STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

March 31, 2022

Keri Toback
Division of Program Operations – East Branch
Medicaid & CHIP Operations Group
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

Dear Ms. Toback,

Re: Project Number 11-W-00245/5 – Healthy Michigan Plan

Enclosed is the calendar year 2021 annual report for the Healthy Michigan Plan. The report provides operational information, program enrollment, and policy changes related to the waiver as specified in the Special Terms and Conditions.

Should you have any questions related to the information contained in this report, please contact Jacqueline Coleman by e-mail at colemanj@michigan.gov.

Sincerely,

[redacted]

Keith White, Director
Actuarial Division

cc: Angela Garner
Nicole McKnight

Enclosure (7)

Medicaid Section 1115 Eligibility and Coverage Demonstration Report - Metrics reporting (AD)

State	Michigan
Demonstration Name	Healthy Michigan Plan
Demonstration Year (DY)	DY 12
Calendar Dates for DY	01/01/2021 - 12/31/2021
Reporting Period	Q4
Calendar Dates for Reporting Period	10/01/2021 - 12/31/2021
Submitted on	3/31/2022

Eligibility and Coverage Demonstration Metrics (AD)[a]

						Demonstration			< 50% FPL[f]			50-100% FPL[f]			>100% FPL[f]	
Reporting topic[b]	#	Metric name	Metric description	Data source	Calculation lag	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]
1.1.1 Enrollment	AD_1	Total enrollment in the demonstration	The unduplicated number of beneficiaries enrolled in the demonstration at any time during the measurement period. This indicator is a count of total program enrollment. It includes those newly enrolled during the measurement period and those whose enrollment continues from a prior period. This indicator is not a point-in-time count. It captures beneficiaries who were enrolled for at least one day during the measurement period.	Administrative records	30 days		961,291			512,956			237,568			210,767
							969,714			516,061			240,300			213,353
							978,069			519,382			242,871			215,816
1.1.1 Enrollment	AD_2	Beneficiaries in suspension status for noncompliance	The number of demonstration beneficiaries in suspension status for noncompliance with demonstration policies as of the last day of the measurement period	Administrative records	30 days		N/A			N/A			N/A			N/A	
							N/A			N/A			N/A			N/A	
							N/A			N/A			N/A			N/A	
1.1.1 Enrollment	AD_3	Beneficiaries in a non-eligibility period who are prevented from re-enrolling for a defined period of time	The number of prior demonstration beneficiaries who are in a non-eligibility period, meaning they are prevented from re-enrolling for some defined period of time, because they were disenrolled for noncompliance with demonstration policies. The count should include those prevented from re-enrolling until their redetermination date.	Administrative records	30 days		0			0			0			0
							0			0			0			0
							0			0			0			0
1.1.1 Enrollment	AD_4	New enrollees	Number of beneficiaries in the demonstration who began a new enrollment spell during the measurement period, have not had Medicaid coverage within the prior 3 months and are not using a state-specific pathway for re-enrollment after being disenrolled for noncompliance	Administrative records	30 days		15,641			9,254			3,646			2,741
							17,838			10,604			3,948			3,286
							17,648			10,636			3,705			3,307
1.1.1 Enrollment	AD_5	Re-enrollments or re-instatements using defined pathways after disenrollment or suspension of benefits for noncompliance with demonstration policies	Number of beneficiaries in the demonstration who began a new enrollment spell (or had benefits re-instated) in the current measurement period by using a state-defined pathway for re-enrollment (or re-instatement of benefits), i.e., meeting certain requirements, after being disenrolled (or having benefits suspended) for noncompliance with premium requirements, community engagement requirements, or other demonstration-specific requirements.	Administrative records	30 days		0			0			0			0
							0			0			0			0
							0			0			0			0
1.1.1 Enrollment	AD_6	Re-enrollments or re-instatements for beneficiaries not using defined pathways after disenrollment or suspension of benefits for noncompliance	Number of beneficiaries in the demonstration who began a new enrollment spell (or had benefits re-instated) in the current measurement period who have had Medicaid coverage within the prior 3 months and are not using a state-specific pathway for re-enrollment after being disenrolled for noncompliance (or re-instatement of benefits after being suspended for noncompliance).	Administrative records	30 days		0			0			0			0
							0			0			0			0
							0			0			0			0
1.1.2 Mid-year loss of demonstration eligibility	AD_7	Monthly count of beneficiaries determined ineligible for Medicaid, any reason, other than at renewal	Beneficiaries determined ineligible for Medicaid, any reason, other than at renewal	Administrative records	30 days		TBD			TBD			TBD			TBD
							TBD			TBD			TBD			TBD
							TBD			TBD			TBD			TBD
1.1.2 Mid-year loss of demonstration eligibility	AD_8	Monthly count of beneficiaries determined ineligible for Medicaid after state processes a change in circumstance reported by a beneficiary	Beneficiaries no longer eligible for Medicaid, failure to provide timely change in circumstance information	Administrative records	30 days		TBD			TBD			TBD			TBD
							TBD			TBD			TBD			TBD
							TBD			TBD			TBD			TBD
1.1.2 Mid-year loss of demonstration eligibility	AD_9	Monthly count of beneficiaries determined ineligible for Medicaid after state processes a change in circumstance reported by a beneficiary	Beneficiaries determined ineligible for Medicaid after state processes a change in circumstance reported by a beneficiary	Administrative records	30 days		TBD			TBD			TBD			TBD
							TBD			TBD			TBD			TBD
							TBD			TBD			TBD			TBD
1.1.2 Mid-year loss of demonstration eligibility	AD_10	Monthly count of beneficiaries no longer eligible for the demonstration due to transfer to another Medicaid eligibility group	Beneficiaries no longer eligible for the demonstration due to transfer to another Medicaid eligibility group	Administrative records	30 days		TBD			TBD			TBD			TBD
							TBD			TBD			TBD			TBD
							TBD			TBD			TBD			TBD
1.1.2 Mid-year loss of demonstration eligibility	AD_11	Monthly count of beneficiaries no longer eligible for the demonstration due to transfer to CHIP	Beneficiaries no longer eligible for the demonstration due to transfer to CHIP	Administrative records	30 days		N/A			N/A			N/A			N/A
							N/A			N/A			N/A			N/A
							N/A			N/A			N/A			N/A
							N/A			N/A			N/A			N/A
			Number of demonstration beneficiaries who lost eligibility for Medicaid during the													

1.1.3 Enrollment duration at time of disenrollment	AD_12	Enrollment duration 0-3 months	Number of demonstration beneficiaries who lost eligibility for Medicaid during the measurement period and whose enrollment spell had lasted 3 or fewer months at the time of disenrollment	Administrative records	30 days	N/A	N/A	N/A	N/A
						N/A	N/A	N/A	N/A
						N/A	N/A	N/A	N/A
1.1.3 Enrollment duration at time of disenrollment	AD_13	Enrollment duration 4-6 months	Number of demonstration beneficiaries who lose eligibility for Medicaid during the measurement period whose enrollment spell had lasted between 4 and 6 months at the time of disenrollment	Administrative records	30 days	N/A	N/A	N/A	N/A
						N/A	N/A	N/A	N/A
						N/A	N/A	N/A	N/A
1.1.3 Enrollment duration at time of disenrollment	AD_14	Enrollment duration 6-12 months	Number of demonstration beneficiaries who lost eligibility for Medicaid during the measurement period whose enrollment spell had lasted 6 or more months (up to 12 months) at the time of disenrollment	Administrative records	30 days	N/A	N/A	N/A	N/A
						N/A	N/A	N/A	N/A
1.1.4 Renewal	AD_15	Beneficiaries due for renewal	Total number of beneficiaries enrolled in the demonstration who were due for renewal during the measurement period	Administrative records	30 days	29,747	16,145	7,284	6,318
						30,403	16,654	7,159	6,590
						25,356	14,567	5,900	4,889
1.1.4 Renewal	AD_16	Beneficiaries determined ineligible for the demonstration at renewal, disenrolled from Medicaid	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who complete the renewal process and are determined ineligible for Medicaid	Administrative records	30 days	TBD	TBD	TBD	TBD
						TBD	TBD	TBD	TBD
						TBD	TBD	TBD	TBD
1.1.4 Renewal	AD_17	Beneficiaries determined ineligible for the demonstration at renewal, transfer to another Medicaid eligibility category	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who complete the renewal process and move from the demonstration to a Medicaid eligibility group not included in the demonstration	Administrative records	30 days	TBD	TBD	TBD	TBD
						TBD	TBD	TBD	TBD
						TBD	TBD	TBD	TBD
1.1.4 Renewal	AD_18	Beneficiaries determined ineligible for the demonstration at renewal, transferred to CHIP	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who complete the renewal process but move from the demonstration to CHIP	Administrative records	30 days	TBD	TBD	TBD	TBD
						TBD	TBD	TBD	TBD
						TBD	TBD	TBD	TBD
1.1.4 Renewal	AD_19	Beneficiaries who did not complete renewal, disenrolled from Medicaid	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who are disenrolled from Medicaid for failure to complete the renewal process	Administrative records	30 days	TBD	TBD	TBD	TBD
						TBD	TBD	TBD	TBD
						TBD	TBD	TBD	TBD
1.1.4 Renewal	AD_20	Beneficiaries who had pending/uncompleted renewals and were still enrolled	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period for whom the state had not completed renewal determination by the end of the measurement period and were still enrolled	Administrative records	30 days	TBD	TBD	TBD	TBD
						TBD	TBD	TBD	TBD
						TBD	TBD	TBD	TBD
1.1.4 Renewal	AD_21	Beneficiaries who retained eligibility for the demonstration after completing renewal forms	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who remained enrolled in the demonstration after responding to renewal notices	Administrative records	30 days	TBD	TBD	TBD	TBD
						TBD	TBD	TBD	TBD
						TBD	TBD	TBD	TBD
1.1.4 Renewal	AD_22	Beneficiaries who renewed ex parte	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who remained enrolled as determined by third-party data sources or available information, rather than beneficiary response to renewal notices	Administrative records	30 days	N/A	N/A	N/A	N/A
						N/A	N/A	N/A	N/A
						N/A	N/A	N/A	N/A
1.1.5 Cost sharing limit	AD_23	Monthly count of beneficiaries who reached 5% limit	Beneficiaries who reached 5% limit	Administrative records	30 days	159,784	144,236	7,900	7,648
						65,952	59,630	3,319	3,003
						45,354	38,849	3,418	3,087
1.1.6 Appeals and grievances	AD_24	Appeals, eligibility	Number of appeals filed by beneficiaries enrolled in the demonstration during the measurement period regarding Medicaid eligibility	Administrative records	None	N/A			
1.1.6 Appeals and grievances	AD_25	Appeals, denial of benefits	Number of appeals filed by beneficiaries enrolled in the demonstration during the measurement period regarding denial of benefits	Administrative records	None	N/A			
1.1.6 Appeals and grievances	AD_26	Grievances, care quality	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding the quality of care or services provided	Administrative records	None	N/A			
1.1.6 Appeals and grievances	AD_27	Grievances, provider or managed care entities	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding a provider or managed care entity. Managed care entities include Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHP), and Prepaid Ambulatory Health Plans (PAHP).	Administrative records	None	N/A			
1.1.6 Appeals and grievances	AD_28	Grievances, other	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding other matters that are not subject to appeal	Administrative records	None	N/A			
1.1.7 Access to care	AD_29	Primary care provider availability	Number of primary care providers enrolled to deliver Medicaid services at the end of the measurement period	Provider enrollment databases	90 days	51,729			

1.1.7 Access to care	AD_30	Primary care provider active participation	Number of primary care providers enrolled to deliver Medicaid services with service claims for 3 or more demonstration beneficiaries during the measurement period	Provider enrollment databases and claims and encounters	90 days			16,858															
1.1.7 Access to care	AD_31	Specialist provider availability	Number of specialists enrolled to deliver Medicaid services at the end of the measurement period	Provider enrollment databases	90 days			82,076															
1.1.7 Access to care	AD_32	Specialist provider active participation	Number of specialists enrolled to deliver Medicaid services with service claims for 3 or more demonstration beneficiaries during the measurement period	Provider enrollment databases and claims and encounters	90 days			38,909															
1.1.7 Access to care	AD_33	Preventive care and office visit utilization	Total utilization of preventive care and office visits per 1,000 demonstration beneficiary months during the measurement period	Claims and encounters and other administrative records	90 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A							
1.1.7 Access to care	AD_34	Prescription drug use	Total utilization of 30-day prescription fills per 1,000 demonstration beneficiary months in the measurement period.	Claims and encounters; other administrative records	90 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A							
1.1.7 Access to care	AD_35	Emergency department utilization, total	Total number of emergency department (ED) visits per 1,000 demonstration beneficiary months during the measurement period	Claims and encounters; other administrative records	90 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A							
1.1.7 Access to care	AD_36	Emergency department utilization, non-emergency	Total number of ED visits for non-emergency conditions per 1,000 demonstration beneficiary months during the measurement period. If the state differentiates emergent/non-emergent visit copayments, then non-emergency visits should be identified for monitoring purposes using the same criteria used to assess the differential copayment. If the state does not differentiate emergent/non-emergent copayments, then non-emergency visits should be defined as all visits not categorized as emergent using the method below.	Claims and encounters; other administrative records	90 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A							
1.1.7 Access to care	AD_37	Inpatient admissions	Total number of inpatient admissions per 1,000 demonstration beneficiary months during the measurement period	Claims and encounters; other administrative records	90 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A							
1.1.8 Quality of care and health outcomes	AD_38A	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) [NCQA; NQF #0027; Medicaid Adult Core Set; Adjusted HEDIS measure][i]	This metric consists of the following components; each assesses different facets of providing medical assistance with smoking and tobacco use cessation: • Advising smokers and tobacco users to quit • Discussing cessation medications • Discussing cessation strategies	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan survey, Adult Version	90 days		106,694	49,371	46.27%	63,970	29,507	46.13%	23,552	11,047	46.90%	19,172	8,817						
1.1.8 Quality of care and health outcomes	AD_38B	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention [PCPI Foundation; NQF #0028]	This metric consists of the following components: 1. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months 2. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention 3. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user	--	--																	
			1. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months	Claims and encounters or registry data	90 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A						
			2. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention	Claims and encounters or registry data	90 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A						
			3. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user	Claims and encounters or registry data	90 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A						
1.1.8 Quality of care and health outcomes	AD_39-1	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD) [NCQA; NQF # 2605; Medicaid adult Core Set; Adjusted HEDIS measure][i]	Percentage of ED visits for beneficiaries age 18 and older who have a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, and who had a follow-up visit with a corresponding principal diagnosis for AOD. Two rates are reported:	--	--																	
			1. Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 30 days of the ED visit (31 total days)	Claims and encounters	90 days		12,489	2,783	22.28%	9,804	2,131	21.74%	1,457	350	24.02%	987	252						
			2. Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)	Claims and encounters	90 days		12,489	1,693	13.56%	9,804	1,305	13.31%	1,457	207	14.21%	987	150						
1.1.8 Quality of care and health outcomes	AD_39-2	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF # 2605; Medicaid adult Core Set; Adjusted HEDIS measure][i]	Percentage of ED visits for beneficiaries age 18 and older who have a principal diagnosis of mental illness or intentional self-harm, and who had a follow-up visit with a corresponding principal diagnosis for mental illness. Two rates are reported:	--	--																	
			1. Percentage of ED visits for mental illness or intentional self-harm for which the beneficiary received follow-up within 30 days of the ED visit (31 total days)	Claims and encounters	90 days		6,821	3,549	52.03%	5,107	2,567	50.26%	904	516	57.08%	701	421						
			2. Percentage of ED visits for mental illness or intentional self-harm for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)	Claims and encounters	90 days		6,821	2,611	38.28%	5,107	1,874	36.69%	904	387	42.81%	701	314						
1.1.8 Quality of care and health outcomes	AD_40	Initiation of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted	Percentage of beneficiaries age 18 and older with a new episode of AOD abuse or dependence who received the following: 1. Initiation of AOD Treatment. Percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication assisted treatment (MAT) within 14 days of the diagnosis 2. Engagement of AOD Treatment. Percentage of beneficiaries who initiate treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit The following diagnosis cohorts are reported for each rate: (1) Alcohol abuse or dependence, (2) Opioid abuse or dependence, (3) Other drug abuse or dependence, and (4) Total AOD abuse or dependence. A total of 8 separate rates are reported for this measure.	--	--																	
			1. Initiation of AOD Treatment - Alcohol abuse or dependence (rate 1, cohort 1)	Claims and encounters or EHR	90 days		36,441	14,288	39.21	26,016	10,391	39.94	5,834	2,174	37.26	4,025	1,460						

		HEDIS measure][i]	2. Initiation of AOD Treatment - Opioid abuse or dependence (rate 1, cohort 2)	Claims and encounters or EHR	90 days	19,338	7,336	37.94	13,454	5,133	38.15	3209	1177	36.68	2,314	850
			3. Initiation of AOD Treatment - Other drug abuse or dependence (rate 1, cohort 3)	Claims and encounters or EHR	90 days	6,477	3,480	53.73	4,869	2,641	54.24	912	487	53.40	598	301
			4. Initiation of AOD Treatment - Total AOD abuse or dependence (rate 1, cohort 4)	Claims and encounters or EHR	90 days	13,530	4,604	34.03	9,939	3,491	35.12	2,077	646	31.10	1,355	404
			5. Engagement of AOD Treatment - Alcohol drug abuse or dependence (rate 2 cohort 1)	Claims and encounters or EHR	90 days	36,440	4,529	12.43	26,016	3,257	12.52	5,834	749	12.84	4,025	457
			6. Engagement of AOD Treatment - Opioid drug abuse or dependence (rate 2, cohort 2)	Claims and encounters or EHR	90 days	19,338	1,762	9.11	13,454	1,175	8.73	318	3,209	9.91	2,314	233
			7. Engagement of AOD Treatment - Other AOD abuse or dependence (rate 2, cohort 3)	Claims and encounters or EHR	90 days	6,477	1,893	29.23	4,869	1,409	28.94	912	315	34.54	598	150
			8. Engagement of AOD Treatment - Total AOD abuse or dependence (rate 2, cohort 4)	Claims and encounters or EHR	90 days	13,530	992	7.33	9,939	769	7.74	2,077	127	6.11	1,355	82
1.1.8 Quality of care and health outcomes	AD_41	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD) [AHRQ; NQF #0272; Medicaid Adult Core Set]	Number of inpatient hospital admissions for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 beneficiary months for beneficiaries age 18 and older	Claims and encounters	90 days	7,989,688	1,879	23.52	4,459,345	1,396	31.31	1906711	282	14.79	1,623,555	201
1.1.8 Quality of care and health outcomes	AD_42	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD) [AHRQ; NQF #0275; Medicaid Adult Core Set]	Number of inpatient hospital admissions for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 beneficiary months for beneficiaries age 40 and older.	Claims and encounters	90 days	3,488,212	856	24.54	1,938,272	575	29.67	819,865	139	16.95	730,053	142
1.1.8 Quality of care and health outcomes	AD_43	PQI 08: Heart Failure Admission Rate (PQI08-AD) [AHRQ; NQF #0277; Medicaid Adult Core Set]	Number of inpatient hospital admissions for heart failure per 100,000 beneficiary months for beneficiaries age 18 and older	Claims and encounters	90 days	7,989,688	1,491	18.66	4,459,345	1,071	24.02	1,906,711	201	10.54	1,623,555	219
1.1.8 Quality of care and health outcomes	AD_44	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD) [AHRQ; NQF #0283; Medicaid Adult Core Set]	Number of inpatient hospital admissions for asthma per 100,000 beneficiary months for beneficiaries aged 18 to 39.	Claims and encounters	90 days	4,501,476	214	4.75	2,521,073	137	5.43	1,086,846	46	4.23	2,521,073	31
1.1.9 Administrative cost	AD_45	Administrative cost of demonstration operation	Cost of contracts or contract amendments and staff time equivalents required to administer demonstration policies, including premium collection, health behavior incentives, premium assistance, community engagement requirements and/or retroactive eligibility waivers	Administrative records	None		$ 674,299.00									
Add rows for any additional state-identified metrics																

Note: States must prominently display the following notice on any display of Measure rates:

The MSC-AD, FUA-AD, FUM-AD, and IET_AD measures (metrics AD_38A, AD_39, and AD_40) are Healthcare Effectiveness Data and Information Set ("HEDIS®") measures that are owned and copyrighted by the National Committee for Quality Assurance ("NCQA"). NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures or specifications.

The measure specification methodology used by CMS is different from NCQA's methodology. NCQA has not validated the adjusted measure specifications but has granted CMS permission to adjust. Calculated measure results, based on the adjusted HEDIS specifications, may be called only "Uncertified, Unaudited HEDIS rates."

Certain non-NCQA measures in the CMS 1115 eligibility and coverage demonstration contain HEDIS Value Sets (VS) developed by and included with the permission of the NCQA. Proprietary coding is contained in the VS. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. NCQA disclaims all liability for use or accuracy of the VS with the non-NCQA measures and any coding contained in the VS.

[a] States should create a new metrics report for each reporting quarter.
[b] The reporting topics correspond to the prompts for reporting topic AD.Mod_1 in the monitoring report template.
[c] Report metrics that are one annual value for a demonstration year only in the report specified in the reporting schedule.
[d] Report count metrics in the numerator column. Administrative costs (AD_45) should also be reported in the numerator column.
[e] If applicable. See CMS-provided technical specifications.
[f] Add columns as necessary to report additional income groups.
[g] Add columns as necessary to report exempt groups.
[h] Add columns as necessary to report specific edibility groups.
[i] Add columns as necessary to report phase-in cohorts, if applicable.
[j] Rates for these metrics reflect Uncertified, Unaudited HEDIS rates.

Checks:
AD_8, AD_9, AD_11, AD_12, AD_13, AD_14 should each be less than or equal to AD_7

	Age 19-26			Age 27-35			Age 36-45			Age 46-55			Age 56-64			Male			Female			
Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator
		223,391			243,269			189,116			166,397			139,118			496,216			465,075		
		224,488			245,055			190,498			167,875			141,798			501,435			468,279		
		225,630			247,101			191,933			169,189			144,216			506,485			471,584		
		N/A			N/A			N/A			N/A			N/A			N/A			N/A		
		N/A			N/A			N/A			N/A			N/A			N/A			N/A		
		N/A			N/A			N/A			N/A			N/A			N/A			N/A		
		-			-			-			-			-			0			0		
		-			-			-			-			-			0			0		
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		4,669			3,960			2,990			2,327			1,695			7,325			8,316		
		5,157			4,304			3,191			2,565			2,621			8,405			9,433		
		5,311			4,387			2,976			2,481			2,493			8,689			8,959		
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N/A	N/A	N/A	N/A	N/A	N/A	N/A
6,711	7,914	5,492	5,053	4,577	15,011	14,736
6,651	8,541	5,446	5,122	4,643	15,867	14,536
6,092	6,765	4,793	4,358	3,348	13,360	11,996
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N/A	N/A	N/A	N/A	N/A	N/A	N/A
35,225	35,571	27,815	33,990	27,183	85,875	73,909
15,312	17,907	12,536	11,787	8,410	39,372	26,580
12,707	11,272	7,638	7,419	6,318	25,841	19,513

N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
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45.99%	12,153	3,769	31.01%	21,969	8,686	39.54%	24,582	11,565	47.05%	27,690	14,609	52.76%	20,235	10,714	52.95%	54,245	23,832	43.93%	52,449	25,539	48.69%	74,061
N/A																						
N/A																						
N/A																						
25.53%	1,651	268	16.23%	3,728	919	24.65%	3,173	742	23.38%	2,622	594	22.65%	1,314	261	19.86%	9,121	1,994	21.86%	3,368	789	23.43%	8,429
15.20%	1,651	165	9.99%	3,728	565	15.16%	3,173	450	14.18%	2,622	350	13.35%	1,314	164	12.48%	9,121	1,227	13.45%	3,368	466	13.84%	8,429
60.06%	2,035	1,128	55.43%	2,113	1,050	49.69%	1,398	699	50.00%	924	493	53.35%	351	179	51.00%	4,198	2,058	49.02%	2,623	1,491	56.84%	4,408
44.79%	2,035	839	41.23%	2,113	771	36.49%	1,398	512	36.62%	924	360	38.96%	351	129	36.75%	4,198	1,490	35.49%	2,623	1,121	42.74%	4,408
36.27	5,445	1,738	31.92	10,056	3,961	3,961	8,720	3,613	41.43	7,821	3,188	40.76	4,398	1,788	53.65	24,044	9,778	40.67	12,397	4,510	36.38	23,325

36.73	1,989	552	27.75	4,486	1,551	34.57	4,602	1,844	40.07	5,075	2,057	40.53	3,186	1,332	41.79	13,475	5,256	39.01	5,863	2,080	35.48	11,565
50.33	712	345	48.46	2,384	1,371	57.51	1,763	986	55.93	1,083	548	50.60	535	230	42.99	4,013	2,230	55.57	2,464	1,250	50.73	5,155
29.82	3,133	959	30.61	4,213	1,406	33.37	3,099	1,084	34.98	2,183	829	37.98	902	326	36.11	8,582	3,122	36.38	4,948	1,482	29.95	8,464
11.35	5,444	539	9.90	10,056	1,530	15.21	8,720	1,246	14.29	7,821	848	10.84	4,399	366	8.33	24,043	3,051	12.69	12,397	1,478	11.92	23,324
10.07	1,989	156	7.84	4,486	440	9.81	4,602	485	10.54	5,075	455	8.97	3,185	226	7.10	13,475	1,223	9.08	5,863	539	9.19	11,565
25.08	712	185	25.98	2,384	801	33.60	1,763	556	31.54	1,083	257	23.73	535	94	17.57	4,013	1,215	30.28	2,464	678	27.52	5,155
6.05	3,133	212	6.77	4,213	335	7.95	3,099	240	7.74	2,183	155	7.10	902	50	5.56	8,582	703	8.19	4,948	289	5.84	8,464
12.38	1,880,268	494	26.27	1,956,388	476	24.33	1,549,251	428	27.63	1,476,862	330	22.34	1,126,919	151	13.43	4,022,327	1,146	28.49	3,967,361	733	18.48	4,992,148
19.45	-	-	-	-	-		884,431	94	10.63	1,476,862	385	26.07	1,126,919	377	33.83	1,725,878	391	22.66	1,762,334	465	26.39	2,251,815
13.49	1,880,268	21	1.12	1,956,388	124	6.34	1,549,251	263	16.98	1,476,862	570	38.6	1,126,919	513	56.94	4,022,327	1,057	26.28	3,967,361	434	10.94	4,992,148
3.47	1,880,268	65	3.46	1,956,388	109	5.57	664,820	40	6.02	-	-	-	-	-	-	2,296,449	107	4.66	2,205,027	107	4.85	2,740,333

