipsychotic medication (Oral Antipsychotic Medications List; Long-Acting Injections 14 Days Supply Medications List or Long-Acting Injections 28 Days Supply Medication List) on an ambulatory basis.
 - Claim/encounter data: An antipsychotic medication (Long-Acting Injections 14 Days Supply or Long-Acting Injections 28 Days Supply value sets).
- Follow the steps outlined below to identify numerator compliance (data element B).

Step 1: Identify the IPSD. The IPSD is the earliest dispensing event for any antipsychotic medication (Oral Antipsychotic Medications List; Long-Acting Injections 14 Days Supply Medications List; Long-Acting Injections 28 Days Supply Medication List; Long-Acting Injections 14 Days Supply value set; Long-Acting Injections 28 Days Supply value set) during the reporting period.

Step 2: Determine the treatment period. Calculate the number of days beginning on the IPSD through the end of the reporting period.

Step 3: Count the days covered by at least one antipsychotic medication (Oral Antipsychotic Medications List; Long-Acting Injections 14 Days Supply Medications List; Long-Acting Injections 28 Days Supply Medication List; Long-Acting Injections 14 Days Supply value set; Long-Acting Injections 28 Days Supply value set) during the treatment period. To ensure that the days supply that extend beyond the reporting period are not counted, subtract any days supply that extends beyond December 31 of the reporting period.

Step 4: Calculate the member's PDC using the following equation. Round to two decimal places, using the .5 rule.

Total days covered by an antipsychotic medication in the treatment period (Step 3)

Total days in treatment period (Step 2)

Step 5: Sum the number of members whose PDC is $\geq 80\%$ for their treatment period.

- F. Data Submission – how MMPs will submit data collected to CMS and the state.
- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>.

MI5.4 Nursing facility residents experiencing one or more falls with a major injury.

Please note: No MMP reporting is required for this measure; MDHHS will gather the necessary data from MDS. MMPs are required to assist MDHHS with the process and more detail regarding the required assistance will be provided by MDHHS.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Periods	Due Date
MI5. Performance and Quality Improvement	Quarterly	Contract	Current Calendar Quarter Ex: 1/1 – 3/31 4/1 – 6/30 7/1 – 9/30 10/1 – 12/31	N/A

Please refer to the MDS 3.0 Quality Measure User’s Manual for further detailed specifications on this measure: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-QM-Users-Manual-V11-Final.pdf>

- A. QA Checks/Thresholds - procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will perform an outlier analysis.
 - As data are received from MMPs over time, CMS and the state will apply threshold checks.
- B. Analysis - how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will evaluate the percentage of long stay residents who have experienced one or more falls with major injury reported in the target period or look-back period.

MI5.5 Urinary tract infection.ⁱⁱ

Please note: No MMP reporting is required for this measure; MDHHS will gather the necessary data from MDS. MMPs are required to assist MDHHS with the process and more detail regarding the required assistance will be provided by MDHHS.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Periods	Due Date
MI5. Performance and Quality Improvement	Quarterly	Contract	Current Calendar Quarter Ex: 1/1-3/31 4/1-6/30 7/1-9/30 10/1-12/31	N/A

Please refer to the MDS 3.0 Quality Measure User’s Manual for further detailed specifications on this measure: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-QM-Users-Manual-V11-Final.pdf>

- A. QA Checks/Thresholds - procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- Guidance will be forthcoming on the established benchmark for this measure for DY 2 through 5.
- B. Analysis - how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
- CMS and the state will evaluate the percentage of long stay residents who have a urinary tract infection.

