MEDICARE-MEDICAID
CAPITATED FINANCIAL ALIGNMENT MODEL
QUALITY WITHHOLD TECHNICAL NOTES (DY 2 – 10): MICHIGAN-SPECIFIC MEASURES

Effective as of January 1, 2017; Issued March 22, 2018;
Updated January 19, 2024

Attachment D
Michigan Quality Withhold Measure Technical Notes: Demonstration Years 2 through 10

Introduction

The measures in this attachment are quality withhold measures for all Medicare-Medicaid Plans (MMPs) in the MI Health Link demonstration for Demonstration Years (DY) 2 through 10. These state-specific measures directly supplement the Medicare-Medicaid Capitated Financial Alignment Model CMS Core Quality Withhold Technical Notes for DY 2 through 12.

DY 2 through 10 in the MI Health Link demonstration are defined as follows:

Year	Dates Covered
DY 2	January 1, 2017 – December 31, 2017
DY 3	January 1, 2018 – December 31, 2018
DY 4	January 1, 2019 – December 31, 2019
DY 5	January 1, 2020 – December 31, 2020
DY 6	January 1, 2021 – December 31, 2021
DY 7	January 1, 2022 – December 31, 2022
DY 8	January 1, 2023 – December 31, 2023
DY 9	January 1, 2024 – December 31, 2024
DY 10	January 1, 2025 – December 31, 2025

Information about the applicable demonstration years for each state-specific measure, as well as benchmarks and other details, can be found in the measure descriptions below. Note that CMS and the State may elect to adjust the benchmarks or other details based on additional analysis or changes in specifications. Stakeholders will have the opportunity to comment on any substantive changes prior to finalization.

Applicability of the Gap Closure Target to the State-Specific Quality Withhold Measures

The gap closure target methodology as described in the CMS Core Quality Withhold Technical Notes **will** apply to the state-specific measures contained in this attachment, unless otherwise noted in the measure descriptions below.

Michigan-Specific Measures: Demonstration Years 2 through 10

Measure: MIW4 – Care Transition Record Transmitted to Health Care Professional

Description:	Percent of members discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care on the day of discharge through two days after discharge
Metric:	Measure MI2.6 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: Michigan-Specific Reporting Requirements
Measure Steward/ Data Source:	State-defined measure

CMIT #:	Modified from 728
Applicable Years:	DY 2 through 10
Utilizes Gap Closure:	No for DY 2 and 3; Yes for DY 4 through 10
Benchmarks:	DY 2 and 3: Timely and accurate reporting of data according to the measure specifications, plus submission of a narrative that describes the policies and procedures the MMP has implemented in order to meet the intent of the measure and continually improve its performance rate. The narrative must also contain a status update that describes the MMP's progress over the course of the calendar year, including an assessment of completed activities and a description of planned/executed interventions to address any issues or barriers. DY 4: 60% DY 5 through 7: 65% DY 8 through 10: 70%
Notes:	For the DY 2 and 3 narrative requirement, the narrative must be submitted via e-mail to integratedcare@michigan.gov. The DY 2 narrative is due by February 28, 2018 and the DY 3 narrative is due by July 1, 2019. If deficiencies are identified in the narrative, the MMP will be given one opportunity to resubmit. For quality withhold purposes in DY 4 through 10, this measure is calculated as follows: Denominator: Of the total number of members, regardless of age, discharged from an inpatient facility to home/self-care or any other sites of care, the total number of members sampled who met inclusion criteria (Data Element B). Numerator: The total number of members for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care on the day of discharge through two days after discharge (Data Element C).

Measure: MIW5 – Medication Review – All Populations

Description:	Percent of members whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year
Metric:	Measure MI5.6 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: Michigan-Specific Reporting Requirements
Measure Steward/ Data Source:	State-defined measure (HEDIS-like)
CMIT #:	Modified from 110
Applicable Years:	DY 2 through 10
Utilizes Gap Closure:	Yes
Benchmarks:	DY 2: 60% DY 3: 70%

	DY 4: 75% DY 5: 80% DY 6: 85% DY 7 through 10: 90%
Notes:	For quality withhold purposes, this measure is calculated as follows: Denominator: Of the total number of members continuously enrolled who were currently enrolled on December 31 of the reporting period, the total number of members sampled who met inclusion criteria (Data Element B). Numerator: The total number of members who had at least one medication review conducted by a prescribing practitioner or clinical pharmacist during the reporting period and the presence of a medication list in the medical record (Data Element C).

Measure: MIW6 – Documentation of Care Goals

Description:	Percent of members with documented discussions of care goals
Metric:	Measure MI2.3 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: Michigan-Specific Reporting Requirements
Measure Steward/ Data Source:	State-defined measure
CMIT #:	N/A
Applicable Years:	DY 2 through 5
Utilizes Gap Closure:	Yes
Benchmarks:	DY 2: 92% DY 3: 95% DY 4 and 5: 98%
Notes:	For quality withhold purposes, this measure is calculated as follows: Denominator: The total number of members with an initial Individual Integrated Care and Supports Plan (IICSP) completed during the reporting period plus the total number of existing IICSPs revised during the reporting period (Data Element A + Data Element C) summed over four quarters. Numerator: The total number of members with at least one documented discussion of care goals in the initial IICSP plus the total number of revised IICSPs with at least one documented discussion of new or existing care goals (Data Element B + Data Element D) summed over four quarters. By summing the denominators and numerators before calculating the rate, the final calculation is adjusted for volume.