White		Black or African American			Asian			American Indian or Alaskan Native			Other race			Unknown race			Hispanic ethnicity			Non-Hispanic ethnicity		
Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]
593,981			246,992			6,679			14,518			2,271			96,850			56,830			904,256	
599,509			248,214			6,795			14,622			2,284			98,290			57,413			912,089	
604,932			249,392			6,939			14,730			2,300			99,776			57,426			920,429	
N/A			N/A			N/A			N/A			N/A			N/A			N/A			N/A	
N/A			N/A			N/A			N/A			N/A			N/A			N/A			N/A	
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0			0			0			0			0			0			0			0	
9,390			4,124			81			228			18			1,800			1,147			14,490	
11,104			4,165			177			260			23			2,109			1,170			16,659	
11,236			3,688			188			250			26			2,260			1,013			16,630	
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N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
18,116	8,090	308	452	38	2,743	1,568	28,176
18,606	7,812	342	482	38	3,123	1,611	28,787
15,006	7,644	111	410	42	2,143	1,544	23,808
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N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
94,271	46,375	899	1,881	248	16,110	8,039	151,711
37,248	21,788	304	1,125	78	5,409	3,237	62,699
25,993	13,374	325	596	54	5,012	2,534	42,810

N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
35,275	47.63%	23,726	10,110	42.61%	715	354	49.51%	1,900	773	40.68%	102	38	37.25%	6,110	2,774	45.40%						
2,214	26.27%	2,716	325	11.97%	33	4	12.12%	355	82	23.10%	23	3	13.04%	933	155	16.61%						
1,331	15.79%	2,716	218	8.03%	33	2	6.06%	355	49	13.80%	23	1	4.35%	933	92	9.86%						
2,455	55.69%	1,769	790	44.66%	27	11	40.74%	159	94	59.12%	18	13	72.22%	440	186	42.27%						
1,816	41.20%	1,769	578	32.67%	27	7	25.93%	159	66	41.51%	18	9	50.00%	440	135	30.68%						
9,536	40.88	9,788	3,444	35.19	114	46	40.35	814	297	36.49	65	24	37.90	2,335	941	40.30						

4,627	40.01	5,794	1,955	33.74	68	24	35.29	466	161	34.55	38	14	42.09	1,407	555	39.45
2,845	55.19	834	382	45.80	13	9	69.23	143	73	51.05	9	6	62.50	323	165	51.08
2,773	32.76	3,938	1,435	36.44	40	16	40.00	290	82	28.28	21	6	29.09	777	292	37.58
3,416	14.65	9,788	745	7.61	114	15	13.16	814	113	13.88	65	8	13.74	2,335	232	9.94
1,234	10.67	5,794	352	6.08	68	9	13.24	466	48	10.30	38	5	17.34	1,407	114	8.10
1,611	31.25	834	152	18.23	13	4	30.77	143	48	33.57	9	3	27.89	323	75	23.22
664	7.84	3,938	257	6.53	40	2	5.00	290	21	7.24	21	-	-	777	48	6.18
980	19.63	2,029,360	706	34.79	141,164	1	0.71	122,427	23	18.79	19,208	10	53.36	685,381	159	23.2
534	23.71	808,149	233	28.83	66,921	3	4.48	47,373	15	31.66	7,801	-	-	306,153	71	23.19
643	12.88	2,029,360	686	33.8	141,164	3	2.13	122,427	12	9.8	19,208	5	25.26	685,381	142	20.72
82	2.99	1,221,211	116	9.50	74,243	-	-	75,054	1	1.33	11,407	-	-	379,228	15	3.96

Unknown ethnicity			Exempt groups[g]			Specific eligibility groups[h] New Adult Group		
Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]
	205			N/A			901,860	
	212			N/A			910,451	
	214			N/A			918,930	
	N/A			N/A			N/A	
	N/A			N/A			N/A	
	N/A			N/A			N/A	
	0			0			0	
	0			0			0	
	0			0			0	
	4			N/A			14,015	
	9			N/A			16,262	
	5			N/A			16,130	
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	N/A			N/A		N/A	
	N/A			N/A		N/A	
		3		N/A			27,999
		5		N/A			28,826
		4		N/A			23,751
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	N/A			N/A		N/A	
	N/A			N/A		N/A	
	N/A			N/A		N/A	
		34		N/A			146,128
		16		N/A			59,830
		10		N/A			40,530

N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
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N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
			N/A	N/A	N/A	N/A	N/A	N/A
						N/A	N/A	N/A
						N/A	N/A	N/A
						N/A	N/A	N/A
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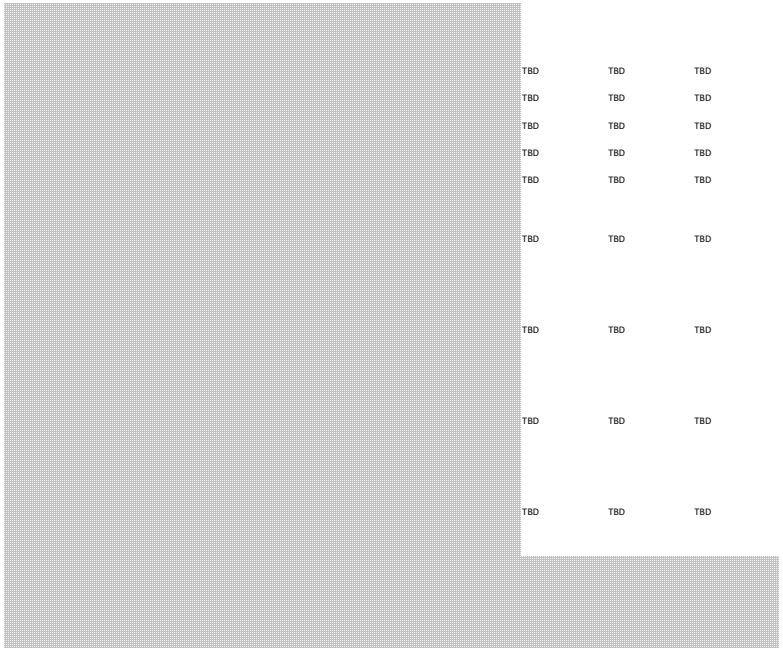
						N/A	N/A	N/A
						N/A	N/A	N/A
						N/A	N/A	N/A



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Medicaid Section 1115 Eligibility and Coverage Demonstration Monitoring Protocol - Planned metrics (AD)
State Michigan
Demonstration Name Healthy Michigan Plan Section 1115 Demonstration
Submitted on 3/31/2022

Standard information on CMS-provided metrics									
State will report (Y/N)	Reporting topic[a]	Reporting priority	#	Metric name	Metric description	Data source	Calculation lag	Measurement period	Reporting frequency
Y	1.1.1 Enrollment	Required	AD_1	Total enrollment in the demonstration	The unduplicated number of beneficiaries enrolled in the demonstration at any time during the measurement period. This indicator is a count of total program enrollment. It includes those newly enrolled during the measurement period and those whose enrollment continues from a prior period. This indicator is not a point-in-time count. It captures beneficiaries who were enrolled for at least one day during the measurement period.	Administrative records	30 days	Month	Quarterly
Y	1.1.1 Enrollment	Required	AD_2	Beneficiaries in suspension status for noncompliance	The number of demonstration beneficiaries in suspension status for noncompliance with demonstration policies as of the last day of the measurement period	Administrative records	30 days	Month	Quarterly
Y	1.1.1 Enrollment	Required	AD_3	Beneficiaries in a non-eligibility period who are prevented from re-enrolling for a defined period of time	The number of prior demonstration beneficiaries who are in a non-eligibility period, meaning they are prevented from re-enrolling for some defined period of time, because they were disenrolled for noncompliance with demonstration policies. The count should include those prevented from re-enrolling until their redetermination date.	Administrative records	30 days	Month	Quarterly
Y	1.1.1 Enrollment	Required	AD_4	New enrollees	Number of beneficiaries in the demonstration who began a new enrollment spell during the measurement period, have not had Medicaid coverage within the prior 3 months and are not using a state-specific pathway for re-enrollment after being disenrolled for noncompliance	Administrative records	30 days	Month	Quarterly
Y	1.1.1 Enrollment	Required for states with a defined re-enrollment or re-instatement pathway	AD_5	Re-enrollments or re-instatements using defined pathways after disenrollment or suspension of benefits for noncompliance with demonstration policies	Number of beneficiaries in the demonstration who began a new enrollment spell (or had benefits re-instated) in the current measurement period by using a state-defined pathway for re-enrollment (or re-instatement of benefits), i.e., meeting certain requirements, after being disenrolled (or having benefits suspended) for noncompliance with premium requirements, community engagement requirements, or other demonstration-specific requirements.	Administrative records	30 days	Month	Quarterly
Y	1.1.1 Enrollment	Required	AD_6	Re-enrollments or re-instatements for beneficiaries not using defined pathways after disenrollment or suspension of benefits for noncompliance	Number of beneficiaries in the demonstration who began a new enrollment spell (or had benefits re-instated) in the current measurement period, have had Medicaid coverage within the prior 3 months and are not using a state-specific pathway for re-enrollment after being disenrolled for noncompliance (or re-instatement of benefits after being suspended for noncompliance)	Administrative records	30 days	Month	Quarterly
Y	1.1.2 Mid-year loss of demonstration eligibility	Required	AD_7	Beneficiaries determined ineligible for Medicaid, any reason, other than at renewal	Total number of beneficiaries in the demonstration determined ineligible for Medicaid and disenrolled during the measurement period (separate reasons reported in other indicators), other than at renewal	Administrative records	30 days	Month	Quarterly
Y	1.1.2 Mid-year loss of demonstration eligibility	Required	AD_8	Beneficiaries no longer eligible for Medicaid, failure to provide timely change in circumstance information	Number of beneficiaries enrolled in the demonstration and who lost eligibility for Medicaid during the measurement period due to failure to provide timely change in circumstance information	Administrative records	30 days	Month	Quarterly
Y	1.1.2 Mid-year loss of demonstration eligibility	Required	AD_9	Beneficiaries determined ineligible for Medicaid after state processes a change in circumstance reported by a beneficiary	Number of beneficiaries who were enrolled in the demonstration and lost eligibility for Medicaid during the measurement period because they are determined ineligible after the state processes a change in circumstance	Administrative records	30 days	Month	Quarterly
Y	1.1.2 Mid-year loss of demonstration eligibility	Required	AD_10	Beneficiaries no longer eligible for the demonstration due to transfer to another Medicaid eligibility group	Number of beneficiaries who were enrolled in the demonstration and transferred from the demonstration to a Medicaid eligibility group not included in the demonstration during the measurement period	Administrative records	30 days	Month	Quarterly
N	1.1.2 Mid-year loss of demonstration eligibility	Recommended	AD_11	Beneficiaries no longer eligible for the demonstration due to transfer to CHIP	Number of beneficiaries who were enrolled in the demonstration and transferred from the demonstration to CHIP during the measurement period	Administrative records	30 days	Month	Quarterly
N	1.1.3 Enrollment duration at time of disenrollment	Recommended	AD_12	Enrollment duration, 0-3 months	Number of demonstration beneficiaries who lost eligibility for Medicaid during the measurement period and whose enrollment spell had lasted 3 or fewer months at the time of disenrollment	Administrative records	30 days	Month	Quarterly
N	1.1.3 Enrollment duration at time of disenrollment	Recommended	AD_13	Enrollment duration, 4-6 months	Number of demonstration beneficiaries who lose eligibility for Medicaid during the measurement period whose enrollment spell had lasted between 4 and 6 months at the time of disenrollment	Administrative records	30 days	Month	Quarterly
N	1.1.3 Enrollment duration at time of disenrollment	Recommended	AD_14	Enrollment duration 6-12 months	Number of demonstration beneficiaries who lost eligibility for Medicaid during the measurement period whose enrollment spell had lasted 6 or more months (up to 12 months) at the time of disenrollment	Administrative records	30 days	Month	Quarterly
Y	1.1.4 Renewal	Required	AD_15	Beneficiaries due for renewal	Total number of beneficiaries enrolled in the demonstration who were due for renewal during the measurement period	Administrative records	30 days	Month	Quarterly

Y	1.1.4 Renewal	Required	AD_16	Beneficiaries determined ineligible for the demonstration at renewal, disenrolled from Medicaid	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who complete the renewal process and are determined ineligible for Medicaid	Administrative records	30 days	Month	Quarterly
Y	1.1.4 Renewal	Required	AD_17	Beneficiaries determined ineligible for the demonstration at renewal, transfer to another Medicaid eligibility category	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who complete the renewal process and move from the demonstration to a Medicaid eligibility group not included in the demonstration	Administrative records	30 days	Month	Quarterly
Y	1.1.4 Renewal	Required	AD_18	Beneficiaries determined ineligible for the demonstration at renewal, transferred to CHIP	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who complete the renewal process, but move from the demonstration to CHIP	Administrative records	30 days	Month	Quarterly
Y	1.1.4 Renewal	Required	AD_19	Beneficiaries who did not complete renewal, disenrolled from Medicaid	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who are disenrolled from Medicaid for failure to complete the renewal process	Administrative records	30 days	Month	Quarterly
Y	1.1.4 Renewal	Required	AD_20	Beneficiaries who had pending/uncompleted renewals and were still enrolled	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period for whom the state had not completed renewal determination by the end of the measurement period and were still enrolled	Administrative records	30 days	Month	Quarterly
Y	1.1.4 Renewal	Required	AD_21	Beneficiaries who retained eligibility for the demonstration after completing renewal forms	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who remained enrolled in the demonstration after responding to renewal notices	Administrative records	30 days	Month	Quarterly
N	1.1.4 Renewal	Recommended	AD_22	Beneficiaries who renewed ex parte	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who remained enrolled as determined by third-party data sources or available information, rather than beneficiary response to renewal notices	Administrative records	30 days	Month	Quarterly
Y	1.1.5 Cost sharing limit	Required	AD_23	Beneficiaries who reached 5% limit	Number of beneficiaries enrolled in the demonstration who reached the 5% of income limit on cost sharing and premiums during the month	Administrative records	30 days	Month	Quarterly
N	1.1.6 Appeals and grievances	Recommended	AD_24	Appeals, eligibility	Number of appeals filed by beneficiaries enrolled in the demonstration during the measurement period regarding Medicaid eligibility	Administrative records	None	Quarter	Quarterly
N	1.1.6 Appeals and grievances	Recommended	AD_25	Appeals, denial of benefits	Number of appeals filed by beneficiaries enrolled in the demonstration during the measurement period regarding denial of benefits	Administrative records	None	Quarter	Quarterly
N	1.1.6 Appeals and grievances	Recommended	AD_26	Grievances, care quality	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding the quality of care or services provided	Administrative records	None	Quarter	Quarterly
N	1.1.6 Appeals and grievances	Recommended	AD_27	Grievances, provider or managed care entities	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding a provider or managed care entity. Managed care entities include Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHP), and Prepaid Ambulatory Health Plans (PAHP).	Administrative records	None	Quarter	Quarterly
N	1.1.6 Appeals and grievances	Recommended	AD_28	Grievances, other	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding other matters that are not subject to appeal	Administrative records	None	Quarter	Quarterly
Y	1.1.7 Access to care	Required	AD_29	Primary care provider availability	Number of primary care providers enrolled to deliver Medicaid services at the end of the measurement period	Provider enrollment databases	90 days	Quarter	Quarterly
Y	1.1.7 Access to care	Required	AD_30	Primary care provider active participation	Number of primary care providers enrolled to deliver Medicaid services with service claims for 3 or more demonstration beneficiaries during the measurement period	Provider enrollment databases and claims and encounters	90 days	Quarter	Quarterly
Y	1.1.7 Access to care	Required	AD_31	Specialist provider availability	Number of specialists enrolled to deliver Medicaid services at the end of the measurement period	Provider enrollment databases	90 days	Quarter	Quarterly
Y	1.1.7 Access to care	Required	AD_32	Specialist provider active participation	Number of specialists enrolled to deliver Medicaid services with service claims for 3 or more demonstration beneficiaries during the measurement period	Provider enrollment databases and claims and encounters	90 days	Quarter	Quarterly
N	1.1.7 Access to care	Recommended	AD_33	Preventive care and office visit utilization	Total utilization of preventive care and office visits per 1,000 demonstration beneficiary months during the measurement period	Claims and encounters and other administrative records	90 days	Quarter	Quarterly
N	1.1.7 Access to care	Recommended	AD_34	Prescription drug use	Total utilization of 30-day prescription fills per 1,000 demonstration beneficiary months in the measurement period	Claims and encounters; other administrative records	90 days	Quarter	Quarterly
N	1.1.7 Access to care	Recommended	AD_35	Emergency department utilization, total	Total number of emergency department (ED) visits per 1,000 demonstration beneficiary months during the measurement period	Claims and encounters; other administrative records	90 days	Quarter	Quarterly

	1.1.7 Access to care	Recommended. Required for states with copayments for non-emergency use.	AD_36	Emergency department utilization, non-emergency	Total number of ED visits for non-emergency conditions per 1,000 demonstration beneficiary months during the measurement period. If the state differentiates emergent/non-emergent visit copayments, then non-emergency visits should be identified for monitoring purposes using the same criteria used to assess the differential copayment. If the state does not differentiate emergent/non-emergent copayments, then non-emergency visits should be defined as all visits not categorized as emergent using the method below.	Claims and encounters; other administrative records	90 days	Quarter	Quarterly	Y
	1.1.7 Access to care	Recommended	AD_37	Inpatient admissions	Total number of inpatient admissions per 1,000 demonstration beneficiary months during the measurement period	Claims and encounters; other administrative records	90 days	Quarter	Quarterly	N
	1.1.8 Quality of care and health outcomes	Required (AD_38A or AD_38B-1 - 3. States do not have to report both.)	AD_38A	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) [NCQA; NQF #0027; Medicaid Adult Core Set; Adjusted HEDIS measure]	This metric consists of the following components; each assesses different facets of providing medical assistance with smoking and tobacco use cessation: • Advising smokers and tobacco users to quit • Discussing cessation medications • Discussing cessation strategies	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan survey, Adult Version	90 days	Calendar year	Annually	
	1.1.8 Quality of care and health outcomes	Required (AD_38A or AD_38B. States do not have to report both.)	AD_38B	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (rate 1) [PCPI Foundation; NQF #0028]	This metric consists of the following components: 1. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months 2. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention 3. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user	Claims and encounters	90 days	Calendar year	Annually	
	1.1.8 Quality of care and health outcomes	Required	AD_39-1	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD) [NCQA; NQF # 2605; Medicaid adult Core Set; Adjusted HEDIS measure]	Percentage of ED visits for beneficiaries age 18 and older who have a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, and who had a follow-up visit with a corresponding principal diagnosis for AOD. Two rates are reported: 1. Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 30 days of the ED visit (31 total days). 2. Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	Claims and encounters	90 days	Calendar year	Annually	Y
	1.1.8 Quality of care and health outcomes	Required	AD_39-2	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF # 2605; Medicaid adult Core Set; Adjusted HEDIS measure]	Percentage of ED visits for beneficiaries age 18 and older who have a principal diagnosis of mental illness or intentional self-harm, and who had a follow-up visit with a corresponding principal diagnosis for mental illness. Two rates are reported: 1. Percentage of ED visits for mental illness or intentional self-harm for which the beneficiary received follow-up within 30 days of the ED visit (31 total days). 2. Percentage of ED visits for mental illness or intentional self-harm for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	Claims and encounters	90 days	Calendar year	Annually	Y
	1.1.8 Quality of care and health outcomes	Required	AD_40	Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 and older with a new episode of AOD abuse or dependence who received the following: 1. Initiation of AOD Treatment. Percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication assisted treatment (MAT) within 14 days of the diagnosis 2. Engagement of AOD Treatment. Percentage of beneficiaries who initiate treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit The following diagnosis cohorts are reported for each rate: (1) Alcohol abuse or dependence, (2) Opioid abuse or dependence, (3) Other drug abuse or dependence, and (4) Total AOD abuse or dependence. A total of 8 separate rates are reported for this measure.	Claims and encounters or EHR	90 days	Calendar year	Annually	Y
	1.1.8 Quality of care and health outcomes	Required	AD_41	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD) [AHRQ; NQF #0272; Medicaid Adult Core Set]	Number of inpatient hospital admissions for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 beneficiary months for beneficiaries age 18 and older	Claims and encounters	90 days	Calendar year	Annually	Y
	1.1.8 Quality of care and health outcomes	Required	AD_42	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD) [AHRQ; NQF #0275; Medicaid Adult Core Set]	Number of inpatient hospital admissions for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 beneficiary months for beneficiaries age 40 and older	Claims and encounters	90 days	Calendar year	Annually	Y
	1.1.8 Quality of care and health outcomes	Required	AD_43	PQI 08: Heart Failure Admission Rate (PQI08-AD) [AHRQ; NQF #0277; Medicaid Adult Core Set]	Number of inpatient hospital admissions for heart failure per 100,000 beneficiary months for beneficiaries age 18 and older	Claims and encounters	90 days	Calendar year	Annually	Y

	1.1.8 Quality of care and health outcomes	Required	AD_44	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD) [AHRQ; NQF #0283; Medicaid Adult Core Set]	Number of inpatient hospital admissions for asthma per 100,000 beneficiary months for beneficiaries aged 18 to 39	Claims and encounters	90 days	Calendar year	Annually
Y									
	1.1.9 Administrative cost	Recommended	AD_45	Administrative cost of demonstration operation	Cost of contracts or contract amendments and staff time equivalents required to administer demonstration policies, including premium collection, health behavior incentives, premium assistance, community engagement requirements and/or retroactive eligibility waivers	Administrative records	None	Demonstration year	Annually
N									
Add rows for any additional state-identified metrics									

[a] The reporting topics correspond to the prompts for reporting topic AD.Mod_1 in the monitoring report template.

End of workbook

Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications		Initial reporting date			
Baseline reporting period (MM/DD/YYYY--MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided specification (Y/N)	Explanation of any deviations from the CMS-provided specifications. Could include different data sources or state-specific definitions, policies, codes, target populations, etc.	Dates covered by first measurement period for metric (MM/DD/YYYY - MM/DD/YYYY)	Report name of first report in which the metric will be submitted (Format: DY1 Q3 quarterly report)	Submission date of first report in which the metric will be reported (MM/DD/YYYY)	State plans to phase in reporting (Y/N)
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	04/01/2019 - 06/30/2019	DY10 Q2	9/30/2019	N
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1	5/31/2020	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	04/01/2019 - 06/30/2019	DY10 Q2	9/30/2019	N
04/01/2020-06/30/2020	TBD	TBD	Y	N/A	04/01/2020-06/30/2020	DY11 Q1	8/31/2020	N
04/01/2020-06/30/2020	TBD	TBD	Y	N/A	04/01/2020-06/30/2020	DY11 Q1	8/31/2020	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1	5/31/2020	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1	5/31/2020	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1	5/31/2020	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1	5/31/2020	N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A	N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A	N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A	N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1	5/31/2020	N

01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020	N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A		N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020	N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A		N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A		N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A		N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A		N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A		N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020	N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A		N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A		N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A		N

01/01/2020-03/31/2020	TBD	TBD	N	TBD	01/01/2020-03/31/2020	DY11 Q1	5/31/2020	N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A	N
TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
01/01/2020-12/31/2020	TBD	TBD	TBD	TBD	01/01/2020-12/31/2020	DY11 Annual Report	3/31/2021	N
01/01/2020-12/31/2020	TBD	TBD	TBD	TBD	01/01/2020-12/31/2020	DY11 Annual Report	3/31/2021	N
01/01/2020-12/31/2020	TBD	TBD	TBD	TBD	01/01/2020-12/31/2020	DY11 Annual Report	3/31/2021	N
01/01/2020-12/31/2020	TBD	TBD	TBD	TBD	01/01/2020-12/31/2020	DY11 Annual Report	3/31/2021	N
01/01/2020-12/31/2020	TBD	TBD	TBD	TBD	01/01/2020-12/31/2020	DY11 Annual Report	3/31/2021	N
01/01/2020-12/31/2020	TBD	TBD	TBD	TBD	01/01/2020-12/31/2020	DY11 Annual Report	3/31/2021	N

01/01/2020-12/31/2020	TBD	TBD	TBD	TBD	01/01/2020-12/31/2020	DY11 Annual Report		3/31/2021	N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A		N

Explanation of any plans to phase in reporting over time
N/A
The state does not have a suspension policy.
N/A
N/A
N/A
N/A
N/A
N/A
N/A
N/A Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established. Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established. Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established. Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established.
N/A

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Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established.

N/A

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Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established.

Medicaid Section 1115 Eligibility and Coverage Demonstration Report - Data and reporting issues (AD)

State	Michigan
Demonstration Name	Healthy Michigan Plan
Demonstration Year (DY)	DY 12
Calendar Dates for DY	01/01/2021 - 12/31/2021
Reporting Period	Q4
Calendar Dates for Reporting Period	10/01/2021 - 12/31/2021
Submitted on	3/31/2022

Data Reporting Issues (AD)

Category	Metric(s) impacted
EXAMPLE: Appeals and grievances (Delete row before submitting)	*EXAMPLE: AD_23 Grievance, other*

Enrollment	*AD_7 - AD_10*
☐ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitorin	
Mid-year loss of demonstration eligibility	*[Add rows as needed]*
☐ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitorin	
Enrollment duration at time of disenrollment	*[Add rows as needed]*
☐ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitorin	
Renewal	*AD_15 - AD_21*
☐ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitorin	
Cost sharing limit	*[Add rows as needed]*
☑ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitorin	
Appeals and grievances	*[Add rows as needed]*
☑ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitorin	
Access to care	*AD_35*
☐ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitorin	
Quality of care and health outcomes	*AD_36 - AD_44*
☐ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitorin	
Administrative cost	*[Add rows as needed]*
☑ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitorin	

Note: States must prominently display the following notice on any display of Measure rates:

The MSC-AD, FUA-AD, FUM-AD, and IET_AD measures (metrics AD_38A, AD_39, and AD_40) are Healthcare Effe copyrighted by the National Committee for Quality Assurance ("NCQA"). NCQA makes no representations, warra reports performance measures and NCQA has no liability to anyone who relies on such measures or specificatior

The measure specification methodology used by CMS is different from NCQA's methodology. NCQA has not valic Calculated measure results, based on the adjusted HEDIS specifications, may be called only "Uncertified, Unaudit

Certain non-NCQA measures in the CMS 1115 eligibility and coverage demonstration contain HEDIS Value Sets (V contained in the VS. Users of the proprietary code sets should obtain all necessary licenses from the owners of tl NCQA measures and any coding contained in the VS.

[a] The state should also use this column to provide updates on any data or reporting issues described in previous r

End of workbook

Summary of issue	Date and report in which issue was first reported
EXAMPLE: *Difficulty collecting data for metric AD_23.*	*EXAMPLE:* *8/1/18; DY 1 Qtr. 1*
Difficulty collecting data	*DATE; DY10 Q2*
ıg protocol.	
g protocol.	
ıg protocol.	
Difficulty collecting data	*DATE; DY10 Q2*
ıg protocol.	
ıg protocol.	
ıg protocol.	
Difficulty collecting data	*DATE; DY10 Q2*
ıg protocol.	
Difficulty collecting data	*DATE; DY10 Q2*
ng protocol.	
ıg protocol.	

ctiveness Data and Information Set ("HEDIS®") measures that are owned and
ınties, or endorsement about the quality of any organization or physician that uses or
ıs.

