

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

Issued February 29, 2024

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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 Model 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

All definitions for terms defined in this section and throughout this Reporting Requirements document apply whenever the term is used, unless otherwise noted.

Calendar Quarter: All quarterly measures are reported on calendar quarters. The four calendar quarters of each calendar year will be as follows: January 1 to March 31, April 1 to June 30, July 1 to September 30, and October 1 to December 31.

Calendar Year: All annual measures are reported on a calendar year basis. For example, Calendar Year (CY) 2024 represents January 1, 2024 through December 31, 2024.

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

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

- For the three MMPs that implemented during Phase I on March 1, 2015, the Implementation Period began on March 1, 2015 and continued until September 30, 2015.
- For the remaining MMPs that implemented during Phase II on May 1, 2015, the Implementation Period began on May 1, 2015 and continued until December 31, 2015.
- For any MMP in both Phase I and Phase II, the Implementation Period began on March 1, 2015 and continued 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. PCPs may be nurse practitioners, physician assistants or board-certified physicians, or a specialist selected by an Enrollee.

Variations from the Core Reporting Requirements 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 completed Individual Integrated Care and Supports Plan (IICSP) that includes the requisite member signature or proxy for the signature.

Core 4.2

For reporting Core 4.2, Michigan MMPs should not include appeals and grievances related to Medicaid behavioral health services. MDHHS contracts directly with Prepaid Inpatient Health Plans (PIHPs) for delivery of these services and MMPs are not responsible for reporting grievances and appeals data for Medicaid behavioral health services. However, Michigan MMPs should include appeals and grievances related to Medicare behavioral health services (including those filed with and/or processed by PIHPs) when reporting Core 4.2.

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 Level of Care Determination (LOCD), 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 LOCD 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
- The following Program Enrollment Type (PET) codes in the Community Health Automated Medicaid Processing System (CHAMPS):
 - PET code ICO-HCBS or ICO-HOSW in CHAMPS to identify individuals using waiver services
 - PET code ICO-HOSN, ICO-NFAC, ICO-CMCF, or ICO-HOSC 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 established a set of quality withhold measures, and MMPs are 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 10: (ii). Note that additional state-specific quality withhold measures are reported separately through the Core Reporting Requirements and HEDIS. For more information about the state-specific quality withhold measures, refer to the Quality Withhold Technical Notes (DY 1): Michigan-Specific Measures and the Quality Withhold Technical Notes (DY 2-10): Michigan-Specific Measures at: <https://www.cms.gov/Medicare-Medicaid->

[Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPQualityWithholdMethodologyandTechnicalNotes.html](#).

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.

MMPs must also comply with contractually-specified timelines regarding completion of 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 Assessments and IICSPs for Members with a Break in Coverage

Level I Assessments

If an 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 their 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 the member's 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 the member's 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 three-way contract. If there are no changes, the MMP is not required to conduct a new Level I Assessment unless requested by the member (or the member's 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 their health status with the MMP, then the MMP may report that member as unwilling to participate in the Level I Assessment. Additionally, in certain circumstances a new Level I Assessment that has been completed for a member upon reenrollment may also be reported in Core 2.3.

If the MMP did not complete a Level I Assessment for the re-enrolled member during their 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 three-way contract. The MMP must make the requisite number of attempts to reach the member (at minimum) after their most recent enrollment effective date, even if the MMP reported that the member was unable to be reached during their 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 the member's authorized representative), provided that the reassessment timeframe specified by the selected Level II Assessment tool (as outlined in Section 2.6.6.3 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 2.6.6.6 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 2.6.6.6 of the three-way contract.

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 IICSP accordingly within the timeframe prescribed by the three-way 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 their 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 three-way 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 the three-way contract requirements regarding the completion of annual Level I reassessments and updates to IICSPs. If the MMP determined that the Level I Assessment/IICSP from a member's prior enrollment was accurate and marked that Level I Assessment/IICSP as complete for the member's current enrollment, the MMP should count continuously from the date that the Level I Assessment/IICSP was completed in the prior enrollment period to determine the due date for the annual Level I 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.

