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MANUAL

Section 1115 Eligibility and Coverage Demonstrations Monitoring Metrics Technical Specifications

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CONTENTS

TABLES

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METRICS

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ACRONYMS

AD	Any demonstration with eligibility and coverage policies
AHRQ	Agency for Healthcare Research and Quality
AOD	Alcohol or other drug
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CE	Community engagement
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic obstructive pulmonary disease
ED	Emergency department
EHR	Electronic health record
EPSDT	Early and periodic screening, diagnostic and treatment
FFY	Federal fiscal year
FPL	Federal poverty level
FUA -AD	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – Adult
FUM-AD	Follow-Up After Emergency Department Visit for Mental Illness - Adult
HB	Health behavior
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
ICD	International Classification of Diseases
IET-AD	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Adult
MCO	Managed care organization
MIPS	Merit-based Incentive Payment System
MSC-AD	Medical Assistance with Smoking and Tobacco Use Cessation - Adult

NCQA	National Committee for Quality Assurance
NQF	National Quality Forum
NYU	New York University
PA	Premium assistance
PAHP	Prepaid ambulatory health plan
PCCM	Primary Care Case Management
PIHP	Prepaid inpatient health plan
POS	Place of service
PQI	Prevention Quality Indicators
PR	Premiums
SNAP	Supplemental Nutrition Assistance Program
TANF	Temporary Assistance for Needy Families

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The Specifications Manual for PCPI Foundation Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (2018) is updated annually by PCPI Foundation. Users of the Specifications Manual must update their software and associated documentation based on the published manual production timelines.

For the New York University algorithm for the emergency department classification scheme in the technical specifications for section 1115 eligibility and coverage demonstration monitoring metrics:

The ICD-10 version of the emergency department utilization classification schemes was developed by the New York University Center for Health and Public Service Research.

Note: the emergency department classification schemes utilize only the final diagnosis on claims and are intended for monitoring broad population-level trends in emergency department use, not for determining retrospectively whether an individual visit was or was not emergent based on clinical symptoms present on admission to the emergency department.

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I. BACKGROUND AND INTRODUCTION

This document provides technical specifications for monitoring metrics[1] for states with section 1115 demonstrations that include the following policies: premiums or account payments, marketplace-focused premium assistance, health behavior incentives, community engagement (CE), and/or retroactive eligibility waivers. These demonstrations are collectively referred to as eligibility and coverage demonstrations.

An important goal of monitoring eligibility and coverage demonstrations is to identify trends that suggest the need for adjustments to improve demonstration performance and protect beneficiaries. These metrics are designed to monitor demonstration performance while minimizing state reporting burden. This set focuses on metrics that can be calculated from Medicaid administrative data. Monitoring metrics are useful to include in formal evaluations to provide context on demonstration operations along with more complex outcome measures and those that draw on non-administrative data sources, including beneficiary surveys.

Eligibility and coverage monitoring metrics were developed with input from subject matter experts in the Centers for Medicare & Medicaid Services (CMS). While most eligibility and coverage metrics track administrative processes and monitor protections provided to beneficiaries, a few refer to definitions included in established quality measures. Note that these metrics are not stand-alone quality measures themselves and were not tested as such. They are intended only for monitoring the status and progress of eligibility and coverage demonstrations.

This technical specifications manual is organized as follows: Section A of this chapter provides an overview of the metrics and Section B provides reporting instructions that apply to the metrics. Chapter II presents technical specifications for each metric.

A. Overview of eligibility and coverage monitoring metrics

The eligibility and coverage metrics are organized into six modules by policy type (Table 1). States should report the metrics in module 1, since these metrics are applicable for all eligibility and coverage demonstrations, plus the metrics corresponding to the policies in the state's demonstration. For example, a state with section 1115 authority for premiums and health behavior incentives would report the metrics in modules 1, 2, and 4. Depending on the operational details of a state's demonstration, some metrics in modules 2 through 6 may not be applicable. States need only report the metrics that are relevant to the state's overall demonstration design. CMS will work with states to refine reporting instructions to align with specific state policies as needed.

[1] The manual uses the term "metrics" because most of the data collected in the demonstration monitoring effort track processes associated with demonstration policies. A small number of metrics are formally endorsed quality measures.

Table 1. Summary of eligibility and coverage metric modules

Module	Demonstration typed	Metric # prefix	Total Number of metrics	Number of required metrics
1	Any demonstration with premiums, marketplace-focused premium assistance, health behavior incentives, community engagement requirements, or retroactive eligibility waivers	AD	45	30
2	Demonstrations with premiums or account payments	PR	21	9
3	Demonstrations with marketplace-focused premium assistance	PA	3	2
4	Demonstrations with health behavior incentives	HB	7	7
5	Demonstrations with community engagement requirements	CE	46	29
6	Demonstrations with retroactive eligibility waivers	RW	3	3
Total			**125**	**80**

Tables 2 through 7, placed at the end of this section, list eligibility and coverage monitoring metrics in modules 1 through 6, respectively. The tables indicate whether each metric is required or recommended. The tables also summarize key reporting parameters, such as the reporting subpopulations and measurement period. Metrics in each module are organized into categories (such as enrollment or access to care). The remainder of this section describes the criteria used to define a metric as required or recommended, as well as the subpopulations measurement periods. In addition to Tables 2 through 7 there are technical specifications for each metric in Chapter II.

- **Required or Recommended.** Metrics are either required or recommended.
  - *Required metrics* provide information that is critical for monitoring the success of eligibility and coverage demonstrations and could be constructed with data that are readily available to states.
  - *Recommended metrics* might be more difficult to report than required metrics, but still provide important information on the operation of a demonstration.

- **Subpopulations.** Some populations may be uniquely impacted by eligibility and coverage demonstrations. When instructed by metric specifications, calculate and report metrics separately by subpopulation, assigning beneficiaries to subpopulations based on their characteristics as of the last day of the measurement period. For disenrollment metrics, disenrolled beneficiaries should be assigned to subpopulations based on status at the time of disenrollment. The subpopulations are organized under four groups: (1) income groups; (2) specific demographic groups; (3) exempt groups; and (4) specific eligibility groups. The various categories within each of these subpopulation groups are delineated as follows:
  - *Income groups* includes reported income subpopulations defined as less than 50% of the federal poverty level (FPL), 50-100% FPL, and greater than 100% FPL. States should report income subpopulations using these categories, unless states have finer gradations for income groups along which a policy varies (e.g., 100-115% FPL and 115%+ FPL), in which case those should be reported instead.
    - States should only report income groups that are relevant for a given metric. For example, the state does not need to report the <50% FPL income group for metric

PR_1 if the state only requires premiums for beneficiaries in income groups above 50% FPL.

- *Specific demographic groups* includes age, sex, race, and ethnicity.
  - Age is defined in groups as follows: 19-26, 27-35, 36-45, 46-55, or 56-64.
  - Sex is defined as male or female.
  - Race is defined as White, Black or African American, Asian, American Indian or Alaskan Native, other, or unknown.
  - Ethnicity is defined Hispanic, non-Hispanic, or unknown.
- *Exempt groups* are in eligibility and income groups that are enrolled in the demonstration but are not required to participate in elements of the demonstration (such as paying premiums) for reasons other than income. For example, exempt groups may include geographic exemptions, employer sponsored insurance exemptions or exemptions due to medical frailty. Exempt groups will vary by state based on the special terms and conditions (STCs) authorizing a demonstration. Exempt groups are included in metrics in the any demonstration module (module 1), but states are asked to report on them separately.

- *Specific eligibility groups* include section 1931 parents, the new adult group, transitional medical assistance beneficiaries, and other Medicaid eligibility groups included in the state's demonstration. Eligibility groups will vary by state based on STCs authorizing a demonstration. Reporting by specific eligibility groups is required where noted in metric specifications.

- In some instances, states may choose to phase in demonstration policies and requirements by cohort, using age groups or other criteria, as a tool to manage the gradual implementation of new operational processes or to support evaluation goals. In these scenarios, in addition to the defined categories within an applicable subpopulation group, states should report monitoring metrics by phase-in cohort, if they are different from the defined subpopulation categories. However, in consultation with CMS and on a case-by-case basis, it may suffice for a state to report certain metrics only by phase-in cohort subpopulations.

- **Measurement period.** This parameter identifies the measurement period (the data collection time frame) for each metric. The measurement period may be a month, quarter, demonstration year, or calendar year. Section B provides detailed guidance and reporting instructions for measurement period.

Table 2. Overview of eligibility and coverage metrics standard across any demonstration with premiums, Marketplace-focused premium assistance, health behavior incentives, community engagement requirements, or retroactive eligibility waivers

Metric	Metric name	Required or recommended	Subpopulations				Measurement period (calculation lag)
			Income groups	Specific demographic groups	Exempt groups	Specific eligibility groups	
Enrollment							
AD_1	Total enrollment in the demonstration	Required	X	X	X	X	Month (30 days)
AD_2	Beneficiaries in suspension status for noncompliance	Required	X	X	X	X	Month (30 days)
AD_3	Beneficiaries in a non-eligibility period who are prevented from re-enrolling for a defined period of time	Required	X	X	X	X	Month (30 days)
AD_4	New enrollees	Required	X	X	X	X	Month (30 days)
AD_5	Re-enrollments or re-instatements using defined pathways after disenrollment or suspension of benefits for noncompliance with demonstration policies	Required	X	X	X	X	Month (30 days)
AD_6	Re-enrollments or re-instatements for beneficiaries not using defined pathways after disenrollment or suspension of benefits for noncompliance	Required	X	X	X	X	Month (30 days)
Mid-year loss of demonstration eligibility							
AD_7	Beneficiaries determined ineligible for Medicaid, any reason, other than at renewal	Required	X	X	X	X	Month (30 days)
AD_8	Beneficiaries no longer eligible for Medicaid, failure to provide timely change in circumstance information	Required	X	X	X	X	Month (30 days)
AD_9	Beneficiaries determined ineligible for Medicaid after state processes a change in circumstance reported by a beneficiary	Required	X	X	X	X	Month (30 days)
AD_10	Beneficiaries no longer eligible for the demonstration due to transfer to another Medicaid eligibility group	Required	X	X	X	X	Month (30 days)
AD_11	Beneficiaries no longer eligible for the demonstration due to transfer to CHIP	Recommended	X	X	X	X	Month (30 days)

Table 2 (continued)

Metric	Metric name	Required or recommended	Subpopulations				Measurement period (calculation lag)
			Income groups	Specific demographic groups	Exempt groups	Specific eligibility groups	
Enrollment duration at time of disenrollment							
AD_12	Enrollment duration 0-3 months	Recommended	X				Month (30 days)
AD_13	Enrollment duration 4-6 months	Recommended	X				Month (30 days)
AD_14	Enrollment duration 6-12 months	Recommended	X				Month (30 days)
Renewal							
AD_15	Beneficiaries due for renewal	Required	X	X	X	X	Month (30 days)
AD _16	Beneficiaries determined ineligible for the demonstration at renewal, disenrolled from Medicaid	Required	X	X	X	X	Month (30 days)
AD_17	Beneficiaries determined ineligible for the demonstration at renewal, transfer to another Medicaid eligibility category	Required	X	X	X	X	Month (30 days)
AD_18	Beneficiaries determined ineligible for the demonstration at renewal, transferred to CHIP	Required	X	X	X	X	Month (30 days)
AD_19	Beneficiaries who did not complete renewal, disenrolled from Medicaid	Required	X	X	X	X	Month (30 days)
AD_20	Beneficiaries who had pending/ uncompleted renewals and were still enrolled	Required	X	X	X	X	Month (30 days)
AD_21	Beneficiaries who retained eligibility for the demonstration after completing renewal forms	Required	X	X	X	X	Month (30 days)
AD_22	Beneficiaries who renewed ex parte	Recommended	X	X	X	X	Month (30 days)
Cost sharing limit							
AD_23	Beneficiaries who reached 5% limit	Required	X	X	X	X	Month (30 days)
Appeals and grievances							
AD_24	Appeals, eligibility	Recommended					Quarter (no lag)
AD_25	Appeals, denial of benefits	Recommended					Quarter (no lag)
AD_26	Grievances, care quality	Recommended					Quarter (no lag)
AD_27	Grievances, provider or managed care entities	Recommended					Quarter (no lag)
AD_28	Grievances, other	Recommended					Quarter (no lag)
Access to care							
AD_29	Primary care provider availability	Required					Quarter (90 days)
AD_30	Primary care provider active participation	Required					Quarter (90 days)

Table 2 (continued)

Metric	Metric name	Required or recommended	Subpopulations				Measurement period (calculation lag)
			Income groups	Specific demographic groups	Exempt groups	Specific eligibility groups	
AD_31	Specialist provider availability	Required					Quarter (90 days)
AD_32	Specialist provider active participation	Required					Quarter (90 days)
AD_33	Preventive care and office visit utilization	Recommended	X	X	X	X	Quarter (90 days)
AD_34	Prescription drug use	Recommended	X	X	X	X	Quarter (90 days)
AD_35	Emergency department utilization, total	Recommended	X	X	X	X	Quarter (90 days)
AD_36	Emergency department utilization, non-emergency	Recommended	X	X	X	X	Quarter (90 days)
AD_37	Inpatient admissions	Recommended	X	X	X	X	Quarter (90 days)
Quality of care and health outcomes							
AD_38A	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)	Required (AD_38A or AD_38B)	X			X	Calendar year (90 days)
AD_38B	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Required (AD_38A or AD_38B)	X			X	Calendar year (90 days)
AD_39-1	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA -AD)	Required	X			X	Calendar year (90 days)
AD_39-2	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)	Required	X			X	Calendar year (90 days)
AD_40	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)	Required	X			X	Calendar year (90 days)
AD_41	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)	Required	X			X	Calendar year (90 days)
AD_42	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)	Required	X			X	Calendar year (90 days)
AD_43	PQI 08: Heart Failure Admission Rate (PQI08-AD)	Required	X			X	Calendar year (90 days)
AD_44	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)	Required	X			X	Calendar year (90 days)
Administrative cost							
AD_45	Administrative cost of demonstration operation	Recommended					Demonstration year (no lag)

Table 3. Additional metrics relevant for states that require premiums or account payments

Metric	Metric name	Required or recommended	Subpopulations				Measurement period (calculation lag)
			Income groups	Specific demographic groups	Exempt groups	Specific eligibility groups	
Enrollment by premium payment status							
PR_1	Beneficiaries subject to premium policy (or account contribution) during the month, not exempt	Required	X			X	Month (30 days)
PR_2	Beneficiaries who were exempt from premiums for that month	Required	X			X	Month (30 days)
PR_3	Beneficiaries who paid a premium during the month	Required	X			X	Month (30 days)
PR_4	Beneficiaries who were subject to premium policy but declare hardship for that month	Required	X			X	Month (30 days)
PR_5	Beneficiaries in short-term arrears (grace period)	Recommended	X			X	Month (30 days)
PR_6	Beneficiaries in long-term arrears	Recommended	X			X	Month (30 days)
PR_7	Beneficiaries with collectible debt	Required	X			X	Month (30 days)
Cumulative enrollment duration in states with time-variant premium policies							
PR_8	Beneficiaries in enrollment duration tier 1	Recommended	X			X	Month (30 days)
PR_9	Beneficiaries in enrollment duration tier 2	Recommended	X			X	Month (30 days)
PR_10	Beneficiaries in enrollment duration tiers 3+	Recommended	X			X	Month (30 days)
Mid-year change in circumstance by premium amount							
PR_11	Beneficiaries for whom the state processed a mid-year change in circumstance in household or income information and who remained enrolled in the demonstration	Recommended	X			X	Month (30 days)
PR_12	No premium change following mid-year processing of a change in household or income information	Recommended	X			X	Month (30 days)
PR_13	Premium increase following mid-year processing of change in household or income information	Recommended	X			X	Month (30 days)
PR_14	Premium decrease following mid-year processing of change in household or income information	Recommended	X			X	Month (30 days)

Table 3 (continued)

Metric	Metric name	Required or recommended	Subpopulations				Measurement period (calculation lag)
			Income groups	Specific demographic groups	Exempt groups	Specific eligibility groups	
Disenrollment or suspension for failure to pay							
PR_15	Beneficiaries disenrolled from the demonstration for failure to pay and therefore disenrolled from Medicaid	Required	X	X		X	Month (30 days)
PR_16	Beneficiaries in a non-eligibility period who were disenrolled for failure to pay and are prevented from re-enrolling for a defined period of time	Required	X	X		X	Month (30 days)
PR_17	Beneficiaries whose benefits are suspended for failure to pay	Required	X	X		X	Month (30 days)
Renewal							
PR_18	No premium change	Recommended	X			X	Month (30 days)
PR_19	Premium increase	Recommended	X			X	Month (30 days)
PR_20	Premium decrease	Recommended	X			X	Month (30 days)
Third party premium payment							
PR_21	Third-party premium payment	Required	X			X	Month (30 days)