ılated the adjusted measure specifications but has granted CMS permission to adjust.
ted HEDIS rates."

/S) developed by and included with the permission of the NCQA. Proprietary coding is
hese code sets. NCQA disclaims all liability for use or accuracy of the VS with the non-

reports. When applicable, the state should note when issues are resolved. If an issue was noted as resolved in the pre

Estimated number of impacted beneficiaries	Known or suspected cause(s) of issue (if applicable)
EXAMPLE: *24*	*EXAMPLE:* *Grievances are submitted via hardcopy through the mail to regional field offices. Often the field offices are slow to report the number of grievances they have received to the central office.*
Unknown	*The state is transitioning to the new waiver reporting format*
Unknown	*The state is transitioning to the new waiver reporting format*
Unknown	*The state is transitioning to the new waiver reporting format*
Unknown	*The state is transitioning to the new waiver reporting format*

vious report, it should not be reported in the current report.

Remediation plan and timeline for resolution (if applicable)/Status update if issue previously reported
EXAMPLE: *Central office is working on an electronic grievance filing system. That system will be completed by the end of the calendar year, and we will be able to quickly generate monthly, quarterly and yearly reports regarding grievances.*
The state will acquire the needed data and receive training on new data sources
The state will acquire the needed data and receive training on new data sources
The state will acquire the needed data and receive training on new data sources
The state will acquire the needed data and receive training on new data sources

Medicaid Section 1115 Eligibility and Coverage Demonstration Report - Metrics reporting (AD)

State	Michigan
Demonstration Name	Healthy Michigan Plan
Demonstration Year (DY)	DY 12
Calendar Dates for DY	01/01/2021 - 12/31/2021
Reporting Period	Q4
Calendar Dates for Reporting Period	10/01/2021 - 12/31/2021
Submitted on	3/31/2022

Eligibility and Coverage Demonstration Metrics (AD)[a]

						Demonstration			< 50% FPL[f]			50-100% FPL[f]			>100% FPL[f]	
Reporting topic[b]	#	Metric name	Metric description	Data source	Calculation lag	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]
1.1.1 Enrollment	AD_1	Total enrollment in the demonstration	The unduplicated number of beneficiaries enrolled in the demonstration at any time during the measurement period. This indicator is a count of total program enrollment. It includes those newly enrolled during the measurement period and those whose enrollment continues from a prior period. This indicator is not a point-in-time count. It captures beneficiaries who were enrolled for at least one day during the measurement period.	Administrative records	30 days		961,291			512,956			237,568			210,767
							969,714			516,061			240,300			213,353
							978,069			519,382			242,871			215,816
1.1.1 Enrollment	AD_2	Beneficiaries in suspension status for noncompliance	The number of demonstration beneficiaries in suspension status for noncompliance with demonstration policies as of the last day of the measurement period	Administrative records	30 days		N/A			N/A			N/A			N/A	
							N/A			N/A			N/A			N/A	
							N/A			N/A			N/A			N/A	
1.1.1 Enrollment	AD_3	Beneficiaries in a non-eligibility period who are prevented from re-enrolling for a defined period of time	The number of prior demonstration beneficiaries who are in a non-eligibility period, meaning they are prevented from re-enrolling for some defined period of time, because they were disenrolled for noncompliance with demonstration policies. The count should include those prevented from re-enrolling until their redetermination date.	Administrative records	30 days		0			0			0			0
							0			0			0			0
							0			0			0			0
1.1.1 Enrollment	AD_4	New enrollees	Number of beneficiaries in the demonstration who began a new enrollment spell during the measurement period, have not had Medicaid coverage within the prior 3 months and are not using a state-specific pathway for re-enrollment after being disenrolled for noncompliance	Administrative records	30 days		15,641			9,254			3,646			2,741
							17,838			10,604			3,948			3,286
							17,648			10,636			3,705			3,307
1.1.1 Enrollment	AD_5	Re-enrollments or re-instatements using defined pathways after disenrollment or suspension of benefits for noncompliance with demonstration policies	Number of beneficiaries in the demonstration who began a new enrollment spell (or had benefits re-instated) in the current measurement period by using a state-defined pathway for re-enrollment (or re-instatement of benefits), i.e., meeting certain requirements, after being disenrolled (or having benefits suspended) for noncompliance with premium requirements, community engagement requirements, or other demonstration-specific requirements.	Administrative records	30 days		0			0			0			0
							0			0			0			0
							0			0			0			0
1.1.1 Enrollment	AD_6	Re-enrollments or re-instatements for beneficiaries not using defined pathways after disenrollment or suspension of benefits for noncompliance	Number of beneficiaries in the demonstration who began a new enrollment spell (or had benefits re-instated) in the current measurement period who have had Medicaid coverage within the prior 3 months and are not using a state-specific pathway for re-enrollment after being disenrolled for noncompliance (or re-instatement of benefits after being suspended for noncompliance).	Administrative records	30 days		0			0			0			0
							0			0			0			0
							0			0			0			0
1.1.2 Mid-year loss of demonstration eligibility	AD_7	Monthly count of beneficiaries determined ineligible for Medicaid, any reason, other than at renewal	Beneficiaries determined ineligible for Medicaid, any reason, other than at renewal	Administrative records	30 days		TBD			TBD			TBD			TBD
							TBD			TBD			TBD			TBD
							TBD			TBD			TBD			TBD
1.1.2 Mid-year loss of demonstration eligibility	AD_8	Monthly count of beneficiaries determined ineligible for Medicaid after state processes a change in circumstance reported by a beneficiary	Beneficiaries no longer eligible for Medicaid, failure to provide timely change in circumstance information	Administrative records	30 days		TBD			TBD			TBD			TBD
							TBD			TBD			TBD			TBD
							TBD			TBD			TBD			TBD
1.1.2 Mid-year loss of demonstration eligibility	AD_9	Monthly count of beneficiaries determined ineligible for Medicaid after state processes a change in circumstance reported by a beneficiary	Beneficiaries determined ineligible for Medicaid after state processes a change in circumstance reported by a beneficiary	Administrative records	30 days		TBD			TBD			TBD			TBD
							TBD			TBD			TBD			TBD
							TBD			TBD			TBD			TBD
1.1.2 Mid-year loss of demonstration eligibility	AD_10	Monthly count of beneficiaries no longer eligible for the demonstration due to transfer to another Medicaid eligibility group	Beneficiaries no longer eligible for the demonstration due to transfer to another Medicaid eligibility group	Administrative records	30 days		TBD			TBD			TBD			TBD
							TBD			TBD			TBD			TBD
							TBD			TBD			TBD			TBD
1.1.2 Mid-year loss of demonstration eligibility	AD_11	Monthly count of beneficiaries no longer eligible for the demonstration due to transfer to CHIP	Beneficiaries no longer eligible for the demonstration due to transfer to CHIP	Administrative records	30 days		N/A			N/A			N/A			N/A
							N/A			N/A			N/A			N/A
							N/A			N/A			N/A			N/A
							N/A			N/A			N/A			N/A
			Number of demonstration beneficiaries who lost eligibility for Medicaid during the													

1.1.3 Enrollment duration at time of disenrollment	AD_12	Enrollment duration 0-3 months	Number of demonstration beneficiaries who lost eligibility for Medicaid during the measurement period and whose enrollment spell had lasted 3 or fewer months at the time of disenrollment	Administrative records	30 days	N/A	N/A	N/A	N/A
						N/A	N/A	N/A	N/A
						N/A	N/A	N/A	N/A
1.1.3 Enrollment duration at time of disenrollment	AD_13	Enrollment duration 4-6 months	Number of demonstration beneficiaries who lose eligibility for Medicaid during the measurement period whose enrollment spell had lasted between 4 and 6 months at the time of disenrollment	Administrative records	30 days	N/A	N/A	N/A	N/A
						N/A	N/A	N/A	N/A
						N/A	N/A	N/A	N/A
1.1.3 Enrollment duration at time of disenrollment	AD_14	Enrollment duration 6-12 months	Number of demonstration beneficiaries who lost eligibility for Medicaid during the measurement period whose enrollment spell had lasted 6 or more months (up to 12 months) at the time of disenrollment	Administrative records	30 days	N/A	N/A	N/A	N/A
						N/A	N/A	N/A	N/A
						N/A	N/A	N/A	N/A
1.1.4 Renewal	AD_15	Beneficiaries due for renewal	Total number of beneficiaries enrolled in the demonstration who were due for renewal during the measurement period	Administrative records	30 days	29,747	16,145	7,284	6,318
						30,403	16,654	7,159	6,590
						25,356	14,567	5,900	4,889
1.1.4 Renewal	AD_16	Beneficiaries determined ineligible for the demonstration at renewal, disenrolled from Medicaid	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who complete the renewal process and are determined ineligible for Medicaid	Administrative records	30 days	TBD	TBD	TBD	TBD
						TBD	TBD	TBD	TBD
						TBD	TBD	TBD	TBD
1.1.4 Renewal	AD_17	Beneficiaries determined ineligible for the demonstration at renewal, transfer to another Medicaid eligibility category	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who complete the renewal process and move from the demonstration to a Medicaid eligibility group not included in the demonstration	Administrative records	30 days	TBD	TBD	TBD	TBD
						TBD	TBD	TBD	TBD
						TBD	TBD	TBD	TBD
1.1.4 Renewal	AD_18	Beneficiaries determined ineligible for the demonstration at renewal, transferred to CHIP	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who complete the renewal process but move from the demonstration to CHIP	Administrative records	30 days	TBD	TBD	TBD	TBD
						TBD	TBD	TBD	TBD
						TBD	TBD	TBD	TBD
1.1.4 Renewal	AD_19	Beneficiaries who did not complete renewal, disenrolled from Medicaid	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who are disenrolled from Medicaid for failure to complete the renewal process	Administrative records	30 days	TBD	TBD	TBD	TBD
						TBD	TBD	TBD	TBD
						TBD	TBD	TBD	TBD
1.1.4 Renewal	AD_20	Beneficiaries who had pending/uncompleted renewals and were still enrolled	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period for whom the state had not completed renewal determination by the end of the measurement period and were still enrolled	Administrative records	30 days	TBD	TBD	TBD	TBD
						TBD	TBD	TBD	TBD
						TBD	TBD	TBD	TBD
1.1.4 Renewal	AD_21	Beneficiaries who retained eligibility for the demonstration after completing renewal forms	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who remained enrolled in the demonstration after responding to renewal notices	Administrative records	30 days	TBD	TBD	TBD	TBD
						TBD	TBD	TBD	TBD
						TBD	TBD	TBD	TBD
1.1.4 Renewal	AD_22	Beneficiaries who renewed ex parte	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who remained enrolled as determined by third-party data sources or available information, rather than beneficiary response to renewal notices	Administrative records	30 days	N/A	N/A	N/A	N/A
						N/A	N/A	N/A	N/A
						N/A	N/A	N/A	N/A
1.1.5 Cost sharing limit	AD_23	Monthly count of beneficiaries who reached 5% limit	Beneficiaries who reached 5% limit	Administrative records	30 days	159,784	144,236	7,900	7,648
						65,952	59,630	3,319	3,003
						45,354	38,849	3,418	3,087
1.1.6 Appeals and grievances	AD_24	Appeals, eligibility	Number of appeals filed by beneficiaries enrolled in the demonstration during the measurement period regarding Medicaid eligibility	Administrative records	None	N/A			
1.1.6 Appeals and grievances	AD_25	Appeals, denial of benefits	Number of appeals filed by beneficiaries enrolled in the demonstration during the measurement period regarding denial of benefits	Administrative records	None	N/A			
1.1.6 Appeals and grievances	AD_26	Grievances, care quality	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding the quality of care or services provided	Administrative records	None	N/A			
1.1.6 Appeals and grievances	AD_27	Grievances, provider or managed care entities	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding a provider or managed care entity. Managed care entities include Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHP), and Prepaid Ambulatory Health Plans (PAHP).	Administrative records	None	N/A			
1.1.6 Appeals and grievances	AD_28	Grievances, other	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding other matters that are not subject to appeal	Administrative records	None	N/A			
1.1.7 Access to care	AD_29	Primary care provider availability	Number of primary care providers enrolled to deliver Medicaid services at the end of the measurement period	Provider enrollment databases	90 days	51,729			

1.1.7 Access to care	AD_30	Primary care provider active participation	Number of primary care providers enrolled to deliver Medicaid services with service claims for 3 or more demonstration beneficiaries during the measurement period	Provider enrollment databases and claims and encounters	90 days			16,858															
1.1.7 Access to care	AD_31	Specialist provider availability	Number of specialists enrolled to deliver Medicaid services at the end of the measurement period	Provider enrollment databases	90 days			82,076															
1.1.7 Access to care	AD_32	Specialist provider active participation	Number of specialists enrolled to deliver Medicaid services with service claims for 3 or more demonstration beneficiaries during the measurement period	Provider enrollment databases and claims and encounters	90 days			38,909															
1.1.7 Access to care	AD_33	Preventive care and office visit utilization	Total utilization of preventive care and office visits per 1,000 demonstration beneficiary months during the measurement period	Claims and encounters and other administrative records	90 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A							
1.1.7 Access to care	AD_34	Prescription drug use	Total utilization of 30-day prescription fills per 1,000 demonstration beneficiary months in the measurement period.	Claims and encounters; other administrative records	90 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A							
1.1.7 Access to care	AD_35	Emergency department utilization, total	Total number of emergency department (ED) visits per 1,000 demonstration beneficiary months during the measurement period	Claims and encounters; other administrative records	90 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A							
1.1.7 Access to care	AD_36	Emergency department utilization, non-emergency	Total number of ED visits for non-emergency conditions per 1,000 demonstration beneficiary months during the measurement period. If the state differentiates emergent/non-emergent visit copayments, then non-emergency visits should be identified for monitoring purposes using the same criteria used to assess the differential copayment. If the state does not differentiate emergent/non-emergent copayments, then non-emergency visits should be defined as all visits not categorized as emergent using the method below.	Claims and encounters; other administrative records	90 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A							
1.1.7 Access to care	AD_37	Inpatient admissions	Total number of inpatient admissions per 1,000 demonstration beneficiary months during the measurement period	Claims and encounters; other administrative records	90 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A							
1.1.8 Quality of care and health outcomes	AD_38A	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) [NCQA; NQF #0027; Medicaid Adult Core Set; Adjusted HEDIS measure][i]	This metric consists of the following components; each assesses different facets of providing medical assistance with smoking and tobacco use cessation: • Advising smokers and tobacco users to quit • Discussing cessation medications • Discussing cessation strategies	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan survey, Adult Version	90 days		106,694	49,371	46.27%	63,970	29,507	46.13%	23,552	11,047	46.90%	19,172	8,817						
1.1.8 Quality of care and health outcomes	AD_38B	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention [PCPI Foundation; NQF #0028]	This metric consists of the following components: 1. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months 2. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention 3. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user	--	--																	
			1. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months	Claims and encounters or registry data	90 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A						
			2. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention	Claims and encounters or registry data	90 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A						
			3. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user	Claims and encounters or registry data	90 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A						
1.1.8 Quality of care and health outcomes	AD_39-1	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD) [NCQA; NQF # 2605; Medicaid adult Core Set; Adjusted HEDIS measure][i]	Percentage of ED visits for beneficiaries age 18 and older who have a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, and who had a follow-up visit with a corresponding principal diagnosis for AOD. Two rates are reported:	--	--																	
			1. Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 30 days of the ED visit (31 total days)	Claims and encounters	90 days		12,489	2,783	22.28%	9,804	2,131	21.74%	1,457	350	24.02%	987	252						
			2. Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)	Claims and encounters	90 days		12,489	1,693	13.56%	9,804	1,305	13.31%	1,457	207	14.21%	987	150						
1.1.8 Quality of care and health outcomes	AD_39-2	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF # 2605; Medicaid adult Core Set; Adjusted HEDIS measure][i]	Percentage of ED visits for beneficiaries age 18 and older who have a principal diagnosis of mental illness or intentional self-harm, and who had a follow-up visit with a corresponding principal diagnosis for mental illness. Two rates are reported:	--	--																	
			1. Percentage of ED visits for mental illness or intentional self-harm for which the beneficiary received follow-up within 30 days of the ED visit (31 total days)	Claims and encounters	90 days		6,821	3,549	52.03%	5,107	2,567	50.26%	904	516	57.08%	701	421						
			2. Percentage of ED visits for mental illness or intentional self-harm for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)	Claims and encounters	90 days		6,821	2,611	38.28%	5,107	1,874	36.69%	904	387	42.81%	701	314						
1.1.8 Quality of care and health outcomes	AD_40	Initiation of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted	Percentage of beneficiaries age 18 and older with a new episode of AOD abuse or dependence who received the following: 1. Initiation of AOD Treatment. Percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication assisted treatment (MAT) within 14 days of the diagnosis 2. Engagement of AOD Treatment. Percentage of beneficiaries who initiate treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit The following diagnosis cohorts are reported for each rate: (1) Alcohol abuse or dependence, (2) Opioid abuse or dependence, (3) Other drug abuse or dependence, and (4) Total AOD abuse or dependence. A total of 8 separate rates are reported for this measure.	--	--																	
			1. Initiation of AOD Treatment - Alcohol abuse or dependence (rate 1, cohort 1)	Claims and encounters or EHR	90 days		36,441	14,288	39.21	26,016	10,391	39.94	5,834	2,174	37.26	4,025	1,460						

		HEDIS measure][i]	2. Initiation of AOD Treatment - Opioid abuse or dependence (rate 1, cohort 2)	Claims and encounters or EHR	90 days	19,338	7,336	37.94	13,454	5,133	38.15	3209	1177	36.68	2,314	850
			3. Initiation of AOD Treatment - Other drug abuse or dependence (rate 1, cohort 3)	Claims and encounters or EHR	90 days	6,477	3,480	53.73	4,869	2,641	54.24	912	487	53.40	598	301
			4. Initiation of AOD Treatment - Total AOD abuse or dependence (rate 1, cohort 4)	Claims and encounters or EHR	90 days	13,530	4,604	34.03	9,939	3,491	35.12	2,077	646	31.10	1,355	404
			5. Engagement of AOD Treatment - Alcohol drug abuse or dependence (rate 2 cohort 1)	Claims and encounters or EHR	90 days	36,440	4,529	12.43	26,016	3,257	12.52	5,834	749	12.84	4,025	457
			6. Engagement of AOD Treatment - Opioid drug abuse or dependence (rate 2, cohort 2)	Claims and encounters or EHR	90 days	19,338	1,762	9.11	13,454	1,175	8.73	318	3,209	9.91	2,314	233
			7. Engagement of AOD Treatment - Other AOD abuse or dependence (rate 2, cohort 3)	Claims and encounters or EHR	90 days	6,477	1,893	29.23	4,869	1,409	28.94	912	315	34.54	598	150
			8. Engagement of AOD Treatment - Total AOD abuse or dependence (rate 2, cohort 4)	Claims and encounters or EHR	90 days	13,530	992	7.33	9,939	769	7.74	2,077	127	6.11	1,355	82
1.1.8 Quality of care and health outcomes	AD_41	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD) [AHRQ; NQF #0272; Medicaid Adult Core Set]	Number of inpatient hospital admissions for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 beneficiary months for beneficiaries age 18 and older	Claims and encounters	90 days	7,989,688	1,879	23.52	4,459,345	1,396	31.31	1906711	282	14.79	1,623,555	201
1.1.8 Quality of care and health outcomes	AD_42	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD) [AHRQ; NQF #0275; Medicaid Adult Core Set]	Number of inpatient hospital admissions for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 beneficiary months for beneficiaries age 40 and older.	Claims and encounters	90 days	3,488,212	856	24.54	1,938,272	575	29.67	819,865	139	16.95	730,053	142
1.1.8 Quality of care and health outcomes	AD_43	PQI 08: Heart Failure Admission Rate (PQI08-AD) [AHRQ; NQF #0277; Medicaid Adult Core Set]	Number of inpatient hospital admissions for heart failure per 100,000 beneficiary months for beneficiaries age 18 and older	Claims and encounters	90 days	7,989,688	1,491	18.66	4,459,345	1,071	24.02	1,906,711	201	10.54	1,623,555	219
1.1.8 Quality of care and health outcomes	AD_44	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD) [AHRQ; NQF #0283; Medicaid Adult Core Set]	Number of inpatient hospital admissions for asthma per 100,000 beneficiary months for beneficiaries aged 18 to 39.	Claims and encounters	90 days	4,501,476	214	4.75	2,521,073	137	5.43	1,086,846	46	4.23	2,521,073	31
1.1.9 Administrative cost	AD_45	Administrative cost of demonstration operation	Cost of contracts or contract amendments and staff time equivalents required to administer demonstration policies, including premium collection, health behavior incentives, premium assistance, community engagement requirements and/or retroactive eligibility waivers	Administrative records	None		$ 674,299.00									
Add rows for any additional state-identified metrics																

Note: States must prominently display the following notice on any display of Measure rates:

The MSC-AD, FUA-AD, FUM-AD, and IET_AD measures (metrics AD_38A, AD_39, and AD_40) are Healthcare Effectiveness Data and Information Set ("HEDIS®") measures that are owned and copyrighted by the National Committee for Quality Assurance ("NCQA"). NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures or specifications.

The measure specification methodology used by CMS is different from NCQA's methodology. NCQA has not validated the adjusted measure specifications but has granted CMS permission to adjust. Calculated measure results, based on the adjusted HEDIS specifications, may be called only "Uncertified, Unaudited HEDIS rates."

Certain non-NCQA measures in the CMS 1115 eligibility and coverage demonstration contain HEDIS Value Sets (VS) developed by and included with the permission of the NCQA. Proprietary coding is contained in the VS. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. NCQA disclaims all liability for use or accuracy of the VS with the non-NCQA measures and any coding contained in the VS.

[a] States should create a new metrics report for each reporting quarter.
[b] The reporting topics correspond to the prompts for reporting topic AD.Mod_1 in the monitoring report template.
[c] Report metrics that are one annual value for a demonstration year only in the report specified in the reporting schedule.
[d] Report count metrics in the numerator column. Administrative costs (AD_45) should also be reported in the numerator column.
[e] If applicable. See CMS-provided technical specifications.
[f] Add columns as necessary to report additional income groups.
[g] Add columns as necessary to report exempt groups.
[h] Add columns as necessary to report specific edibility groups.
[i] Add columns as necessary to report phase-in cohorts, if applicable.
[j] Rates for these metrics reflect Uncertified, Unaudited HEDIS rates.

Checks:
AD_8, AD_9, AD_11, AD_12, AD_13, AD_14 should each be less than or equal to AD_7

	Age 19-26			Age 27-35			Age 36-45			Age 46-55			Age 56-64			Male			Female			
Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator
		223,391			243,269			189,116			166,397			139,118			496,216			465,075		
		224,488			245,055			190,498			167,875			141,798			501,435			468,279		
		225,630			247,101			191,933			169,189			144,216			506,485			471,584		
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		4,669			3,960			2,990			2,327			1,695			7,325			8,316		
		5,157			4,304			3,191			2,565			2,621			8,405			9,433		
		5,311			4,387			2,976			2,481			2,493			8,689			8,959		
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6,711	7,914	5,492	5,053	4,577	15,011	14,736
6,651	8,541	5,446	5,122	4,643	15,867	14,536
6,092	6,765	4,793	4,358	3,348	13,360	11,996
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35,225	35,571	27,815	33,990	27,183	85,875	73,909
15,312	17,907	12,536	11,787	8,410	39,372	26,580
12,707	11,272	7,638	7,419	6,318	25,841	19,513

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45.99%	12,153	3,769	31.01%	21,969	8,686	39.54%	24,582	11,565	47.05%	27,690	14,609	52.76%	20,235	10,714	52.95%	54,245	23,832	43.93%	52,449	25,539	48.69%	74,061
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25.53%	1,651	268	16.23%	3,728	919	24.65%	3,173	742	23.38%	2,622	594	22.65%	1,314	261	19.86%	9,121	1,994	21.86%	3,368	789	23.43%	8,429
15.20%	1,651	165	9.99%	3,728	565	15.16%	3,173	450	14.18%	2,622	350	13.35%	1,314	164	12.48%	9,121	1,227	13.45%	3,368	466	13.84%	8,429
60.06%	2,035	1,128	55.43%	2,113	1,050	49.69%	1,398	699	50.00%	924	493	53.35%	351	179	51.00%	4,198	2,058	49.02%	2,623	1,491	56.84%	4,408
44.79%	2,035	839	41.23%	2,113	771	36.49%	1,398	512	36.62%	924	360	38.96%	351	129	36.75%	4,198	1,490	35.49%	2,623	1,121	42.74%	4,408
36.27	5,445	1,738	31.92	10,056	3,961	3,961	8,720	3,613	41.43	7,821	3,188	40.76	4,398	1,788	53.65	24,044	9,778	40.67	12,397	4,510	36.38	23,325

36.73	1,989	552	27.75	4,486	1,551	34.57	4,602	1,844	40.07	5,075	2,057	40.53	3,186	1,332	41.79	13,475	5,256	39.01	5,863	2,080	35.48	11,565
50.33	712	345	48.46	2,384	1,371	57.51	1,763	986	55.93	1,083	548	50.60	535	230	42.99	4,013	2,230	55.57	2,464	1,250	50.73	5,155
29.82	3,133	959	30.61	4,213	1,406	33.37	3,099	1,084	34.98	2,183	829	37.98	902	326	36.11	8,582	3,122	36.38	4,948	1,482	29.95	8,464
11.35	5,444	539	9.90	10,056	1,530	15.21	8,720	1,246	14.29	7,821	848	10.84	4,399	366	8.33	24,043	3,051	12.69	12,397	1,478	11.92	23,324
10.07	1,989	156	7.84	4,486	440	9.81	4,602	485	10.54	5,075	455	8.97	3,185	226	7.10	13,475	1,223	9.08	5,863	539	9.19	11,565
25.08	712	185	25.98	2,384	801	33.60	1,763	556	31.54	1,083	257	23.73	535	94	17.57	4,013	1,215	30.28	2,464	678	27.52	5,155
6.05	3,133	212	6.77	4,213	335	7.95	3,099	240	7.74	2,183	155	7.10	902	50	5.56	8,582	703	8.19	4,948	289	5.84	8,464
12.38	1,880,268	494	26.27	1,956,388	476	24.33	1,549,251	428	27.63	1,476,862	330	22.34	1,126,919	151	13.43	4,022,327	1,146	28.49	3,967,361	733	18.48	4,992,148
19.45	-	-	-	-	-		884,431	94	10.63	1,476,862	385	26.07	1,126,919	377	33.83	1,725,878	391	22.66	1,762,334	465	26.39	2,251,815
13.49	1,880,268	21	1.12	1,956,388	124	6.34	1,549,251	263	16.98	1,476,862	570	38.6	1,126,919	513	56.94	4,022,327	1,057	26.28	3,967,361	434	10.94	4,992,148
3.47	1,880,268	65	3.46	1,956,388	109	5.57	664,820	40	6.02	-	-	-	-	-	-	2,296,449	107	4.66	2,205,027	107	4.85	2,740,333