MI5.6 Care for Adults – Medication Review. (Modified from NQF # 0553) ⁱⁱ

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
MI5. Performance and Quality Improvement	Annually	Contract	Calendar Year, beginning CY2	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members continuously enrolled who were currently enrolled on December 31 of the reporting period.	Total number of members continuously enrolled who were currently enrolled on December 31 of the reporting period.	Field type: Numeric
B.	Total number of members sampled who met inclusion criteria.	Of the total reported in A, the number of members sampled who met inclusion criteria.	Field type: Numeric Note: Is a subset of A
C.	Total number of members who had at least one medication review conducted by a prescribing practitioner or clinical pharmacist during the reporting period and the presence of a medication list in the medical record.	Of the total reported in B, the number of members who had at least one medication review conducted by a prescribing practitioner or clinical pharmacist during the reporting period and the presence of a medication list in the medical record.	Field Type: Numeric Note: Is a subset of B.

B. QA Checks/Thresholds - procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- Guidance will be forthcoming on the established benchmark for this measure for DY 2 through 5.

C. Edits and Validation Checks - validation checks that should be performed by each MMP prior to data submission.

- Confirm those data elements listed above as subsets of other elements.
- MMPs should validate that data element B is less than or equal to data element A.

- MMPs should validate that data element C is less than or equal to data element B.
 - All data elements should be positive values.
- D. Analysis - how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.
- CMS and the state will evaluate the percentage of members who had a medication review completed during the reporting period.
- E. Notes - additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should include all members aged 21 years and older³, regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. A subset of all members that are eligible will be included in the sample. Medicaid-only members should not be included.
 - For reporting, the MMPs may elect to use a hybrid methodology and select a sample. Sampling should be systematic to ensure all eligible individuals have an equal chance of inclusion. The sample size should be 411, plus oversample to allow for substitution. For further instructions on selecting the sample size, please see page MI-10 of this document.
 - If an MMP does not elect to sample, data element B should be equal to data element A.
 - Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during the reporting period (i.e., January through December). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
 - A medication list is a list of the member's medications in the medical record. The medication list may include medication names only or may include medication names, dosages and frequency, over-the-counter (OTC) medications and herbal or supplemental therapies.
 - A medication review is a review of all of a member's medications, including prescription medications, OTC medications, and herbal or supplemental therapies.
 - A clinical pharmacist is a pharmacist with extensive education in the biomedical, pharmaceutical, sociobehavioral and clinical sciences. Clinical pharmacists are experts in the therapeutic use of medications and are a primary source of scientifically valid information and advice regarding the safe, appropriate and cost-effective use of medications. Most clinical pharmacists have a Doctor of Pharmacy (PharmD) degree and many have completed one or more years of post-graduate training (e.g., a general and/or specialty pharmacy residency). In some states, clinical pharmacists have prescriptive authority.

³ The HEDIS eligible population for this measure is limited to individuals 66 years of age and older. This measure has been modified to apply to the full Michigan demonstration population.

- A prescribing practitioner is a practitioner with prescribing privileges, including nurse practitioners, physician assistants and other non-MDs who have the authority to prescribe medications.
- Members who use hospice services or elect to use a hospice benefit at any time during the reporting period are excluded from the eligible population. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice value set).

Administrative Specifications

- If the MMP elects to only use administrative data to identify members with a medication review completed (data element C), any of the following meet criteria:
 - Either of the following meet criteria:
 1. Both of the following on the same claim during the reporting period where the provider type is a prescribing practitioner or clinical pharmacist:
 - A least one medication review (Medication Review value set)
 - The presence of a medication list in the medical record (Medication List value set)
 2. Transitional care management services (Transitional Care Management Services value set) during the reporting period.

Hybrid Specifications

- If the MMP elects to use hybrid sampling, refer to the *Administrative Specifications* to identify positive numerator hits from administrative data.
- A medication list, signed and dated during the reporting period by the appropriate practitioner type (prescribing practitioner or clinical pharmacist), meets criteria (the practitioner's signature is considered evidence that the medications were reviewed).
- When reviewing a member's medical record, documentation must come from the same medical record and must include one of the following:
 - A medication list in the medical record, **and** evidence of a medication review by a prescribing practitioner or clinical pharmacist and the date when it was performed.
 - Notation that the member is not taking any medication and the date when it was noted.
- MMPs may use their own EHR (i.e., a supplemental data source) when using the hybrid specifications. If medication reconciliation is conducted by pharmacists and the results are communicated to the PCP, the MMP would be encouraged to use these supplemental data. Reconciliation and record transmission must be documented by the MMP in its EHR.