Table 4. Additional metrics relevant for states with Marketplace-focused premium assistance programs

Metric	Metric name	Required or recommended	Subpopulations				Measurement period (calculation lag)
			Income groups	Specific demographic groups	Exempt groups	Specific eligibility groups	
Enrollment by premium payment status							
PA_1	Beneficiaries who lost Medicaid eligibility due to mid-year change in circumstance, and transitioned to a qualified health plan offered in the Marketplace	Required	X	X		X	Month (30 days)
PA_2	Beneficiaries who lost Medicaid eligibility at renewal, and transitioned to a qualified health plan offered in the Marketplace	Required	X	X		X	Month (30 days)
Access to care							
PA_3	Wraparound service utilization, by service	Recommended	X	X		X	Quarter (90 days)

Table 5. Additional metrics relevant for states with programs with health behavior incentives

Metric	Metric name	Required or recommended	Subpopulations				Measurement period (calculation lag)
			Income groups	Specific demographic groups	Exempt groups	Specific eligibility groups	
Enrollment							
HB_1	Total enrollment among beneficiaries subject to health behavior incentives	Required	X	X		X	Quarter (90 days)
Use of incentivized services: claims-based analysis							
HB_2	Beneficiaries using incentivized services that can be documented through claims, by service	Required	X	X		X	Quarter (90 days)
Other incentivized behaviors not documented through claims-based analysis							
HB_3	Completion of incentivized health behavior(s) not documented through claims analysis (i.e. health risk assessments), by health behavior	Required	X	X		X	Quarter (90 days)
HB_4	Completion of all incentivized health behaviors (both claims-based and other), if there are multiple	Required	X	X		X	Quarter (90 days)
Rewards granted for completion of incentivized health behaviors							
HB_5	Beneficiaries granted a premium reduction for completion of incentivized health behaviors	Required	X	X		X	Quarter (90 days)
HB_6	Beneficiaries granted a financial reward other than a premium reduction for completion of incentivized health behaviors	Required	X	X		X	Quarter (90 days)
HB_7	Beneficiaries granted a reward in the form of additional covered benefits for completion of incentivized health behaviors	Required	X	X		X	Quarter (90 days)

Table 6. Additional metrics relevant for states with community engagement requirements

Metric	Metric name	Required or recommended	Subpopulations				Measurement period (calculation lag)
			Income groups	Specific demographic groups	Exempt groups	Specific eligibility groups	
Community engagement enrollment							
CE_1	Total beneficiaries subject to the community engagement requirement, not exempt	Required		X		X	Month (30 days)
CE_2	Total beneficiaries who were exempt from community engagement requirements in the month	Required		X		X	Month (30 days)
CE_3	Beneficiaries with approved good cause circumstances	Required		X		X	Month (30 days)
CE_4	Beneficiaries subject to the community engagement requirement and in suspension status due to failure to meet requirement	Required		X		X	Month (30 days)
CE_5	Beneficiaries subject to the community engagement requirement and receiving benefits who met the requirement for qualifying activities	Required		X		X	Month (30 days)
CE_6	Beneficiaries subject to the community engagement requirement and receiving benefits but in a grace period or allowable month of noncompliance	Required		X		X	Month (30 days)
CE_7	Beneficiaries who successfully completed make-up hours or other activities to retain active benefit status after failing to meet the community engagement requirement in a previous month	Required		X		X	Month (30 days)
CE_8	Beneficiaries in a non-eligibility period who were disenrolled for noncompliance with the community engagement requirement and are prevented from re-enrolling for a defined period of time	Required		X		X	Month (30 days)
Community engagement requirement qualifying activities							
CE_9	Beneficiaries who met the community engagement requirement by satisfying requirements of other programs	Required		X		X	Month (30 days)
CE_10	Beneficiaries who met the community engagement requirement through employment for the majority of their required hours	Required		X		X	Month (30 days)

Table 6. (*continued*)

Metric	Metric name	Required or recommended	Subpopulations				Measurement period (calculation lag)
			Income groups	Specific demographic groups	Exempt groups	Specific eligibility groups	
CE_11	Beneficiaries who met the community engagement requirement through job training or job search for the majority of their required hours	Required		X		X	Month (30 days)
CE_12	Beneficiaries who met the community engagement requirement through educational activity for the majority of their required hours	Required		X		X	Month (30 days)
CE_13	Beneficiaries who met the community engagement requirement who were engaged in other qualifying activity for the majority of their required hours	Required		X		X	Month (30 days)
CE_14	Beneficiaries who met the community engagement requirement by combining two or more activities	Required		X		X	Month (30 days)
Basis of beneficiary exemptions from community engagement requirement							
CE_15	Beneficiaries exempt from Medicaid community engagement requirements because they were exempt from requirements of SNAP and/or TANF	Required		X		X	Month (30 days)
CE_16	Beneficiaries exempt from Medicaid community engagement requirements on the basis of pregnancy	Required		X		X	Month (30 days)
CE_17	Beneficiaries exempt from community engagement requirements due to former foster youth status	Required		X		X	Month (30 days)
CE_18	Beneficiaries exempt from Medicaid community engagement requirements due to medical frailty	Required		X		X	Month (30 days)
CE_19	Beneficiaries exempt from Medicaid community engagement requirements on the basis of caretaker status	Required		X		X	Month (30 days)
CE_20	Beneficiaries exempt from Medicaid community engagement requirements due to unemployment insurance compensation	Required		X		X	Month (30 days)
CE_21	Beneficiaries exempt from Medicaid community engagement requirements due to substance abuse treatment status	Required		X		X	Month (30 days)
CE_22	Beneficiaries exempt from Medicaid community engagement requirements due to student status	Required		X		X	Month (30 days)

Table 6. (*continued*)

Metric	Metric name	Required or recommended	Subpopulations				Measurement period (calculation lag)
			Income groups	Specific demographic groups	Exempt groups	Specific eligibility groups	
CE_23	Beneficiaries exempt from community engagement requirements because they were excused by a medical professional	Required		X		X	Month (30 days)
CE_24	Beneficiaries exempt from Medicaid community engagement requirements, other	Required		X		X	Month (30 days)
Supports and assistance							
CE_25	Total number of beneficiaries receiving supports to participate and placement assistance	Required		X		X	Month (30 days)
CE_26	Beneficiaries provided with transportation assistance	Recommended		X		X	Month (30 days)
CE_27	Beneficiaries provided with childcare assistance	Recommended		X		X	Month (30 days)
CE_28	Beneficiaries provided with language supports	Recommended		X		X	Month (30 days)
CE_29	Beneficiaries assisted with placement in community engagement activities	Recommended		X		X	Month (30 days)
CE_30	Beneficiaries provided with other non-Medicaid assistance	Recommended		X		X	Month (30 days)
Reasonable modifications for beneficiaries with disabilities							
CE_31	Beneficiaries who requested reasonable modifications to community engagement processes or requirements due to disability	Recommended		X		X	Month (30 days)
CE_32	Beneficiaries granted reasonable modifications to community engagement processes or requirements due to disability	Recommended		X		X	Month (30 days)
New suspensions and disenrollments during the measurement period							
CE_33	Beneficiaries newly suspended for failure to complete community engagement requirements	Required		X		X	Month (30 days)
CE_34	Beneficiaries newly disenrolled for noncompliance with community engagement requirement	Required		X		X	Month (30 days)
Reinstatement of benefits after suspension							
CE_35	Total beneficiaries whose benefits were reinstated after being in suspended status for noncompliance	Required		X		X	Month (30 days)
CE_36	Beneficiaries whose benefits were reinstated because their time-limited suspension period ended	Recommended		X		X	Month (30 days)

Table 6. (*continued*)

Metric	Metric name	Required or recommended	Subpopulations				Measurement period (calculation lag)
			Income groups	Specific demographic groups	Exempt groups	Specific eligibility groups	
CE_37	Beneficiaries whose benefits were reinstated because they completed required community engagement activities	Recommended		X		X	Month (30 days)
CE_38	Beneficiaries whose benefits were reinstated because they completed "on-ramp" activities other than qualifying community engagement activities	Recommended		X		X	Month (30 days)
CE_39	Beneficiaries whose benefits were reinstated because they newly meet community engagement exemption criteria or had a good cause circumstance	Recommended		X		X	Month (30 days)
CE_40	Beneficiaries whose benefits were reinstated after successful appeal of suspension for noncompliance	Recommended		X		X	Month (30 days)
Re-entry after disenrollment							
CE_41	Total beneficiaries re-enrolling after disenrollment for noncompliance	Required		X		X	Month (30 days)
CE_42	Beneficiaries re-enrolling after completing required community engagement activities	Recommended		X		X	Month (30 days)
CE_43	Beneficiaries re-enrolling after completing "on-ramp" activities other than qualifying community engagement activities	Recommended		X		X	Month (30 days)
CE_44	Beneficiaries re-enrolling after re-applying, subsequent to being disenrolled for noncompliance with community engagement requirements	Recommended		X		X	Month (30 days)
CE_45	Beneficiaries re-enrolling because they newly met community engagement exemption criteria or had a good cause circumstance	Recommended		X		X	Month (30 days)
CE_46	Beneficiaries re-enrolling after successful appeal of disenrollment for noncompliance	Recommended		X		X	Month (30 days)

Table 7. Additional metrics relevant for states with retroactive eligibility waivers

Metric	Metric name	Required or recommended	Subpopulations				Measurement period (calculation lag)
			Income groups	Specific demographic groups	Exempt groups	Specific eligibility groups	
At application							
RW_1	Beneficiaries who indicated that they had unpaid medical bills at the time of application	Required					Month (30 days)
At renewal							
RW_2	Beneficiaries who had a coverage gap at renewal	Required					Quarter (90 days)
RW_3	Beneficiaries who had a coverage gap at renewal and had claims denied	Required					Quarter (90 days)

B. Reporting eligibility and coverage demonstration monitoring metrics

This section provides reporting guidance applicable to section 1115 eligibility and coverage demonstration monitoring metrics. The technical specifications for calculating each metric are presented in Chapter II.

Technical assistance. To help states collect, report, and use the section 1115 eligibility and coverage demonstration monitoring metrics, CMS offers technical assistance. Please submit technical assistance requests to: 1115MonitoringAndEvaluation@cms.hhs.gov. When you contact this mailbox, please copy your CMS project officer on the message.

Measurement periods baseline year. When reporting eligibility and coverage demonstration monitoring metrics, use the following guidance for determining the measurement periods and baseline year.

- For metrics with a monthly measurement period, the first monthly measurement period consists of the full calendar month in which the demonstration started (approval start date). For example, if the demonstration started on March 15, the first month is March 1 through March 31. The second month is April 1 through April 30.
- For metrics with a quarterly measurement period, the first quarterly measurement period begins on the first day of the month in which the demonstration started (approval start date), and consists of the first three calendar months of the demonstration. For example, if the demonstration started on March 15, the first quarter is March 1 through May 31. The second quarter is June 1 through August 31.
- For the CMS-constructed metric with a demonstration year measurement period, the first measurement period begins on the first day of the month in which the demonstration started (approval start date), and consists of 12 consecutive calendar months of the demonstration. For example, if the demonstration started on March 15, 2018, the demonstration year measurement period is March 1, 2018 through February 28, 2019. The only CMS-constructed metric in the set of eligibility and coverage monitoring metrics with a demonstration year measurement period is AD_45 (Administrative cost of demonstration operation). All other yearly metrics are quality of care and health outcomes metrics, which have a calendar year measurement period.
- For the quality of care and health outcomes metrics, the first measurement period is the first calendar year that includes at least six months of the demonstration period. For example, if the demonstration started on March 15, 2018, the measurement period is January 1, 2018 through December 31, 2018, to align with the measurement period for these measures in other quality reporting programs. However for a demonstration that started on August 15, 2018, the baseline year for quality of care and health outcomes will be January 1, 2019 through December 31, 2019.
- Certain metrics with calendar year measurement periods may require more than one year of data. For example, metric AD_40 includes a negative diagnosis history review 60 days prior to the index episode start date. When available, states should use data prior to the demonstration start to establish a negative diagnosis history or total length of Medicaid enrollment for purposes of qualifying for inclusion in the quality of care and health outcomes metrics. Refer to the metric specifications for additional details on measurement periods for these metrics.

- The quality of care and health outcome metrics that require two years of data (AD_38A and AD_38B) will be reported for the first time following the second calendar year that includes at least six months of the demonstration period. The measures should be reported annually thereafter, using the two most recent years of data.
- For metrics that require monthly or quarterly data collection and reporting, as well as the CMS-constructed metric that is reported for the demonstration year (AD_45), the baseline year will begin on the first day of the month in which the demonstration started (approval start date), and consist of 12 consecutive calendar months of the demonstration. For example, for a demonstration started on March 15, 2018, the baseline year is March 1, 2018 through February 28, 2019.
- For quality of care and health outcomes metrics, the first calendar year that includes at least six months of the demonstration will be the baseline year. For example, for a demonstration started on March 15, 2018, the baseline year for quality of care and health outcomes metrics will be January 1, 2018 through December 31, 2018. However for a demonstration that started on July 15, 2018, the baseline year for quality of care and health outcomes will be January 1, 2019 through December 31, 2019.
- Requirements for individual metrics vary and the baseline year should be determined in consultation with CMS and documented in the state monitoring protocols. Please confirm these measurement periods for your state with your CMS project officer.

Table 8 illustrates these guidelines, using the demonstration start date of March 15, 2018 as an example.

Table 8. Example of alignment between demonstration years and measurement periods for a demonstration that began on March 15, 2018

	Monthly reporting		Quarterly reporting		Annual reporting			
	Start date	End date	Start date	End date	Start date	End date	Start date	End date
Demonstration year	CMS-constructed metrics						Quality of care and health outcomes metrics	
Baseline year	Mar 1 Apr 1 May 1 June 1 … Feb 1	Mar 31 Apr 30 May 31 June 30 …. Feb 28	Mar 1 June 1 Sep 1 Dec 1	May 31 Aug 31 Nov 30 Feb 28	Mar 1, 2018	Feb 28, 2019	Jan 1, 2018	Dec 31, 2018
Year 1	Monthly as defined in the baseline year row		Quarterly as defined in the baseline year row		Mar 1, 2019	Feb 29, 2020	Jan 1, 2019	Dec 31, 2019
Year 2					Mar 1, 2020	Feb 28, 2021	Jan 1, 2020	Dec 31, 2020
Year 3					Mar 1, 2021	Feb 28, 2022	Jan 1, 2021	Dec 31, 2021
Year 4					Mar 1, 2022	Feb 28, 2023	Jan 1, 2022	Dec 31, 2022

Metric calculation and reporting. States should report data to CMS in accordance with the agreed-upon reporting schedule and format. Most metrics should be calculated with a lag following the last day of the measurement period to allow for more complete reconciliation of enrollment actions and delays in provider claiming and reporting (claims run-out). The length of the lag period varies by metric, as noted in Chapter II. Most metrics are calculated after a 30-day lag. Claims-based metrics and other closely connected metrics should be calculated after a one-quarter (90-day) lag.

Guidelines for including metrics and narrative information in monitoring reports are as follows:

- Each quarterly report should contain (1) narrative information on implementation for the most recent demonstration quarter; (2) monthly metrics from the most recent quarter (note all monthly metrics have a 30-day lag); (3) quarterly metrics that do not require a lag from the most recent quarter; and (4) quarterly metrics that require a 90-day lag from the prior quarter.
- Demonstration year metrics should be included in the annual report.
- Calendar year metrics should be reported in the first quarterly (or annual) report that allows for 90 days of run-out after the end of the calendar year (assuming the calendar year includes at least 6 months of demonstration implementation, per definition of the baseline year). The demonstration year end date determines the appropriate quarterly report for reporting these metrics.

Table 9 outlines the reporting schedule by measurement period and calculation lag. Table 10 illustrates these guidelines, using the demonstration start date of March 15, 2018 as an example. Measurement period and calculation lag are defined for each metric in Chapter II.