White		Black or African American			Asian			American Indian or Alaskan Native			Other race			Unknown race			Hispanic ethnicity			Non-Hispanic ethnicity		
Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]
593,981			246,992			6,679			14,518			2,271			96,850			56,830			904,256	
599,509			248,214			6,795			14,622			2,284			98,290			57,413			912,089	
604,932			249,392			6,939			14,730			2,300			99,776			57,426			920,429	
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9,390			4,124			81			228			18			1,800			1,147			14,490	
11,104			4,165			177			260			23			2,109			1,170			16,659	
11,236			3,688			188			250			26			2,260			1,013			16,630	
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18,116	8,090	308	452	38	2,743	1,568	28,176
18,606	7,812	342	482	38	3,123	1,611	28,787
15,006	7,644	111	410	42	2,143	1,544	23,808
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N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
94,271	46,375	899	1,881	248	16,110	8,039	151,711
37,248	21,788	304	1,125	78	5,409	3,237	62,699
25,993	13,374	325	596	54	5,012	2,534	42,810

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N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
35,275	47.63%	23,726	10,110	42.61%	715	354	49.51%	1,900	773	40.68%	102	38	37.25%	6,110	2,774	45.40%						
2,214	26.27%	2,716	325	11.97%	33	4	12.12%	355	82	23.10%	23	3	13.04%	933	155	16.61%						
1,331	15.79%	2,716	218	8.03%	33	2	6.06%	355	49	13.80%	23	1	4.35%	933	92	9.86%						
2,455	55.69%	1,769	790	44.66%	27	11	40.74%	159	94	59.12%	18	13	72.22%	440	186	42.27%						
1,816	41.20%	1,769	578	32.67%	27	7	25.93%	159	66	41.51%	18	9	50.00%	440	135	30.68%						
9,536	40.88	9,788	3,444	35.19	114	46	40.35	814	297	36.49	65	24	37.90	2,335	941	40.30						

4,627	40.01	5,794	1,955	33.74	68	24	35.29	466	161	34.55	38	14	42.09	1,407	555	39.45
2,845	55.19	834	382	45.80	13	9	69.23	143	73	51.05	9	6	62.50	323	165	51.08
2,773	32.76	3,938	1,435	36.44	40	16	40.00	290	82	28.28	21	6	29.09	777	292	37.58
3,416	14.65	9,788	745	7.61	114	15	13.16	814	113	13.88	65	8	13.74	2,335	232	9.94
1,234	10.67	5,794	352	6.08	68	9	13.24	466	48	10.30	38	5	17.34	1,407	114	8.10
1,611	31.25	834	152	18.23	13	4	30.77	143	48	33.57	9	3	27.89	323	75	23.22
664	7.84	3,938	257	6.53	40	2	5.00	290	21	7.24	21	-	-	777	48	6.18
980	19.63	2,029,360	706	34.79	141,164	1	0.71	122,427	23	18.79	19,208	10	53.36	685,381	159	23.2
534	23.71	808,149	233	28.83	66,921	3	4.48	47,373	15	31.66	7,801	-	-	306,153	71	23.19
643	12.88	2,029,360	686	33.8	141,164	3	2.13	122,427	12	9.8	19,208	5	25.26	685,381	142	20.72
82	2.99	1,221,211	116	9.50	74,243	-	-	75,054	1	1.33	11,407	-	-	379,228	15	3.96

Unknown ethnicity			Exempt groups[g]			Specific eligibility groups[h] New Adult Group		
Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]	Denominator	Numerator[d]	Rate/Percentage[e]
	205			N/A			901,860	
	212			N/A			910,451	
	214			N/A			918,930	
	N/A			N/A			N/A	
	N/A			N/A			N/A	
	N/A			N/A			N/A	
	0			0			0	
	0			0			0	
	0			0			0	
	4			N/A			14,015	
	9			N/A			16,262	
	5			N/A			16,130	
	0			0			0	
	0			0			0	
	0			0			0	
	0			0			0	
	0			0			0	
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	TBD			TBD			TBD	
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	N/A			N/A			N/A	
	N/A			N/A			N/A	
	N/A			N/A			N/A	
	N/A			N/A			N/A	

	N/A			N/A		N/A	
	N/A			N/A		N/A	
	N/A			N/A		N/A	
	N/A			N/A		N/A	
	N/A			N/A		N/A	
	N/A			N/A		N/A	
	N/A			N/A		N/A	
	N/A			N/A		N/A	
		3		N/A			27,999
		5		N/A			28,826
		4		N/A			23,751
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	N/A			N/A		N/A	
	N/A			N/A		N/A	
	N/A			N/A		N/A	
		34		N/A			146,128
		16		N/A			59,830
		10		N/A			40,530

N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
			N/A	N/A	N/A	N/A	N/A	N/A
						N/A	N/A	N/A
						N/A	N/A	N/A
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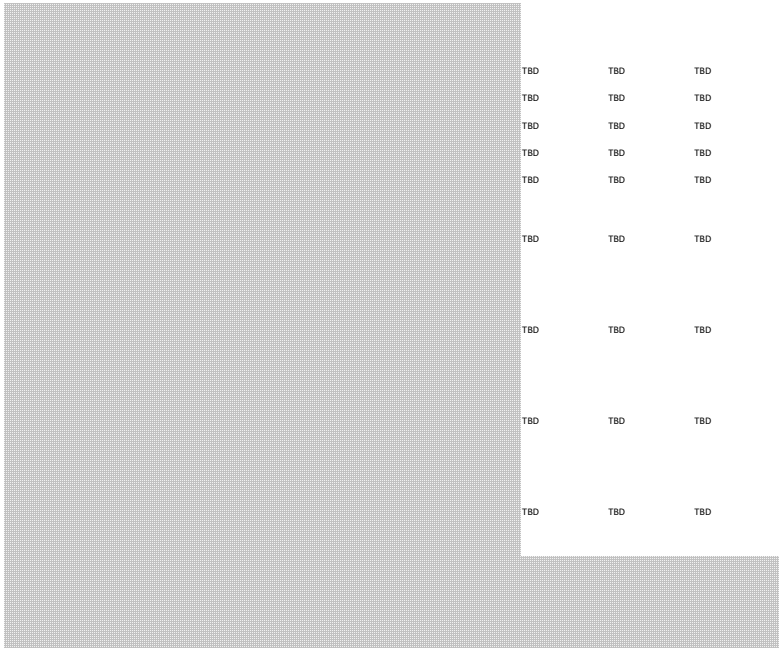
						N/A	N/A	N/A
						N/A	N/A	N/A
						N/A	N/A	N/A
						N/A	N/A	N/A



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Medicaid Section 1115 Eligibility and Coverage Demonstration Monitoring Protocol - Planned metrics (AD)
State Michigan
Demonstration Name Healthy Michigan Plan Section 1115 Demonstration
Submitted on 3/31/2022

Standard information on CMS-provided metrics									
State will report (Y/N)	Reporting topic[a]	Reporting priority	#	Metric name	Metric description	Data source	Calculation lag	Measurement period	Reporting frequency
Y	1.1.1 Enrollment	Required	AD_1	Total enrollment in the demonstration	The unduplicated number of beneficiaries enrolled in the demonstration at any time during the measurement period. This indicator is a count of total program enrollment. It includes those newly enrolled during the measurement period and those whose enrollment continues from a prior period. This indicator is not a point-in-time count. It captures beneficiaries who were enrolled for at least one day during the measurement period.	Administrative records	30 days	Month	Quarterly
Y	1.1.1 Enrollment	Required	AD_2	Beneficiaries in suspension status for noncompliance	The number of demonstration beneficiaries in suspension status for noncompliance with demonstration policies as of the last day of the measurement period	Administrative records	30 days	Month	Quarterly
Y	1.1.1 Enrollment	Required	AD_3	Beneficiaries in a non-eligibility period who are prevented from re-enrolling for a defined period of time	The number of prior demonstration beneficiaries who are in a non-eligibility period, meaning they are prevented from re-enrolling for some defined period of time, because they were disenrolled for noncompliance with demonstration policies. The count should include those prevented from re-enrolling until their redetermination date.	Administrative records	30 days	Month	Quarterly
Y	1.1.1 Enrollment	Required	AD_4	New enrollees	Number of beneficiaries in the demonstration who began a new enrollment spell during the measurement period, have not had Medicaid coverage within the prior 3 months and are not using a state-specific pathway for re-enrollment after being disenrolled for noncompliance	Administrative records	30 days	Month	Quarterly
Y	1.1.1 Enrollment	Required for states with a defined re-enrollment or re-instatement pathway	AD_5	Re-enrollments or re-instatements using defined pathways after disenrollment or suspension of benefits for noncompliance with demonstration policies	Number of beneficiaries in the demonstration who began a new enrollment spell (or had benefits re-instated) in the current measurement period by using a state-defined pathway for re-enrollment (or re-instatement of benefits), i.e., meeting certain requirements, after being disenrolled (or having benefits suspended) for noncompliance with premium requirements, community engagement requirements, or other demonstration-specific requirements.	Administrative records	30 days	Month	Quarterly
Y	1.1.1 Enrollment	Required	AD_6	Re-enrollments or re-instatements for beneficiaries not using defined pathways after disenrollment or suspension of benefits for noncompliance	Number of beneficiaries in the demonstration who began a new enrollment spell (or had benefits re-instated) in the current measurement period, have had Medicaid coverage within the prior 3 months and are not using a state-specific pathway for re-enrollment after being disenrolled for noncompliance (or re-instatement of benefits after being suspended for noncompliance)	Administrative records	30 days	Month	Quarterly
Y	1.1.2 Mid-year loss of demonstration eligibility	Required	AD_7	Beneficiaries determined ineligible for Medicaid, any reason, other than at renewal	Total number of beneficiaries in the demonstration determined ineligible for Medicaid and disenrolled during the measurement period (separate reasons reported in other indicators), other than at renewal	Administrative records	30 days	Month	Quarterly
Y	1.1.2 Mid-year loss of demonstration eligibility	Required	AD_8	Beneficiaries no longer eligible for Medicaid, failure to provide timely change in circumstance information	Number of beneficiaries enrolled in the demonstration and who lost eligibility for Medicaid during the measurement period due to failure to provide timely change in circumstance information	Administrative records	30 days	Month	Quarterly
Y	1.1.2 Mid-year loss of demonstration eligibility	Required	AD_9	Beneficiaries determined ineligible for Medicaid after state processes a change in circumstance reported by a beneficiary	Number of beneficiaries who were enrolled in the demonstration and lost eligibility for Medicaid during the measurement period because they are determined ineligible after the state processes a change in circumstance	Administrative records	30 days	Month	Quarterly
Y	1.1.2 Mid-year loss of demonstration eligibility	Required	AD_10	Beneficiaries no longer eligible for the demonstration due to transfer to another Medicaid eligibility group	Number of beneficiaries who were enrolled in the demonstration and transferred from the demonstration to a Medicaid eligibility group not included in the demonstration during the measurement period	Administrative records	30 days	Month	Quarterly
N	1.1.2 Mid-year loss of demonstration eligibility	Recommended	AD_11	Beneficiaries no longer eligible for the demonstration due to transfer to CHIP	Number of beneficiaries who were enrolled in the demonstration and transferred from the demonstration to CHIP during the measurement period	Administrative records	30 days	Month	Quarterly
N	1.1.3 Enrollment duration at time of disenrollment	Recommended	AD_12	Enrollment duration, 0-3 months	Number of demonstration beneficiaries who lost eligibility for Medicaid during the measurement period and whose enrollment spell had lasted 3 or fewer months at the time of disenrollment	Administrative records	30 days	Month	Quarterly
N	1.1.3 Enrollment duration at time of disenrollment	Recommended	AD_13	Enrollment duration, 4-6 months	Number of demonstration beneficiaries who lose eligibility for Medicaid during the measurement period whose enrollment spell had lasted between 4 and 6 months at the time of disenrollment	Administrative records	30 days	Month	Quarterly
N	1.1.3 Enrollment duration at time of disenrollment	Recommended	AD_14	Enrollment duration 6-12 months	Number of demonstration beneficiaries who lost eligibility for Medicaid during the measurement period whose enrollment spell had lasted 6 or more months (up to 12 months) at the time of disenrollment	Administrative records	30 days	Month	Quarterly
Y	1.1.4 Renewal	Required	AD_15	Beneficiaries due for renewal	Total number of beneficiaries enrolled in the demonstration who were due for renewal during the measurement period	Administrative records	30 days	Month	Quarterly

Y	1.1.4 Renewal	Required	AD_16	Beneficiaries determined ineligible for the demonstration at renewal, disenrolled from Medicaid	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who complete the renewal process and are determined ineligible for Medicaid	Administrative records	30 days	Month	Quarterly
Y	1.1.4 Renewal	Required	AD_17	Beneficiaries determined ineligible for the demonstration at renewal, transfer to another Medicaid eligibility category	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who complete the renewal process and move from the demonstration to a Medicaid eligibility group not included in the demonstration	Administrative records	30 days	Month	Quarterly
Y	1.1.4 Renewal	Required	AD_18	Beneficiaries determined ineligible for the demonstration at renewal, transferred to CHIP	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who complete the renewal process, but move from the demonstration to CHIP	Administrative records	30 days	Month	Quarterly
Y	1.1.4 Renewal	Required	AD_19	Beneficiaries who did not complete renewal, disenrolled from Medicaid	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who are disenrolled from Medicaid for failure to complete the renewal process	Administrative records	30 days	Month	Quarterly
Y	1.1.4 Renewal	Required	AD_20	Beneficiaries who had pending/uncompleted renewals and were still enrolled	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period for whom the state had not completed renewal determination by the end of the measurement period and were still enrolled	Administrative records	30 days	Month	Quarterly
Y	1.1.4 Renewal	Required	AD_21	Beneficiaries who retained eligibility for the demonstration after completing renewal forms	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who remained enrolled in the demonstration after responding to renewal notices	Administrative records	30 days	Month	Quarterly
N	1.1.4 Renewal	Recommended	AD_22	Beneficiaries who renewed ex parte	Number of beneficiaries enrolled in the demonstration and due for renewal during the measurement period who remained enrolled as determined by third-party data sources or available information, rather than beneficiary response to renewal notices	Administrative records	30 days	Month	Quarterly
Y	1.1.5 Cost sharing limit	Required	AD_23	Beneficiaries who reached 5% limit	Number of beneficiaries enrolled in the demonstration who reached the 5% of income limit on cost sharing and premiums during the month	Administrative records	30 days	Month	Quarterly
N	1.1.6 Appeals and grievances	Recommended	AD_24	Appeals, eligibility	Number of appeals filed by beneficiaries enrolled in the demonstration during the measurement period regarding Medicaid eligibility	Administrative records	None	Quarter	Quarterly
N	1.1.6 Appeals and grievances	Recommended	AD_25	Appeals, denial of benefits	Number of appeals filed by beneficiaries enrolled in the demonstration during the measurement period regarding denial of benefits	Administrative records	None	Quarter	Quarterly
N	1.1.6 Appeals and grievances	Recommended	AD_26	Grievances, care quality	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding the quality of care or services provided	Administrative records	None	Quarter	Quarterly
N	1.1.6 Appeals and grievances	Recommended	AD_27	Grievances, provider or managed care entities	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding a provider or managed care entity. Managed care entities include Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHP), and Prepaid Ambulatory Health Plans (PAHP).	Administrative records	None	Quarter	Quarterly
N	1.1.6 Appeals and grievances	Recommended	AD_28	Grievances, other	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding other matters that are not subject to appeal	Administrative records	None	Quarter	Quarterly
Y	1.1.7 Access to care	Required	AD_29	Primary care provider availability	Number of primary care providers enrolled to deliver Medicaid services at the end of the measurement period	Provider enrollment databases	90 days	Quarter	Quarterly
Y	1.1.7 Access to care	Required	AD_30	Primary care provider active participation	Number of primary care providers enrolled to deliver Medicaid services with service claims for 3 or more demonstration beneficiaries during the measurement period	Provider enrollment databases and claims and encounters	90 days	Quarter	Quarterly
Y	1.1.7 Access to care	Required	AD_31	Specialist provider availability	Number of specialists enrolled to deliver Medicaid services at the end of the measurement period	Provider enrollment databases	90 days	Quarter	Quarterly
Y	1.1.7 Access to care	Required	AD_32	Specialist provider active participation	Number of specialists enrolled to deliver Medicaid services with service claims for 3 or more demonstration beneficiaries during the measurement period	Provider enrollment databases and claims and encounters	90 days	Quarter	Quarterly
N	1.1.7 Access to care	Recommended	AD_33	Preventive care and office visit utilization	Total utilization of preventive care and office visits per 1,000 demonstration beneficiary months during the measurement period	Claims and encounters and other administrative records	90 days	Quarter	Quarterly
N	1.1.7 Access to care	Recommended	AD_34	Prescription drug use	Total utilization of 30-day prescription fills per 1,000 demonstration beneficiary months in the measurement period	Claims and encounters; other administrative records	90 days	Quarter	Quarterly
N	1.1.7 Access to care	Recommended	AD_35	Emergency department utilization, total	Total number of emergency department (ED) visits per 1,000 demonstration beneficiary months during the measurement period	Claims and encounters; other administrative records	90 days	Quarter	Quarterly

	1.1.7 Access to care	Recommended. Required for states with copayments for non-emergency use.	AD_36	Emergency department utilization, non-emergency	Total number of ED visits for non-emergency conditions per 1,000 demonstration beneficiary months during the measurement period. If the state differentiates emergent/non-emergent visit copayments, then non-emergency visits should be identified for monitoring purposes using the same criteria used to assess the differential copayment. If the state does not differentiate emergent/non-emergent copayments, then non-emergency visits should be defined as all visits not categorized as emergent using the method below.	Claims and encounters; other administrative records	90 days	Quarter	Quarterly	Y
	1.1.7 Access to care	Recommended	AD_37	Inpatient admissions	Total number of inpatient admissions per 1,000 demonstration beneficiary months during the measurement period	Claims and encounters; other administrative records	90 days	Quarter	Quarterly	N
	1.1.8 Quality of care and health outcomes	Required (AD_38A or AD_38B-1 - 3. States do not have to report both.)	AD_38A	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) [NCQA; NQF #0027; Medicaid Adult Core Set; Adjusted HEDIS measure]	This metric consists of the following components; each assesses different facets of providing medical assistance with smoking and tobacco use cessation: • Advising smokers and tobacco users to quit • Discussing cessation medications • Discussing cessation strategies	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan survey, Adult Version	90 days	Calendar year	Annually	
	1.1.8 Quality of care and health outcomes	Required (AD_38A or AD_38B. States do not have to report both.)	AD_38B	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (rate 1) [PCPI Foundation; NQF #0028]	This metric consists of the following components: 1. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months 2. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention 3. Percentage of beneficiaries aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user	Claims and encounters	90 days	Calendar year	Annually	
	1.1.8 Quality of care and health outcomes	Required	AD_39-1	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD) [NCQA; NQF # 2605; Medicaid adult Core Set; Adjusted HEDIS measure]	Percentage of ED visits for beneficiaries age 18 and older who have a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, and who had a follow-up visit with a corresponding principal diagnosis for AOD. Two rates are reported: 1. Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 30 days of the ED visit (31 total days). 2. Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	Claims and encounters	90 days	Calendar year	Annually	Y
	1.1.8 Quality of care and health outcomes	Required	AD_39-2	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF # 2605; Medicaid adult Core Set; Adjusted HEDIS measure]	Percentage of ED visits for beneficiaries age 18 and older who have a principal diagnosis of mental illness or intentional self-harm, and who had a follow-up visit with a corresponding principal diagnosis for mental illness. Two rates are reported: 1. Percentage of ED visits for mental illness or intentional self-harm for which the beneficiary received follow-up within 30 days of the ED visit (31 total days). 2. Percentage of ED visits for mental illness or intentional self-harm for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	Claims and encounters	90 days	Calendar year	Annually	Y
	1.1.8 Quality of care and health outcomes	Required	AD_40	Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 and older with a new episode of AOD abuse or dependence who received the following: 1. Initiation of AOD Treatment. Percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication assisted treatment (MAT) within 14 days of the diagnosis 2. Engagement of AOD Treatment. Percentage of beneficiaries who initiate treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit The following diagnosis cohorts are reported for each rate: (1) Alcohol abuse or dependence, (2) Opioid abuse or dependence, (3) Other drug abuse or dependence, and (4) Total AOD abuse or dependence. A total of 8 separate rates are reported for this measure.	Claims and encounters or EHR	90 days	Calendar year	Annually	Y
	1.1.8 Quality of care and health outcomes	Required	AD_41	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD) [AHRQ; NQF #0272; Medicaid Adult Core Set]	Number of inpatient hospital admissions for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 beneficiary months for beneficiaries age 18 and older	Claims and encounters	90 days	Calendar year	Annually	Y
	1.1.8 Quality of care and health outcomes	Required	AD_42	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD) [AHRQ; NQF #0275; Medicaid Adult Core Set]	Number of inpatient hospital admissions for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 beneficiary months for beneficiaries age 40 and older	Claims and encounters	90 days	Calendar year	Annually	Y
	1.1.8 Quality of care and health outcomes	Required	AD_43	PQI 08: Heart Failure Admission Rate (PQI08-AD) [AHRQ; NQF #0277; Medicaid Adult Core Set]	Number of inpatient hospital admissions for heart failure per 100,000 beneficiary months for beneficiaries age 18 and older	Claims and encounters	90 days	Calendar year	Annually	Y

	1.1.8 Quality of care and health outcomes	Required	AD_44	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD) [AHRQ; NQF #0283; Medicaid Adult Core Set]	Number of inpatient hospital admissions for asthma per 100,000 beneficiary months for beneficiaries aged 18 to 39	Claims and encounters	90 days	Calendar year	Annually
Y									
	1.1.9 Administrative cost	Recommended	AD_45	Administrative cost of demonstration operation	Cost of contracts or contract amendments and staff time equivalents required to administer demonstration policies, including premium collection, health behavior incentives, premium assistance, community engagement requirements and/or retroactive eligibility waivers	Administrative records	None	Demonstration year	Annually
N									
Add rows for any additional state-identified metrics									

[a] The reporting topics correspond to the prompts for reporting topic AD.Mod_1 in the monitoring report template.

End of workbook

Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications		Initial reporting date			
Baseline reporting period (MM/DD/YYYY--MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided specification (Y/N)	Explanation of any deviations from the CMS-provided specifications. Could include different data sources or state-specific definitions, policies, codes, target populations, etc.	Dates covered by first measurement period for metric (MM/DD/YYYY - MM/DD/YYYY)	Report name of first report in which the metric will be submitted (Format: DY1 Q3 quarterly report)	Submission date of first report in which the metric will be reported (MM/DD/YYYY)	State plans to phase in reporting (Y/N)
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	04/01/2019 - 06/30/2019	DY10 Q2	9/30/2019	N
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1	5/31/2020	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	04/01/2019 - 06/30/2019	DY10 Q2	9/30/2019	N
04/01/2020-06/30/2020	TBD	TBD	Y	N/A	04/01/2020-06/30/2020	DY11 Q1	8/31/2020	N
04/01/2020-06/30/2020	TBD	TBD	Y	N/A	04/01/2020-06/30/2020	DY11 Q1	8/31/2020	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1	5/31/2020	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1	5/31/2020	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1	5/31/2020	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1	5/31/2020	N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A	N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A	N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A	N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1	5/31/2020	N

01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020	N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A		N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020	N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A		N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A		N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A		N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A		N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A		N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020	N
01/01/2020-03/31/2020	TBD	TBD	Y	N/A	01/01/2020-03/31/2020	DY11 Q1		5/31/2020	N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A		N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A		N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A		N

01/01/2020-03/31/2020	TBD	TBD	N	TBD	01/01/2020-03/31/2020	DY11 Q1	5/31/2020	N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A	N
TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD	TBD
01/01/2020-12/31/2020	TBD	TBD	TBD	TBD	01/01/2020-12/31/2020	DY11 Annual Report	3/31/2021	N
01/01/2020-12/31/2020	TBD	TBD	TBD	TBD	01/01/2020-12/31/2020	DY11 Annual Report	3/31/2021	N
01/01/2020-12/31/2020	TBD	TBD	TBD	TBD	01/01/2020-12/31/2020	DY11 Annual Report	3/31/2021	N
01/01/2020-12/31/2020	TBD	TBD	TBD	TBD	01/01/2020-12/31/2020	DY11 Annual Report	3/31/2021	N
01/01/2020-12/31/2020	TBD	TBD	TBD	TBD	01/01/2020-12/31/2020	DY11 Annual Report	3/31/2021	N
01/01/2020-12/31/2020	TBD	TBD	TBD	TBD	01/01/2020-12/31/2020	DY11 Annual Report	3/31/2021	N

01/01/2020-12/31/2020	TBD	TBD	TBD	TBD	01/01/2020-12/31/2020	DY11 Annual Report		3/31/2021	N
N/A	N/A	N/A	N	N/A	N/A	N/A	N/A		N

Explanation of any plans to phase in reporting over time
N/A
The state does not have a suspension policy.
N/A
N/A
N/A
N/A
N/A
N/A
N/A
N/A Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established. Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established. Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established. Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established.
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Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established.

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Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established.

Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established.

Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established.

N/A

Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established.

TBD

TBD

N/A

N/A

N/A

N/A

N/A

N/A

N/A

N/A

Michigan will prioritize required metrics and will evaluate the feasibility of incorporating recommended metrics when demonstration waiver reporting becomes established.

Medicaid Section 1115 Eligibility and Coverage Demonstration Report - Data and reporting issues (AD)

State	Michigan
Demonstration Name	Healthy Michigan Plan
Demonstration Year (DY)	DY 12
Calendar Dates for DY	01/01/2021 - 12/31/2021
Reporting Period	Q4
Calendar Dates for Reporting Period	10/01/2021 - 12/31/2021
Submitted on	3/31/2022

Data Reporting Issues (AD)

Category	Metric(s) impacted
EXAMPLE: Appeals and grievances (Delete row before submitting)	*EXAMPLE: AD_23 Grievance, other*

Enrollment	*AD_7 - AD_10*
☐ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitorin	
Mid-year loss of demonstration eligibility	*[Add rows as needed]*
☐ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitorin	
Enrollment duration at time of disenrollment	*[Add rows as needed]*
☐ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitorin	
Renewal	*AD_15 - AD_21*
☐ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitorin	
Cost sharing limit	*[Add rows as needed]*
☑ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitorin	
Appeals and grievances	*[Add rows as needed]*
☑ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitorin	
Access to care	*AD_35*
☐ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitorin	
Quality of care and health outcomes	*AD_36 - AD_44*
☐ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitorin	
Administrative cost	*[Add rows as needed]*
☑ The state does not have any data and reporting issues related to this section. All associated metrics are reported as outlined in monitorin	

Note: States must prominently display the following notice on any display of Measure rates:

The MSC-AD, FUA-AD, FUM-AD, and IET_AD measures (metrics AD_38A, AD_39, and AD_40) are Healthcare Effe copyrighted by the National Committee for Quality Assurance ("NCQA"). NCQA makes no representations, warra reports performance measures and NCQA has no liability to anyone who relies on such measures or specificatior

The measure specification methodology used by CMS is different from NCQA's methodology. NCQA has not valic Calculated measure results, based on the adjusted HEDIS specifications, may be called only "Uncertified, Unaudit

Certain non-NCQA measures in the CMS 1115 eligibility and coverage demonstration contain HEDIS Value Sets (V contained in the VS. Users of the proprietary code sets should obtain all necessary licenses from the owners of tl NCQA measures and any coding contained in the VS.