Reporting on Passively Enrolled and Opt-In Enrolled Members

When reporting all Michigan state-specific measures, MMPs should include all members who meet the criteria for inclusion in the measure regardless of whether the member was enrolled through passive enrollment or opt-in enrollment. Medicaid-only members should not be included.

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 at the time of reporting deadline, 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.

Hybrid Sampling

Some demonstration-specific measures may allow medical record/supplemental documentation review (i.e., manual abstraction of data) to identify the numerator. In these instances, the sample size should be 411, plus additional records should be oversampled 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) using claim header level information.
- Step 2:** Determine the final sample size. The final sample size will be 411 unless the eligible population is less than 411. If the eligible population is less than 411, follow Step 5 to determine the final sample size.
- Step 3:** Determine the oversample which should include 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 oversample.

Step 4: If the eligible population exceeds the final sample size as determined in Step 2, proceed to Step 6. If the eligible population is less than or equal to the final sample size as determined in Step 2, proceed to Step 5.

Step 5: 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 6: 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, 2018, 2020, 2022, and 2024 and from Z to A in 2015, 2017, 2019, 2021, 2023, and 2025).

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 7: 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 5, for instances in which the eligible population was less than or equal to the number derived from Step 2.

Step 8: 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 9: 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-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html>

Michigan's Implementation, Ongoing, and Continuous Reporting Periods

Phase		Dates	Explanation
Demonstration Year 1			
Continuous Reporting	Implementation Period	<u>Phase 1 MMPs:</u> 3-1-15 through 9-30-15 <u>Phase 2 MMPs:</u> 5-1-15 through 12-31-15	<u>Phase 1:</u> From the first effective enrollment date through the end of September. <u>Phase 2:</u> From the first effective enrollment date through the end of December.
	Ongoing Period	3-1-15 through 12-31-16	From the first effective enrollment date through the end of the first demonstration year.
Demonstration Year 2			
Continuous Reporting	Ongoing Period	1-1-17 through 12-31-17	From January 1, 2017 through the end of the second demonstration year.
Demonstration Year 3			
Continuous Reporting	Ongoing Period	1-1-18 through 12-31-18	From January 1, 2018 through the end of the third demonstration year.
Demonstration Year 4			
Continuous Reporting	Ongoing Period	1-1-19 through 12-31-19	From January 1, 2019 through the end of the fourth demonstration year.

Phase		Dates	Explanation
Demonstration Year 5			
Continuous Reporting	Ongoing Period	1-1-20 through 12-31-20	From January 1, 2020 through the end of the fifth demonstration year.
Demonstration Year 6			
Continuous Reporting	Ongoing Period	1-1-21 through 12-31-21	From January 1, 2021 through the end of the sixth demonstration year.
Demonstration Year 7			
Continuous Reporting	Ongoing Period	1-1-22 through 12-31-22	From January 1, 2022 through the end of the seventh demonstration year.
Demonstration Year 8			
Continuous Reporting	Ongoing Period	1-1-23 through 12-31-23	From January 1, 2023 through the end of the eighth demonstration year.
Demonstration Year 9			
Continuous Reporting	Ongoing Period	1-1-24 through 12-31-24	From January 1, 2024 through the end of the ninth demonstration year.
Demonstration Year 10			
Continuous Reporting	Ongoing Period	1-1-25 through 12-31-25	From January 1, 2025 through the end of the tenth demonstration year.

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 5:00 p.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.
2. Specify in the email which measure(s) need resubmission;
3. Specify for which reporting period(s) the resubmission is needed; and
4. Provide a brief explanation for why the data need to be resubmitted.
5. After review of the request, the MI HelpDesk will notify the MMP once the FAI DCS and/or HPMS has been re-opened.
6. Resubmit data through the applicable reporting system.
7. 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. – **Retired**
- MI1.2 Level I and Level II Assessment Completion for persons with mental illness. – **Retired**

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 Individual Integrated Care and Supports Plans (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.
- MMPs should validate that data element B is less than or equal to data element A.
- 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.
 - $\text{Percentage} = (B / A) * 100$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Data Element A

- MMPs should only include those members who are currently enrolled as of the last day of the reporting period, including deceased members who were enrolled through the end of the reporting period. The last day of the reporting

period is the anchor date, or the date on which all reported members must be enrolled in the MMP.