Given the dynamic nature of Medicaid data, states should calculate metrics at the same time for each measurement period throughout the demonstration. This practice applies even if data are not shared with CMS until a later date. Therefore, if a state submits monitoring data to CMS on a quarterly basis, the state should calculate each monthly metric 30 days, or about one month, after the last day of the measurement month, and the submission should contain three monthly values for each monthly metric. For example, if the quarterly measurement period is March 1 through May 31, the state should calculate metrics for the calendar month of March on April 30, for the calendar month of April on May 31, and for the calendar month of May on June 30. The quarterly submission to CMS should contain three monthly metric values, each for March, April, and May.

General guidance. When reporting eligibility and coverage demonstration monitoring metrics, please follow these guidelines for all metrics:

- **Enrolled in the demonstration.** Beneficiaries "enrolled in the demonstration" includes beneficiaries enrolled in the demonstration and actively receiving benefits. For monthly metrics that count active beneficiaries, any beneficiary enrolled in the section 1115 demonstration and actively receiving benefits (not suspended) for at least one day in the month is eligible for inclusion in monthly metrics. Do not count beneficiaries whose

benefits are suspended as enrolled. For example, if a beneficiary is in suspended status for the entire month, the beneficiary should be excluded from metrics that count enrollment for that month. Beneficiaries enrolled in the section 1115 demonstration and actively receiving benefits for at least one month (30 consecutive days) during the measurement period for quarterly and annual metrics are eligible for inclusion in metric calculations; however, there may be different measure-specific continuous eligibility requirements for the quality of care and health outcomes measures.

- **Enrollment spell**. An enrollment spell is a period of continuous enrollment with no breaks. This is applicable to metrics that reference enrollment spells. For example, AD_3 *Monthly count of re-enrollments using defined pathways after disenrollment for noncompliance with demonstration policies* refers to beneficiaries who began a new enrollment spell during the measurement period.
- **Claim type.** When specified, include only *paid claims* or *paid, suspended, pending, and denied claims*, as instructed in the metric's technical specification.
- **Quality of care and health outcomes metrics.** Some metrics included in the technical specifications are health care quality measures used in other CMS programs.[2] To help states calculate these metrics, the technical specifications for measures in the Adult Core Set can be found in Appendix B: Technical Specifications for Medicaid Quality Measures, Adapted from FFY 2019 Adult Core Set Measure Specifications.
- **Established value sets.** A small number of eligibility and coverage metrics reference Healthcare Effectiveness Data and Information Set (HEDIS) value sets or other lists that contain complete sets of codes used to identify a treatment service or diagnosis.[3] When referenced, use these value sets to calculate a metric. Established value sets typically change as measure stewards update them. When referenced, states should use the most current versions of established code sets (or data elements) in the established value sets to calculate a metric. Established value sets are available to states upon request by contacting 1115MonitoringAndEvaluation@cms.hhs.gov.
- **State-specific typologies for appeals and grievances.** Metrics AD_24 through AD_28 require states to report types of appeals and grievances according to the state's typology. For example, for metric AD_24, a state can report all appeals relevant to eligibility even if the appeals are coded using multiple categories in the state's system. Along with metric values, states should submit definitions for their typology.
- **State-specific typologies for primary care and specialist providers.** Metrics AD_29 through AD_32 specify that states should report providers by state classification of primary care provider or specialist provider. Along with metric values, states should submit the list of state-specific provider type or specialties included.

[2] Metrics that are health care quality measures include: AD_38A, AD_38B, AD_39, AD_40, AD_41, AD_42, AD_43, and AD_44. See Appendix A.

[3] See Appendix C for a complete list of value sets referenced in metric specifications in Chapter II, by metric, and accompanying instructions. States can obtain these value sets upon request from CMS. Appendix C does not list value sets that are necessary for the nine quality of care and health outcome metrics.

Table 9. Metric reporting in quarterly and annual monitoring reports, by measurement period and calculation lag

Report name:	DY1 Q1 report	DY1 Q2 report	DY1 Q3 report	DY1 Q4 (annual) report	DY2 Q1 report	DY2 Q2 report	DY2 Q3 report
Report due date:	Due 60 days after quarter ends	Due 60 days after quarter ends	Due 60 days after quarter ends	Due 90 days after quarter ends	Due 60 days after quarter ends	Due 60 days after quarter ends	Due 60 days after quarter ends
Metric measurement periods, by calculation lag[a]							
Narrative information on implementation	DY1 Q1	DY1 Q2	DY1 Q3	DY1 Q4	DY2 Q1	DY2 Q2	DY2 Q3
Month	DY1 Q1	DY1 Q2	DY1 Q3	DY1 Q4	DY2 Q1	DY2 Q2	DY2 Q3
Quarter, no lag	DY1 Q1	DY1 Q2	DY1 Q3	DY1 Q4	DY2 Q1	DY2 Q2	DY2 Q3
Quarter, 90 days	NA	DY1 Q1	DY1 Q2	DY1 Q3	DY1 Q4	DY2 Q1	DY2 Q2
Demonstration year, no lag	NA	NA	NA	DY1	NA	NA	NA
Calendar year, 90 days[b]	NA	NA	CY 1 if DY ends 6/30	CY 1 if DY ends 1/31 – 5/31	CY1 if DY ends 12/31	CY 2 if DY ends 9/30 – 11/30	CY 2 if DY ends 7/31– 8/31

[a] All monthly metrics have a 30-day calculation lag, the annual DY metric has no lag; all annual CY metrics have a 90-day lag

[b] Report due dates for calendar year metrics are defined in terms of the demonstration year measurement period. The demonstration year measurement period begins on the first day of the month in which the demonstration started (approval start date). For example, a demonstration that begins on July 15 would have a demonstration year start date of July 1 and end date of June 30. To determine which report should include the calendar year metrics for a demonstration that begins on July 15, identify the report associated with a demonstration year end of June 30 (i.e., DY1 Q3 report).

DY = Demonstration year

CY = Calendar year

CY 1 = The calendar year during which the demonstration begins

CY 2 = The calendar year that immediately follows CY 1

NA = not applicable (information not expected to be included in report)

Table 10. Example of metric reporting in quarterly and annual monitoring reports for the first year of a demonstration that began on March 15, 2018

Report name:	DY1 Q1 report	DY1 Q2 report	DY1 Q3 report	DY1 Q4 (annual) report	DY2 Q1 report	DY2 Q2 report	DY2 Q3 report
Report due date:	Due 60 days after quarter ends	Due 60 days after quarter ends	Due 60 days after quarter ends	Due 90 days after quarter ends	Due 60 days after quarter ends	Due 60 days after quarter ends	Due 60 days after quarter ends
Metric measurement periods, by calculation lag							
Narrative information on implementation	Mar 1, 2018 – Mar 31, 2018	Apr 1, 2018 – Apr 30, 2018	May 1, 2018 – May 31, 2018	Jun 1, 2018 – Jun 30, 2019	Jul 1, 2019 – Jul 31, 2019	Aug 1, 2019 – Aug 31, 2019	Sep 1, 2019 – Sep 30, 2019
Month	Mar 1, 2018 – Mar 31, 2018	Apr 1, 2018 – Apr 30, 2018	May 1, 2018 – May 31, 2018	Jun 1, 2018 – Jun 30, 2019	Jul 1, 2019 – Jul 31, 2019	Aug 1, 2019 – Aug 31, 2019	Sep 1, 2019 – Sep 30, 2019
Quarter, no lag	Mar 1, 2018 – May 31, 2018	Jun 1, 2018 – Aug 31, 2018	Sep 1, 2018 – Nov 30, 2018	Dec 1, 2018 – Feb 28, 2019	Mar 1, 2019 – May 31, 2019	Jun 1, 2019 – Aug 31, 2019	Sep 1, 2019 – Nov 30, 2019
Quarter, 90 days	NA	Mar 1, 2018 – May 31, 2018	Jun 1, 2018 – Aug 31, 2018	Sep 1, 2018 – Nov 31, 2018	Dec 1, 2018 – Feb 28, 2019	Mar 1, 2019 – May 31, 2019	Jun 1, 2019 – Aug 31, 2019
Demonstration year, no lag	NA	NA	NA	Mar 1, 2018 – Feb 28, 2019	NA	NA	NA
Calendar year, 90 days	NA	NA	NA	Jan 1, 2018 – Dec 31, 2018	NA	NA	NA

The quarters this demonstration are as follows: Q1 = Mar 1 - May 31, Q2 = Jun 1 – Aug 31, Q3 = Sep 1 – Nov 30, Q4 = Dec 1 – Feb 28

DY = Demonstration year

NA = not applicable (information not expected to be included in report)

C. Using technical specifications

Table 11 defines the elements included in specifications for metrics in Chapter II. The description column explains each metric element.

Table 11. Table shell for the metrics' technical specifications

Metric #: Metric name	
Metric element	**Description**
Measure sets/endorsements	Names the measure steward and describes whether the metric is included in other measure sets (such as the Adult Core Set) and is endorsed by NQF. This element only appears where applicable.
Description	Brief measure description.
Counted variable	When the metric is a count, this element describes the counted variable. This element only appears when the metric is a count.
Numerator	When the metric is a rate, this element describes the numerator in the rate equation. This element is excluded when the metric is a count and from metrics that reference existing quality measures.
Denominator	When the metric is a rate, this element describes the denominator in the rate equation. This element is excluded when the metric is a count and from metrics that reference existing quality measures.
Metric calculation	When the metric is a rate, this element provides instructions for calculating the metric. This element is excluded when the metric is a count.
Additional guidance	Any additional guidance required to report this metric. This field only appears where applicable.
Required or recommended	Indicates whether the metric is required or recommended.
Measurement period (calculation lag)	Describes whether the measurement period is a month, quarter, demonstration year, or calendar year. (Indicates whether there is a 30-day, 90-day, or no calculation lag)
Subpopulations	Describes population subgroups that states must report separately.
Relationship to other metrics[a]	Describes components of this metric that are used in other eligibility and coverage demonstration monitoring metrics. This field only appears where applicable.
Data source	Describes the likely data source(s) used to report this metric.
Claim type	Describes the types of claims to include when calculating the metric. This field only appears where applicable.

[a] Appendix D lists all relationships to other metrics, by individual metric.

II. TECHNICAL SPECIFICATIONS

A. Metrics to be reported for any demonstration with premiums, premium assistance, health behavior incentives, community engagement requirements, or retroactive eligibility waivers

1. Enrollment

Metric AD_1: Total enrollment in the demonstration	
Metric element	**Description**
Description	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.
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration for at least one day during the measurement period. Step 2. Count unique beneficiaries (de-duplicated) who meet the criteria in Step 1.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific demographic groups Exempt groups Specific eligibility groups (required)
Relationship to other metrics	This metric provides an overall count of demonstration enrollment that can be used to check against other enrollment metrics (each should be equal to or smaller than this metric).
Data source	Administrative records

Metric AD_2: Beneficiaries in suspension status for noncompliance	
Metric element	**Description**
Description	The number of demonstration beneficiaries in suspension status for noncompliance with demonstration policies as of the last day of the measurement period
Counted variable	Step 1. Identify beneficiaries who were in suspension status from Medicaid benefits during the measurement period as a result of noncompliance with demonstration policies in the current or a prior measurement period and who remained in suspended status as of the last day of the measurement period. Step 2. Count unique demonstration beneficiaries (deduplicated) who meet the criteria in Step 1.
Required or recommended	Required if state has a suspension policy
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific demographic groups Exempt groups Specific eligibility groups (required) Note: Exempt groups may not be an applicable subpopulation for this metric in every state. For example, this metric is not applicable to states that have a demonstration that focuses solely on one eligibility and coverage policy, such as community engagement. Only states that have multiple eligibility and coverage policies, where some groups are exempt from noncompliance penalties associated with one policy, but not others, should report exempt subgroups for this metric.
Relationship to other metrics	Beneficiaries in suspension status are not included in AD_1
Data source	Administrative records

Metric AD_3: Beneficiaries in a non-eligibility period who are prevented from re-enrolling for a defined period of time

Metric element	Description
Description	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.
Counted variable	Step 1. Identify beneficiaries who were in a non-eligibility period as of the last day of the measurement period. Step 2. Include beneficiaries who are prevented from re-enrolling until their redetermination date or another date established by the state. Step 3. Count unique beneficiaries (deduplicated) who met the criteria in Steps 1 and 2.
Required or recommended	Required if state has a non-eligibility period policy
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific demographic groups Exempt groups Specific eligibility groups (required) Note: Exempt groups may not be an applicable subpopulation for this metric in every state. For example, this metric is not applicable to states that have a demonstration that focuses solely on one eligibility and coverage policy, such as community engagement. Only states that have multiple eligibility and coverage policies, where some groups are exempt from noncompliance penalties associated with one policy, but not others, should report exempt subgroups for this metric.
Data source	Administrative records

Metric AD_4: New enrollees

Metric element	Description
Description	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.
Counted variable	Step 1. Identify beneficiaries in the demonstration who began a new enrollment spell during the measurement period. Step 2. Retain beneficiaries who had **not** had a previous spell of enrollment that ended within the prior 3 months (i.e., were not enrolled at any time within the prior 3 months). Step 3. [This step is only applicable in states that disenroll beneficiaries for noncompliance with demonstration policies.] Retain beneficiaries who were **not** using a state-defined re-enrollment pathway after being previously disenrolled for noncompliance with demonstration requirements. Step 4. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1, 2, and 3.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific demographic groups Exempt groups Specific eligibility groups (required)
Data source	Administrative records

Metric AD_5: Re-enrollments or re-instatements using defined pathways after disenrollment or suspension of benefits for noncompliance with demonstration policies

Metric element	Description
Description	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.
Counted variable	Step 1. Identify beneficiaries in the demonstration who began a new enrollment spell (or had benefits re-instated) during the measurement period. Step 2. Retain beneficiaries who had a previous enrollment spell that ended within the prior 3 months (i.e., who were enrolled at some time in the previous three months) or whose benefits were in suspension status as of the last day of the prior month. Step 3. Retain beneficiaries that used a state-defined re-enrollment or re-instatement pathway. Defined pathways may include, but are not limited to, the following: • Paying owed premiums • Completing sufficient community engagement hours • Specialty community engagement activities such as state-approved educational courses This should include only beneficiaries who were previously disenrolled or had benefits suspended for noncompliance with any of the following: • Premium requirements • Community engagement requirements • Other demonstration-specific requirements Step 4. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1, 2 and 3.
Required or recommended	Required for states with a defined re-enrollment or re-instatement pathway
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific demographic groups Exempt groups Specific eligibility groups (required) Note: Exempt groups may not be an applicable subpopulation for this metric in every state. For example, this metric is not applicable to states that have a demonstration that focuses solely on one eligibility and coverage policy, such as community engagement. Only states that have multiple eligibility and coverage policies, where some groups are exempt from noncompliance penalties associated with one policy, but not others, should report exempt subgroups for this metric.
Data source	Administrative records

Metric AD_6: Re-enrollments or re-instatements for beneficiaries not using defined pathways after disenrollment or suspension of benefits for noncompliance

Metric element	Description
Description	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).
Counted variable	Step 1. Identify beneficiaries in the demonstration who began a new enrollment spell (or had benefits re-instated) during the measurement period. Step 2. Retain beneficiaries who had a previous enrollment spell that ended within the prior 3 months (i.e., who were enrolled at some time in the previous three months) or whose benefits were in suspension status as of the last day of the prior month. Step 3. [This step is only applicable in states that disenroll or suspend benefits for beneficiaries for noncompliance with demonstration policies.] Retain beneficiaries who were **not** using a state-defined re-enrollment pathway after disenrollment for noncompliance with the following: • Premium requirements • Community engagement requirements • Other demonstration-specific requirements For example, beneficiaries may begin a new enrollment spell or have benefits re-instated due to changes in their household income, eligibility group status, or resolution of appeals. Step 4. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1, 2, and 3.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific demographic groups Exempt groups Specific eligibility groups (required) Note: Exempt groups may not be an applicable subpopulation for this metric in every state. For example, this metric is not applicable to states that have a demonstration that focuses solely on one eligibility and coverage policy, such as community engagement. Only states that have multiple eligibility and coverage policies, where some groups are exempt from noncompliance penalties associated with one policy, but not others, should report exempt subgroups for this metric.
Data source	Administrative records

2. Mid-year loss of demonstration eligibility

Metric AD_7: Beneficiaries determined ineligible for Medicaid, any reason, other than at renewal	
Metric element	**Description**
Description	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
Counted variable	Step 1. Identify beneficiaries who were enrolled in the demonstration for at least one day during the measurement period (AD_1). Step 2. Retain those determined ineligible for Medicaid during the measurement period and who were ineligible as of the last day of the month. Step 3. Exclude beneficiaries determined ineligible at renewal. Step 4. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1, 2 and 3.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific demographic groups Exempt groups Specific eligibility groups (required)
Relationship to other metrics	Metric AD_7 is the sum of metrics AD_12, AD_13, and AD_14
Data source	Administrative records