[a] The state should also use this column to provide updates on any data or reporting issues described in previous r

End of workbook

Summary of issue	Date and report in which issue was first reported
EXAMPLE: *Difficulty collecting data for metric AD_23.*	*EXAMPLE:* *8/1/18; DY 1 Qtr. 1*
Difficulty collecting data	*DATE; DY10 Q2*
ıg protocol.	
g protocol.	
ıg protocol.	
Difficulty collecting data	*DATE; DY10 Q2*
ıg protocol.	
ıg protocol.	
ıg protocol.	
Difficulty collecting data	*DATE; DY10 Q2*
ıg protocol.	
Difficulty collecting data	*DATE; DY10 Q2*
ng protocol.	
ıg protocol.	

ctiveness Data and Information Set ("HEDIS®") measures that are owned and
ınties, or endorsement about the quality of any organization or physician that uses or
ıs.

ılated the adjusted measure specifications but has granted CMS permission to adjust.
ted HEDIS rates."

/S) developed by and included with the permission of the NCQA. Proprietary coding is
hese code sets. NCQA disclaims all liability for use or accuracy of the VS with the non-

reports. When applicable, the state should note when issues are resolved. If an issue was noted as resolved in the pre

Estimated number of impacted beneficiaries	Known or suspected cause(s) of issue (if applicable)
EXAMPLE: *24*	*EXAMPLE:* *Grievances are submitted via hardcopy through the mail to regional field offices. Often the field offices are slow to report the number of grievances they have received to the central office.*
Unknown	*The state is transitioning to the new waiver reporting format*
Unknown	*The state is transitioning to the new waiver reporting format*
Unknown	*The state is transitioning to the new waiver reporting format*
Unknown	*The state is transitioning to the new waiver reporting format*

vious report, it should not be reported in the current report.

Remediation plan and timeline for resolution (if applicable)/Status update if issue previously reported
EXAMPLE: *Central office is working on an electronic grievance filing system. That system will be completed by the end of the calendar year, and we will be able to quickly generate monthly, quarterly and yearly reports regarding grievances.*
The state will acquire the needed data and receive training on new data sources
The state will acquire the needed data and receive training on new data sources
The state will acquire the needed data and receive training on new data sources
The state will acquire the needed data and receive training on new data sources

Michigan Department of Health and Human Services

Medical Services Administration

Bureau of Medicaid Care Management and Quality Assurance

Healthy Michigan Plan
Healthy Behaviors Incentives Program Report

Quarterly Report
October-December 2021

Produced by:

Managed Care Plan Division

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Introduction

Pursuant to PA 208 of 2018, sections 105d(1)e and 105d(12), a Health Risk Assessment has been developed for the Healthy Michigan Plan (form DCH-1315). It is designed as a two part document, where the beneficiary completes the first three sections and the health care provider completes the last section. It includes questions on a wide range of health issues, a readiness to change assessment, and a discussion about behavior change between the beneficiary and the health care provider. The topics in the assessment cover all of the behaviors identified in PA 208 including alcohol use, substance use disorders, tobacco use, obesity and immunizations. It also includes the recommended healthy behaviors identified in the Michigan Health and Wellness 4X4 Plan, which include annual physicals, healthy diet, regular physical exercise and reducing tobacco use. As of April 2018, three new questions were added on the topics of annual dental visit, access to transportation and unmet basic needs. The question on anxiety and depression was removed and replaced with a question on chronic stress based on feedback regarding the most meaningful ways to ask about self-reported behavioral health status.

Health Risk Assessment Part 1

Health Risk Assessments completion through Michigan ENROLLS

In February 2014, the enrollment broker for the Michigan Department of Health and Human Services (Michigan ENROLLS) began administering the first section of the Health Risk Assessment to Healthy Michigan Plan beneficiaries who call to enroll in a health plan. In addition to asking new beneficiaries all of the questions in Section 1 of the Health Risk Assessment, call center staff inform beneficiaries that an annual preventive visit, including completion of the last three sections of the Health Risk Assessment, is a covered benefit of the Healthy Michigan Plan.

Completion of the Health Risk Assessment is voluntary; callers may refuse to answer some or all of the questions. Beneficiaries who are auto-assigned into a health plan are not surveyed. Survey results from Michigan ENROLLS are updated daily in CareConnect360 for secure transmission to the appropriate health plan to assist with outreach and care management.

The completion of the Health Risk Assessment with the enrollment broker was temporarily put on hold in May 2019.

Health Risk Assessment Part 2

Health Risk Assessments completion with Provider Attestation

In April 2014, the Healthy Michigan Plan was launched, and an initial preventive health visit to a primary care provider was promoted for all new beneficiaries. Beneficiaries were also encouraged to complete the last section of the Health Risk Assessment at this initial appointment. This final section of the Health Risk Assessment is designed as a tool for identifying annual healthy behavior goals.

Completion of this section of the Health Risk Assessment is also voluntary. Healthy Michigan Plan Beneficiaries who complete a Health Risk Assessment with a health care provider attestation and agree to maintain or address healthy behaviors are eligible for an incentive. Beginning in April 2018, in discussion with the beneficiary, health care providers also choose between 4 statements to attest to whether the beneficiary achieved or made significant progress towards the healthy behavior goal(s) he or she had previously selected to work on the year before. Only beneficiaries who both made significant progress towards the previous year goal AND select one or more goals for the upcoming year are eligible for an incentive.

The data displayed in Part 2 of this report reflect the healthy behavior goals selected in the final section of the Health Risk Assessment. As shown in Table 13, a total of 18,655 Health Risk Assessments were completed in the October-December 2021 quarter. Health Risk Assessment completion is reported by age, gender and Federal Poverty Level in Table 14.

Among beneficiaries who completed the Health Risk Assessment, 14,915 or 80.0% of beneficiaries agreed to address health risk behaviors. In addition, 3,433 or 18.4% of beneficiaries who completed the Health Risk Assessment chose to maintain current healthy behaviors, meaning that 98.4% of beneficiaries are choosing to address or maintain healthy behaviors. The healthy behaviors goal statements selected are reported in Table 15. Healthy behavior goal statements are also reported by age and FPL in Figures 15-2 and 15-3.

Of the 14,915 beneficiaries who agreed to address health risk behaviors, 53.1% chose to address more than one healthy behavior. Tables 13 and 14 report the most frequently selected health risk behaviors to address, alone and in combination.

Health Risk Assessment Completion with Health Care Provider

Table 13. Count of Health Risk Assessments (HRA) Completed with Attestation by Month submitted

MONTH	COMPLETE	TOTAL
January 2021	5,095	422,306
February 2021	5,809	428,115
March 2021	8,502	436,617
April 2021	8,475	445,092
May 2021	6,977	452,069
June 2021	7,121	459,190
July 2021	6,640	465,830
August 2021	6,983	472,813
September 2021	6,998	479,811
October 2021	6,372	486,183
November 2021	6,899	493,082
December 2021	5,384	498,466

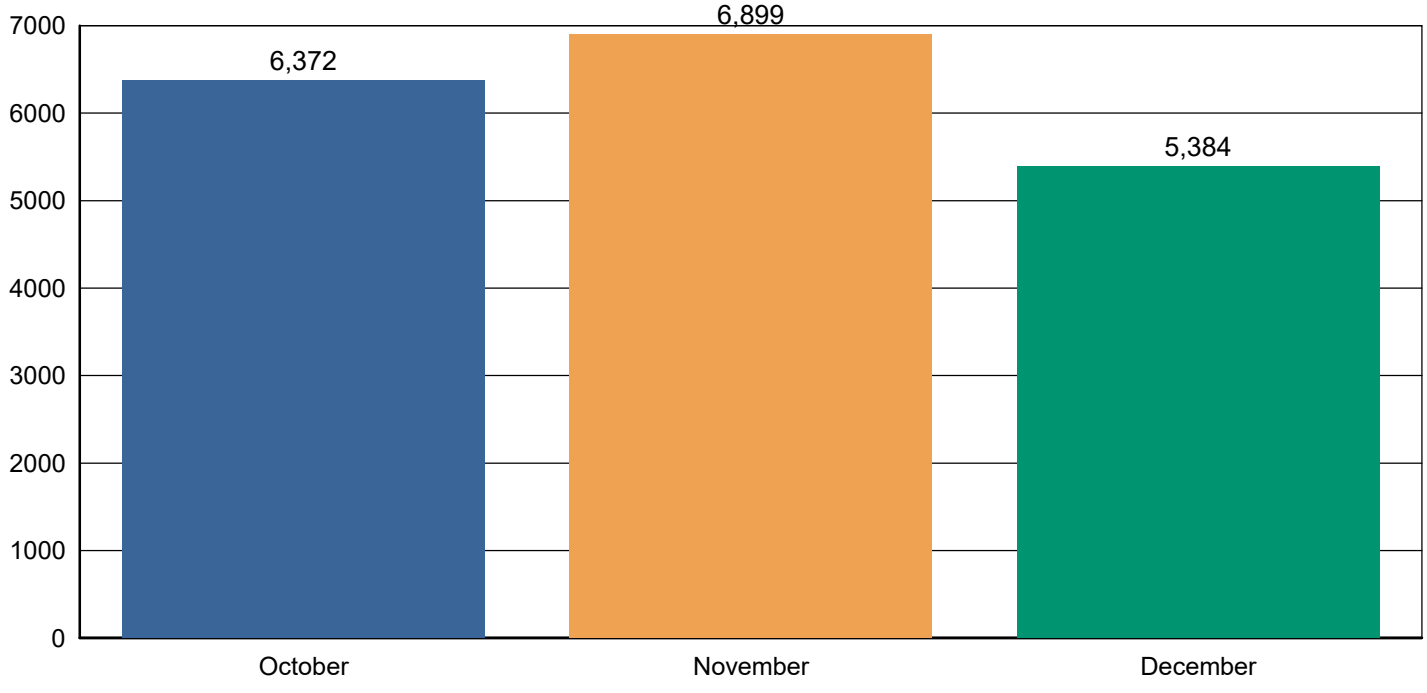
Table 14. Demographics of Population that Completed HRA with Attestation

October 2021 - December 2021

AGE GROUP	COMPLETED HRA	
19 - 34	6,314	33.85%
35 - 49	5,201	27.88%
50 +	7,140	38.27%
GENDER		
F	10,578	56.70%
M	8,077	43.30%
FPL		
< 100% FPL	14,281	76.55%
100 - 133% FPL	4,374	23.45%
TOTAL	**18,655**	**100.00%**

Figure 13-1. Health Risk Assessments Completed with Attestation

October - December 2021



Healthy Behaviors Statement Selection

Section 4. Healthy Behaviors: In discussion with the beneficiary, health care providers choose between 5 statements to attest to the healthy behaviors goals that the beneficiary will strive for this year. The 5 statements are:

A. Patient does not have health risk behaviors that need to be addressed at this time.

B. Patient has identified at least one behavior to address over the next year to improve their health.

C. Patient has a serious medical, behavioral or social condition or conditions which precludes addressing unhealthy behaviors at this time.

D. Unhealthy behaviors have been identified, patient's readiness to change has been assessed, and patient is not ready to make changes at this time.

E. Patient has committed to maintain their previously achieved Healthy Behavior Goal(s).

Figures 15-1 through 15-3 show Healthy Behaviors Statement Selections for the total population, and by age and FPL.

Table 15. Healthy Behaviors Statement Selection
October - December 2021

CHECK-UP	TOTAL	PERCENT
A. No Health Risk Behaviors	3,148	16.88%
B. Address Health Risk Behaviors	14,915	79.95%
C. Condition(s) Preclude Addressing Health Risk Behaviors	169	0.91%
D. Not Ready	138	0.74%
E. Maintain Previous Healthy Behavior Goals	285	1.53%
TOTAL	**18,655**	**100.00%**

Figure 15-1. Healthy Behaviors Statement Selection
October - December 2021

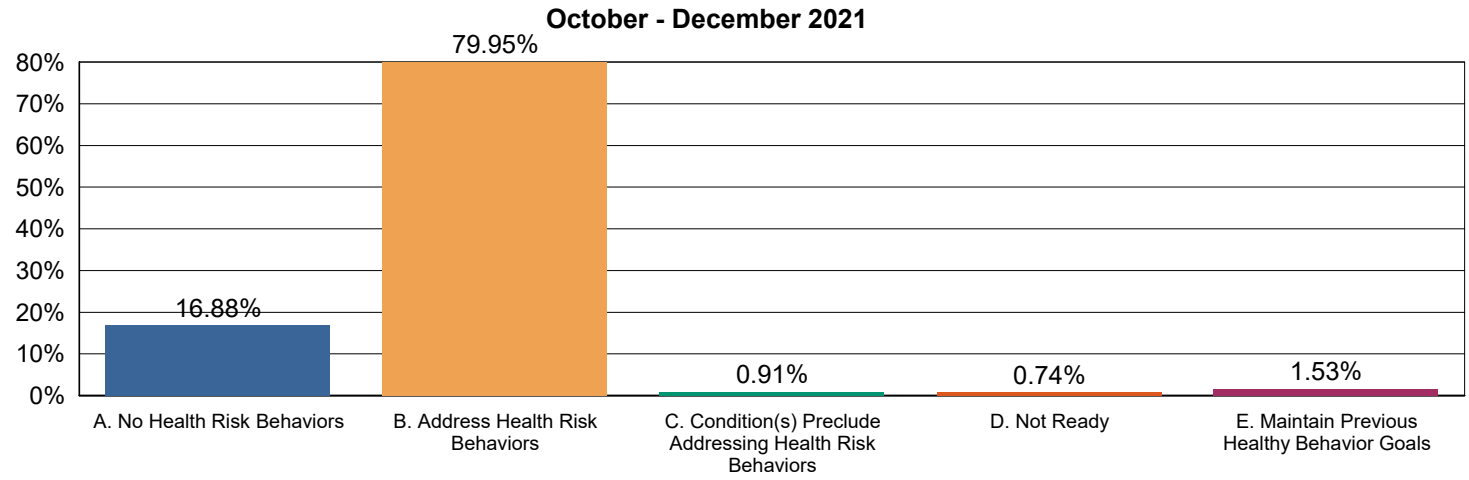


Figure 15-2. Statement Selection by Age
October - December 2021

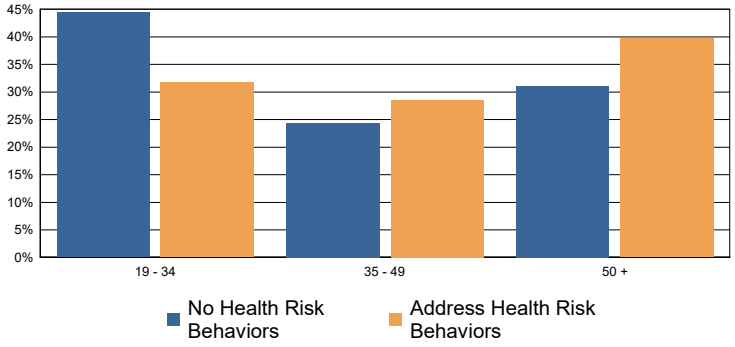
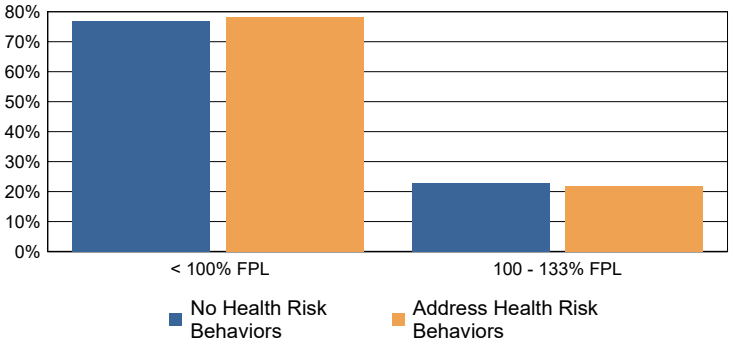


Figure 15-3. Statement Selection by FPL
October - December 2021



Selection of Health Risk Behaviors to Address

Section 4. Healthy Behaviors: In discussion with the beneficiary, when Statement B, "Patient has identified at least one behavior they intend to address over the next year to improve their health" is selected, providers choose one or more of the following 11 statements to identify the healthy behaviors the beneficiary has chosen to address for the year:

1. Increase physical activity, Learn more about nutrition and improve diet, and/or weight loss.
2. Reduce/quit tobacco use.
3. Annual Influenza vaccine.
4. Agrees to follow-up appointment for screening or management (if necessary) of hypertension, cholesterol and/or diabetes.
5. Reduce/quit alcohol consumption.
6. Treatment for Substance Use Disorder.
7. Dental Visit.
8. Follow-up appointment for maternity care/reproductive health.
9. Follow-up appointment for recommended cancer or other preventative screening(s).
10. Follow-up appointment for mental health/behavioral health.
11. Other: explain _____

Of the 14,915 HRAs submitted through October-December 2021 where the beneficiary chose to address health risk behaviors, 53.12% of beneficiaries chose more than one healthy behavior to address. The top 10 most selected behavior combinations and the rate that each behavior was selected in combination and alone are presented in the tables below:

Table 16. Health Risk Behaviors Selected in Combination and Alone

Health Risk Behavior	Chose this behavior and at least one more	Chose ONLY this behavior
Weight Loss	63.02%	23.37%
Tobacco Cessation	23.90%	6.07%
Immunization Status (Annual Flu Vaccine)	29.53%	2.58%
Follow-up for Chronic Conditions	32.42%	5.26%
Addressing Alcohol Abuse	3.70%	0.35%
Addressing Substance Abuse	1.54%	0.26%
Dental visit	14.94%	2.84%
Follow-up appointment for maternity care/reproductive health	1.76%	0.19%
Follow-up appointment for recommended cancer or other preventative screening(s)	14.80%	1.60%
Follow-up appointment for mental health/behavioral health	7.24%	1.78%
Other	6.38%	2.59%

Table 17. Top 10 Most Selected Health Risk Behavior Combinations

Health Risk Behavior Combination	Count	Percent
1. Weight Loss ONLY	3,486	23.37%
2. Tobacco Cessation ONLY	906	6.07%
3. Follow-up for Chronic Conditions	784	5.26%
4. Weight Loss, Follow-up for Chronic Conditions	764	5.12%
5. Weight Loss, Immunization Status	726	4.87%
6. Weight Loss, Immunization Status, Follow-up for Chronic Conditions	530	3.55%
7. Weight Loss, Tobacco Cessation	527	3.53%
8. Other	386	2.59%
9. Immunization Status (Annual Flu Vaccine)	384	2.58%
10. Immunization Status, Follow-up for Chronic Conditions	289	1.94%
Total for Top 10	8,782	58.88%
Total for All Other Combinations	6,133	41.12%
Total	**14,915**	**100.00%**

Healthy Behaviors Goals Progress

Section 4. Healthy Behaviors Goals Progress: In discussion with the patient, health care providers choose between 4 statements to attest to whether the patient achieved or made significant progress towards the health behavior goal(s) he or she had previously selected to work on the year before. The 4 statements are:

A. Not applicable - this is the first known Healthy Michigan Plan Health Risk Assessment for this patient.
B. Yes.
C. No.
D. Patient had a serious medical, behavioral, or social condition or conditions which precluded addressing unhealthy behaviors.

1,103 Health Risk Assessments were submitted during this quarter where this question was not available because the Healthy Behavior Goals Progress question was not available on the original form of the Health Risk Assessment.

Figures 18-1 through 18-3 show Healthy Behavior Goals Progress for the total population, and by age and FPL.

Table 18. Healthy Behaviors Goals Progress
October - December 2021

GOALS PROGRESS	TOTAL	PERCENT
A. First known HRA	10,486	59.74%
B. Achieved Goal(s)	6,077	34.62%
C. Did Not Achieve Goal(s)	895	5.10%
D. Condition(s) Precludе Addressing Health Risk Behaviors	94	0.54%
TOTAL	**17,552**	**100.00%**

Figure 18-1. Healthy Behaviors Goals Progress
October - December 2021

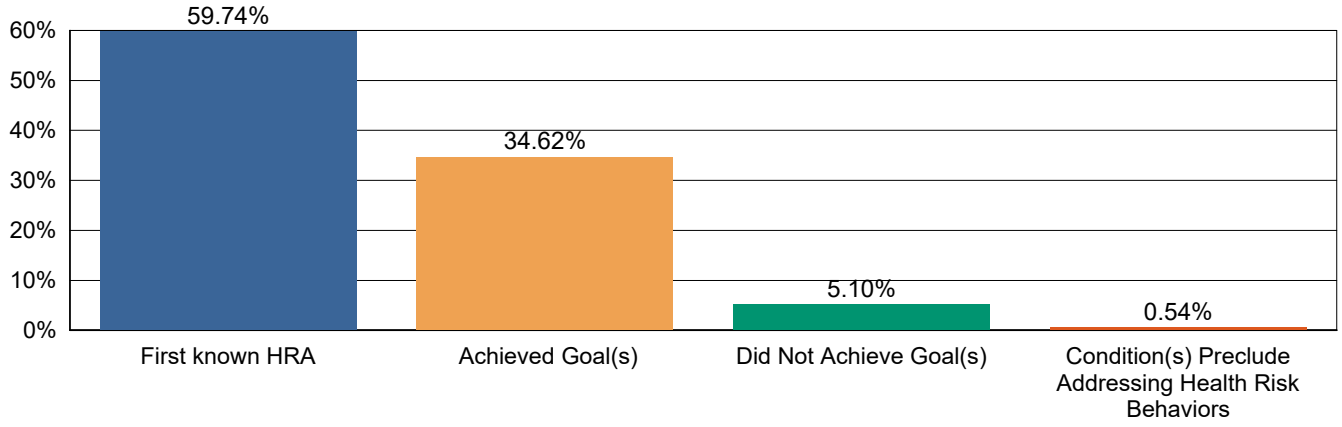


Figure 18-2. Statement Selection by Age
October - December 2021

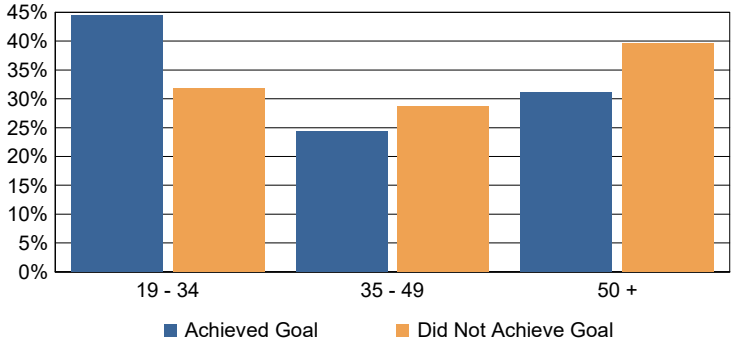
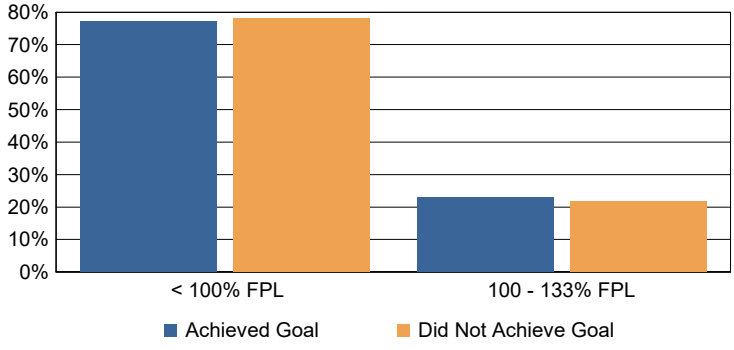


Figure 18-3. Statement Selection by FPL
October - December 2021



Additional Healthy Behaviors

To improve the ability of individuals to participate in the Healthy Behaviors Incentives Program, additional mechanisms to document healthy behaviors were added April 1, 2018 for individuals who may have completed healthy behavior activities but do not have a submitted Health Risk Assessment for documentation. The mechanisms include documented participation in approved wellness and population health management programs and claims/encounters review for beneficiaries who utilize preventive and wellness services. Completion of these additional healthy behavior options is also voluntary. The data displayed in this section of the report reflect counts of the number of wellness programs and preventive services completed by beneficiaries. Beneficiaries may choose to complete one or more of these programs in a given 12 month period, however, they will still only be eligible for one incentive per year. The last section of this report focuses on the number of distinct HMP beneficiaries who completed one or more healthy behavior activities.

A total of 6,405 wellness programs were completed in the October-December 2021 quarter. Wellness Program completion is reported by age, gender and Federal Poverty Level in Table 20. Wellness Programs are reported by health domain in Table 21.

A total of 393,997 Preventive Services were completed in the October-December 2021 quarter. Preventive Services completion is reported by age, gender and Federal Poverty Level in Table 23. Preventive Services are reported by health domain in Table 24.

A total of 393,187 distinct HMP beneficiaries completed at least one healthy behavior in the previous twelve months, January 01, 2021-December 31, 2021. Healthy Behavior completion is reported by type of healthy behavior activity in Table 25.