- The 90th day of enrollment should be based on each member's most recent effective enrollment date in the MMP. Members must be continuously enrolled from the most recent effective enrollment date through 90 days of enrollment (or longer) with no gaps in enrollment.
- For the purposes of reporting this measure, 90 days of enrollment will be equivalent to three full calendar months.

Data Element B

- For data element B, MMPs should only include members with a completed 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 from the member's first day of enrollment through the end of the reporting period.
- MMPs should only report completed IICSPs in data element B when the member or the member's authorized representative was involved in the development of the IICSP.

General Guidance

- MMPs should refer to the Michigan three-way contract for specific requirements pertaining to an 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

Element Letter	Element Name	Definition	Allowable Values
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.
- 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.
- 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.
- 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 an initial IICSP completed during the reporting period who had at least one documented discussion of care goals in the initial IICSP.
 - $\text{Percentage} = (B / A) * 100$
 - Existing IICSPs revised during the reporting period that had at least one documented discussion of new or existing care goals.
 - $\text{Percentage} = (D / C) * 100$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Data Element A

- 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).
- 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 the member's authorized representative) in the completion of the IICSP should be reported.

Data Element B

- MMPs should only include members in data element B when the discussion of care goals with the member (or the member's authorized representative) is clearly documented in the member's initial IICSP.

Data Element C

- MMPs should include all IICSPs for members who 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 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 the member's authorized representative) in the revision to the IICSP should be reported.
- 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.

Data Element D

- MMPs should only include IICSPs in data element D when a new or previously documented care goal is discussed with the member (or the member's 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.

General Guidance

- The Michigan three-way contract section 2.6.8.7 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.
- 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.

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 that occurred during the reporting period for members who were continuously enrolled from the date of the inpatient hospital discharge through 30 days after the inpatient hospital discharge, with no gaps in enrollment.	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.
- MMPs should validate that data element B is less than or equal to data element A.
- 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.
 - $\text{Percentage} = (B / A) * 100$
 - Use enrollment data to evaluate the total number of acute inpatient hospital discharges per 10,000 member months during the reporting period.
 - $\text{Rate} = (A / \text{Total Member Months}) * 10,000$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Data Element A

- MMPs should include all acute inpatient hospital discharges for members who meet the criteria outlined in data element A, regardless of whether they are disenrolled as of the end of the reporting period.
- The denominator for this measure is based on acute inpatient hospital discharges, not members.
- To identify all acute inpatient hospital discharges during the reporting period:
 - 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 must be within the reporting period.
- Report on all inpatient stays identified with discharges within the reporting period, including denied and pended claims.

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.

- 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.

Data Element A Exclusions

- Exclude discharges for members who use hospice services or elect to use a hospice benefit at any time between the hospital discharge date and 30 days following the hospital discharge. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record, claims/encounter data (Hospice Encounter value set; Hospice Intervention value set), or supplemental data.
- Exclude discharges due to death, using the Discharges due to Death value set.
- 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).

Data Element B

- 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.
- 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, Other Ambulatory Visits value set, and Telephone 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.

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)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 (e.g., 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
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 through two days after discharge.	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 through two days after discharge.	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.

- The quality withhold benchmark for DY 2 and 3 is timely and accurate reporting of data according to the measure specifications, plus submission of a narrative. The quality withhold benchmark is 60% for DY 4, 65% for DY 5 through DY 7, and 70% for DY 8 through 10. For more information, refer to the Quality Withhold Technical Notes (DY 2-10): Michigan-Specific Measures.

- C. Edits and Validation Checks – validation checks that should be performed by each plan prior to data submission.
- 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.
- 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 through two days after discharge.
 - $\text{Percentage} = (C / B) * 100$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Definitions

- The primary physician or other health care professional designated for follow-up care may be the designated primary care provider (PCP), 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.
- 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 the patient.