Metric AD_8: Beneficiaries no longer eligible for Medicaid, failure to provide timely change in circumstance information	
Metric element	**Description**
Description	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
Counted variable	Step 1. Identify beneficiaries who were enrolled in the demonstration for at least one day during the measurement period (AD_1). Step 2. Retain those determined ineligible for Medicaid during the measurement period for the following reason and who were ineligible as of the last day of the measurement period: • Failure to provide timely change in circumstance information Step 3. Exclude beneficiaries determined ineligible at renewal. Step 4. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1, 3, and 3.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific demographic groups Exempt groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of Metric AD_7
Data source	Administrative records

Metric AD_9: Beneficiaries determined ineligible for Medicaid after state processes a change in circumstance reported by a beneficiary

Metric element	Description
Description	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.
Counted variable	Step 1. Identify beneficiaries who were enrolled in the demonstration for at least one day during the measurement period (AD_1). Step 2. Retain those determined ineligible for Medicaid during the measurement period for the following reason and who were ineligible as of the last day of the measurement period: • State processed a change in circumstance Step 3. Exclude beneficiaries determined ineligible at renewal. Step 4. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1, 2 and 3.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific demographic groups Exempt groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of Metric AD_7
Data source	Administrative records

Metric AD_10: Beneficiaries no longer eligible for the demonstration due to transfer to another Medicaid eligibility group

Metric element	Description
Description	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
Counted variable	Step 1. Identify beneficiaries who were enrolled in the demonstration for at least one day during the measurement period (AD_1). Step 2. Retain those determined ineligible for the demonstration during the measurement period, who remained eligible for Medicaid coverage under an eligibility group not included in the demonstration and who were transferred to that eligibility group. Status should be assessed as of the last day of the measurement period. Step 3. Exclude beneficiaries determined ineligible at renewal. Step 4. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific demographic groups Exempt groups Specific eligibility groups (required)
Data source	Administrative records

Metric AD_11: Beneficiaries no longer eligible for the demonstration due to transfer to CHIP	
Metric element	**Description**
Description	Number of beneficiaries who were enrolled in the demonstration and transferred from the demonstration to CHIP during the measurement period
Counted variable	Step 1. Identify beneficiaries who were enrolled in the demonstration for at least one day during the measurement period (AD_1). Step 2. Retain those determined ineligible for Medicaid during the measurement period who remained eligible for CHIP coverage and were transferred to CHIP. Status should be assessed as of the last day of the measurement period. Step 3. Exclude beneficiaries determined ineligible at renewal. Step 4. Count unique beneficiaries (deduplicated) that meet the criteria in Steps 1, 2 and 3.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific demographic groups Exempt groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of Metric AD_7
Data source	Administrative records

3. Enrollment duration at time of disenrollment

Metric AD_12: Enrollment duration, 0-3 months	
Metric element	**Description**
Description	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
Counted variable	Step 1. Identify demonstration beneficiaries determined ineligible for Medicaid during the measurement period, other than at renewal (metric AD_7). Step 2. Retain beneficiaries whose enrollment spell had lasted 3 or fewer months at the time of disenrollment. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups
Relationship to other metrics	Subset of metric AD_7
Data source	Administrative records

Metric AD_13: Enrollment duration, 4-6 months

Metric element	Description
Description	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
Counted variable	Step 1. Identify demonstration beneficiaries determined ineligible for Medicaid during the measurement period, other than at renewal (metric AD_7). Step 2. Retain beneficiaries whose enrollment spell had lasted between 4 and 6 months at the time of disenrollment. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups
Relationship to other metrics	Subset of metric AD_7
Data source	Administrative records

Metric AD_14: Enrollment duration, 6-12 months

Metric element	Description
Description	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
Counted variable	Step 1. Identify demonstration beneficiaries determined ineligible for Medicaid during the measurement period, other than at renewal (metric AD_7). Step 2. Retain beneficiaries whose enrollment spell had lasted 6 or more months (up to 12 months) at the time of disenrollment. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups
Relationship to other metrics	Subset of metric AD_7
Data source	Administrative records

4. Renewal

Metric AD_15: Beneficiaries due for renewal	
Metric element	**Description**
Description	Total number of beneficiaries enrolled in the demonstration who were due for renewal during the measurement period
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration during the measurement period (metric AD_1). Step 2. Retain beneficiaries due for renewal during the measurement period. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Additional guidance	All annual renewals that came up for redetermination during the measurement period should be included, regardless of the disposition (including pending, determined eligible, determined ineligible, and/or ineligible due to failure to return documentation).
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific demographic groups Exempt groups Specific eligibility groups (required)
Relationship to other metrics	This metric is equal to the sum of metrics AD_16, AD_17, AD_18, AD_19, AD_20, AD_21, and AD_22
Data source	Administrative records

Metric AD_16: Beneficiaries determined ineligible for the demonstration at renewal, disenrolled from Medicaid	
Metric element	**Description**
Description	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
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration who were due for renewal during the measurement period (metric AD_15). Step 2. Retain beneficiaries who completed the renewal process. Step 3. Retain beneficiaries determined ineligible for Medicaid. Step 4. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1, 2, and 3.
Additional guidance	Exclude beneficiaries determined ineligible outside the annual renewal process. Beneficiaries determined ineligible at mid-year due to a change in circumstance are counted in metrics AD_7 through AD_11.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific demographic groups Exempt groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric AD_15
Data source	Administrative records

Metric AD_17: Beneficiaries determined ineligible for the demonstration at renewal, transfer to another Medicaid eligibility category

Metric element	Description
Description	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
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration who were due for renewal during the measurement period (metric AD_15). Step 2. Retain beneficiaries who completed the renewal process. Step 3. Retain beneficiaries who transferred to another Medicaid eligibility group. Step 4. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1, 2, and 3.
Additional guidance	Exclude beneficiaries determined ineligible outside the annual renewal process. Beneficiaries determined ineligible at mid-year due to a change in circumstance are counted in metrics AD_7 through AD_11.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific demographic groups Exempt groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric AD_15
Data source	Administrative records

Metric AD_18: Beneficiaries determined ineligible for the demonstration at renewal, transferred to CHIP

Metric element	Description
Description	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
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration who were due for renewal during the measurement period (metric AD_15). Step 2. Retain beneficiaries who completed the renewal process. Step 3. Retain beneficiaries who transferred to CHIP. Step 4. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1, 2, and 3.
Additional guidance	Exclude beneficiaries determined ineligible outside the annual renewal process. Beneficiaries determined ineligible at mid-year due to a change in circumstance are counted in metrics AD_7 through AD_11.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific demographic groups Exempt groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric AD_15
Data source	Administrative records

Metric AD_19: Beneficiaries who did not complete renewal, disenrolled from Medicaid

Metric element	Description
Description	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
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration who were due for renewal during the measurement period (metric AD_15). Step 2. Retain beneficiaries who were disenrolled from Medicaid for failure to complete the renewal process. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Additional guidance	Exclude beneficiaries determined ineligible outside the annual renewal process. Beneficiaries determined ineligible at mid-year due to a change in circumstance are counted in metrics AD_7 through AD_11.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific demographic groups Exempt groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric AD_15
Data source	Administrative records

Metric AD_20: Beneficiaries who had pending/ uncompleted renewals and were still enrolled

Metric element	Description
Description	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
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration who were due for renewal during the measurement period (metric AD_15). Step 2. Retain beneficiaries for whom the state had not completed renewal determination by the last day of the measurement period. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Additional guidance	Some pending renewal determinations will be completed between the last day of the measurement period and the time that enrollment monitoring metrics should be generated - 30 days after the close of the measurement period. Renewal dispositions during this time window that result in demonstration ineligibility should be counted with AD_16 - AD_19. Renewal dispositions during this time window that resulted in continued demonstration eligibility without breaks in coverage for services (for example, if the state covers services back to the renewal date) should be counted in AD_21.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific demographic groups Exempt groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric AD_15
Data source	Administrative records

Metric AD_21: Beneficiaries who retained eligibility for the demonstration after completing renewal forms

Metric element	Description
Description	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
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration who were due for renewal during the measurement period (metric AD_15). Step 2. Retain beneficiaries who completed the renewal process by responding to beneficiary notices. Step 3. Retain beneficiaries who remained enrolled. Step 4. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1, 2, and 3.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific demographic groups Exempt groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric AD_15
Data source	Administrative records

Metric AD_22: Beneficiaries who renewed ex parte

Metric element	Description
Description	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
Counted variable	Step 1. Identify beneficiaries due for renewal during the measurement period (metric AD_15). Step 2. Retain beneficiaries who remained enrolled as of the last day during the measurement period as determined by third-party data sources or available information, rather than beneficiary response to renewal notices. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific demographic groups Exempt groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric AD_15
Data source	Administrative records

5. Cost sharing limit

Metric AD_23: Beneficiaries who reached 5% limit	
Metric element	**Description**
Description	Number of beneficiaries enrolled in the demonstration who reached the 5% of income limit on cost sharing and premiums during the month.
Counted variable	Step 1. Identify beneficiaries enrolled for the demonstration (metric AD_1). Step 2. Retain beneficiaries who reached the 5% of income limit on cost sharing and premiums during the measurement period. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required for states with cost-sharing or premiums.
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific demographic groups Exempt groups Specific eligibility groups (required)
Data source	Administrative records

6. Appeals and grievances

Metric AD_24: Appeals, eligibility	
Metric element	**Description**
Description	Number of appeals filed by beneficiaries enrolled in the demonstration during the measurement period regarding Medicaid eligibility
Counted variable	Step 1. Identify appeals regarding Medicaid eligibility filed by demonstration beneficiaries during the measurement period. Step 2. Count each appeal identified in Step 1 once, regardless of whether more than one appeal is filed by the same beneficiary. Appeals that are processed through multiple levels of review should only be counted once.
Additional guidance	There is no typology for tracking appeals filed by Medicaid beneficiaries; each state tracks and categorizes appeals differently. States should map their own categories onto those in AD_24 (for eligibility-related categories) and AD_25 (for categories related to denial of benefits).
Required or recommended	Recommended
Measurement period (calculation lag)	Quarter (no lag)
Data source	Administrative records

Metric AD_25: Appeals, denial of benefits	
Metric element	**Description**
Description	Number of appeals filed by beneficiaries enrolled in the demonstration during the measurement period regarding denial of benefits
Counted variable	Step 1. Identify appeals regarding denial of benefits filed by demonstration beneficiaries during the measurement period. Step 2. Count each appeal identified in Step 1 once, regardless of whether more than one appeal is filed by the same beneficiary. Appeals that are processed through multiple levels of review should only be counted once.
Additional guidance	There is no typology for tracking appeals filed by Medicaid beneficiaries; each state tracks and categorizes appeals differently. States should map their own categories onto those in AD_24 (for eligibility-related categories) and AD_25 (for categories related to denial of benefits).
Required or recommended	Recommended
Measurement period (calculation lag)	Quarter (no lag)
Data source	Administrative records

Metric AD_26: Grievances, care quality	
Metric element	**Description**
Description	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding the quality of care or services provided
Counted variable	Step 1. Identify grievances regarding the quality of care services provided filed by demonstration beneficiaries during the measurement period. Step 2. Count each grievance identified in Step 1 once, regardless of whether more than one grievance is filed by the same enrollee.
Additional guidance	There is no national typology for tracking grievances filed by Medicaid beneficiaries; each state tracks and categorizes grievances differently. States should map their own categories onto those in AD_26 (for categories related to care quality), AD_27 (for provider/managed care entity-related categories), and AD_28 (for categories that cannot be classified into either care quality or provider/managed care entities).
Required or recommended	Recommended
Measurement period (calculation lag)	Quarter (no lag)
Data source	Administrative records

Metric AD_27: Grievances, provider or managed care entities

Metric element	Description
Description	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).
Counted variable	Step 1. Identify grievances filed by demonstration beneficiaries during the measurement period regarding a provider (including primary care case management providers) or managed care entity. Step 2. Count each grievance identified in Step 1 once, regardless of whether more than one grievance is filed by the same beneficiary.
Additional guidance	There is no national typology for tracking grievances filed by Medicaid beneficiaries; each state tracks and categorizes grievances differently. States should map their own categories onto those in AD_26 (for categories related to care quality), AD_27 (for provider/managed care entity-related categories), and AD_28 (for categories that cannot be classified into either care quality or provider/managed care entities).
Required or recommended	Recommended
Measurement period (calculation lag)	Quarter (no lag)
Data source	Administrative records

Metric AD_28: Grievances, other

Metric element	Description
Description	Number of grievances filed by beneficiaries enrolled in the demonstration during the measurement period regarding other matters that are not subject to appeal
Counted variable	Step 1. Identify grievances regarding other matters that are not subject to appeal filed by demonstration beneficiaries during the measurement period. Exclude grievances counted in AD_26 and AD_27. Step 3. Count each grievance identified in Step 1 once, regardless of whether more than one grievance is filed by the same beneficiary.
Additional guidance	There is no national typology for tracking grievances filed by Medicaid beneficiaries; each state tracks and categorizes grievances differently. States should map their own categories onto those in AD_26 (for categories related to care quality), AD_27 (for provider/managed care entity-related categories), and AD_28 (for categories that cannot be classified into either care quality or provider/managed care entities).
Required or recommended	Recommended
Measurement period (calculation lag)	Quarter (no lag)
Data source	Administrative records

7. Access to care

Metric AD_29: Primary care provider availability	
Metric element	**Description**
Description	Number of primary care providers enrolled to deliver Medicaid services at the end of the measurement period
Counted variable	Step 1. Identify primary care providers who were enrolled to deliver Medicaid services to demonstration beneficiaries and were qualified to deliver Medicaid services as of the last day of the measurement period. Step 2. Count unique primary care providers (deduplicated) who meet the criteria in Step 1.
Additional guidance	Standards for classifying, enrolling, and qualifying physician providers vary by state. States should report which providers were considered primary care providers for this metric. Sources for physician provider data also vary by state. These data may be available in provider enrollment databases maintained by the state or by the managed care organizations the state contracts with to serve beneficiaries. The metric is intended to capture the set of providers potentially available to demonstration beneficiaries. If there is a distinction between all providers enrolled and qualified to deliver Medicaid services and those available to demonstration beneficiaries, the metric should only include providers available to demonstration beneficiaries.
Required or recommended	Required
Measurement period (calculation lag)	Quarter (90 days)
Data source	Provider enrollment databases

Metric AD_30: Primary care provider active participation	
Metric element	**Description**
Description	Number of primary care providers enrolled to deliver Medicaid services with service claims for 3 or more demonstration beneficiaries during the measurement period
Counted variable	Step 1. Identify all primary care providers enrolled to deliver Medicaid services to demonstration beneficiaries as of the last day of the measurement period (metric AD_29). Step 2. Retain primary care providers that are identified as the servicing or billing provider on claims that have service end dates during the measurement period. Step 3. Retain primary care providers from Step 2 that have claims for 3 or more unique demonstration beneficiaries (at least one claim per beneficiary) during the measurement period. Step 4. Count unique providers (deduplicated) who meet the criteria in Steps 1, 2, and 3.
Additional guidance	Standards for classifying, enrolling, and qualifying physician providers vary by state. States should report which providers were considered primary care providers for this metric. Sources for physician provider data also vary by state. These data may be available in provider enrollment databases maintained by the state or by the managed care organizations the state contracts with to serve beneficiaries.
Required or recommended	Required
Measurement period (calculation lag)	Quarter (90 days)
Data source	Provider enrollment databases and claims and encounters
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Metric AD_31: Specialist provider availability	
Metric element	**Description**
Description	Number of specialists enrolled to deliver Medicaid services at the end of the measurement period
Counted variable	Step 1. Identify specialist providers who were enrolled to deliver Medicaid services to demonstration beneficiaries and were qualified to deliver Medicaid services as of the last day of the measurement period. Step 2. Count unique specialist providers (deduplicated) who meet the criteria in Step 1.
Additional guidance	Standards for classifying, enrolling, and qualifying specialist providers vary by state. States should report which providers were considered specialty providers for this metric. Sources for specialist provider data also vary by state. These data may be available in provider enrollment databases maintained by the state or by the managed care organizations the state contracts with to serve beneficiaries. The metric is intended to capture the set of providers potentially available to demonstration beneficiaries. If there is a distinction between all providers enrolled and qualified to deliver Medicaid services and those available to demonstration beneficiaries, the metric should only include providers available to demonstration beneficiaries.
Required or recommended	Required
Measurement period (calculation lag)	Quarter (90 days)
Data source	Provider enrollment databases