Wellness Programs

Table 19. Count of Wellness Programs Reported for Total population by Month submitted

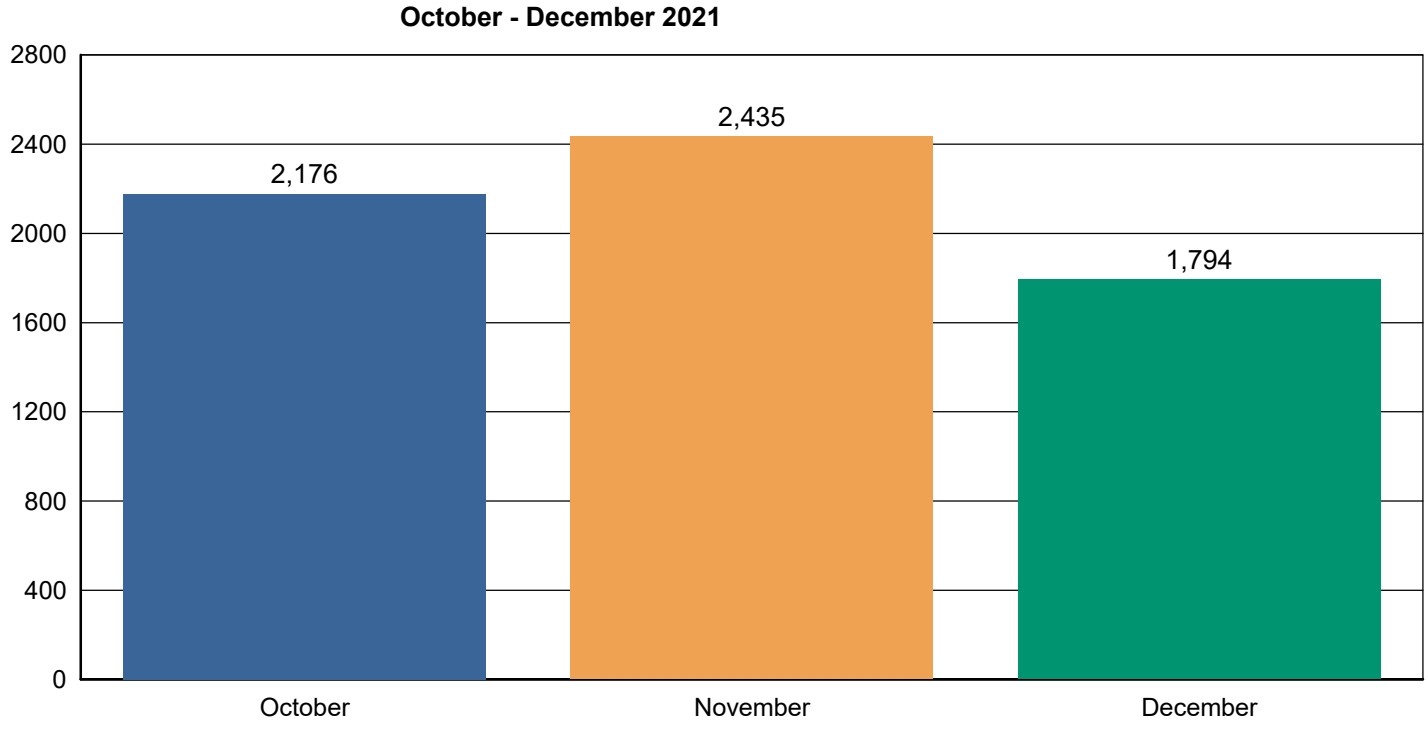
MONTH	COMPLETE	TOTAL
January 2021	2,447	102,758
February 2021	2,071	104,829
March 2021	3,598	108,427
April 2021	3,448	111,875
May 2021	2,524	114,399
June 2021	2,941	117,340
July 2021	2,440	119,780
August 2021	2,270	122,050
September 2021	3,047	125,097
October 2021	2,176	127,273
November 2021	2,435	129,708
December 2021	1,794	131,502

Table 20. Wellness Programs Reported for Age Group, Gender and FPL

October 2021 - December 2021

AGE GROUP	COMPLETED	
19 - 34	1,431	22.34%
35 - 49	2,327	36.33%
50 +	2,647	41.33%
GENDER		
F	3,165	49.42%
M	3,240	50.59%
FPL		
< 100% FPL	5,160	80.56%
100 - 133% FPL	1,245	19.44%
TOTAL	**6,405**	**100.00%**

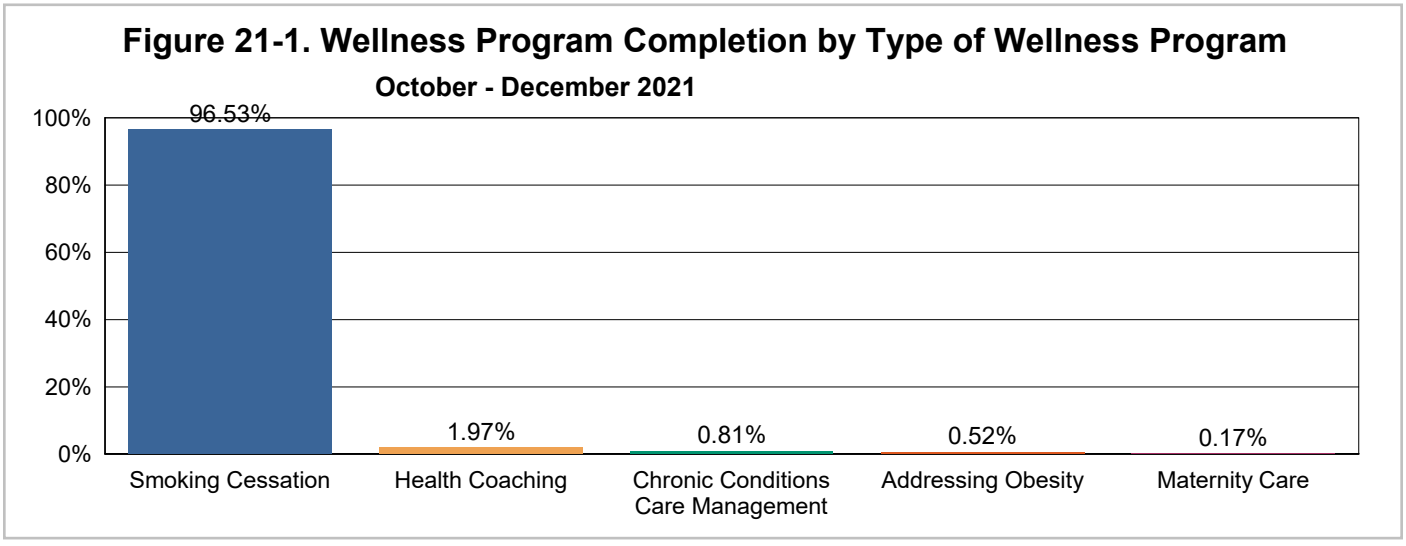
Figure 19-1. Wellness Program Reported for Total Population



Wellness Programs: The Managed Care Plans offer a range of wellness and population health management programs to their members as part of the Healthy Behaviors Incentives Program. All Managed Care Plans offer a tobacco cessation program which follows standardized criteria. For this reason, 96.53% of wellness programs reported are tobacco cessation programs. Completed wellness programs by program type are displayed in Table 21 for the quarter October-December 2021.

Table 21. Wellness Program Completition by Type of Wellness Program
October - December 2021

Wellness Programs	TOTAL	PERCENT
Smoking Cessation	6,183	96.53%
Health Coaching	126	1.97%
Chronic Conditions Care Management	52	0.81%
Addressing Obesity	33	0.52%
Maternity Care	11	0.17%
TOTAL	**6,405**	**100.00%**



Preventive Services

Table 22. Count of Preventive Services Reported for Total population by Month submitted

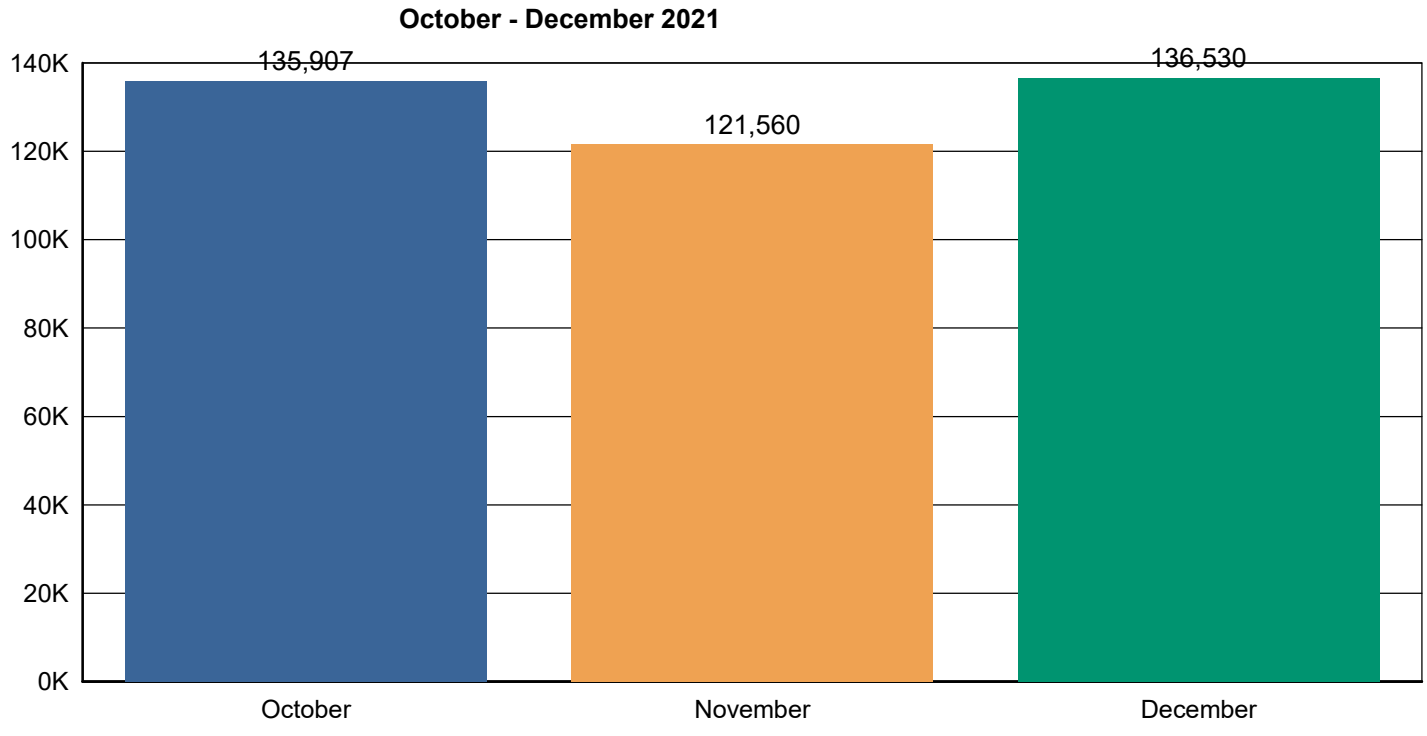
MONTH	COMPLETE	TOTAL
January 2021	119,982	4,541,933
February 2021	96,754	4,638,687
March 2021	195,569	4,834,256
April 2021	179,080	5,013,336
May 2021	128,438	5,141,774
June 2021	136,601	5,278,375
July 2021	124,568	5,402,943
August 2021	110,598	5,513,541
September 2021	128,238	5,641,779
October 2021	135,907	5,777,686
November 2021	121,560	5,899,246
December 2021	136,530	6,035,776

Table 23. Preventive Services Reported for Age Group, Gender and FPL

October 2021 - December 2021

AGE GROUP	COMPLETED	
19 - 34	166,946	42.37%
35 - 49	104,231	26.46%
50 +	122,820	31.17%
GENDER		
F	286,498	72.72%
M	107,499	27.28%
FPL		
< 100% FPL	296,339	75.21%
100 - 133% FPL	97,658	24.79%
TOTAL	**393,997**	**100.00%**

Figure 22-1. Preventive Services Reported for Total Population

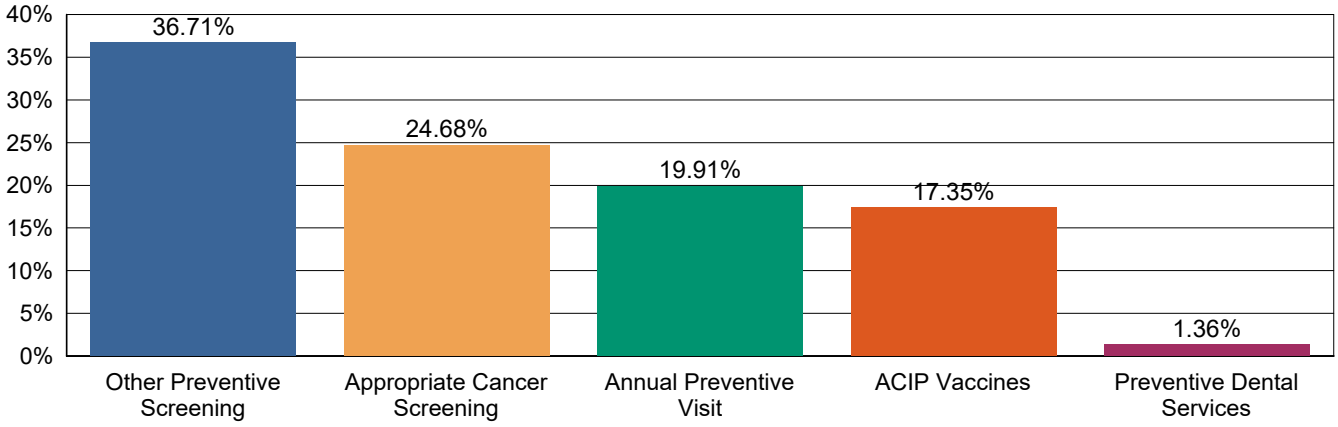


Preventive Services Reported: All Healthy Michigan Plan Enrollees can participate in the Healthy Behaviors Incentives Program by utilizing select preventive services. Utilization of these services are identified through claims/encounter review. The preventive services utilized and their percentage of total preventive services reported are displayed in Table 24 for the quarter October-December 2021. The associated codes for the selected preventive services can be found in Appendix 1.

Table 24. Preventive Services Completion by Type of Preventive Service
October - December 2021

Preventive Services	TOTAL	PERCENT
Other Preventive Screening	144,620	36.71%
Appropriate Cancer Screening	97,230	24.68%
Annual Preventive Visit	78,437	19.91%
ACIP Vaccines	68,368	17.35%
Preventive Dental Services	5,342	1.36%
TOTAL	**393,997**	**100.00%**

Figure 24-1. Preventive Services Completion by Type of Preventive Service
October - December 2021



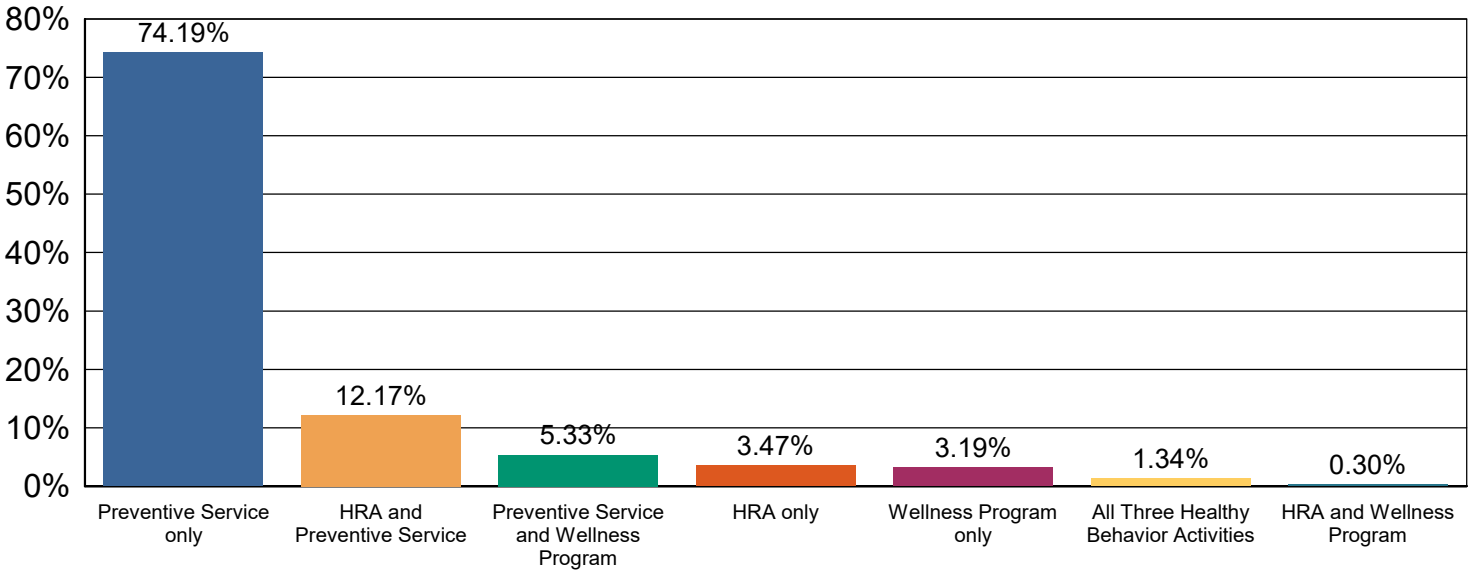
Healthy Behavior Activities

Table 25. Count of distinct HMP beneficiaries who completed Healthy Behavior Activities for January 2021 - December 2021

Healthy Behavior Activity	Total	Percent
HRA only	13,637	3.47%
Wellness Program only	12,544	3.19%
Preventive Service only	291,706	74.19%
HRA and Preventive Service	47,864	12.17%
HRA and Wellness Program	1,199	0.31%
Preventive Service and Wellness Program	20,952	5.33%
All Three Healthy Behavior Activities	5,285	1.34%
TOTAL	**393,187**	**100.00%**

Figure 25.1 Count of Distinct HMP Beneficiaries who completed one or more Healthy Behavior Activities

January 2021 - December 2021



Appendix 1: Healthy Behaviors incentives Program - Preventive Services Procedure and Diagnosis Codes

PREVENTIVE DENTAL SERVICES	
PROCEDURE CODE	DIAGNOSIS CODE
D0120	Z0120, Z0121, Z1384
D0191	Z0120, Z0121, Z1384
D1110	Z0120, Z0121, Z1384
D1354	Z0120, Z0121

ACIP VACCINES	
PROCEDURE CODE	DIAGNOSIS CODE
90620	NA
90621	NA
90630	NA
90632	NA
90636	NA
90649	NA
90650	NA
90651	NA
90654	NA
90656	NA
90658	NA
90661	NA
90670	NA
90673	NA
90674	NA
90686	NA
90688	NA
90707	NA
90714	NA
90715	NA
90716	NA
90732	NA
90733	NA
90734	NA
90736	NA
90740	NA
90744	NA
90746	NA
90747	NA
G0008	NA
G0009	NA
G0010	NA
Q2034	NA
Q2035	NA
Q2036	NA
Q2037	NA
Q2038	NA
Q2039	NA

ANNUAL PREVENTIVE VISIT	
PROCEDURE CODE	DIAGNOSIS CODE
99385	NA
99386	NA
99395	NA
99396	NA
99401	NA
99402	NA

CANCER SCREENING: BREAST	
PROCEDURE CODE	DIAGNOSIS CODE
77063	NA
77067	NA
G0202	NA

CANCER SCREENING: CERVICAL/VAGINAL	
PROCEDURE CODE	DIAGNOSIS CODE
87623	NA
87624	NA
87625	NA
88141	NA
88142	NA
88143	NA
88147	NA
88148	NA
88155	NA
88164	NA
88165	NA
88166	NA
88167	NA
88174	NA
88175	NA
G0101	NA
G0476	NA
Q0091	NA

CANCER SCREENING: COLORECTAL	
PROCEDURE CODE	DIAGNOSIS CODE
45330	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
45331	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
45333	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
45338	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
45346	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
45378	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
45380	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
45384	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
45385	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
45388	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
81528	NA
82270	NA
82274	Z1211, Z1212, Z1213, Z800, Z8371, Z86010
G0104	NA
G0105	NA
G0121	NA
G0328	NA

CANCER SCREENING: LUNG	
PROCEDURE CODE	DIAGNOSIS CODE
71250	F172, Z122, Z720, Z87891
G0297	NA

CANCER SCREENING: PROSTATE	
PROCEDURE CODE	DIAGNOSIS CODE
84152	Z125, Z8042
84153	Z125, Z8042
84154	Z125, Z8042
G0102	NA
G0103	NA

HEP C VIRUS INFECTION SCREENING	
PROCEDURE CODE	DIAGNOSIS CODE
86803	NA
G0472	NA

HIV SCREENING	
PROCEDURE CODE	DIAGNOSIS CODE
86689	Z114
86701	Z114
86702	Z114
86703	Z114
87389	Z114
87390	Z114
87391	Z114
87534	Z114
87535	Z114
87536	Z114
87537	Z114
87538	Z114
87539	Z114
87806	Z114
G0432	NA
G0433	NA
G0435	NA

OSTEOPOROSIS SCREENING	
PROCEDURE CODE	DIAGNOSIS CODE
76977	Z13820, Z8262
77078	Z13820, Z8262
77080	Z13820, Z8262
77081	Z13820, Z8262

STI SCREENING: CHLAMYDIA	
PROCEDURE CODE	DIAGNOSIS CODE
87110	NA
87270	NA
87320	NA
87490	NA
87491	NA
87492	NA
87810	NA

STI SCREENING: GONORRHEA	
PROCEDURE CODE	DIAGNOSIS CODE
87590	NA
87591	NA
87592	NA
87850	NA

STI SCREENING: HEP B (NONPREGNANT)	
PROCEDURE CODE	DIAGNOSIS CODE
86704	NA
86705	NA
86706	NA
87340	NA
G0499	NA

STI SCREENING: SYPHILIS (NONPREGNANT)	
PROCEDURE CODE	DIAGNOSIS CODE
86592	NA
86593	NA

TUBERCULOSIS SCREENING	
PROCEDURE CODE	DIAGNOSIS CODE
86480	Z111, Z201
86481	Z111, Z201
86580	Z111, Z201
87116	Z111, Z201

Health and Aging Services Administration
Bureau of Medicaid Care Management and Customer Service

PERFORMANCE MONITORING REPORT

Healthy Michigan Plan Measures

Composite – All Plans

January 2022

Revised February 3, 2022

Produced by:
Quality Improvement and Program Development – Managed Care Plan Division

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Executive Summary

This Performance Monitoring Report (PMR) is produced by the Quality Improvement and Program Development (QIPD) Section of the Managed Care Plan Division (MCPD) to track quality, access, and utilization in the Michigan Medicaid program to better support high quality care for beneficiaries.

The Michigan Department of Health and Human Services (MDHHS) monitors the performance of the State's Medicaid Health Plans (MHPs) through 22 key performance measures aimed at improving the quality and efficiency of health care services provided to the Michigan residents enrolled in a Medicaid program. These measures include Healthy Michigan Plan (HMP) Measures, MDHHS Dental Measures, CMS Core Set Measures, HEDIS Measures, and Managed Care Quality Measures. **This report focuses only on the following HMP Measures:**

Healthy Michigan Plan (HMP) Measures				
Adults' Generic Drug Utilization	*Completion of Annual HRA*	*Outreach & Engagement to Facilitate Entry to PCP*	*Transition into Consistently Fail to Pay (CFP) Status*	*Transition out of Consistently Fail to Pay (CFP) Status*

Data for these measures are represented on a quarterly basis. The body of the report contains a cross-plan analysis of the most current data available for each of these measures. Measurement Periods may vary and are based on the specifications for that individual measure. Appendix A contains specific three letter codes identifying each of the MHPs. Appendix B contains the one-year plan specific analysis for each measure.

MHPs are contractually obligated to achieve specified standards for most measures. The following table displays the number of MHPs meeting or exceeding the standards for the performance measure versus total MHPs, as reported in the Performance Monitoring Report, during the listed quarter for fiscal year 2022 unless otherwise noted.

Table 1: Fiscal Year 2022[1]

Quarterly Reported Measures	**Reported in 1st Quarter**		**Reported in 2nd Quarter**		**Reported in 3rd Quarter**		**Reported in 4th Quarter**	
Adults' Generic Drug Utilization	N/A							
Completion of Annual HRA	4/10							
Outreach & Engagement to Facilitate Entry to PCP	7/10							
	> 100% FPL	≤100% FPL	> 100% FPL	≤100% FPL	> 100% FPL	≤100% FPL	> 100% FPL	≤100% FPL
Transition into CFP Status – Cohort 1	8/9	9/9						
Transition into CFP Status – Cohort 2	9/9	9/9						
Transition into CFP Status – Cohort 3	9/9	8/9						
Transition out of CFP Status – Cohort 1	7/7	7/8						
Transition out of CFP Status – Cohort 2	9/9	7/9						
Transition out of CFP Status – Cohort 3	9/9	8/9						

[1] Results with a denominator less than 9 for the Transition into CFP Status measure do not include those with a result of "N/A".

Healthy Michigan Plan Enrollment

Michigan Medicaid Managed Care (HMP-MC) enrollment has remained steady over the past year. In December 2021, enrollment was 762,101, up 58,207 enrollees (8.3%) from January 2021. An increase of 2,116 enrollees (0.3%) was realized between November 2021 and December 2021.

Figure 1: HMP-MC Enrollment, January 2021 – December 2021

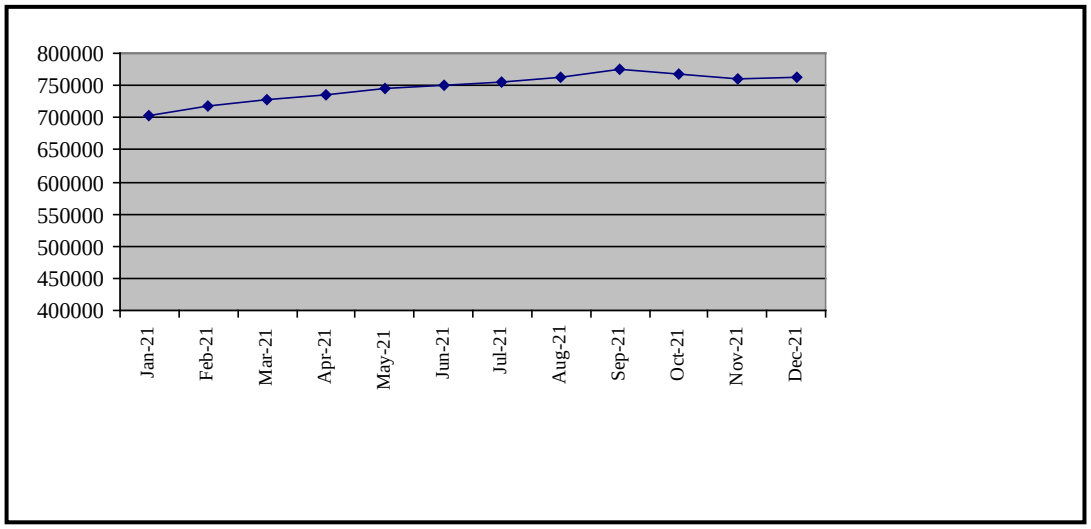
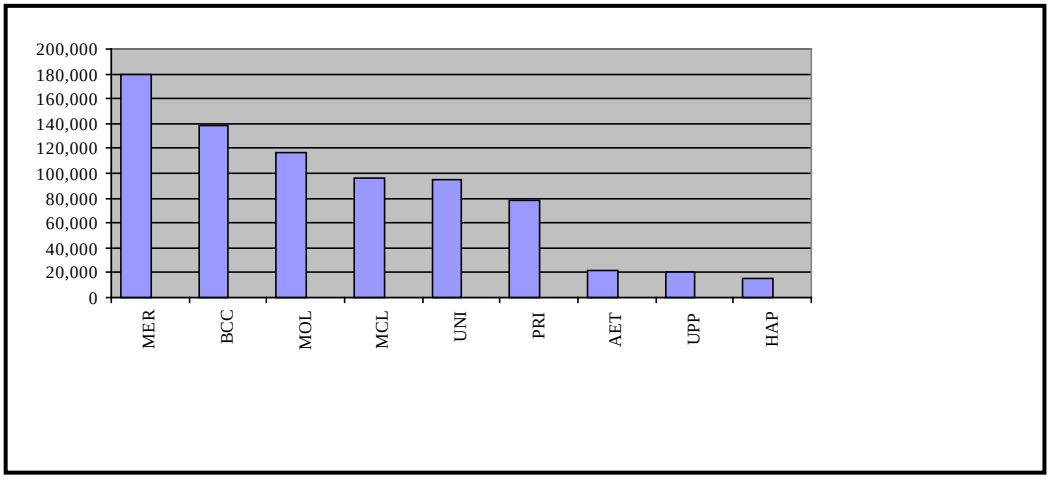


Figure 2: HMP-MC Enrollment by Medicaid Health Plan, January 2021



Medicaid Health Plan News

The Performance Monitoring Report contains data for all Michigan Medicaid Health Plans, where data is available. Ten Medicaid Health Plans are contracted with the State of Michigan to provide comprehensive health care services.