Data Element A

- 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).
- For purposes of this measure, a patient can qualify for the measure multiple times during the reporting period if they have multiple inpatient discharges.
- 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.

Data Element A Exclusion

- MMPs should exclude patients who died and patients who left against medical advice or discontinued care using the Inpatient Facility Discharge Exclusions value set.

Data Element B

- MMPs may elect to use medical record or supplemental documentation to identify the numerator (i.e., hybrid sampling). For further instructions on hybrid sampling, please see pages MI-9 to MI-10 of this document.
- If MMPs do not elect to sample, data element B should be equal to data element A.

Data Element C

- To determine data element C, 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.
- 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, direct secure messaging, health information exchange using certified electronic health record technology (CEHRT), or mutual access to an electronic health record (EHR).
- If a discharge occurs on the last day of the report period, look two days past the end of the reporting period to identify if a transition record was transmitted on the day of discharge through two days after discharge.

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.
- N/A.
- 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 current reporting period.
 - $\text{Rate} = (B / A) * 1,000$
 - Average number of critical incident and abuse reports for members receiving LTSS during the prior four reporting periods (i.e., rolling year).
 - $\text{Average number} = \text{Sum of B for prior four reporting periods} / 4$
 - Weighted average number of critical incident and abuse reports per 1,000 members receiving LTSS during the prior four reporting periods.
 - $\text{Rate} = (\text{Sum of B for prior four reporting periods} / \text{Sum of A for prior four reporting periods}) * 1,000$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Definitions

- 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.
- Abuse refers to the following:
 - Willful use of offensive, abusive, or demeaning language by a caretaker that causes mental anguish;
 - Knowing, reckless, or intentional acts or failures to act which cause injury or death to an individual or which place that individual at risk of injury or death;
 - Rape or sexual assault;
 - Corporal punishment or striking of an individual;
 - Unauthorized use or the use of excessive force in the placement of bodily restraints on an individual; and
 - Use of bodily or chemical restraints on an individual which is not in compliance with federal or state laws and administrative regulations.

Data Element A

- 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).

Data Element B

- For data element B, MMPs should include all new critical incident and abuse cases that are reported during the reporting period, regardless of whether 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.
- 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.

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 full-time and part-time care coordinators.	Total number of full-time and part-time care coordinators who have been employed by the MMP for at least three 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.
- MMPs should validate that data element B is less than or equal to data element A.
- 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 full-time and part-time care coordinators who have undergone training for supporting self-direction.
 - $\text{Percentage} = (B / A) * 100$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Data Element A

- 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 three months at any point during the reporting period, they should be included in this measure.

Data Element B

- 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).

General Guidance

- MMPs should refer to the Michigan three-way contract for specific requirements pertaining to a care coordinator and to training for supporting self-direction.
- 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 hospital discharges for members age 21 years and older at the time of discharge with an admission for one of the following conditions: 1. Diabetes with short-term complications 2. Diabetes with long-term complications 3. Uncontrolled diabetes 4. Diabetes with lower-extremity amputation 5. Chronic obstructive pulmonary disease 6. Asthma 7. Hypertension 8. Heart failure 9. Community-acquired pneumonia 10. Urinary tract infection	Of the total reported in A, the number of hospital discharges for members age 21 years and older at the time of discharge with an admission for one of the following conditions: 1. Diabetes with short-term complications 2. Diabetes with long-term complications 3. Uncontrolled diabetes 4. Diabetes with lower-extremity amputation 5. Chronic obstructive pulmonary disease 6. Asthma 7. Hypertension 8. Heart failure 9. Community-acquired pneumonia 10. 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.
- N/A.
- 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 at the time of discharge per 100,000 members.
 - $\text{Rate} = (B / A) * 100,000$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Data Element A

- 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).