Metric AD_32: Specialist provider active participation	
Metric element	**Description**
Description	Number of specialists enrolled to deliver Medicaid services with service claims for 3 or more demonstration beneficiaries during the measurement period
Counted variable	Step 1. Identify specialist providers enrolled to deliver Medicaid services to demonstration beneficiaries as of the last day of the measurement period (metric AD_31). Step 2. Retain specialist providers that are identified as the servicing or billing provider on claims that have service end dates during the measurement period. Step 3. Retain specialist providers from Step 2 if they have claims for 3 or more unique beneficiaries (at least one claim per beneficiary) during the measurement period. Step 4. Count unique providers (deduplicated) who meet the criteria in Steps 1, 2, and 3.
Additional guidance	Standards for classifying, enrolling, and qualifying specialist providers vary by state. States should report which providers were considered specialty providers for this metric. Sources for specialist provider data also vary by state. These data may be available in provider enrollment databases maintained by the state or by the managed care organizations the state contracts with to serve beneficiaries.
Required or recommended	Required
Measurement period (calculation lag)	Quarter (90 days)
Data source	Provider enrollment databases and claims and encounters
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Metric AD_33: Preventive care and office visit utilization

Metric element	Description
Description	Total utilization of preventive care and office visits per 1,000 demonstration beneficiary months during the measurement period
Numerator	Step 1. Identify all preventive care and office visits with service end dates during the measurement period for demonstration beneficiaries included in the denominator. To identify preventive care and office visits, count professional and institutional claims that include any of the codes in the following: • HEDIS Well-Care Value Set • HEDIS Ambulatory Visits Value Set • HEDIS Other Ambulatory Visits Value Set Step 2. Keep all professional claims and only outpatient institutional claims that meet either of the following conditions: • Type of Bill is 71X or 77X (where X is any third digit) • Type of Bill is 85X (where X is any third digit) AND Revenue Center Code starts with 096, 097, or 098) Step 3. Count the unique number of claim headers (visits) identified in Steps 1 and 2.
Denominator	Total number of months of beneficiary demonstration enrollment during the measurement period. Beneficiaries that are continuously enrolled during the reporting quarter contribute 3 months to the denominator.
Metric calculation	Calculate the rate by dividing the number of claim headers (visits) in the numerator by the number of beneficiary months in the denominator and then multiply by 1,000, as follows: (Number of visits / Number of demonstration beneficiary months) * 1,000
Additional guidance	To view the HEDIS Value Sets used in this metric, submit a technical assistance request to 1115MonitoringAndEvaluation@cms.hhs.gov.
Required or recommended	Recommended
Measurement period (calculation lag)	Quarter (90 days)
Subpopulations	Income groups Specific demographic groups Exempt groups Specific eligibility groups (required)
Data source	Claims and encounters; other administrative records
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Metric AD_34: Prescription drug use

Metric element	Description
Description	Total utilization of 30-day prescription fills per 1,000 demonstration beneficiary months in the measurement period.
Numerator	Step 1. Identify all prescription fill claims with a prescription fill date during the measurement period for demonstration beneficiaries included in the denominator. Step 2. Standardize prescription fills into 30-day fills using the following logic: a. Claims for a 30-day supply or less than 30-days supply count as one prescription fill. b. Claims for supply greater than 30 days should be standardized into 30-day fills. For example, a 60-day supply equals two prescription fills, a 90-day supply equals three prescription fills. Step 3. Count the total number of standardized 30-day prescription fills identified in Step 2.
Denominator	Total number of months of beneficiary demonstration enrollment during the measurement period. Beneficiaries that are continuously enrolled during the reporting quarter contribute 3 months to the denominator.
Metric calculation	Calculate the rate by dividing the number of prescription fills in the numerator by the number of beneficiary months in the denominator and then multiply by 1,000, as follows: (Number of prescription fills / Number of demonstration beneficiary months) * 1,000
Required or recommended	Recommended
Measurement period (calculation lag)	Quarter (90 days)
Subpopulations	Income groups Specific demographic groups Exempt groups Specific eligibility groups (required)
Data source	Claims and encounters; other administrative records
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Metric AD_35: Emergency department utilization, all use	
Metric element	**Description**
Description	Total number of emergency department (ED) visits per 1,000 demonstration beneficiary months during the measurement period
Numerator	Step 1. Identify the total number of ED visits with service end dates during the measurement period for demonstration beneficiaries in the denominator. Use either of the following to identify ED visits: • HEDIS ED Value Set • A procedure code in the HEDIS ED Procedure Code Value Set with a place of service code in the HEDIS ED POS Value Set Step 2. Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits to the same facility on the same ending date of service as one visit. Step 3. Calculate the number of ED visits identified in Steps 1 and 2.
Denominator	Total number of months of beneficiary demonstration enrollment during the measurement period. Beneficiaries that are continuously enrolled during the reporting quarter contribute 3 months to the denominator.
Metric Calculation	Calculate the rate by dividing the number of ED visits in the numerator by the number of beneficiary months in the denominator and then multiply by 1,000, as follows: (Number of ED visits / Number of demonstration beneficiary months) * 1,000
Additional guidance	To view the HEDIS Value Sets used in this metric, submit a technical assistance request to 1115MonitoringAndEvaluation@cms.hhs.gov.
Required or recommended	Recommended
Measurement period (calculation lag)	Quarter (90 days)
Subpopulations	Income groups Specific demographic groups Exempt groups Specific eligibility groups (required)
Data source	Claims and encounters; other administrative records
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Metric AD_36: Emergency department utilization, non-emergency

Metric element	Description
Description	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.
Numerator	Step 1. Identify the total number of ED visit claims with service end dates during the measurement period for demonstration beneficiaries in the denominator. Use either of the following to identify ED visits: • HEDIS ED Value Set • A procedure code in the HEDIS ED Procedure Code Value Set with a place of service code in the HEDIS ED POS Value Set This should be the same set of ED claims counted in the numerator of AD_35. If the state differentiates emergent/non-emergent visit copayments, follow Step 2 and then skip to Step 7. If the state does not differentiate emergent/non-emergent copayments, follow Steps 3 through 7 to identify non-emergency visits. Step 2. Using the state-defined criteria for identifying non-emergency visits, identify ED visits for which the state charged the beneficiary a non-emergency ED visit co-pay. Skip to Step 7. Step 3. Classify ED visits that resulted in an inpatient stay as emergent. An ED visit resulted in an inpatient stay if there is an inpatient stay claim for the same beneficiary with an admission date on the ED service end date or the following day. Use the following to Identify inpatient stay claims: • HEDIS Inpatient Stay Value Set Step 4. To classify the remaining visits, download the algorithm for the New York University ED classification schemes for ICD-10, found here: (https://wagner.nyu.edu/faculty/billings/nyued-background). Note: the ED classification schemes utilize only the primary diagnosis on claims and are intended for monitoring broad population-level trends, not for determining whether an individual visit was or was not emergent based on clinical symptoms present on admission to the ED. Step 5. Using the probabilities in the classification schemes, classify ED visits with service dates during the measurement period as likely emergent or non-emergent. Drop visits that meet the following criteria: • Visits with a primary diagnosis code for - Injury as identified in the classification scheme, where the variable “injury” generated by the algorithm equals 100%. - Substance abuse as identified in the classification scheme, where the variable “drug” generated by the algorithm equals 100%. - Alcohol as identified in the classification scheme, where the variable “alcohol” generated by the algorithm equals 100%. - Mental health as identified in the classification scheme, where the variable “psych” generated by the algorithm equals 100% or 67%. - Unclassified as identified in the classification scheme, where the variable “unclassified” generated by the algorithm equals 100%. • Visits with a primary diagnosis code where the sum of probabilities across the following emergent category variables generated by the algorithm is greater than or equal to 70%: - ED_Care_Needed__not_Preventable - ED_Care_Needed__Preventable_Avoi - Emergent__PC_Treatable Step 6. Classify all remaining ED visits as non-emergent. Step 7. Count the unique number of non-emergent ED visits defined in Step 2 (if the state differentiates emergent/non-emergent visit copayments*) or* Step 6. Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits to the same facility on the same ending date of service as one visit.
Denominator	Total number of months of beneficiary demonstration enrollment during the measurement period. Beneficiaries that are continuously enrolled during the reporting quarter contribute 3 months to the denominator.

Metric AD_36: Emergency department utilization, non-emergency	
Metric element	**Description**
Metric Calculation	Calculate the rate by dividing the number of non-emergent ED visits in the numerator by the number of beneficiary months in the denominator and then multiply by 1,000, as follows: (Number of non-emergent ED visits / Number of demonstration beneficiary months) * 1,000
Additional guidance	To view the HEDIS Value Sets used in this metric, submit a technical assistance request to 1115MonitoringAndEvaluation@cms.hhs.gov.
Required or recommended	Recommended. Required for states with copayments for non-emergency use.
Measurement period (calculation lag)	Quarter (90 days)
Subpopulations	Income groups Specific demographic groups Exempt groups Specific eligibility groups (required)
Data source	Claims and encounters and other administrative records
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

Metric AD_37: Inpatient admissions	
Metric element	**Description**
Description	Total number of inpatient admissions per 1,000 demonstration beneficiary months during the measurement period
Numerator	Step 1. Identify all inpatient stays (acute and non-acute) with discharge dates during the measurement period for demonstration beneficiaries in the denominator. Use the following to identify inpatient stays: • HEDIS Inpatient Stay Value Set Step 2. Retain only stays with discharge dates that fall during the measurement period. Step 3. Calculate the number of inpatient admissions using all stays identified in steps 1 and 2. Count each stay once regardless of the duration of the stay.
Denominator	Total number of months of beneficiary demonstration enrollment during the measurement period. Beneficiaries that are continuously enrolled during the reporting quarter contribute 3 months to the denominator.
Metric calculation	Calculate the rate by dividing the number of inpatient stays in the numerator by the number of beneficiary months in the denominator and then multiply by 1,000, as follows: (Number of inpatient stays/Number of demonstration beneficiary months) * 1,000
Additional guidance	To view the HEDIS Value Sets used in this metric, submit a technical assistance request to 1115MonitoringAndEvaluation@cms.hhs.gov.
Required or recommended	Recommended
Measurement period (calculation lag)	Quarter (90 days)
Subpopulations	Income groups Specific demographic groups Exempt groups Specific eligibility groups (required)
Data source	Claims and encounters and other administrative records
Claim type	Only use paid claims. (Do not use suspended, pending, or denied claims.)

8. Quality of care and health outcomes

Metric AD_38A: Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)	
Metric element	**Description**
Measure sets/endorsement	FFY 2019 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) (NQF# 0027) Measure steward: NCQA
Description	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
Metric calculation	Instructions for calculating this metric can be found in Appendix B: Technical Specifications for Medicaid Quality Measures, Adapted from FFY 2019 Adult Core Set Measure Specifications.
Required or recommended	Required (38A or 38B. States do not have to report both).
Measurement period (calculation lag)	Calendar year (90 days). See Appendix B for additional information on the measurement period.
Subpopulations	Income groups Specific eligibility groups (required if sampling allows for reporting at this level)
Data source	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan survey, Adult Version

Metric AD_38B: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Metric element	Description
Measure sets/endorsement	2018 Merit-Based Incentive Payment System (MIPS) Quality Measures (NQF# 0028) Measure steward: PCPI Foundation
Description	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
Metric calculation	Instructions for calculating this metric can be found in the MIPS Quality Measure Technical Specifications for 2018 reporting, Quality ID #226 (NQF# 0028) Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention Beneficiaries who have been enrolled in the demonstration for at least one continuous month (30 days) in the measurement period, and who meet the additional criteria in the MIPS Technical Specifications, should be included in this calculation.
Additional guidance	The 2018 PCPI Foundation measure specifications are available at: https://qpp.cms.gov/docs/QPP_quality_measure_specifications/Claims-Registry-Measures/2018_Measure_226_Claims.pdf This measure specification includes clinical concepts and claim codes that are not typically found in Medicaid claims. As such, states are encouraged to explore the feasibility of reporting this measure. States may also choose to work with providers to encourage providers to include the codes on claims they submit.
Required or recommended	Required (AD_38A or AD_38B. States do not have to report both.)
Measurement period (calculation lag)	Calendar year (90 days). See measure steward specifications for additional information on the measurement period.
Subpopulations	Income groups Specific eligibility groups (required)
Data source	Claims and encounters
Claim type	Use all paid, suspended, pending and denied claims

Metric AD_39-1: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)

Metric element	Description
Measure sets/endorsement	FFY 2019 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) (NQF# 2605) Measure steward: NCQA
Description	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).
Metric calculation	Instructions for calculating this metric can be found in Appendix B: Technical Specifications for Medicaid Quality Measures, Adapted from FFY 2019 Adult Core Set Measure Specifications.
Required or recommended	Required
Measurement period (calculation lag)	Calendar year (90 days). See Appendix B for additional information on the measurement period.
Subpopulations	Income groups Specific eligibility groups (required)
Data source	Claims and encounters
Claim type	Use all paid, suspended, pending and denied claims

Metric AD_39-2: Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)

Metric element	Description
Measure sets/endorsement	FFY 2019 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) (NQF# 2605) Measure steward: NCQA
Description	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).
Metric calculation	Instructions for calculating this metric can be found in Appendix B: Technical Specifications for Medicaid Quality Measures, Adapted from FFY 2019 Adult Core Set Measure Specifications.
Required or recommended	Required
Measurement period (calculation lag)	Calendar year (90 days). See Appendix B for additional information on the measurement period.
Subpopulations	Income groups Specific eligibility groups (required)
Data source	Claims and encounters
Claim type	Use all paid, suspended, pending and denied claims

Metric AD_40: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)

Metric element	Description
Measure sets/endorsement	FFY 2019 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) (NQF# 0004) Measure steward: NCQA
Description	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.
Metric calculation	Instructions for calculating this metric can be found in Appendix B: Technical Specifications for Medicaid Quality Measures, Adapted from FFY 2019 Adult Core Set Measure Specifications.
Required or recommended	Required
Measurement period (calculation lag)	Calendar year (90 days). See Appendix B for additional information on the measurement period.
Subpopulations	Income groups Specific eligibility groups (required)
Data source	Claims and encounters or EHR
Claim type	Use all paid, suspended, pending and denied claims

Metric AD_41: PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)

Metric element	Description
Measure sets/endorsement	FFY 2019 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) (NQF# 0272) Measure steward: AHRQ
Description	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
Metric calculation	Instructions for calculating this metric can be found in Appendix B: Technical Specifications for Medicaid Quality Measures, Adapted from FFY 2019 Adult Core Set Measure Specifications.
Required or recommended	Required
Measurement period (calculation lag)	Calendar year (90 days). See Appendix B for additional information on the measurement period.
Subpopulations	Income groups Specific eligibility groups (required)
Data source	Claims and encounters
Claim type	Use paid claims only

Metric AD_42: PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)

Metric element	Description
Measure sets/endorsement	FFY 2019 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) (NQF# 0275) Measure steward: AHRQ
Description	Number of inpatient hospital admissions for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 beneficiary months for beneficiaries age 40 and older
Metric calculation	Instructions for calculating this metric can be found in Appendix B: Technical Specifications for Medicaid Quality Measures, Adapted from FFY 2019 Adult Core Set Measure Specifications.
Required or recommended	Required
Measurement period (calculation lag)	Calendar year (90 days). See Appendix B for additional information on the measurement period.
Subpopulations	Income groups Specific eligibility groups (required)
Data source	Claims and encounters
Claim type	Use paid claims only

Metric AD_43: PQI 08: Heart Failure Admission Rate (PQI08-AD)

Metric element	Description
Measure sets/endorsement	FFY 2019 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) (NQF# 0277) Measure steward: AHRQ
Description	Number of inpatient hospital admissions for heart failure per 100,000 beneficiary months for beneficiaries age 18 and older
Metric calculation	Instructions for calculating this metric can be found in Appendix B: Technical Specifications for Medicaid Quality Measures, Adapted from FFY 2019 Adult Core Set Measure Specifications.
Required or recommended	Required
Measurement period (calculation lag)	Calendar year (90 days). See Appendix B for additional information on the measurement period.
Subpopulations	Income groups Specific eligibility groups (required)
Data source	Claims and encounters
Claim type	Use paid claims only