As of October 1, 2021, Total Health Care (THC) is no longer an active Medicaid Health Plan. However, their information will continue to appear in the quarterly PMRs until such data is no longer available.

Cross-Plan Performance Monitoring Analyses

The following section includes a cross-plan analysis for each performance measure. An analysis of the most current data available for each performance measure is included. For detailed questions regarding measurement periods or standards, see the Performance Monitoring Specifications.

Adults' Generic Drug Utilization

Measure
The percentage of generic prescriptions filled for adult members of health plans during the measurement period.

Standard
N/A – Informational Only

Measurement Period
April 2021 – June 2021

Data Source
MDHHS Data Warehouse

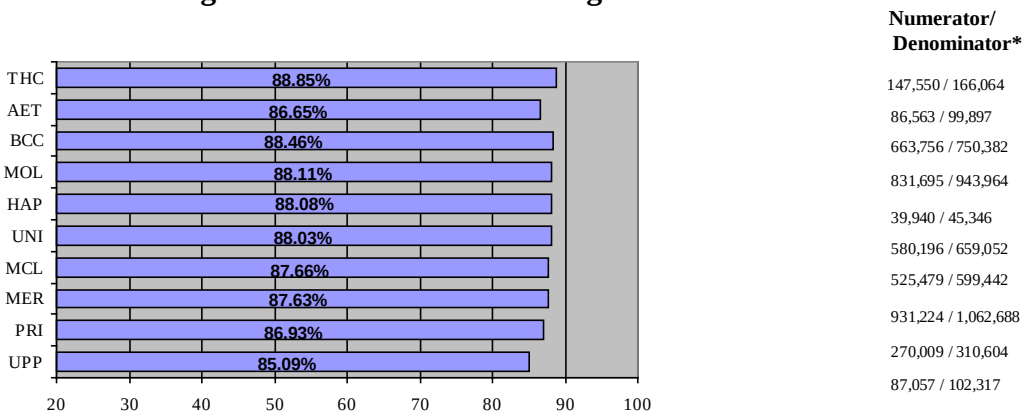
Measurement Frequency
Quarterly

Summary: Results ranged from 85.09% to 88.85%.

Table 2: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	4,196,277	4,777,032	87.84%
Fee for Service (FFS) only	4,355	5,039	86.43%
Managed Care only	4,174,768	4,752,518	87.84%
MA-MC	1,915,383	2,189,139	87.49%
HMP-MC	2,234,916	2,535,780	88.14%

Figure 3: Adults' Generic Drug Utilization



Adult's Generic Drug Utilization Percentages

*Numerator depicts the number of eligible beneficiaries who had generic prescriptions filled. Denominator depicts the total number of eligible beneficiaries.

Completion of Annual Health Risk Assessment (HRA)

Measure
The percentage of Healthy Michigan Plan members enrolled in a health plan who had an incentive eligible Health Risk Assessment (HRA) completed during the measurement period.

Standard
At or above 12% (as shown on bar graph below)

Measurement Period
July 2020 – June 2021

Data Source
MDHHS Data Warehouse

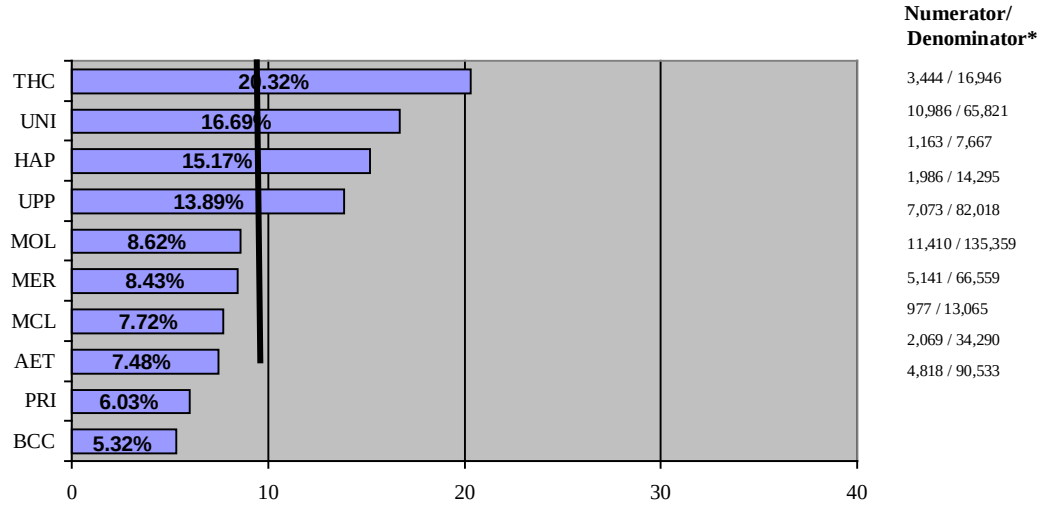
Measurement Frequency
Quarterly

Summary: Four plans (**HAP, THC, UNI, and UPP)**, met or exceeded the standard, while six plans (AET, BCC, MCL, MER, MOL, and PRI), did not. Results ranged from 5.32% to 20.32%.

Table 3: Program Total

Medicaid Program	Numerator	Denominator	Percentage
HMP-MC	54,240	587,051	9.24%

Figure 4: Completion of Annual HRA



Completion of Annual HRA Percentages

*Numerator depicts the number of eligible beneficiaries who completed at least one incentive eligible HRA with an attestation date during the measurement period. Denominator depicts the total number of eligible beneficiaries.

Outreach and Engagement to Facilitate Entry to Primary Care

Measure
The percentage of Healthy Michigan Plan members who have an ambulatory or preventive care visit within 150 days of enrollment into a health plan who had not previously had an ambulatory or preventive care visit since enrollment in Healthy Michigan Plan.

Standard
At or above 50% (as shown on bar graph below)

Enrollment Dates
January 2021 – March 2021

Data Source
MDHHS Data Warehouse

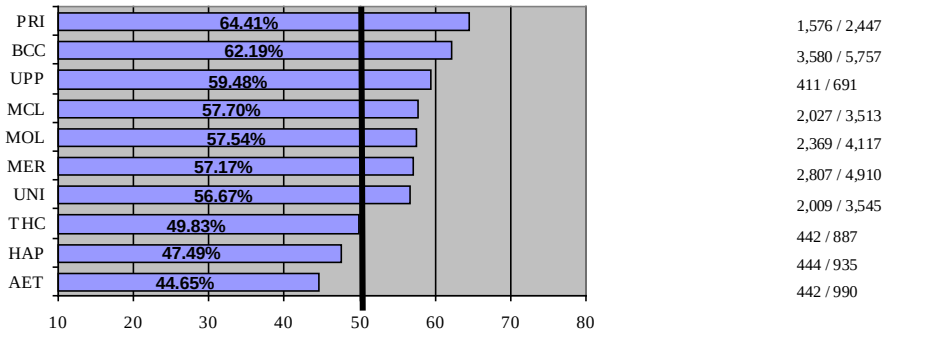
Measurement Frequency
Quarterly

Summary: Seven plans (**BCC, MCL, MER, MOL, PRI, UNI, and UPP)**, met or exceeded the standard, while three plans (AET, HAP, and THC), did not. Results ranged from 44.65% to 64.41%.

Table 4: Program Total[2]

Medicaid Program	Numerator	Denominator	Percentage
HMP-MC	21,954	33,539	65.46%

Figure 5: Outreach & Engagement to Facilitate Entry to Primary Care



Outreach & Engagement to Facilitate Entry to Primary Care Percentages

*Numerator depicts the number of eligible beneficiaries who had an ambulatory or preventive care visit within 150 days of enrollment in a health plan. Denominator depicts the total number of eligible beneficiaries.

[2] This includes visits during the HMP FFS period prior to enrollment in a Medicaid health plan.

Transition into Consistently Fail to Pay (CFP) Status

Measure
The percentage of Healthy Michigan Plan members who transitioned from non-CFP status into CFP status during the last quarter of the measurement period.

Standard
Income level over 100% FPL – At or **below** 30%
Income level up to 100% FPL – At or **below** 7%

Measurement Period
November 2020 – December 2021

Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

*****This is a reverse measure. A lower rate indicates better performance.***

Summary:
In ***Cohort 1***, for income levels over 100% FPL, all plans (without a rate of "N/A") met or exceeded the standard. Results ranged from 2.68% to 4.90%. For income levels up to 100% FPL, all plans met or exceeded the standard. Results ranged from 3.30% to 5.52%.

In ***Cohort 2***, for income levels over 100% FPL, all plans met or exceeded the standard. Results ranged from 2.82% to 7.78%. For income levels up to 100% FPL, all plans met or exceeded the standard. Results ranged from 3.56% to 6.06%.

In ***Cohort 3***, for income levels over 100% FPL, eight plans (**AET, BCC, MCL, MER, MOL, PRI, UNI, and UPP**) met or exceeded the standard, while one plan (HAP) did not. Results ranged from 2.13% to 9.44%. For income levels up to 100% FPL, results ranged from 3.14% to 7.96%.

Table 5: Transition into CFP Status - Cohort 1[3]

MHP	FPL over 100% (N)	FPL over 100% (D)	Rate	Standard Achieved	FPL up to 100% (N)	FPL up to 100% (D)	Rate	Standard Achieved
AET	7	143	4.90%	Yes	31	562	5.52%	Yes
BCC	93	1,965	4.73%	Yes	205	5,743	3.57%	Yes
HAP	4	78	N/A	N/A	16	304	5.26%	Yes
MCL	47	1,593	2.95%	Yes	158	4,148	3.81%	Yes
MER	102	3,286	3.10%	Yes	302	8,530	3.54%	Yes
MOL	54	1,543	3.50%	Yes	159	4,751	3.35%	Yes
PRI	28	1,043	2.68%	Yes	78	2,366	3.30%	Yes
UNI	51	1,603	3.18%	Yes	160	3,902	4.10%	Yes
UPP	23	525	4.38%	Yes	38	1,040	3.65%	Yes

[3] Results showing N/A are for plans with a numerator less than 5 and a denominator less than 30.

Table 6: Transition into CFP Status - Cohort 2

MHP	FPL over 100% (N)	FPL over 100% (D)	Rate	Standard Achieved	FPL up to 100% (N)	FPL up to 100% (D)	Rate	Standard Achieved
AET	11	168	6.55%	Yes	30	665	4.51%	Yes
BCC	109	2,264	4.81%	Yes	287	6,748	4.25%	Yes
HAP	7	90	7.78%	Yes	22	363	6.06%	Yes
MCL	69	1,855	3.72%	Yes	178	4,881	3.65%	Yes
MER	174	3,585	4.85%	Yes	389	9,803	3.97%	Yes
MOL	89	1,806	4.93%	Yes	266	5,800	4.59%	Yes
PRI	38	1,172	3.24%	Yes	92	2,583	3.56%	Yes
UNI	69	1,760	3.92%	Yes	214	4,606	4.65%	Yes
UPP	17	602	2.82%	Yes	38	1,060	3.58%	Yes

Table 7: Transition into CFP Status - Cohort 3

MHP	FPL over 100% (N)	FPL over 100% (D)	Rate	Standard Achieved	FPL up to 100% (N)	FPL up to 100% (D)	Rate	Standard Achieved
AET	17	180	9.44%	Yes	35	742	4.72%	Yes
BCC	101	2,156	4.68%	Yes	279	6,984	3.99%	Yes
HAP	5	76	6.58%	Yes	30	377	**7.96%**	**No**
MCL	70	1,778	3.94%	Yes	156	4,962	3.14%	Yes
MER	149	3,592	4.15%	Yes	401	10,376	3.86%	Yes
MOL	97	1,777	5.46%	Yes	241	6,355	3.79%	Yes
PRI	62	1,222	5.07%	Yes	93	2,782	3.34%	Yes
UNI	97	1,786	5.43%	Yes	210	4,771	4.40%	Yes
UPP	12	564	2.13%	Yes	40	1,118	3.58%	Yes

Transition out of Consistently Fail to Pay (CFP) Status

Measure
The percentage of Healthy Michigan Plan members who transitioned from CFP status to non-CFP status during the last quarter of the measurement period.

Standard
Income level over 100% FPL – At or above 2%
Income level up to 100% FPL – At or above 2%

Measurement Period
November 2020 – December 2021

Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

Summary:
In ***Cohort 1***, for income levels over 100% FPL, all plans (without a rate of "N/A") met or exceeded the standard. Results ranged from 3.16% to 4.90%. For income levels up to 100% FPL, seven plans (without a rate of "NA": **BCC, MCL, MER, MOL, PRI, UNI, and UPP**) met or exceeded the standard, while one plan (AET) did not. Results ranged from 1.33% to 3.45%.

In ***Cohort 2***, for income levels over 100% FPL, all plans met or exceeded the standard. Results ranged from 2.00% to 4.36%. For income levels up to 100% FPL, seven plans (**BCC, HAP, MCL, MER, PRI, UNI, and UPP**) met or exceeded the standard, while two plans (AET and MOL) did not. Results ranged from 1.31% to 3.97%.

In ***Cohort 3***, for income levels over 100% FPL, all plans met or exceeded the standard. Results ranged from 2.94% to 5.36%. For income levels up to 100% FPL, eight plans (**BCC, HAP, MCL, MER, MOL, PRI, UNI, and UPP)** met or exceeded the standards, while one plan (AET) did not. Results ranged from 1.91% to 3.48%.

Table 8: Transition out of CFP Status - Cohort 1[4]

MHP	FPL over 100% (N)	FPL over 100% (D)	Rate	Standard Achieved	FPL up to 100% (N)	FPL up to 100% (D)	Rate	Standard Achieved
AET	4	227	N/A	N/A	5	376	**1.33%**	**No**
BCC	92	1,929	4.77%	Yes	96	3,389	2.83%	Yes
HAP	1	159	N/A	N/A	1	201	N/A	N/A
MCL	62	1,639	3.78%	Yes	90	2,758	3.26%	Yes
MER	132	3,785	3.49%	Yes	181	6,035	3.00%	Yes
MOL	75	1,907	3.93%	Yes	100	3,468	2.88%	Yes
PRI	39	866	4.50%	Yes	41	1,205	3.40%	Yes
UNI	78	1,592	4.90%	Yes	64	2,607	2.45%	Yes
UPP	15	475	3.16%	Yes	21	609	3.45%	Yes

[4] Results showing N/A are for plans with a numerator less than 5 and a denominator less than 30.

Table 9: Transition out of CFP Status – Cohort 2

MHP	FPL over 100% (N)	FPL over 100% (D)	Rate	Standard Achieved	FPL up to 100% (N)	FPL up to 100% (D)	Rate	Standard Achieved
AET	7	288	2.43%	Yes	6	458	**1.31%**	**No**
BCC	100	2,292	4.36%	Yes	100	3,861	2.59%	Yes
HAP	5	194	2.58%	Yes	7	281	2.49%	Yes
MCL	61	1,855	3.29%	Yes	96	3,018	3.18%	Yes
MER	140	4,109	3.41%	Yes	195	6,539	3.97%	Yes
MOL	46	2,301	2.00%	Yes	69	4,070	**1.70%**	**No**
PRI	40	1,015	3.94%	Yes	46	1,420	3.24%	Yes
UNI	66	1,697	3.89%	Yes	96	2,865	3.35%	Yes
UPP	14	439	3.19%	Yes	21	602	3.49%	Yes

Table 10: Transition out of CFP Status - Cohort 3

MHP	FPL over 100% (N)	FPL over 100% (D)	Rate	Standard Achieved	FPL up to 100% (N)	FPL up to 100% (D)	Rate	Standard Achieved
AET	8	272	2.94%	Yes	10	523	**1.91%**	**No**
BCC	93	2,326	4.00%	Yes	107	4,113	2.60%	Yes
HAP	9	168	5.36%	Yes	6	249	2.41%	Yes
MCL	59	1,967	3.00%	Yes	94	3,127	3.01%	Yes
MER	136	4,224	3.22%	Yes	192	7,275	2.64%	Yes
MOL	73	2,452	2.98%	Yes	97	4,486	2.16%	Yes
PRI	48	1,033	4.65%	Yes	48	1,399	3.43%	Yes
UNI	61	1,778	3.43%	Yes	102	2,928	3.48%	Yes
UPP	16	447	3.58%	Yes	16	610	2.62%	Yes

Appendix A: Three Letter Medicaid Health Plan Codes

Below is a list of three letter codes established by MDHHS identifying each Medicaid Health Plan.

AET	Aetna Better Health of Michigan
BCC	Blue Cross Complete of Michigan
HAP	HAP Empowered
MCL	McLaren Health Plan
MER	Meridian Health Plan of Michigan
MOL	Molina Healthcare of Michigan
PRI	Priority Health Choice
THC	Total Health Care
UNI	UnitedHealthcare Community Plan
UPP	Upper Peninsula Health Plan

Appendix B: One Year Plan-Specific Analysis

Aetna Better Health of Michigan – AET

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 20 – Jun 20**	**Informational Only**	**86.65%**	**N/A**
Completion of Annual HRA	**Jul 20 – Jun 21**	**12%**	**7.48%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 21 – Mar 21**	**50%**	**44.65%**	**No**

Transition into CFP Status: [Nov 20 – Dec 21]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≤30%	**4.90%**	**Yes**	**6.55%%**	**Yes**	**9.44%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≤7%	**5.52%**	**Yes**	**4.51%**	**Yes**	**4.72%**	**Yes**

This is a reverse measure. A lower rate indicates better performance.

Transition out of CFP Status: [Nov 20 – Dec 21]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≥2%	**N/A**	**N/A**	**2.43%**	**Yes**	**2.94%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≥2%	**1.33%**	**No**	**1.31%**	**No**	**1.91%**	**No**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Blue Cross Complete of Michigan – BCC

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 20 – Jun 20**	**Informational Only**	**88.46%**	**N/A**
Completion of Annual HRA	**Jul 20 – Jun 21**	**12%**	**5.32%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 21 – Mar 21**	**50%**	**62.19%**	**Yes**

Transition into CFP Status: [Nov 20 – Dec 21]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≤30%	**4.73%**	**Yes**	**4.81%**	**Yes**	**4.68%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≤7%	**3.57%**	**Yes**	**4.25%**	**Yes**	**3.99%**	**Yes**

This is a reverse measure. A lower rate indicates better performance.

Transition out of CFP Status: [Nov 20 – Dec 21]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≥2%	**4.77%**	**Yes**	**4.36%**	**Yes**	**4.00%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≥2%	**2.83%**	**Yes**	**2.59%**	**Yes**	**2.60%**	**Yes**

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Appendix B: One Year Plan-Specific Analysis

HAP Empowered – HAP

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 20 – Jun 20**	**Informational Only**	**88.08%**	**N/A**
Completion of Annual HRA	**Jul 20 – Jun 21**	**12%**	**15.17%**	**Yes**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 21 – Mar 21**	**50%**	**47.49%**	**No**

Transition into CFP Status: [Nov 20 – Dec 21]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≤30%	**N/A**	**N/A**	**7.78%**	**Yes**	**6.58%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≤7%	**5.26%**	**Yes**	**6.06%**	**Yes**	**7.96%**	**No**

This is a reverse measure. A lower rate indicates better performance.

Transition out of CFP Status: [Nov 20 – Dec 21]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≥2%	**N/A**	**N/A**	**2.58%**	**Yes**	**5.36%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≥2%	**N/A**	**N/A**	**2.49%**	**Yes**	**2.41%**	**Yes**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

McLaren Health Plan – MCL

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 20 – Jun 20**	**Informational Only**	**87.66%**	**N/A**
Completion of Annual HRA	**Jul 20 – Jun 21**	**12%**	**7.72%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 21 – Mar 21**	**50%**	**57.70%**	**Yes**

Transition into CFP Status: [Nov 20 – Dec 21]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≤30%	**2.95%**	**Yes**	**3.72%**	**Yes**	**3.94%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≤7%	**3.81%**	**Yes**	**3.65%**	**Yes**	**3.14%**	**Yes**

This is a reverse measure. A lower rate indicates better performance.

Transition out of CFP Status: [Nov 20 – Dec 21]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≥2%	**3.78%**	**Yes**	**3.29%**	**Yes**	**3.00%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≥2%	**3.26%**	**Yes**	**3.18%**	**Yes**	**3.01%**	**Yes**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Meridian Health Plan of Michigan – MER

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 20 – Jun 20**	**Informational Only**	**87.63%**	**N/A**
Completion of Annual HRA	**Jul 20 – Jun 21**	**12%**	**8.43%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 21 – Mar 21**	**50%**	**57.17%**	**Yes**

Transition into CFP Status: [Nov 20 – Dec 21]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≤30%	**3.10%**	**Yes**	**4.85%**	**Yes**	**4.15%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≤7%	**3.54%**	**Yes**	**3.97%**	**Yes**	**3.86%**	**Yes**

This is a reverse measure. A lower rate indicates better performance.

Transition out of CFP Status: [Nov 20 – Dec 21]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≥2%	**3.49%**	**Yes**	**3.41%**	**Yes**	**3.22%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≥2%	**3.00%**	**Yes**	**2.98%**	**Yes**	**2.64%**	**Yes**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Molina Healthcare of Michigan – MOL

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 20 – Jun 20**	**Informational Only**	**88.11%**	**N/A**
Completion of Annual HRA	**Jul 20 – Jun 21**	**12%**	**8.62%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 21 – Mar 21**	**50%**	**57.54%**	**Yes**

Transition into CFP Status: [Nov 20 – Dec 21]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≤30%	**3.50%**	**Yes**	**4.93%**	**Yes**	**5.46%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≤7%	**3.35%**	**Yes**	**4.59%**	**Yes**	**3.79%**	**Yes**

This is a reverse measure. A lower rate indicates better performance.

Transition out of CFP Status: [Nov 20 – Dec 21]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≥2%	**3.93%**	**Yes**	**2.00%**	**Yes**	**2.98%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≥2%	**2.88%**	**Yes**	**1.70%**	**No**	**2.16%**	**Yes**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Priority Health Choice – PRI

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 20 – Jun 20**	**Informational Only**	**86.93%**	**N/A**
Completion of Annual HRA	**Jul 20 – Jun 21**	**12%**	**6.03%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 21 – Mar 21**	**50%**	**64.41%**	**Yes**

Transition into CFP Status: [Nov 20 – Dec 21]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≤30%	**2.68%**	**Yes**	**3.24%**	**Yes**	**5.07%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≤7%	**3.30%**	**Yes**	**3.56%**	**Yes**	**3.34%**	**Yes**

This is a reverse measure. A lower rate indicates better performance.

Transition out of CFP Status: [Nov 20 – Dec 21]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≥2%	**4.50%**	**Yes**	**3.94%**	**Yes**	**4.65%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≥2%	**3.40%**	**Yes**	**3.24%**	**Yes**	**3.43%**	**Yes**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

UnitedHealthcare Community Plan – UNI

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 20 – Jun 20**	**Informational Only**	**88.03%**	**N/A**
Completion of Annual HRA	**Jul 20 – Jun 21**	**12%**	**16.69%**	**Yes**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 21 – Mar 21**	**50%**	**56.67%**	**Yes**

Transition into CFP Status: [Nov 20 – Dec 21]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≤30%	**3.18%**	**Yes**	**3.92%**	**Yes**	**5.43%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≤7%	**4.10%**	**Yes**	**4.65%**	**Yes**	**4.40%**	**Yes**

This is a reverse measure. A lower rate indicates better performance.

Transition out of CFP Status: [Nov 20 – Dec 21]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≥2%	**4.90%**	**Yes**	**3.89%**	**Yes**	**3.43%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≥2%	**2.45%**	**Yes**	**3.35%**	**Yes**	**3.48%**	**Yes**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Appendix B: One Year Plan-Specific Analysis

Upper Peninsula Health Plan – UPP

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 20 – Jun 20**	**Informational Only**	**85.09%**	**N/A**
Completion of Annual HRA	**Jul 20 – Jun 21**	**12%**	**13.89%**	**Yes**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 21 – Mar 21**	**50%**	**59.48%**	**Yes**

Transition into CFP Status: [Nov 20 – Dec 21]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≤30%	**4.38%**	**Yes**	**2.82%**	**Yes**	**2.13%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≤7%	**3.65%**	**Yes**	**3.58%**	**Yes**	**3.58%**	**Yes**

This is a reverse measure. A lower rate indicates better performance.

Transition out of CFP Status: [Nov 20 – Dec 21]						
Standard >100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≥2%	**3.16%**	**Yes**	**3.19%**	**Yes**	**3.58%**	**Yes**
Standard ≤100% FPL	**Cohort 1 Result**	**Standard Achieved**	**Cohort 2 Result**	**Standard Achieved**	**Cohort 3 Result**	**Standard Achieved**
≥2%	**3.45%**	**Yes**	**3.49%**	**Yes**	**2.62%**	**Yes**

- Shaded areas represent data that are newly reported this month.
- For questions regarding measurement periods or standards, see the Performance Monitoring Specifications

Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Meeting Minutes

Date: Wednesday, February 24, 2021
Time: 1:00 p.m. – 4:30 p.m.
Where: Microsoft Teams Meeting

Attendees: **Council Members:** Jeff Towns, Amber Bellazaire, Alison Hirschel, April Stopcynski, Barry Cargill, Bill Mayer, Lisa Dedden Cooper, Deb Brinson, Dianne Haas, Dominick Pallone, Farah Jalloul, Chris George (for Amy Hundley), Jim Milanowski, Jason Jorkasky, Kim Singh, Marion Owen, Phillip Bergquist, Salli Pung, Stacie Saylor (for Rebecca Blake), Norm Hess, Amy Zaagman

Staff: Kate Massey, Lonnie Barnett, Brian Keisling, Pam Diebolt, Michelle Doebler, Erin Emerson, Sara Grivetti, Farah Hanley, Phil Kurdunowicz, Amy Miller, Jackie Prokop, Steve Prichard, Penny Rutlege, Robert Swanson, Cindy Linn, Mary Beth Kern-Collins

Other Attendees: Randy Walainis, Angela Minicuci, Linda Jordan, Pooja Neiman, Tiffany Stone, Virginia Gibson, Rich Farran, Bobbi Kuyers

Welcome, Introductions, Announcements

Alison Hirschel opened the meeting and introductions were made.

MDHHS Leadership Change

New Director - Elizabeth Hertel

Kate Massey announced that Elizabeth Hertel, who formerly served as Michigan Department of Health and Human Services (MDHHS) Chief Deputy for Administration, was appointed by Governor Whitmer to serve as director of MDHHS on January 22, 2021. David Knezek has been selected as Ms. Hertel's replacement as Chief Deputy for Administration.