- A review of side effects for a single medication at the time of prescription alone is not sufficient.
- An outpatient visit is not required to meet criteria.

F. Data Submission - how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>.

Section MI VI. SystemsMI6.1 Integrated Care Bridge Record. – *Retired***Section MI VII. Utilization**MI7.1 Emergency department visits for ambulatory care-sensitive conditions.
(Rosenthal)

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
MI7. Utilization	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of emergency department (ED) visits.	Total number of ED visits during the reporting period.	Field Type: Numeric
B.	Total number of non-emergent ED visits.	Of the total reported in A, the number of non-emergent ED visits during the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of emergent/primary care treatable ED visits.	Of the total reported in A, the number of emergent/primary care treatable ED visits during the reporting period.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of emergent preventable/avoidable ED visits.	Of the total reported in A, the number of emergent preventable/avoidable ED visits during the reporting period.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
E.	Total number of emergent not preventable/avoidable ED visits.	Of the total reported in A, the number of emergent not preventable/avoidable ED visits during the reporting period.	Field Type: Numeric Note: Is a subset of A.
F.	Total number of ED visits with an injury principal diagnosis.	Of the total reported in A, the number of ED visits with an injury principal diagnosis during the reporting period.	Field Type: Numeric Note: Is a subset of A.
G.	Total number of ED visits with a mental health principal diagnosis.	Of the total reported in A, the number of ED visits with a mental health principal diagnosis during the reporting period.	Field Type: Numeric Note: Is a subset of A.
H.	Total number of ED visits with an alcohol-related principal diagnosis.	Of the total reported in A, the number of ED visits with an alcohol-related principal diagnosis during the reporting period.	Field Type: Numeric Note: Is a subset of A.
I.	Total number of ED visits with a drug-related health principal diagnosis.	Of the total reported in A, the number of ED visits with a drug-related health principal diagnosis during the reporting period.	Field Type: Numeric Note: Is a subset of A.
J.	Total number of ED visits that were unclassified.	Of the total reported in A, the number of ED visits that were unclassified during the reporting period.	Field Type: Numeric Note: Is a subset of A.

- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will perform an outlier analysis.
 - As data are received from MMPs over time, CMS and the state will apply threshold checks.
- C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.
- Confirm those data elements listed above as subsets of other elements.
 - MMPs should validate that data elements B, C, D, E, F, G, H, I, and J are less than or equal to data element A.
 - All data elements should be positive values.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of:

- Non-emergent ED visits during the reporting period.
 - Emergent/primary care treatable ED visits during the reporting period.
 - Emergent preventable/avoidable ED visits during the reporting period.
 - Emergent not preventable/avoidable ED visits during the reporting period.
 - ED visits with an injury principal diagnosis during the reporting period.
 - ED visits with a mental health diagnosis during the reporting period.
 - ED visits with an alcohol-related principal diagnosis during the reporting period.
 - ED visits with a drug-related health principal diagnosis during the reporting period.
 - ED visits that were unclassified during the reporting period.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
 - MMPs should include all ED visits for members who meet the criteria outlined in data element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all ED visits for members regardless if they are currently enrolled or disenrolled as of the last day of the reporting period).
 - The denominator for this measure is based on ED visits, not members.
 - The Excel files for this measure can be downloaded at the following website: <http://wagner.nyu.edu/faculty/billings/nyued-background>
 - If a member has more than one ED visit on the same day during the reporting period, only count the visit that occurred first towards the denominator. If a member has multiple ED visits during the reporting period that do not occur on the same day, count all ED visits toward the denominator.
 - Non-emergent: The patient's initial complaint, presenting symptoms, vital signs, medical history, and age indicated that immediate medical care was not required within 12 hours.
 - Emergent: Emergency department care was needed.
 - Emergent/primary care treatable: Based on information in the patient's record, treatment was required within 12 hours, but care could have been provided effectively and safely in a primary care setting. The compliant did not require continuous observation and no procedures were performed or resources used that are not available in a primary care setting (e.g., CAT scan or certain lab tests).
 - Emergent preventable/avoidable: Emergency department care was required based on the compliant or procedures performed/resources used, but the emergent nature of the condition was potentially preventable/avoidable if timely and effective ambulatory care had been received during the episode of illness (e.g., the flare-ups of asthma, diabetes, congestive heart failure, etc.).