Metric AD_44: PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)

Metric element	Description
Measure sets/endorsement	2019 Medicaid Adult Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) (NQF# 0283) Measure steward: AHRQ
Description	Number of inpatient hospital admissions for asthma per 100,000 beneficiary months for beneficiaries aged 18 to 39
Metric calculation	Instructions for calculating this metric can be found in Appendix B: Technical Specifications for Medicaid Quality Measures
Required or recommended	Required
Measurement period (calculation lag)	Calendar year (90 days). See Appendix B for additional information on the measurement period.
Subpopulations	Income groups Specific eligibility groups (required)
Data source	Claims and encounters
Claim type	Use paid claims only

9. Administrative cost

Metric AD_45: Administrative cost of demonstration operation	
Metric element	**Description**
Description	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
Counted variable	Step 1. Calculate the total costs in dollars incurred during the measurement period for contracts or contract amendments. Costs include those related to the following: • Premium collection • Health behavior incentives • Premium assistance • Community engagement policies • Retroactive eligibility waivers Include costs from: • Managed care organizations that serve beneficiaries covered by the demonstration, if the marginal administrative cost beyond the medical coverage capitation rate can be identified. • Modifications or new contracts for information technology support required for data systems changes. • Any stand-alone contracts with other vendors that the state established or modified to support demonstration implementation (for example, additional call center support). Step 2. Identify the number of full time equivalent (FTE) staff devoted to administering demonstration policies. Include both new hires as well existing staff whose work is being redirected to administration of the demonstration. Group FTEs into labor categories defined by the state. Include staff administering the following: • Premium collection • Health behavior incentives • Premium assistance • Community engagement requirements • Retroactive eligibility waivers Step 3. Calculate the dollar value of FTEs by multiplying the median salary and value of benefits for each labor category by the number of FTEs in the category. Sum across all labor categories to obtain the total cost of staff time. Step 4. Calculate total administrative costs in dollars by summing the costs calculated in Steps 1 and 3.
Required or recommended	Recommended
Measurement period (calculation lag)	Demonstration year (no lag)
Data source	Administrative records

B. Additional metrics to be reported for demonstrations that require premiums or account payments

1. Enrollment by premium payment status

Metric PR_1: Beneficiaries subject to premium policy (or account contribution) during the month, not exempt	
Metric element	**Description**
Description	The number of beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium policy (or account contribution policy), regardless of whether they paid or did not pay during the measurement period.
Counted variable	Step 1. Identify beneficiaries who were enrolled in the demonstration as of the last day of the month. Step 2. Retain beneficiaries whose income and eligibility group were subject to the premium policy (or account contribution policy) during the measurement period, regardless of whether they pay or do not pay during the measurement period. Step 3. Exclude beneficiaries in income and eligibility groups who are subject to premiums, but who have an individual exemption from the policy. These individuals are counted in metric PR_2. Step 4. Count unique beneficiaries (deduplicated) who meet criteria for Steps 1, 2, and 3.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific eligibility groups (required)
Relationship to other metrics	This metric is equal to the sum of metrics PR_3, PR_4, PR_5, and PR_6. The number of beneficiaries identified in Step 1 should be a smaller number than metric AD_1, which includes beneficiaries enrolled at any time of the month, including those no longer enrolled as of the last day of the month. Metric AD_1 also includes individuals who have an exemption from the premium policy but those individuals are excluded from this measure.
Data source	Administrative records

Metric PR_2: Beneficiaries who were exempt from premiums for that month	
Metric element	**Description**
Description	Among beneficiaries enrolled in the demonstration who were subject to the premium (or account contribution) policy on the basis of income or eligibility group, the count of those exempt from owing premiums or other monthly payments, and therefore not required to make payments. For example, demonstration policies may exempt beneficiaries who would otherwise be subject to premiums as incentives for health behaviors or other activities.
Counted variable	Count unique beneficiaries (deduplicated) in income and eligibility groups subject to premium (or account contribution) policy who were enrolled in the demonstration but were exempt from the premium policy as of the last day of the measurement period. Exclude hardship exemptions, which should be counted under PR_4.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific eligibility groups (required)
Data source	Administrative records

Metric PR_3: Beneficiaries who paid a premium during the month	
Metric element	**Description**
Description	Among beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium (or account contribution) policy, number of beneficiaries who paid this month
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium policy (or account contribution policy) (metric PR_1). Step 2. Retain beneficiaries who paid premiums or other monthly payment during the measurement period. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric PR_1
Data source	Administrative records

Metric PR_4: Beneficiaries who were subject to premium policy but declare hardship for that month	
Metric element	**Description**
Description	Among beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium (or account contribution) policy, number of beneficiaries who were able to claim temporary hardship and were therefore not required to make a payment in the measurement period
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium policy (or account contribution policy) (metric PR_1). Step 2. Retain beneficiaries who successfully claimed temporary hardship and were therefore not required to make payment. Beneficiaries whose payments were deferred, but must still be paid, should not be counted. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required for states that allow beneficiaries to avoid paying premiums or other monthly payments by claiming temporary hardship
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric PR_1
Data source	Administrative records

Metric PR_5: Beneficiaries in short-term arrears (grace period)	
Metric element	**Description**
Description	Among beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium (or account contribution) policy, the number of those who did not pay in the measurement period, but have not yet exceeded their grace period
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium policy (or account contribution policy) (metric PR_1). Step 2. Retain beneficiaries who did not pay during the measurement period, but had not yet exceeded their grace period (if the state has a grace period), as of the last day of the measurement period. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required if state has a grace period
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric PR_1
Data source	Administrative records

Metric PR_6: Beneficiaries in long-term arrears	
Metric element	**Description**
Description	Among beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium (or account contribution) policy, number of beneficiaries who did not pay this month, and who remain enrolled even though they have exceeded the grace period.
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium policy (or account contribution policy) (metric PR_1). Step 2. Retain beneficiaries who did not pay during the measurement period and who remained enrolled even though they have exceeded their grace period (if the state has a grace period), as of the last day of the measurement period. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required if state has a grace period and allows continued enrollment for any income and eligibility groups otherwise subject to premiums once the grace period has been exceeded
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric PR_1
Data source	Administrative records

Metric PR_7: Beneficiaries with collectible debt	
Metric element	**Description**
Description	Among beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium policy (or account contribution policy), number of beneficiaries who had collectible debt.
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium policy (or account contribution policy) (metric PR_1). Step 2. Retain beneficiaries who had collectible debt as of the last day of the measurement period. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric PR_1. This metric could include beneficiaries who are counted in metrics PR_2, PR_3, PR_4, PR_5, or PR_6, depending on state debt and enrollment policies. For example, a beneficiary may have paid the amount due for the current measurement period, and be included in the count for PR_3, but have unpaid amounts from prior measurement periods.
Data source	Administrative records

2. Cumulative enrollment duration in states with time-variant premium policies

Metric PR_8: Beneficiaries in enrollment duration tier 1	
Metric element	**Description**
Description	Number of beneficiaries enrolled in the demonstration and subject to premium policies whose cumulative length of enrollment fell in tier 1 – the shortest enrollment duration, during which beneficiaries are subject to the first set of program rules and requirements. Tiers are defined in terms of enrollment periods that are distinguished by different premium or copayment liabilities.
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium policy (or account contribution policy) (metric PR_1). Step 2. Retain beneficiaries whose cumulative length of enrollment fell into tier 1 as of the last day of the measurement period. • Tier 1 refers to the first set of program rules and requirements beneficiaries are subject to upon enrollment. • Tiers are distinguished by different premium or copayment liabilities. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Recommended in states with time-variant premium policies
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific eligibility groups (required)
Data source	Administrative records

Metric PR_9: Beneficiaries in enrollment duration tier 2

Metric element	Description
Description	Number of beneficiaries enrolled in the demonstration and subject to premium policies whose cumulative length of enrollment fell in tier 2 - the enrollment duration that follows tier 1, during which beneficiaries are subject to the set of program rules and requirements in effect after exceeding the enrollment duration for tier 1. Tiers are defined in terms of enrollment periods that are distinguished by different premium or copayment liabilities.
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium policy (or account contribution policy) (metric PR_1). Step 2. Retain beneficiaries (deduplicated) whose cumulative length of enrollment fell into tier 2 as of the last day of the measurement period. • Tier 2 refers to the first set of program rules and requirements beneficiaries are subject to after exceeding the timeframe for tier 1. • Tiers are distinguished by different premium or copayment liabilities. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Recommended in states with time-variant premium policies
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific eligibility groups (required)
Data source	Administrative records

Metric PR_10: Beneficiaries in enrollment duration tiers 3+

Metric element	Description
Description	Number of beneficiaries enrolled in the demonstration and subject to premium policies whose cumulative length of enrollment fell in tier 3 – the enrollment duration that follows tier 2, during which beneficiaries are subject to the set of program rules and requirements in effect after exceeding the enrollment duration for tier 2. Tiers are defined in terms of enrollment periods that are distinguished by different premium or copayment liabilities. States with more than three tiers of program rules should calculate additional metrics to report enrollment counts for current enrollees within each tier.
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium policy (or account contribution policy) (metric PR_1). Step 2. Retain beneficiaries whose cumulative length of enrollment fell into tier 3 as of the last day of the measurement period. • Tier 3 refers to the first set of program rules and requirements beneficiaries are subject to after exceeding the timeframe for tier 2. • Tiers are distinguished by different premium or copayment liabilities. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Additional guidance	In addition to reporting for Tier 3, report separately for each Tier above Tier 3 following the specifications for Tier 3.
Required or recommended	Recommended in states with time-variant premium policies
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific eligibility groups (required)
Data source	Administrative records

3. Mid-year change in circumstance by premium amount

Metric PR_11: Beneficiaries for whom the state processed a mid-year change in circumstance in household or income information and who remained enrolled in the demonstration	
Metric element	**Description**
Description	Among beneficiaries enrolled in the demonstration who were not in their renewal month, number of beneficiaries for whom the state processed a change in household size or income during the measurement period and who remained enrolled in the demonstration
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the premium policy (or account contribution policy) (metric PR_1). Step 2. Retain beneficiaries for whom the state processed a change in household size or income during the measurement period. Step 3. Exclude beneficiaries who were in their renewal month. Step 4. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1, 2, and 3.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific eligibility groups (required)
Relationship to other metrics	This metric is equal to the sum of metrics PR_12, PR_13, and PR_14
Data source	Administrative records

Metric PR_12: No premium change following mid-year processing of a change in household or income information	
Metric element	**Description**
Description	Among beneficiaries enrolled in the demonstration who experienced a change in household size or income during the month (not their renewal month) and remained enrolled in the demonstration as of the last day of the measurement period, the number whose premium obligations or other monthly payments did not change.
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration for whom the state processed a change in household size or income during the measurement period (not in their renewal month) and who remain enrolled in the demonstration in an income and eligibility group subject to premiums (metric PR_11). Step 2. Retain beneficiaries whose premium obligations or other monthly payments were the same on both the last day of the measurement period and the first enrolled date in the measurement period. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric PR_11
Data source	Administrative records

Metric PR_13: Premium increase following mid-year processing of change in household or income information

Metric element	Description
Description	Among beneficiaries enrolled in the demonstration who experienced a change in household size or income during the month (not their renewal month) and remained enrolled in the demonstration as of the last day of the measurement period, the number whose premium obligations or other monthly payments increased
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration for whom the state processed a change in household size or income during the measurement period (not in their renewal month) and who remain enrolled in the demonstration in an income and eligibility group subject to premiums (metric PR_11). Step 2. Retain beneficiaries whose premium obligations or other monthly payments were greater on the last day of the measurement period than on the first enrolled date in the measurement period. This includes beneficiaries who were not previously required to make payments, but must begin making payments following the change in circumstance. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric PR_11
Data source	Administrative records

Metric PR_14: Premium decrease following mid-year processing of change in household or income information

Metric element	Description
Description	Among beneficiaries enrolled in the demonstration who experienced a change in household size or income during the month (not their renewal month) and remained enrolled in the demonstration as of the last day of the measurement period, the number whose premium obligations or other monthly payments decreased
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration for whom the state processed a change in household size or income during the measurement period (not in their renewal month) and who remain enrolled in the demonstration in an income and eligibility group subject to premiums (metric PR_11). Step 2. Retain beneficiaries whose premium obligations or other monthly payments were lower on the last day of the measurement period than on the first enrolled date in the measurement period. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric PR_11
Data source	Administrative records

4. Disenrollment or suspension for failure to pay

Metric PR_15: Beneficiaries disenrolled from the demonstration for failure to pay and therefore disenrolled from Medicaid	
Metric element	**Description**
Description	Number of demonstration beneficiaries disenrolled from Medicaid as of the last day of the measurement period for failure to pay premiums
Counted variable	Step 1. Identify beneficiaries determined ineligible for Medicaid other than at renewal (AD_7). Step 2. Retain beneficiaries who were disenrolled from Medicaid during the measurement period for failure to pay premiums and who remained disenrolled as of the last day of the measurement period. Step 3. Count unique demonstration beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required only for states with premiums or monthly payment with a policy of termination for failure to pay
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric AD_7, relevant only for demonstrations with monthly payment requirements
Data source	Administrative records

Metric PR_16: Beneficiaries in a non-eligibility period who were disenrolled for failure to pay and are prevented from re-enrolling for a defined period of time	
Metric element	**Description**
Description	The number of prior demonstration beneficiaries who were disenrolled from Medicaid for failure to pay premiums and are in a non-eligibility period, meaning they are prevented from re-enrolling for some defined period of time, including those prevented from re-enrolling until their redetermination date.
Counted variable	Step 1. Identify beneficiaries who were in a non-eligibility period status as of the last day of the measurement period (metric AD_3). Step 2. Retain beneficiaries who were in a non-eligibility period for failure to pay premiums in the current or a prior measurement period. Step 3. Count unique beneficiaries (deduplicated) who met the criteria in Steps 1 and 2.
Required or recommended	Required if state has a non-eligibility period policy
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific demographic groups Specific eligibility groups (required)
Data source	Administrative records

Metric PR_17: Beneficiaries whose benefits are suspended for failure to pay	
Metric element	**Description**
Description	Number of demonstration beneficiaries whose benefits were suspended during the measurement period for failure to pay premiums
Counted variable	Step 1. Identify demonstration beneficiaries who were suspended from Medicaid benefits during the measurement period for failure to pay premiums and remained in suspension status as of the last day of the measurement period. Step 2. Count unique demonstration beneficiaries (deduplicated) who meet the criteria in Step 1.
Required or recommended	Required only for states with premiums or monthly payment with a policy of suspending benefits (without disenrollment) for failure to pay
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric AD_2
Data source	Administrative records

5. Renewal

Metric PR_18: No premium change	
Metric element	**Description**
Description	Number of beneficiaries enrolled in the demonstration due for renewal during the measurement period who are redetermined as eligible for the demonstration and remain in income and eligibility groups subject to premiums, with no change in premiums or other monthly payments.
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration who were due for renewal during the measurement period and redetermined as eligible for the demonstration (include beneficiaries in metrics AD_21 and AD_22). Step 2. Retain beneficiaries who were in income and eligibility groups subject to the premium policy (or account contribution policy) as of the last day of the measurement period. Step 3. Retain beneficiaries whose premiums or other monthly payments were the same on both the last day of the measurement period and the first enrolled date in the measurement period Step 4. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1, 2, and 3.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific eligibility groups (required)
Relationship to other metrics	The sum of metrics PR_18, PR_19, and PR_20 should equal the sum of metrics AD_21 and AD_22 among beneficiaries required to pay premiums
Data source	Administrative records

Metric PR_19: Premium increase	
Metric element	**Description**
Description	Number of beneficiaries enrolled in the demonstration due for renewal during the measurement period who were redetermined as eligible for the demonstration and remain in income and eligibility groups subject to premiums, with an increase in required premiums or other monthly payments.
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration who were due for renewal during the measurement period and redetermined as eligible for the demonstration (include beneficiaries in metrics AD_21 and AD_22). Step 2. Retain beneficiaries who were in income and eligibility groups subject to the premium policy (or account contribution policy) as of the last day of the measurement period. Step 3. Retain beneficiaries whose premiums or other monthly payments were greater on the last day of the measurement period than on the first enrolled date in the measurement period. This includes beneficiaries who were not previously required to make payments, but must begin making payments following renewal. Step 4. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1, 2, and 3.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific eligibility groups (required)
Relationship to other metrics	The sum of metrics PR_18, PR_19, and PR_20 should equal the sum of metrics AD_21 and AD_22, among beneficiaries required to pay premiums
Data source	Administrative records