Budget Update

Fiscal Year (FY)22 Budget Update

Farah Hanley shared a PowerPoint presentation to provide details on the FY 2022 Executive Budget recommendation, and the document was discussed.

COVID-19 Updates

COVID-19 Immunization Update

Robert Swanson provided the following updates on COVID-19 immunization:

- As of February 24, 2021, vaccines manufactured by Pfizer and Moderna have received approval for use by the Food and Drug Administration (FDA), which must be administered in two doses.
- To date, over 1.9 million COVID-19 vaccine doses have been administered in Michigan, which include:
  - 1.2 million individuals age16 years and older (15% of Michigan's total population) who have received at least one dose of a vaccine,
  - 700,000 individuals aged 16 years and older (8.2% of Michigan's total population) who have received a second dose of COVID-19 vaccine,
  - 37% of individuals over the age of 65 who have received at least one dose of COVID-19 vaccine, and
  - 16.5% of individuals over the age of 65 who have received a second dose.
- Vaccine deliveries that had been delayed due to weather are expected to be completed by Friday, February 26, 2021. Further, Michigan is on track to receive 200,000 vaccine doses per week.
- A third vaccine manufactured by Johnson & Johnson, which will only require a single dose, is expected to receive approval for use by the FDA soon. Mr. Swanson indicated that this vaccine will be targeted for allocation to certain populations, including home-bound individuals. In response to an inquiry, it was further indicated that homebound individuals will be among those prioritized for receiving the Johnson & Johnson vaccine due to the difficulty and costliness of reaching this population.
- The State of Michigan was among those states chosen by the Centers for Disease Control and Prevention (CDC) for a pilot program to administer COVID-19 vaccine to Federally Qualified Health Centers (FQHCs) directly from the CDC, which would not be deducted from the state allocation.
- The State of Michigan is working to distribute COVID-19 vaccine to the two Tribes within the state who did not elect to receive their vaccine allotment directly from the federal government through Indian Health Services.
- Mr. Swanson shared that MDHHS is working to implement a program that will encourage special vaccination and outreach projects focusing on people ages 60 and older in communities with the high Social Vulnerability Index (SVI) and high COVID mortality rates. The department is seeking applications from provider groups to administer COVID-19 vaccines under this program. Each applicant may apply for up to 2,500 doses. Applications are available on the MDHHS website at www.michigan.gov/covidvaccine.
- Meeting attendees were referred to the COVID-19 Vaccine Dashboard for metrics on COVID-19 Vaccine distribution, including race data.

MDHHS staff and meeting attendees continued to discuss COVID-19 vaccination outreach efforts at length.

COVID-19 Vaccines for Homebound Individuals

Sara Grivetti shared that the MDHHS Public Health Administration, Aging and Adult Services Administration, and Medical Services Administration are working together to develop a strategy for administering COVID-19 vaccinations to homebound individuals. Ms. Grivetti noted that such an effort will be complex as it includes identifying those who are truly homebound, scheduling vaccine appointments, coordination with a vaccinator, and administering the vaccine in a way that offers a level of comfort for the person receiving the vaccine when the vaccinator enters the home. The local Area Agencies on Aging are also assisting with the department's efforts to identify homebound individuals. In addition, MDHHS intends to reach out to beneficiaries of other Medicaid programs (e.g., Program of All-Inclusive Care for the Elderly [PACE], Home Help, etc.) who are homebound as part of this strategy. A meeting attendee requested that the Department consider providing vaccine administration reimbursement for provider types who do not typically provide vaccines. In response, MDHHS staff outlined current COVID-19 Vaccine Administration policy as described in Bulletin MSA 20-75 (issued December 23, 2020), and indicated the Department would explore extending reimbursement to additional provider types. MDHHS staff and meeting attendees continued to discuss this issue.

Extension of Federal Public Health Emergency (PHE)

The Biden administration sent a letter to the states indicating their intent to continue the PHE throughout 2021 and that states will be notified 60 days prior to the expiration. In addition, the current enhanced Federal Matching Assistance Percentage (FMAP) rate for services to treat COVID-19 is extended through the end of the fiscal quarter in which the PHE is terminated.

Coverage of FDA Emergency Use Authorization (EUA) Drugs, Devices, and Biological Products

MDHHS staff provided a summary of bulletin MSA 20-81-COVID-19 Response: Coverage of FDA EUA Drugs, Devices and Biological Products for COVID-19 Prevention and Treatment, issued February 2, 2021.

Long-Term Care

Long-Term Care COVID-19 Immunizations and Data

MDHHS staff shared an update on the Federal Pharmacy Partnership for Long-Term Care (LTC). A PowerPoint presentation was provided and the document was discussed.

Education and Promotion Activities

MDHHS staff from the office of communications shared information on the department's efforts to promote COVID-19 vaccine administration, and invited meeting attendees to share educational materials developed by department staff. A PowerPoint presentation was provided and the document was discussed.

Update for Care and Recovery Centers (CRCs) and COVID-19 Relief Facilities

The purpose of CRCs is to provide care for COVID-19 positive patients discharging from a hospital or residents from nursing facilities that are unable to care for residents with confirmed COVID-19 positive who have not met the criteria for discontinuation of Transmission-Based Precautions, but do not require hospitalization. As of February 17, 2021, there are 23 operational CRCs in Michigan with a total of 459 beds operating statewide, with 82% of these beds currently available. In correspondence with a recent decline in COVID-19 case rates and COVID-19-related hospitalizations, MDHHS has received requests to decommission certain CRCs and reduce bed capacity. In response, the department is continuing to monitor trending COVID-19 data to inform future decisions about a potential reduction in CRC capacity.

Public Act (PA) 231 of 2020 requires that in order for a nursing facility to maintain or admit COVID-19 positive residents, the facility must seek approval from MDHHS and demonstrate that there are staff and facilities available that are dedicated to treating **only** COVID-19 positive patients as a condition of approval. The requirements of PA 231 of 2021 are further outlined in bulletin MSA 20-73, issued November 16, 2020, and MSA 20-78, issued November 30, 2020.

Long-Term Care Facility Visitation

Erin Emerson announced that due to the progress of ongoing COVID-19 vaccination efforts and the decline in COVID-19 cases, MDHHS is considering an expansion of long-term care facility visitation policy. Under the current MDHHS guidance, long-term care facility visitation is only allowed in counties with a risk level of A, B, C, or D as determined by the MI Safe Start Plan if the facility has not had a positive COVID-19 case within 14 days, unless the local health department has determined that the facility should not allow visitors. As of February 19, 2021, over 50 Michigan counties were determined to have a COVID-19 risk level lower than "E".

Citing the negative health effects among nursing home residents that can result from social isolation away from family members, Bill Mayer further encouraged the department to allow greater opportunity for long term care facility visitation, especially as vaccination rates increase. In response, Ms. Emerson noted that no final decisions have been made, but that MDHHS staff are actively discussing the possibility of broadly allowing nursing home visitation with limited exceptions as vaccination and COVID-19 case rates allow. MDHHS staff and meeting attendees continued to discuss this issue.

MIChoice - PACE Ombudsmen Program

Alison Hirschel announced that the Michigan Elder Justice Initiative (MEJI) has received funding to start a new Ombudsman program to advocate for and support the needs of MIChoice, PACE, and Community Transition Services applicants and participants that will begin on March 1, 2021.

Electronic Visit Verification (EVV) Update

MDHHS is continuing to move forward with implementing an EVV system for providers of personal care services as required by the 21st Century CURES Act. The development of the EVV system has been delayed; the department now plans to complete development of the EVV system by FY 2022 with a planned implementation for FY 2023. In response to an inquiry, Sara Grivetti confirmed that MDHHS will notify providers directly about the delay and give advance notice prior to the new implementation date. MDHHS is also working to obtain CMS approval for the new implementation date.

Maternal and Child Health Updates

12 Months Post-Partum Coverage

MDHHS has received funding in the FY21 budget to extend Medicaid coverage for pregnant women from 60 days post-partum to 12 months post-partum and is exploring options for implementation.

Healthy Michigan Plan (HMP)

Caseload Growth

Jackie Prokop discussed the impact of the current COVID-19 PHE on HMP enrollment and shared that there are currently 885,500 beneficiaries enrolled in HMP, compared to 694,000 HMP enrollees in February 2020. Much of this increase is due to the MDHHS suspension of Medicaid case closures for the duration of the PHE except in limited circumstances beginning March 18, 2020 as described in bulletin MSA 20-19.

Supreme Court Oral Arguments Date

Erin Emerson shared that oral arguments in the Supreme Court on an appeal over Medicaid work requirement programs in Arkansas and New Hampshire are currently scheduled to take place on March 29, 2021. Following the action by CMS to notify states of its determination that work requirements are not compatible with the purpose of Medicaid, the U.S. Solicitor General filed a motion asking the Court to remove the case from its docket. As of February 24, 2021, no action had been taken on this motion.

Policy Updates

A policy update handout was distributed and the following item was discussed:

- MSA 20-49 - COVID-19 Response: Update to Bulletin MSA 20-17 - ICD-10-CM Coding Guidance and Exemption of Co-Pays for Services to Treat COVID-19.

Future Agenda Items

Bill Mayer invited meeting attendees to share potential topics to include on the agenda for the next MCAC meeting to take place on May 26, 2021.

The meeting was adjourned at 3:49 p.m.

Next Meeting: May 26, 2021

Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Meeting Minutes

Date: Wednesday, May 26, 2021
Time: 1:00 p.m. – 4:30 p.m.
Where: Microsoft Teams Meeting

Attendees: **Council Members:** Alison Hirschel, Amy Zaagman, April Stopcyzynski, Bill Mayer, David Herbel, Deb Brinson, Farah Jalloul, Chris Goerge (for Amy Hundley), Philip Bergquist, Kim Singh, Amber Bellazaire, Lisa Dedden Cooper, Dianne Haas, Jim Milanowski, Barry Cargill, Jason Jorkasky, Jeff Towns, Kristin Reese, Marion Owen, Robert Sheehan, Salli Pung, Jean Ingersoll, Dominick Pallone

Staff: Terri Adams, Brian Barrie, Deanna Charest, Shannon David, Pam Diebolt, Erin Emerson, Kim Hamilton, Farah Hanley, Brian Keisling, Marie LaPres, Cindy Linn, Kayla Lowers, Kate Massey, Jackie Prokop, Mary Shraubin, Margo Sharp, Heather Slawinski, Carmen Starkweather, Janell Troutman

Other Attendees: Randy Walainis, Kathy Sunlin (HCAM), Pat Anderson (HCAM), Linda Jordan, Tiffany Stone, Virginia Gibson (MSMS)

Welcome, Introductions, Announcements

Alison Hirschel opened the meeting and introductions were made. In addition, Ms. Hirschel announced that Brian Barrie will be retiring as director of the Michigan Department of Health and Human Services (MDHHS) Long-Term Care Services Division.

MDHHS & MSA Leadership Change

Kate Massey further informed meeting attendees of the following additional leadership changes taking place in MDHHS:

- Sara Grivetti has resigned as director of the Bureau of Medicaid Long Term Care Services & Support. Until a permanent replacement is named, leadership responsibilities for this bureau will be shared by Ms. Massey and Erin Emerson.
- Alexis Travis has accepted the position of director of the MDHHS Public Health Administration.

Budget Update

Farah Hanley gave an update on the fiscal year (FY) 2021 and 2022 budget process. A PowerPoint presentation was shared with attendees and the document was discussed.

COVID-19 Updates

COVID-19 Immunization Update

Terri Adams, Manager of the MDHHS Immunization Outreach & Education section, gave an update on the progress of COVID-19 vaccine administration in Michigan, including the department's outreach efforts to eligible individuals. A PowerPoint presentation was provided, and the document was discussed.

COVID Vaccines for Homebound Individuals

A meeting attendee requested an update on the department's efforts to administer the COVID-19 vaccine to homebound individuals. In response, staff indicated that MDHHS is working with the local Area Agencies on Aging (AAA) to identify homebound individuals who are eligible to receive the vaccine. Once identified, the department will remove those who have already received the COVID-19 vaccine and refer the remaining names to the local health departments for follow-up. In addition, MDHHS is working to set up mobile vaccine clinics to serve this population as well.

Ford Field Impact

Jean Ingersoll gave an update on the impact of the Ford Field vaccination clinics on the state's efforts to administer COVID-19 vaccinations. A PowerPoint presentation was provided, and the document was discussed.

Extension of Federal Public Health Emergency (PHE)

Jackie Prokop shared that while the federal COVID-19 PHE has officially been extended through July 31, 2021, the Biden Administration submitted a letter to states indicating its intent to continue the PHE through December 31, 2021. During this time, the redetermination process for most Medicaid beneficiaries remains suspended. Some Modified Adjusted Gross Income (MAGI) related Medicaid cases have been run through the auto-renewal process with those able to be approved having their renewal date forwarded out a year. Those unable to be auto-approved (and all supplemental security income [SSI] related cases) will remain open pending plans for normalization after the end of the PHE. In response to an inquiry, MDHHS staff indicated that once the PHE ends, the department expects to be able to re-start the redetermination process in phases. In addition, MDHHS is exploring possible eligibility policy changes to account for direct federal stimulus payments received by Medicaid beneficiaries during the PHE when determining Medicaid eligibility. CMS has promised States that they will receive 60 days' notice prior to the end of the PHE for planning purposes.

Temporary Policy Changes to Address the COVID-19 PHE - Update

MDHHS staff discussed the following policies related to the current COVID-19 PHE:

- Bulletin MSA 21-14 – COVID-19 Response: Update to Bulletin MSA 20-37
- Bulletin MSA 21-17 - COVID-19 Response: Coverage of U.S. Food & Drug Administration (FDA) Emergency Use Authorization (EUA) Monoclonal Antibody COVID-19 Infusions by Emergency Medical Services (EMS) Providers
- Proposed Policy 2109-Eligibility – COVID-19 Response: Update to Bulletin MSA 20-19

Long-Term Care

Update for Care and Recovery Centers (CRCs) and COVID-19 Relief Facilities

Erin Emerson shared that MDHHS is continuing to operate CRCs and COVID-19 relief facilities to care for COVID-19 patients requiring nursing facility care. As COVID-19 cases have declined in recent months, MDHHS has been able to reduce CRC capacity to 10 facilities currently in operation in accordance with a reduction in need for services. Of the 10 CRC facilities currently operating, only 35% of available beds are occupied. In addition, the department is continuing to evaluate data from the COVID-19 relief facilities to determine any appropriate oversight policy changes. In response to an inquiry, Ms. Emerson offered to share demographic data for CRC and COVID-19 relief facility patients.

Long-Term Care Facility Testing

In accordance with the most recent Centers for Disease Control and Prevention (CDC) recommendations, MDHHS has updated guidance for Long-Term Care facilities to indicate that weekly testing of staff who have been fully vaccinated against COVID-19 is no longer required. Fully vaccinated staff are only required to undergo a COVID-19 test if they have been exposed to the virus and become symptomatic. Staff who have not received the COVID-19 vaccine are still subject to a weekly testing requirement. In addition, MDHHS has updated its reimbursement methodology to encourage facilities to use rapid point-of-care COVID-19 testing.

Update on Long-Term Care Facility Visitation

MDHHS has also issued updated guidance to allow communal dining in long-term care facilities and rescind masking and social distancing requirements in cases in which all participants in that activity are fully vaccinated against COVID-19. The guidance also allows for relaxed visitation restrictions as a result of increased vaccination rates among the long-term care facility resident population. In response to an inquiry, Erin Emerson indicated that independent living facilities may choose to adopt MDHHS COVID-19 response guidance for long-term care facilities if appropriate to meet their individual needs, but they are not required to do so.

Electronic Visit Verification (EVV) Update

Brian Keisling shared that MDHHS is continuing work on the implementation of an EVV process for providers of personal care services. Since funding may be available in the FY22 budget for system updates needed to implement the EVV process, the department has convened internal workgroups to plan for stakeholder outreach and explore EVV models that are currently in place in other states to determine the best path forward for Michigan.

Requesting Home and Community-Based Services (HCBS) Funding that is Available through the American Rescue Plan Act (ARPA)

In response to an inquiry, Kate Massey indicated that MDHHS is currently in the process of evaluating proposals to utilize ARPA funding to expand access to HCBS for the purpose of applying to receive these funds.

Maternal and Child Health updates

Maternal and Infant Health Program (MIHP) Pilot & Breastfeeding Plan

MDHHS staff shared information on several department initiatives related to Maternal and Child Health, including a planned MIHP pilot and a breastfeeding plan. A PowerPoint presentation was provided, and the document was discussed.

Doula Coverage

MDHHS is in the process of developing policy to provide Medicaid coverage of doula services. A doula is a non-clinical individual who typically provides physical, emotional, and educational support services to pregnant individuals during the prenatal, labor and delivery, and postpartum period. Evidence indicates doula services are associated with improved birth outcomes. Doula services have been shown to positively impact social determinants of health, support birth equity, and decrease existing health and racial disparities. In the process of developing this policy change, MDHHS has conducted stakeholder meetings, held discussions with federal partners, and examined similar coverage policy for these services that are currently in place in other states.

12 Months Post-Partum Coverage

Jackie Prokop shared that MDHHS is exploring options for providing Medicaid coverage for pregnant women 12 months post-partum, which would require systems changes. As a provision of ARPA, states may begin providing coverage for this population under State Plan authority beginning April 1, 2022. MDHHS staff and meeting attendees discussed potential options for protecting coverage for pregnant women 12 months post-partum from January 1, 2022 through March 30, 2022 if the federal PHE ends on December 31, 2021.

Healthy Michigan Plan (HMP)

Caseload Growth

As of May 26, 2021, 913,828 beneficiaries are enrolled in HMP, compared to approximately 624,000 beneficiaries enrolled in HMP in February 2020.

MI Communication with CMS on Community Engagement

On April 6, 2021, MDHHS received a letter from CMS that officially revoked the State's authority to implement work requirements as a condition of continued eligibility in HMP. Implementation of work requirements was previously stopped on March 4, 2020, pursuant to a court order from the United States District Court for the District of Columbia in Young et al. v. Azar et al. While the Supreme Court had been scheduled to hear arguments on a challenge to state work requirements for Medicaid beneficiaries, the case was removed from the docket when CMS announced its intent to rescind authority for states to implement these requirements.

We Treat Hep C

MDHHS staff shared information on the department's public health initiative to eliminate the Hepatitis C virus (HCV) in Medicaid and HMP beneficiaries. A PowerPoint presentation was provided, and the document was discussed.

KB vs Lyon MDHHS Update

In 2018, a class action lawsuit was filed against MDHHS alleging that the Department failed to provide adequate behavioral health services to Medicaid-eligible children, with a specific focus on Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. In 2020, MDHHS entered into an interim settlement agreement with the plaintiffs, contingent upon the implementation of policy and process changes to improve the department's delivery of behavioral health services and supports, specifically to children with behavioral health disorders and developmental disabilities, with a focus on EPSDT services. To assist with developing a plan to implement these changes, MDHHS has contracted with the Center for Health Care Strategies. A meeting attendee requested access to the environmental scan conducted by the Center for Health Care Strategies as part of this effort. In response, MDHHS staff indicated they would consider the request and share the information if possible, in consideration of the ongoing litigation in KB vs. Lyon.

Policy Updates

A policy update handout was distributed to meeting attendees, participants were invited to contact MDHHS staff with any questions about the bulletins and proposed policies listed.

Future Agenda Items

Alison Hirschel invited meeting attendees to share any potential agenda items they would like to discuss at future MCAC meetings. In response, meeting attendees suggested having a discussion on claims data for the duration of the COVID-19 PHE to examine utilization trends, as well as the future of the coverage of telehealth services.

The meeting was adjourned at 4:11 p.m.

Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Meeting Minutes

Date: Wednesday, August 26, 2021
Time: 1:00 p.m. – 4:30 p.m.
Where: Microsoft Teams Meeting

Attendees: **Council Members:** Farah Jalloul, Jeff Towns, Barry Cargill, Alison Hirschel, Amber Bellazaire, Amy Zaagman, April Stopczynski, Bill Mayer, David Herbel, Jim Milanowski, Jason Jorkasky, Kristin Reese, Marion Owen, Robert Sheehan, Salli Pung, Lisa Dedden Cooper, Phillip Bergquist

Staff: Leslie Asman, Katie Commey, Pam Diebolt, Christopher George, Brian Keisling, Phil Kurdunowicz, Marie LaPres, Cindy Linn, Kate Massey, Jackie Prokop, Penny Rutledge, Mary Schrauben, Pam Diebolt, Amanda Chrysler, Jon Villasurda, Scott Wamsley, Heidi Loynes

Other Attendees: Sierra Hollingsworth, Cathy Sunlin, Erin Mortensen, Renee Topolski, Tiffany Stone, Virginia Gibson, Amanda Murray, Kelly Bidelman, Kaitlyn Anderson

Welcome, Introductions, Announcements

Alison Hirschel opened the meeting and introductions were made.

Medical Services Administration (MSA) Leadership Update

Kate Massey shared that Penny Rutledge has been named director of the Bureau of Medicaid Care Management and Customer Service, and that Scott Wamsley, acting director of the Aging and Adult Services Administration, has agreed to assist MSA in an acting role with leadership duties over the Bureau of Long-Term Care Services and Supports.

MI Kids Now (KB v. Michigan Department of Health and Human Services [MDHHS]) Update

Phil Kurdunowicz gave an update on the progress of the MI Kids Now initiative to improve MDHHS' delivery of behavioral health services to Medicaid-eligible children with a specific focus on Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. A PowerPoint presentation was provided, and the issue was discussed.

Long-Term Care

Update on Long-Term Care Facility Visitation

A meeting attendee relayed several concerns from nursing facility residents and their families regarding continued visitation limitations. In response, MDHHS staff indicated that the department establishes visitation guidance based on direction from the Centers for Medicare & Medicaid Services (CMS), and that any complaints or concerns regarding nursing facility visitation rules should be directed to the Department of Licensing and Regulatory Affairs (LARA) or the MDHHS Public Health Administration. MDHHS staff and meeting attendees continued to discuss this issue at length.

Requesting Home and Community-Based Services (HCBS) Funding Available Through the American Rescue Plan Act (ARPA)

Kate Massey shared that one provision of ARPA allows for a temporary 10 percent increase in Federal Matching Assistance Percentage (FMAP) reimbursement to offset the additional costs states incur in the process of transitioning nursing facility residents to home and community-based settings in response to the COVID-19 public health emergency (PHE). This FMAP increase applies for both Medicaid fee-for-service (FFS) and managed care plans. Under this provision, states will accrue the enhanced FMAP on existing expenditures between April 1, 2021 and March 2022. The enhanced matching dollars will then be placed by CMS into a state-specific account that will be available to use until March 31, 2024. As a condition of receiving the enhanced FMAP rate, states must submit a plan to CMS for how the additional funding will be utilized. MDHHS has submitted its initial plan for CMS review, and is working to conduct stakeholder outreach for input on subsequent updates.

Home Help Policy – 40-Hour Cap

Proposed Policy 2132-HH was issued for public comment on July 22, 2021, and discusses a 40-hour weekly limit on payments for home help services provided to one client. The public comment period closes on August 26, 2021, and interested parties are encouraged to submit any feedback they have on the policy. MDHHS staff will analyze the input that is received and consider the comments for inclusion in the final policy.

Direct Care Workforce Advisory Committee Update

Scott Wamsley shared that MDHHS has sponsored an advisory committee to address a shortage of direct care workers in Michigan. Some of the issues the committee will examine include wages, retention, training, credentialing, and career paths for direct care workers, with subcommittees organized to address specific topics. In response to an inquiry, Mr. Wamsley confirmed that the Behavioral Health and Developmental Disabilities Administration (BHDDA) is involved in this effort as well.

COVID-19 Updates

Post-PHE Guidance

Jackie Prokop shared that while the COVID-19 PHE remains in place, Medicaid beneficiaries may not lose eligibility unless they move out of state, become deceased, or request to be removed from Medicaid coverage. In December 2020, the Trump administration released guidance directing that once the PHE ends, states must resume the eligibility redetermination process within six months. If states determined during the PHE that a beneficiary no longer met traditional eligibility criteria, this guidance indicated that upon the conclusion of the PHE, the states must immediately send the affected beneficiary a letter informing them that they are no longer eligible for Medicaid coverage. In August 2021, the Biden administration released new guidance directing states to resume the eligibility redetermination process within 12 months after the end of the PHE. As an update to previous guidance, states are directed to process all eligibility renewals using the most recent beneficiary information available, regardless of any previous determinations made during the PHE.

CMS Emergency Rule - Mandating Vaccination of Nursing Home Employees

On November 4, 2021, CMS issued a new rule requiring that all non-exempt nursing home employees at facilities participating in Medicare and Medicaid must be fully vaccinated against COVID-19 no later than January 4, 2022. Many details of the rule are not yet known, but will be shared at future MCAC meetings when available. MDHHS staff and meeting attendees continued to discuss this issue at length.

Advisory Committee on Immunization Practices (ACIP) Recommendations/Governors Executive Directive

Terri Adams, director of the MDHHS Division of Immunization, shared an update on long-term care COVID-19 vaccinations, including information on ACIP recommendations for certain individuals to receive an additional dose of a COVID-19 vaccine. A PowerPoint presentation was provided, and the document was discussed.

Immunization Update

MDHHS staff shared that the department is engaging in outreach to encourage parents to ensure their children up-to-date an all needed vaccinations, in part to mitigate the effects of rising COVID-19 cases in Michigan on the state's healthcare system.

Policy Updates

Michigan's State Demonstration Certified Community Behavioral Health Clinic (CCBHC) initiative

Jon Villasurda gave an update on the implementation of the CCBHC initiative. A PowerPoint

presentation was provided and the issue was discussed.

Community Health Workers

In response to an inquiry, MDHHS staff emphasized the important role that community health workers play in assisting Medicaid beneficiaries with navigating the healthcare system. Because of the important services they provide, the department continues to look for ways community health workers can be utilized to best serve the needs of Medicaid beneficiaries.

Fee Schedule Updates - COVID Booster Medicare Rates

MDHHS issued bulletin MSA 20-75 on December 23, 2020, which indicated that during the PHE, COVID-19 vaccine products will be made available to providers at no cost, and that COVID-19 vaccine services will be reimbursed at 100% of Medicare rates. In accordance with MSA 20-75, the department is continuing to update rates for Current Procedural Terminology (CPT) codes related to administration of vaccine services as the information becomes available. Provider specific fee schedules can be accessed on the MDHHS website at www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information. Meeting attendees were invited to submit any questions related to COVID-19 vaccine services to MSAPolicy@michigan.gov.

General Updates

Jackie Prokop shared that enrollment in the Healthy Michigan Plan is continuing to increase over the course of the PHE, and that as of August 26, 2021, 937,025 beneficiaries are enrolled in the program.

Future Agenda Items

For future meetings, an attendee suggested including a discussion of updates on the implementation of legislation regarding “do not resuscitate” orders that was signed into law in 2017.

The meeting was adjourned at 3:33 p.m.