Measure: MIW7 – Urinary Tract Infection

Description:	Percent of nursing facility long stay residents who have a urinary tract infection
Metric:	Measure MI5.5 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: Michigan-Specific Reporting Requirements

Measure Steward/ Data Source:	State-defined measure
CMIT #:	532
Applicable Years:	DY 2 and 3
Utilizes Gap Closure:	No
Benchmark:	4%
Notes:	For quality withhold purposes, this measure is calculated as follows: Denominator: All long-stay residents with a selected target assessment, except those with exclusions. Numerator: Long-stay residents with a selected target assessment that indicates urinary tract infection within the last 30 days. Note that lower rates are better for this measure.

Measure: MIW8 – Annual Dental Visit

Description:	Percent of members who had one or more dental visits with a dental practitioner during the reporting period
Metric:	Measure MI7.3 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: Michigan-Specific Reporting Requirements
Measure Steward/ Data Source:	State-defined measure
CMIT #:	N/A
Applicable Years:	DY 4 through 10
Utilizes Gap Closure:	Yes
Benchmarks:	DY 4: 55% DY 5 through 7: 60% DY 8 through 10: 65%
Notes:	For quality withhold purposes, this measure is calculated as follows: Denominator: The total number of members who were continuously enrolled in the MMP during the reporting period, and who were enrolled on December 31 of the reporting period (Data Element A). Numerator: The total number of members who had one or more dental visits with a dental practitioner during the reporting period (Data Element B).

Measure: MIW9 – Minimizing Facility Length of Stay

Description:	The ratio of the MMP's observed performance rate to the MMP's expected performance rate. The performance rate is based on the proportion of admissions to an institutional facility that result in successful discharge to the community within 100 days of admission.
Metric:	Core Measure 9.3 of the Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements

Measure Steward/ Data Source:	CMS-defined measure
CMIT #:	968
Applicable Years:	DY 6 through 10
Utilizes Gap Closure:	No
Benchmarks:	DY 6: 1.00 DY 7: 1.25 DY 8 through 10: 1.50
Notes:	The analysis for this measure is based on the MMP's observed-to-expected (O/E) ratio, which compares the actual performance rate to the performance rate that the MMP is expected to have given its case mix. The observed rate and expected rate are calculated as follows: 1. The observed rate equals the total number of discharges from a facility to the community that occurred within 100 days or less of admission (Data Element B) divided by the total number of admissions to facilities (Data Element A). 2. The expected rate equals the total number of expected discharges to the community (Data Element C) divided by the total number of admissions to a facility (Data Element A). Note that a higher O/E ratio indicates better performance (i.e., the MMP's O/E ratio must be greater than or equal to the benchmark to receive a "met" designation). An O/E ratio that is greater than 1.00 signifies a higher than expected rate of successful discharges.

Measure: MIW10 – Antidepressant Medication Management – Effective Acute Phase Treatment

Description:	Percent of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment for at least 84 days (12 weeks)
Measure Steward/ Data Source:	NCQA/HEDIS (MMPs should follow the version of the HEDIS Technical Specifications that is referenced in the HEDIS Reporting Requirements HPMS memorandum issued for the relevant reporting year)
HEDIS Label:	Antidepressant Medication Management (AMM) – Effective Acute Phase Treatment
CMIT #:	63
Applicable Years:	DY 6 through 10
Utilizes Gap Closure:	Yes
Benchmarks:	DY 6: 65% DY 7: 68% DY 8 through 10: 71%

Notes:	This measure will be removed from the quality withhold analysis if the MMP has fewer than 1,000 enrollees as of July of the measurement year. It will also be removed if the MMP's HEDIS audit designation is "NA", which indicates that the denominator is too small (<30) to report a valid rate.

Measure: MIW11 – Colorectal Cancer Screening

Description:	Percent of members 51–75 years of age who had appropriate screening for colorectal cancer
Measure Steward/ Data Source:	NCQA/HEDIS (MMPs should follow the version of the HEDIS Technical Specifications that is referenced in the HEDIS Reporting Requirements HPMS memorandum issued for the relevant reporting year)
HEDIS Label:	DY 6 through 8: Colorectal Cancer Screening (COL) DY 9 and 10: Colorectal Cancer Screening (COL-E)
CMIT #:	139
Applicable Years:	DY 6 through 10
Utilizes Gap Closure:	Yes
Benchmarks:	DY 6: 62% DY 7: 66% DY 8 through 10: 72%
Notes:	As of DY 7 (measurement year 2022), the HEDIS specifications were revised to reflect an expanded age range. However, for purposes of the quality withhold analysis, the 51-75 age stratification will be used. This measure will be removed from the quality withhold analysis if the MMP has fewer than 1,000 enrollees as of July of the measurement year. It will also be removed if the MMP's HEDIS audit designation is "NA", which indicates that the denominator is too small (<30) to report a valid rate.

Measure: MIW12 – Medication Reconciliation Post-Discharge

Description:	Percent of discharges for members 18 years of age and older who had documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days)
Measure Steward/ Data Source:	NCQA/HEDIS (MMPs should follow the version of the HEDIS Technical Specifications that is referenced in the HEDIS Reporting Requirements HPMS memorandum issued for the relevant reporting year)
HEDIS Label:	Transitions of Care (TRC) – Medication Reconciliation Post-Discharge
CMIT #:	729
Applicable Years:	DY 6 through 10
Utilizes Gap Closure:	Yes
Benchmarks:	DY 6 and 7: 62% DY 8 through 10: 65%

Notes:	This measure will be removed from the quality withhold analysis if the MMP has fewer than 1,000 enrollees as of July of the measurement year. It will also be removed if the MMP's HEDIS audit designation is "NA", which indicates that the denominator is too small (<30) to report a valid rate.