Metric PR_20: Premium decrease	
Metric element	**Description**
Description	Number of beneficiaries enrolled in the demonstration due for renewal during the measurement period who were redetermined as eligible for the demonstration and remained in income and eligibility groups subject to the demonstration, with a decrease in required premiums or other monthly payments
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration who were due for renewal during the measurement period and redetermined as eligible for the demonstration (include beneficiaries in metrics AD_21 and AD_22). Step 2. Retain beneficiaries who were in income and eligibility groups subject to the premium policy (or account contribution policy) as of the last day of the measurement period. Step 3. Retain beneficiaries whose premiums or other monthly payments were smaller on the last day of the measurement period than on the first enrolled date in the measurement period. Step 4. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1, 2, and 3.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific eligibility groups (required)
Relationship to other metrics	The sum of metrics PR_18, PR_19, and PR_20 should equal the sum of metrics AD_21 and AD_22, among beneficiaries required to pay premiums
Data source	Administrative records

6. Third party premium payment

Metric PR_21: Third-party premium payment	
Metric element	**Description**
Description	Number of beneficiaries enrolled in the demonstration who had any portion of their premium or other monthly payments paid by a third party.
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration who were in income and eligibility groups subject to the premium policy (or account contribution policy) and who were not exempt (metric PR_1). Step 2. Retain beneficiaries who had any portion of their premium or other monthly payments paid by a third party. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific eligibility groups (required)
Data source	Administrative records

C. Additional metrics to be reported for demonstrations with Marketplace-focused premium assistance programs

1. Enrollment by premium payment status

Metric PA_1: Beneficiaries who lost Medicaid eligibility due to mid-year change in circumstance, and transitioned to a qualified health plan offered in the Marketplace	
Metric element	**Description**
Description	Number of demonstration beneficiaries who lost eligibility for Medicaid during the measurement period due to a change in circumstance who transitioned to a qualified health plan offered in the Marketplace (Health Insurance Exchange).
Counted variable	Step 1. Identify demonstration beneficiaries determined ineligible for Medicaid after state processed a change in circumstance reported by a beneficiary (metric AD_9). Step 2. Retain beneficiaries who transitioned to a qualified health plan offered in the Marketplace (Health Insurance Exchange) as of the last day of the measurement period. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required if identifying his transition is feasible
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric AD_9
Data source	Administrative records

Metric PA_2: Beneficiaries who lost Medicaid eligibility at renewal, and transitioned to a qualified health plan offered in the Marketplace	
Metric element	**Description**
Description	Number of demonstration beneficiaries who lost eligibility for Medicaid during the measurement period due to the outcome of eligibility renewal processes and transitioned to a qualified health plan offered in the Marketplace (Health Insurance Exchange).
Counted variable	Step 1. Identify demonstration beneficiaries determined ineligible for the demonstration at renewal, disenrolled from Medicaid (metric AD_16). Step 2. Retain beneficiaries who transitioned to a qualified health plan offered in the Marketplace (Health Insurance Exchange) as of the last day of the measurement period. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required if identifying his transition is feasible
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Income groups Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric AD_16
Data source	Administrative records

2. Access to care

Metric PA_3: Wraparound service utilization, by service	
Metric element	**Description**
Description	Total utilization of wraparound services during the measurement period per 1,000 demonstration beneficiary months during the measurement period
Numerator	Step 1. Identify all claims Medicaid paid for wraparound services provided to demonstration beneficiaries during the measurement period. Wraparound services will vary by state. Examples of wraparound services are: • Non-emergency medical transportation • EPSDT services for 19 – 20 year olds • Dental services • Vision services • Family planning services Step 2. Retain only claims with service end dates that fall during the measurement period. Step 3. Calculate the unique number of services identified in Steps 1 and 2. Count multiple claim headers with overlapping service dates (based on service begin date and service end date) and the same procedure code as one service.
Denominator	Number of demonstration beneficiary months during the measurement period. Beneficiaries that are continuously enrolled during the reporting quarter contribute 3 months to the denominator.
Metric calculation	Calculate the rate by dividing the number of wraparound service claims in the numerator by the number of beneficiary months in the denominator and then multiply by 1,000, as follows: (Number of wraparound service claims / Number of demonstration beneficiary months) * 1,000
Required or recommended	Recommended
Measurement period (calculation lag)	Quarter (90 days)
Subpopulations	Income groups Specific demographic groups Specific eligibility groups (required)
Data source	Claims and encounters

D. Additional metrics to be reported for demonstrations with health behavior incentives

1. Enrollment

Metric HB_1: Total enrollment among beneficiaries subject to health behavior incentives	
Metric element	**Description**
Description	Number of beneficiaries subject to health behavior incentive policies who were enrolled in the demonstration at any time during the measurement period
Counted variable	Step 1. Identify beneficiaries who were enrolled in the demonstration at any time during the measurement period. Step 2. Retain beneficiaries who were subject to health behavior incentive policies during the measurement period. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Quarter (90 days)
Subpopulations	Income groups Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric serves as a denominator to pair with metrics HB_2, HB_3, and HB_4 to create rates. Note, because this measure is quarterly, the number of beneficiaries identified in Step 1 may exceed the count of ever-enrolled beneficiaries in a reporting month (AD_1).
Data source	Administrative records

2. Use of incentivized services: Claims-based analysis

Metric HB_2: Beneficiaries using incentivized services that can be documented through claims, by service	
Metric element	**Description**
Description	Total number of beneficiaries enrolled in the demonstration at any point during the measurement period who utilized financially incentivized services that can be documented through claims since the beginning of their enrollment spell
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration at any time during the measurement period and subject to health behavior incentives (metric HB_1). Step 2. Retain beneficiaries who utilized financially incentivized services that can be documented through claims at any time since the beginning of the beneficiary's enrollment spell. The claim service date does **not** need to be during the measurement period. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Additional guidance	Specific services vary by state; report a separate metric for each incentivized service if state has multiple services through which beneficiaries can accrue financial benefit
Required or recommended	Required
Measurement period (calculation lag)	Quarter (90 days)
Subpopulations	Income groups Specific demographic groups Specific eligibility groups (required)
Data source	Administrative records, claims and encounters

3. Other incentivized behaviors not documented through claims-based analysis

Metric HB_3: Completion of incentivized health behavior(s) not documented through claims analysis (i.e. health risk assessments), by health behavior	
Metric element	**Description**
Description	Number of beneficiaries enrolled in the demonstration at any point during the measurement period who have completed each incentivized health behavior not documented through claims analysis (i.e. health risk assessments) since the beginning of their enrollment spell
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration at any time during the measurement period and subject to health behavior incentives (metric HB_1). Step 2. Retain beneficiaries who completed each incentivized health behavior **not** documented through claims analysis (i.e. health risk assessments) since the beginning of their enrollment spell. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Additional guidance	Specific health behaviors incentives vary by state; report separate metrics for each incentivized health behavior if state has multiple behaviors through which beneficiaries can accrue financial benefit
Required or recommended	Required
Measurement period (calculation lag)	Quarter (90 days)
Subpopulations	Income groups Specific demographic groups Specific eligibility groups (required)
Data source	Administrative records

Metric HB_4: Completion of all incentivized health behaviors (both claims-based and other), if there are multiple	
Metric element	**Description**
Description	Number of beneficiaries enrolled in the demonstration at any point during the measurement period who have completed all incentivized health behaviors (including incentivized services documented through claims and other health behaviors not documented through claims) since the beginning of their enrollment spell
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration at any time during the measurement period and subject to health behavior incentives (metric HB_1). Step 2. Retain beneficiaries who completed **all** incentivized health behaviors since the beginning of their enrollment spell. Include incentivized services documented through claims and other health behaviors documented through administrative records when determining if a beneficiary has completed all behaviors. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Additional guidance	Specific incentivized health behaviors vary by state
Required or recommended	Required
Measurement period (calculation lag)	Quarter (90 days)
Subpopulations	Income groups Specific demographic groups Specific eligibility groups (required)
Data source	Administrative records, claims and encounters

4. Rewards granted for completion of incentivized health behaviors

Metric HB_5: Beneficiaries granted a premium reduction for completion of incentivized health behaviors	
Metric element	**Description**
Description	Number of beneficiaries enrolled in the demonstration who were flagged for or granted a reward related to premium obligations during the measurement period, regardless of whether the premium reduction occurs during the measurement period or in the future.
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration at any time during the measurement period and subject to health behavior incentives (metric HB_1). Step 2. Retain beneficiaries who were flagged for a reward or granted a reward related to premium obligations during the measurement period, regardless of whether the premium reduction occurs during the measurement period or in a future time period. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Quarter (90 days)
Subpopulations	Income groups Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric can be compared to numbers in metrics HB_2, HB_3, and/or HB_4, to understand whether behavior completions are resulting in accrual of rewards, depending on state policy
Data source	Administrative records

Metric HB_6: Beneficiaries granted a financial reward other than a premium reduction for completion of incentivized health behaviors	
Metric element	**Description**
Description	Number of beneficiaries enrolled in the demonstration who were flagged for or granted a reward other than a premium reduction during the measurement period, regardless of when the reward is realized
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration at any time during the measurement period and subject to health behavior incentives (metric HB_1). Step 2. Retain beneficiaries who were flagged for or granted a reward other than a premium reduction during the measurement period, regardless of when the reward is realized. For example, some states might award gift cards or credits to accounts that can be used for additional benefits. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Quarter (90 days)
Subpopulations	Income groups Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric can be compared to numbers in metrics HB_2, HB_3, and/or HB_4 to understand whether behavior completions are resulting in accrual of rewards, depending on state policy
Data source	Administrative records

Metric HB_7: Beneficiaries granted a reward in the form of additional covered benefits for completion of incentivized health behaviors

Metric element	Description
Description	Number of beneficiaries enrolled in the demonstration who were flagged for or granted a reward that takes the form of an additional covered benefit or service, by benefit or service type, during the measurement period.
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration at any time during the measurement period and subject to health behavior incentives (metric HB_1). Step 2. Retain beneficiaries who were flagged for or granted a reward that takes the form of an additional covered benefit or service, by benefit or service type, during the measurement period. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2 by benefit or service type. For example, if beneficiaries can earn additional dental and vision coverage, the number of people gaining these coverages should be counted separately. Individuals earning both types of coverage would be included in both counts.
Additional guidance	Benefit or service types will vary by state. States should report this metric by each benefit or service type applicable to their demonstration policies.
Required or recommended	Required
Measurement period (calculation lag)	Quarter (90 days)
Subpopulations	Income groups Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric can be compared to numbers in metrics HB_2, HB_3, and/or HB_4, to understand whether behavior completions are resulting in accrual of rewards, depending on state policy.
Data source	Administrative records

E. Additional metrics to be reported for demonstrations with community engagement requirements

1. Community engagement enrollment

Metric CE_1: Total beneficiaries subject to the community engagement requirement, not exempt	
Metric element	**Description**
Description	The number of beneficiaries enrolled in the demonstration whose income and eligibility group were subject to the community engagement requirement and who did not have an individual exemption from the requirement or an approved good cause circumstance
Counted variable	Step 1. Identify beneficiaries who were enrolled in the demonstration and receiving benefits as of the last day of the measurement period. Step 2. Retain beneficiaries whose income and eligibility group were subject to community engagement requirements during the measurement period. Step 3. Exclude beneficiaries in income and eligibility groups who were subject to community engagement requirements, but who had an individual exemption from the policy or who had an approved good cause circumstance on the last day of the measurement period. These individuals are counted in metrics CE_2 and CE_3 respectively. Step 4. Count unique beneficiaries (deduplicated) who meet the criteria for Steps 1, 2, and 3.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	Metrics CE_1, CE_2, and CE_3 should sum to the total number of enrolled beneficiaries receiving benefits in income and eligibility groups subject to community engagement requirements
Data source	Administrative records

Metric CE_2: Total beneficiaries who were exempt from the community engagement requirement in the month	
Metric element	**Description**
Description	The number of beneficiaries enrolled in income and eligibility groups that were subject to the community engagement requirement, but had an individual exemption from the policy. This excludes circumstances that give rise to good cause.
Counted variable	Step 1. Identify beneficiaries who were enrolled in the demonstration in income and eligibility groups subject to community engagement requirements. Step 2. Retain beneficiaries who were exempt from the community engagement requirement for any reason as of the last day of the measurement period. Beneficiaries with circumstances that gave rise to good cause should **not** be retained. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria for Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	Metrics CE_1, CE_2, and CE_3 should sum to the total number of enrolled beneficiaries receiving benefits in income and eligibility groups subject to community engagement requirements
Data source	Administrative records

Metric CE_3: Beneficiaries with approved good cause circumstances

Metric element	Description
Description	The number of beneficiaries enrolled in the demonstration who met the state criteria for good cause circumstances, such as serious illness, birth or death of a family member, severe weather, family emergencies, or life-changing event
Counted variable	Step 1. Identify beneficiaries who were enrolled in the demonstration in income and eligibility groups subject to community engagement requirements. Step 2. Retain beneficiaries who met the state criteria for good cause circumstances, such as serious illness, birth or death of a family member, severe weather, family emergencies, or life-changing event, as of the last day of the measurement period. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria for Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	Metrics CE_1, CE_2, and CE_3 should sum to the total number of enrolled beneficiaries receiving benefits in income and eligibility groups subject to community engagement requirements
Data source	Administrative records

Metric CE_4: Beneficiaries subject to the community engagement requirement and in suspension status due to failure to meet requirement

Metric element	Description
Description	The number of demonstration beneficiaries in suspension status due to failure to meet the community engagement requirement, including those newly suspended for noncompliance during the measurement period
Counted variable	Step 1. Identify beneficiaries who were in suspension status for noncompliance with demonstration policies as of the last day of the measurement period (AD_2). Step 2. Retain beneficiaries who were in suspension status during the measurement period for failure to meet the community engagement requirement in the current or a prior measurement period and remained in suspended status as of the last day of the measurement period. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required if state has a suspension policy
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric AD_2
Data source	Administrative records

Metric CE_5: Beneficiaries subject to the community engagement requirement and receiving benefits who met the requirement for qualifying activities

Metric element	Description
Description	The number of beneficiaries enrolled in the demonstration who were subject to the community engagement requirement and met the requirement by engaging in qualifying activities
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration and subject to the community engagement requirement and receiving benefits as of the last day of the measurement period (metric CE_1). Step 2. Retain beneficiaries who are flagged as having met the requirement for qualifying activities as of the last day of the measurement period. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_1
Data source	Administrative records

Metric CE_6: Beneficiaries subject to the community engagement requirement and receiving benefits but in a grace period or allowable month of noncompliance

Metric element	Description
Description	The number of beneficiaries enrolled in the demonstration who were subject to the community engagement requirement but did not meet the requirement. This includes beneficiaries who have not yet begun qualifying activities and those who logged some hours, but failed to meet total required hours.
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration who were subject to the community engagement requirement and receiving benefits as of the last day of the measurement period (metric CE_1). Step 2. Retain beneficiaries who did not meet the community engagement requirement in the measurement period. Include beneficiaries who had either: • Not yet begun qualifying activities (grace period) • Logged some hours, but failed to meet total required hours Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_1
Data source	Administrative records

Metric CE_7: Beneficiaries who successfully completed make-up hours or other activities to retain active benefit status after failing to meet the community engagement requirement in a previous month

Metric element	Description
Description	The number of beneficiaries enrolled in the demonstration who were subject to the community engagement requirement and met additional requirements to retain active benefit status after previously failing to meet the requirement. This captures beneficiaries who successfully satisfy the "opportunity to cure" and therefore are not suspended (if state has this policy).
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration who were subject to the community engagement requirement and receiving benefits as of the last day of the reporting period (metric CE_1). Step 2. Retain beneficiaries who met additional requirements to retain active benefit status in the measurement period, after previously failing to meet the requirement. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_1 for states with an "opportunity to cure" policy
Data source	Administrative records

Metric CE_8: Beneficiaries in a non-eligibility period who were disenrolled for noncompliance with the community engagement requirement and are prevented from re-enrolling for a defined period of time

Metric element	Description
Description	The number of prior demonstration beneficiaries who were disenrolled from Medicaid for noncompliance with the community engagement requirement and are in a non-eligibility period, meaning they are prevented from re-enrolling for some defined period of time. The count should include those prevented from re-enrolling until their redetermination date.
Counted variable	Step 1. Identify beneficiaries who were in a non-eligibility period status as of the last day of the measurement period (metric AD_3). Step 2. Retain beneficiaries who were in a non-eligibility period for failure to meet the community engagement requirement in the current or a prior measurement period. Step 3. Count unique beneficiaries (deduplicated) who met the criteria in Steps 1 and 2.
Required or recommended	Required if state has a non-eligibility period policy
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Data source	Administrative records