Data Element B

- The PQI overall composite measure includes hospitalizations for one of the following conditions during the reporting period:
 - Diabetes Short-Term Complications (PQI #01)
 - Diabetes Long-Term Complications (PQI #03)
 - Chronic Obstructive Pulmonary Disease or Asthma in Older Adults (PQI #05)
 - Hypertension (PQI #07)
 - Heart Failure (PQI #08)
 - Community-acquired Pneumonia (PQI #11)
 - Urinary Tract Infection (PQI #12)
 - Uncontrolled Diabetes (PQI #14)
 - Asthma in Younger Adults (PQI #15)
 - Lower-Extremity Amputation among Patients with Diabetes (PQI #16)
- The numerator for this measure is based on hospital 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.

- 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_resources.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>
 - When using the AHRQ quality indicator software to generate measure results, MMPs should report the Observed Rate.

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. – **Retired**

MI5.3 Adherence to antipsychotic medications for individuals with schizophrenia. – **Retired**

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/nhqqualitymeasures.html>

- 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/nhqqualitymeasures.html>

- 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 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 who were continuously enrolled in the MMP during the reporting period, and 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.
- The quality withhold benchmark is 60% for DY 2, 70% for DY 3, 75% for DY 4, 80% for DY 5, 85% for DY 6, and 90% for DY 7 through DY 10. For more information, refer to the Quality Withhold Technical Notes (DY 2-10): Michigan-Specific Measures.
- C. Edits and Validation Checks – validation checks that should be performed by each MMP prior to data submission.
- 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.
- 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.
 - $\text{Percentage} = (C / B) * 100$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Definitions

- 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.
- 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.

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 two months [60 days] is not considered continuously enrolled).

Data Element A Exclusions

- Exclude members who use hospice services or elect to use a hospice benefit at any time during the reporting period from the eligible population, regardless of when the services began. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record, claims/encounter data (Hospice Encounter value set; Hospice Intervention value set), or supplemental data.
- Exclude members who die any time during the reporting period. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record, claims/encounter data, or supplemental data.

Data Element B

- MMPs may elect to use medical record review or supplemental documentation to identify the numerator (i.e., hybrid sampling). For further instructions on hybrid sampling, please see pages MI-9 to MI-10 of this document.
- If an MMP does not elect to sample, data element B should be equal to data element A.

Data Element C

Administrative Specifications

- If the MMP elects to only use administrative data to identify members with a medication review completed, either of the following meets criteria:
 - Both of the following during the same visit during the reporting period where the provider type is a prescribing practitioner or clinical pharmacist:
 - At least one medication review (Medication Review value set).
 - The presence of a medication list in the medical record (Medication List value set).
 - Transitional care management services (Transitional Care Management Services value set) during the reporting period.
- Exclude services provided in an acute inpatient setting (Acute Inpatient value set; Acute Inpatient POS value set).

Hybrid Specifications

- 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.
- 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.
- Do not include medication lists or medication reviews performed in an acute inpatient setting.
- A medication review performed without the member present meets criteria.
- 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.

General Guidance

- This measure is reported starting with the MMP's second year of operation (i.e., Calendar Year 2). All MMPs that have operated for at least two years must report the measure.

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 (ED) 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 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.

- MMPs should validate that the sum of data elements B, C, D, E, F, G, H, I, and J is equal to data element A.

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.
 - $\text{Percentage} = (B / A) * 100$
- Emergent/primary care treatable ED visits during the reporting period.
 - $\text{Percentage} = (C / A) * 100$
- Emergent preventable/avoidable ED visits during the reporting period.
 - $\text{Percentage} = (D / A) * 100$
- Emergent not preventable/avoidable ED visits during the reporting period.
 - $\text{Percentage} = (E / A) * 100$
- ED visits with an injury principal diagnosis during the reporting period.
 - $\text{Percentage} = (F / A) * 100$
- ED visits with a mental health principal diagnosis during the reporting period.
 - $\text{Percentage} = (G / A) * 100$
- ED visits with an alcohol-related principal diagnosis during the reporting period.
 - $\text{Percentage} = (H / A) * 100$
- ED visits with a drug-related health principal diagnosis during the reporting period.
 - $\text{Percentage} = (I / A) * 100$
- ED visits that were unclassified during the reporting period.
 - $\text{Percentage} = (J / A) * 100$

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

Definitions

- 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.).