- Emergent not preventable/avoidable: Emergency department care was required and ambulatory care treatment could not have prevented the condition (e.g., trauma, appendicitis, myocardial infarction, etc.).
- For reporting data element I, alcohol principal diagnoses should be excluded.
- Codes to identify ED visits are provided in the ED value set.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>.

MI7.2 Unduplicated members receiving HCBS and unduplicated members receiving nursing facility services.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
MI7. Utilization	Annually	Contract	Calendar Year	By the end of the fourth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members.	Total number of members who were continuously enrolled in the MMP for six months during the reporting period.	Field Type: Numeric
B.	Total number of members receiving HCBS.	Of the total reported in A, the number of members receiving HCBS during the reporting period who did not receive nursing facility services during the reporting period.	Field Type: Numeric Note: Is a subset of A.

Element Letter	Element Name	Definition	Allowable Values
C.	Total number of members receiving nursing facility services.	Of the total reported in A, the number of members receiving nursing facility services during the reporting period who did not receive HCBS during the reporting period.	Field Type: Numeric Note: Is a subset of A.
D.	Total number of members receiving both HCBS and nursing facility services during the reporting period.	Of the total reported in A, the number of members receiving both HCBS and nursing facility services during the reporting period.	Field Type: Numeric Note: Is a subset of A.

- B. QA Checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will perform an outlier analysis.
 - As data are received from MMPs over time, CMS and the state will apply threshold checks.
- C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.
- Confirm those data elements listed above as subsets of other elements.
 - MMPs should validate that data elements B, C, and D are less than or equal to data element A.
 - All data elements should be positive values.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will use enrollment data and will evaluate the percentage of members who received:
- HCBS during the reporting period who did not receive nursing facility services during the reporting period.
 - Nursing facility services during the reporting period who did not receive HCBS during the reporting period.
 - Both HCBS and nursing facility services during the reporting period.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
 - MMPs should include all members who meet the criteria outlined in data element A, regardless if they are disenrolled as of the end of the reporting period (i.e., include all members regardless if they are

currently enrolled or disenrolled as of the last day of the reporting period).

- This measure only includes LTSS services provided under the MI Health Link waiver. LTSS services provided under the PIHP waiver should not be included in this measure.
- The member must be continuously enrolled for six months during the reporting period, with no gaps in enrollment, to be included in this measure.
- Members receiving only HCBS should be counted for data element B (unduplicated). Members receiving only nursing facility services should be counted for data element C (unduplicated). Members receiving both HCBS and nursing facility services should be counted for data element D (unduplicated). Data elements B, C, and D are mutually exclusive.
- Unduplicated means a member should only be counted once for the type of service they receive. For example, if a member received nursing facility services in two different facilities during the reporting period, they would only count once toward members receiving nursing facility services during the reporting period (data element C).
- Include members who were receiving HCBS or nursing facility services for any length of time during the reporting period.
- HCBS refers to Home and Community Based Services.
- Nursing facility services include any type of nursing facility care, including skilled and custodial services.

F. Data Submission – how MMPs will submit data collected to CMS and the state.

- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>.

MI7.3 Annual Dental Visit.