- Unclassified: ED visits for which the NYU algorithm (see General Guidance) categorized the primary diagnosis as “unclassified” and ED visits for which the primary diagnosis is not accounted for in the NYU algorithm.

Data Element A

- MMPs should include all ED visits for 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 ED visits for members regardless of whether 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. Codes to identify ED visits are provided in the ED value set.
- 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.

Data Element I Exclusion

- For reporting data element I, alcohol principal diagnoses should be excluded.

Data Element J

- All ED visits that are not included in data elements B, C, D, E, F, G, H, and I should be reported in data element J. This includes all ED visits categorized by the NYU algorithm as “unclassified” and all ED visits not accounted for by the NYU algorithm.

General Guidance

- The NYU algorithm Excel files for this measure can be downloaded at the following website: <http://wagner.nyu.edu/faculty/billings/nyued-background>
- A principal diagnosis code for an ED visit may not be classified distinctly into one category. The diagnosis code is assigned a probability which is captured in data elements B through J. Therefore, the sum of data elements B through J should equal “1” for each ED visit. Once the results for all ED visits have been aggregated, the total value of data elements B through J should sum to equal the total value of data element A.
- MMPs should be consistent in using the same claim type (i.e., ED facility claim or ED professional claim) for both the ED service and ED discharge diagnosis.

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, with no gaps in enrollment.	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.
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.
- MMPs should validate that data elements B, C, and D are less than or equal to data element A.
- 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 receiving:
- HCBS during the reporting period who did not receive nursing facility services during the reporting period.
 - $\text{Percentage} = (B / A) * 100$
 - Nursing facility services during the reporting period who did not receive HCBS during the reporting period.
 - $\text{Percentage} = (C / A) * 100$
 - Both HCBS and nursing facility services during the reporting period.
 - $\text{Percentage} = (D / A) * 100$
- E. Notes – additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

Definitions

- HCBS refers to Home and Community Based Services.
- Nursing facility services include any type of nursing facility care, including skilled and custodial services.
- 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).

Data Element A

- 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).

Data Element B

- Members receiving only HCBS should be counted for data element B (unduplicated).

Data Element C

- Members receiving only nursing facility services should be counted for data element C (unduplicated).

Data Element D

- Members receiving both HCBS and nursing facility services should be counted for data element D (unduplicated).

General Guidance

- 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.
- Include members who were receiving HCBS or nursing facility services for any length of time during the reporting period.
- Data elements B, C, and D are mutually exclusive.

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.ⁱⁱ

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 continuously enrolled who were currently enrolled on December 31 of the reporting period.	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

Element Letter	Element Name	Definition	Allowable Values
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.
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

Element Letter	Element Name	Definition	Allowable Values
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.

- The quality withhold benchmark is 55% for DY 4, 60% for DY 5 through DY 7, and 65% for DY 8 through DY 10. For more information, refer to the Quality Withhold Technical Notes (DY 2-10): Michigan-Specific Measures.

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

- 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.

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.
 - $\text{Percentage} = (B / A) * 100$
- Age 21-64 who had one or more dental visits with a dental practitioner during the reporting period.
 - $\text{Percentage} = (D / C) * 100$
- Age 65-79 who had one or more dental visits with a dental practitioner during the reporting period.
 - $\text{Percentage} = (F / E) * 100$

- Age 80 or older who had one or more dental visits with a dental practitioner during the reporting period.
 - $\text{Percentage} = (H / G) * 100$

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

Definition

- A dental practitioner is 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.

Data Elements A, C, E, and G

- 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 two 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.

Data Elements A, C, E, and G Exclusion

- Exclude members who use hospice services or elect to use a hospice benefit at any time during the reporting period from the eligible population, regardless of when the services began. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record, claims/encounter data (Hospice Encounter value set; Hospice Intervention value set), or supplemental data.

Data Elements B, D, F, and H

- Members must have one or more dental visits with a dental practitioner during the reporting period to be included in data elements B, D, F, or H. Any visit with a dental practitioner during the reporting period meets 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>