CONTINUOUS REPORTING				
Reporting Section	Reporting Frequency	Level	Reporting Period	Due Date
MI7. Utilization	Annually	Contract	Calendar Year	By the end of the sixth month following the last day of the reporting period

A. Data element definitions – details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

Element Letter	Element Name	Definition	Allowable Values
A.	Total number of members.	Total number of members who were continuously enrolled in the MMP during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric
B.	Total number of members who had one or more dental visits.	Of the total reported in A, the number of members who had one or more dental visits with a dental practitioner during the reporting period.	Field Type: Numeric Note: Is a subset of A.
C.	Total number of members age 21-64.	Total number of members age 21-64 who were continuously enrolled in the MMP during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric
D.	Total number of members age 21-64 who had one or more dental visits.	Of the total reported in C, the number of members age 21-64 who had one or more dental visits with a dental practitioner during the reporting period.	Field Type: Numeric Note: Is a subset of C.
E.	Total number of members age 65-79.	Total number of members age 65-79 who were continuously enrolled in the MMP during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric
F.	Total number of members age 65-79 who had one or more dental visits.	Of the total reported in E, the number of members age 65-79 who had one or more dental visits with a dental practitioner during the reporting period.	Field Type: Numeric Note: Is a subset of E.

Element Letter	Element Name	Definition	Allowable Values
G.	Total number of members age 80 and older.	Total number of members age 80 and older who were continuously enrolled in the MMP during the reporting period, and who were enrolled on December 31 of the reporting period.	Field Type: Numeric
H.	Total number of members age 80 and older who had one or more dental visits.	Of the total reported in G, the number of members age 80 and older who had one or more dental visits with a dental practitioner during the reporting period.	Field Type: Numeric Note: Is a subset of G.

- B. QA checks/Thresholds – procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.
- CMS and the state will perform an outlier analysis.
 - As data are received from MMPs over time, CMS and the state will apply threshold checks.
- C. Edits and Validation checks – validation checks that should be performed by each MMP prior to data submission.
- Confirm those data elements listed above as subsets of other elements.
 - MMPs should validate that data element B is less than or equal to data element A.
 - MMPs should validate that data element D is less than or equal to data element C.
 - MMPs should validate that data element F is less than or equal to data element E.
 - MMPs should validate that data element H is less than or equal to data element G.
 - MMPs should confirm that the sum of data elements C, E, and G should not exceed the value of data element A.
 - MMPs should confirm that the sum of data elements D, F, and H should not exceed the value of data element B.
 - All data elements should be positive values.
- D. Analysis – how CMS and the state will evaluate reported data, as well as how other data sources may be monitored. CMS and the state will evaluate the percentage of members:
- Who had one or more dental visits with a dental practitioner during the reporting period.
 - Age 21-64 who had one or more dental visits with a dental practitioner during the reporting period.

- Age 65-79 who had one or more dental visits with a dental practitioner during the reporting period.
 - Age 80 or older who had one or more dental visits with a dental practitioner during the reporting period.
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.
- MMPs should include all members regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.
 - Continuous enrollment is defined as no more than one gap in enrollment of up to 45 days during the reporting period (i.e., January through December). To determine continuous enrollment for a member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
 - Members must be enrolled on December 31 of the reporting period to be included in this measure. MMPs should use the member's age as of December 31 to determine in which age bracket they should be reported.
 - Members who use hospice services or elect to use a hospice benefit at any time during the reporting period are excluded from the eligible population. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice value set).
 - A dental practitioner is defined as a practitioner who holds a Doctor of Dental Surgery (DDS) or a Doctor of Dental Medicine (DMD) degree from an accredited school of dentistry and is licensed to practice dentistry by a state board of dental examiners. Certified and licensed dental hygienists are considered dental practitioners.
 - Codes to identify dental visits are provided in the Dental Visits value set.
- F. Data Submission – how MMPs will submit data collected to CMS and the state.
- MMPs will submit data collected for this measure in the above specified format through a secure data collection site established by CMS. This site can be accessed at the following web address: <https://Financial-Alignment-Initiative.NORC.org>.