2. Community engagement requirement qualifying activities

Metric CE_9: Beneficiaries who met the community engagement requirement by satisfying requirements of other programs	
Metric element	**Description**
Description	The number of beneficiaries enrolled in the demonstration who were subject to the community engagement requirement and met the requirement by satisfying requirements in other programs such as SNAP or TANF, regardless of whether they are "deemed" by the state to be in compliance with Medicaid requirements or must take reporting action
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration who were subject to the community engagement requirement and met the requirement by engaging in qualifying activities (metric CE_5). Step 2. Retain beneficiaries who met the community engagement requirement by satisfying requirements in other programs (e.g. SNAP or TANF). Include those "deemed" by the state to be in compliance with Medicaid requirements and those who must take reporting action. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_5
Data source	Administrative records

Metric CE_10: Beneficiaries who met the community engagement requirement through employment for the majority of their required hours	
Metric element	**Description**
Description	The number of beneficiaries enrolled in the demonstration who were subject to and met the community engagement requirement, who were self-employed or employed in subsidized and/or unsubsidized settings. Includes both those "deemed" by the state to be in compliance with Medicaid requirements because they are working more than the number of required hours and those who must report their hours.
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration who were subject to the community engagement requirement who met the requirement by engaging in qualifying activities (metric CE_5). Step 2. Retain beneficiaries who were engaged any of the following for at least half of their required hours: 1. Self-employed 2. Employed in subsidized and/or unsubsidized settings during the measurement period. Include those "deemed" by the state to be in compliance with Medicaid requirements because they are working more than the number of required hours and those who must report their hours. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_5
Data source	Administrative records

Metric CE_11: Beneficiaries who met the community engagement requirement through job training or job search for the majority of their required hours

Metric element	Description
Description	The number of beneficiaries enrolled in the demonstration who were subject to and met the community engagement requirement, who were engaged in on-the-job training, job skills training, vocational education and training, job search activities, job search training, a state-sponsored workforce program, or similar activity
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration who were subject to the community engagement requirement who met the requirement by engaging in qualifying activities (metric CE_5). Step 2. Retain beneficiaries who were engaged any of the following for at least half of their required hours: 1. On-the-job training 2. Job skills training 3. Vocational education and training 4. Job search activities 5. Job search training 6. State-sponsored workforce program, or similar activity Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_5
Data source	Administrative records

Metric CE_12: Beneficiaries who met the community engagement requirement through educational activity for the majority of their required hours

Metric element	Description
Description	The number of beneficiaries enrolled in the demonstration who were subject to and met the community engagement requirement, who were engaged in education related to employment, general education, accredited English-as-a-second-language education, accredited homeschooling, or a state-designated class
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration who were subject to the community engagement requirement who met the requirement by engaging in qualifying activities (metric CE_5). Step 2. Retain beneficiaries who were engaged in any of the following for at least half of their required hours: 1. Education related to employment 2. General education 3. Accredited English-as-a-second-language education 4. Accredited homeschooling 5. State-designated class Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_5
Data source	Administrative records

Metric CE_13: Beneficiaries who met the community engagement requirement who were engaged in other qualifying activity for the majority of their required hours

Metric element	Description
Description	The number of beneficiaries enrolled in the demonstration who were subject to the community engagement requirement and met the requirement through a state-specified activity not captured by other reporting categories, including community work experience, community service/public service, volunteer work, caregiving for a dependent, participation in substance use disorder treatment, enrollment in Medicaid employer-sponsored insurance premium assistance, or other activity.
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration who were subject to the community engagement requirement who met the requirement by engaging in qualifying activities (metric CE_5). Step 2. Retain beneficiaries who were engaged in a state-specified activity not captured by other reporting categories for at least half of their required hours, including: 1. Community work experience 2. Community service/public service 3. Volunteer work, caregiving for a dependent 4. Participation in substance use disorder treatment, 5. Enrollment in Medicaid employer-sponsored insurance premium assistance 6. Other activity Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_5
Data source	Administrative records

Metric CE_14 Beneficiaries who met the community engagement requirement by combining two or more activities

Metric element	Description
Description	The number of beneficiaries enrolled in the demonstration who were subject to the community engagement requirement and met the requirement by engaging in a combination of activities defined in metrics CE_10 through CE_13, such as a combination of employment and education
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration who were subject to the community engagement requirement who met the requirement by engaging in qualifying activities (metric CE_5). Step 2. Retain beneficiaries who met the community engagement requirement during the measurement period by engaging in two or more of the following activities: 1. Employment 2. Job training or job search 3. Educational activity 4. Other qualifying activity Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_5
Data source	Administrative records

3. Basis of beneficiary exemptions from community engagement requirement

Metric CE_15: Beneficiaries exempt from Medicaid community engagement requirements because they were exempt from requirements of SNAP and/or TANF

Metric element	Description
Description	The number of beneficiaries enrolled in the demonstration who were exempt from the community engagement requirement because they were exempt from the SNAP and/or TANF work requirements. This does not include beneficiaries who are meeting SNAP and/or TANF work requirements.
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration in income and eligibility groups who were subject to the community engagement requirement who were individually exempt in the measurement period (metric CE_2). Step 2. Retain beneficiaries who were exempt from the community engagement requirement as of the last day of the measurement period because they are exempt from SNAP and/or TANF work requirements. Exclude beneficiaries who are meeting SNAP and/or TANF work requirements. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_2
Data source	Administrative records

Metric CE_16: Beneficiaries exempt from Medicaid community engagement requirements on the basis of pregnancy

Metric element	Description
Description	The number of beneficiaries enrolled in the demonstration who were exempt from the community engagement requirement because they are pregnant
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration in income and eligibility groups who were subject to the community engagement requirement who were individually exempt in the measurement period (metric CE_2). Step 2. Retain beneficiaries who were exempt from the community engagement requirement as of the last day of the measurement period due to pregnancy. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_2
Data source	Administrative records

Metric CE_17: Beneficiaries exempt from Medicaid community engagement requirements due to former foster youth status

Metric element	Description
Description	The number of beneficiaries enrolled in the demonstration who were exempt from the community engagement requirement because they were formerly part of the foster care system
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration in income and eligibility groups who were subject to the community engagement requirement who were individually exempt in the measurement period (metric CE_2). Step 2. Retain beneficiaries who were exempt from the community engagement requirement as of the last day of the measurement period because they were formerly part of the foster care system. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_2
Data source	Administrative records

Metric CE_18: Beneficiaries exempt from Medicaid community engagement requirements due to medical frailty

Metric element	Description
Description	The number of beneficiaries enrolled in the demonstration who were exempt from the community engagement requirement because they are identified as medically frail
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration in income and eligibility groups who were subject to the community engagement requirement who were individually exempt in the measurement period (metric CE_2). Step 2. Retain beneficiaries who were exempt from the community engagement requirement as of the last day of the measurement period because they are identified as medically frail during the measurement period. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_2
Data source	Administrative records

Metric CE_19: Beneficiaries exempt from Medicaid community engagement requirements on the basis of caretaker status

Metric element	Description
Description	The number of beneficiaries enrolled in the demonstration who were exempt from the community engagement requirement because they are primary caregiver of a dependent child or incapacitated/disabled household member
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration in income and eligibility groups who were subject to the community engagement requirement who were individually exempt in the measurement period (metric CE_2). Step 2. Retain beneficiaries who were exempt from the community engagement requirement as of the last day of the measurement period because they are primary caregiver of a dependent child or incapacitated/disabled household member. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_2
Data source	Administrative records

Metric CE_20: Beneficiaries exempt from Medicaid community engagement requirements on the basis of unemployment insurance compensation

Metric element	Description
Description	The number of beneficiaries enrolled in the demonstration who were exempt from the community engagement requirement because they are receiving unemployment insurance compensation
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration in income and eligibility groups who were subject to the community engagement requirement who were individually exempt in the measurement period (metric CE_2). Step 2. Retain beneficiaries who were exempt from the community engagement requirement as of the last day of the measure period because they are receiving unemployment insurance compensation. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_2
Data source	Administrative records

Metric CE_21: Beneficiaries exempt from Medicaid community engagement requirements due to substance abuse treatment status

Metric element	Description
Description	The number of beneficiaries enrolled in the demonstration who were exempt the community engagement requirement because they are participating in a drug or alcohol treatment and rehabilitation program
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration in income and eligibility groups who were subject to the community engagement requirement who were individually exempt in the measurement period (metric CE_2). Step 2. Retain beneficiaries who were exempt from the community engagement requirement as of the last day of the measurement period because they are participating in a drug or alcohol treatment and rehabilitation program during the measurement period. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_2
Data source	Administrative records

Metric CE_22: Beneficiaries exempt from Medicaid community engagement requirements due to student status

Metric element	Description
Description	The number of beneficiaries enrolled in the demonstration who were exempt from the community engagement requirement because they are a student enrolled a number of hours/week, defined by state
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration in income and eligibility groups who were subject to the community engagement requirement who were individually exempt in the measurement period (metric CE_2). Step 2. Retain beneficiaries who were exempt from the community engagement requirement as of the last day of the measurement period because they are a student enrolled a number of hours/week, defined by state. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_2
Data source	Administrative records

Metric CE_23: Beneficiaries exempt from Medicaid community engagement requirements because they were excused by a medical professional

Metric element	Description
Description	The number of beneficiaries enrolled in the demonstration who were exempt from the community engagement requirement because a medical professional determined the beneficiary had an acute medical condition separate from disability or frailty
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration in income and eligibility groups who were subject to the community engagement requirement who were individually exempt in the measurement period (metric CE_2). Step 2. Retain beneficiaries who were exempt from the community engagement requirement as of the last day of the measurement period because a medical professional determined the beneficiary had an acute medical condition separate from disability or frailty. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_2
Data source	Administrative records

Metric CE_24: Beneficiaries exempt from Medicaid community engagement requirements, other

Metric element	Description
Description	The number of beneficiaries enrolled in the demonstration who were exempt from the community engagement requirement because they are exempt for another reason not captured by other reporting categories, including age above the upper limit defined by the state and enrollment in employer-sponsored insurance through premium assistance.
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration in income and eligibility groups who were subject to the community engagement requirement who were individually exempt in the measurement period (metric CE_2). Step 2. Retain beneficiaries who were exempt from the community engagement requirement as of the last day of the measurement period because they are exempt for another reason not captured by other reporting categories, including age above the upper limit defined by the state and enrollment in employer-sponsored insurance through premium assistance. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_2
Data source	Administrative records

4. Supports and assistance

Metric CE_25: Total beneficiaries receiving supports to participate and placement assistance	
Metric element	**Description**
Description	The number of beneficiaries enrolled in the demonstration who were given supports to enable them to participate, including supports due to disability and assistance from other agencies and entities complementing Medicaid efforts
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration who were subject to the community engagement requirement (metric CE_1). Step 2.Identify beneficiaries who were given supports to enable them to participate, including supports due to disability and assistance from other agencies and entities complementing Medicaid efforts, during the measurement period. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric includes individuals counted in metrics CE_26 through CE_30. Beneficiaries may be counted more in more than one of metrics CE_26 through CE_30, but should only be counted once in metric CE_25, regardless of the number of different types of supports received.
Data source	Administrative records

Metric CE_26: Beneficiaries provided with transportation assistance	
Metric element	**Description**
Description	The number of beneficiaries enrolled in the demonstration who were given transportation assistance to enable participation in community engagement activities
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration who were given supports to enable them to participate (CE_25). Step 2. Retain beneficiaries who were provided with transportation assistance to enable participation in community engagement activities. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_25
Data source	Administrative records

Metric CE_27: Beneficiaries provided with childcare assistance

Metric element	Description
Description	The number of beneficiaries enrolled in the demonstration who were given childcare assistance to enable participation in community engagement activities
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration who were given supports to enable them to participate (CE_25). Step 2. Retain beneficiaries who were given childcare assistance to enable participation in community engagement activities. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_25
Data source	Administrative records

Metric CE_28: Beneficiaries provided with language supports

Metric element	Description
Description	The number of beneficiaries enrolled in the demonstration who were given language supports to enable participation in community engagement activities
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration who were given supports to enable them to participate (CE_25). Step 2. Retain beneficiaries who were given language supports to enable participation in community engagement activities. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_25
Data source	Administrative records

Metric CE_29: Beneficiaries assisted with placement in community engagement activities

Metric element	Description
Description	The number of beneficiaries enrolled in the demonstration who were given placement assistance, including through state department of labor support centers
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration who were given supports to enable them to participate (CE_25). Step 2. Retain beneficiaries who were given placement assistance, including through state department of labor support centers. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_25
Data source	Administrative records

Metric CE_30 Beneficiaries provided with other non-Medicaid assistance

Metric element	Description
Description	The number of beneficiaries enrolled in the demonstration who were given other assistance, including assistance from other agencies and entities complementing Medicaid efforts, to participate in community engagement activities
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration who were given supports to enable them to participate (CE_25). Step 2. Retain beneficiaries who were given other assistance, not captured in CE_26, 27, 28, or 29, to participate in community engagement activities. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_25
Data source	Administrative records

5. Reasonable modifications for beneficiaries with disabilities

Metric CE_31: Beneficiaries who requested reasonable modifications to community engagement processes or requirements due to disability	
Metric element	**Description**
Description	The number of beneficiaries enrolled in the demonstration who requested a reasonable modification of community engagement processes (such as assistance with exemption requests or appeals) or requirements (such as the number of hours) due to disability
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration who were subject to (metric CE_1), exempt from (CE_2) the community engagement requirement, or had a good cause circumstance (CE_3). Step 2. Retain beneficiaries who requested a reasonable modification of community engagement processes (such as assistance with exemption requests or appeals) or requirements (such as the number of hours) due to disability, during the measurement period. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Data source	Administrative records

Metric CE_32: Beneficiaries granted reasonable modifications to community engagement processes or requirements due to disability	
Metric element	**Description**
Description	The number of beneficiaries enrolled in the demonstration who were granted a modification of community engagement processes (such as assistance with exemption requests or appeals) or requirements (such as the number of hours) due to disability
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration who were subject to (metric CE_1), exempt from (CE_2) the community engagement requirement, or had a good cause circumstance (CE_3). Step 2. Retain beneficiaries who were granted a reasonable modification of community engagement processes (such as assistance with exemption requests or appeals) or requirements (such as the number of hours) due to disability, during the measurement period. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Data source	Administrative records

6. New suspensions and disenrollments during the measurement period

Metric CE_33: Beneficiaries newly suspended for failure to complete community engagement requirements	
Metric element	**Description**
Description	The number of demonstration beneficiaries newly suspended for noncompliance during the measurement period (if state has a suspension policy)
Counted variable	Step 1. Identify beneficiaries who were subject to the community engagement requirement and in suspension status due to failure to meet requirement (metric CE_4). Step 2. Retain beneficiaries who were newly suspended for noncompliance during the measurement period. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_4
Data source	Administrative records

Metric CE_34: Beneficiaries newly disenrolled for failure to complete community engagement requirements	
Metric element	**Description**
Description	The number of demonstration beneficiaries newly disenrolled for noncompliance with community engagement requirements during the measurement period
Counted variable	Count unique beneficiaries (deduplicated) who were disenrolled from Medicaid during the measurement period for noncompliance with community engagement requirements and who remained disenrolled as of the last day of the measurement period
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Data source	Administrative records

7. Reinstatement of benefits after suspension

Metric CE_35: Total beneficiaries whose benefits were reinstated after being in suspended status for noncompliance	
Metric element	**Description**
Description	The number of demonstration beneficiaries whose benefits were reinstated during the measurement period after suspension in a prior month triggered by noncompliance with community engagement requirements, including those reinstated due to compliance, determination of exemption, and successful appeal, or good cause circumstances
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration who were subject to the community engagement requirement and met the requirement by engaging in qualifying activities (metric CE_5), exempt from the community engagement requirement (CE_2), or who had a good cause circumstance (CE_3). Step 2. Retain beneficiaries who were in suspension status in a month prior to the measurement period where the suspension was triggered by noncompliance with community engagement requirements. Step 3. Retain beneficiaries whose benefits were reinstated during the measurement period. Include only beneficiaries whose benefits remained reinstated as of the last day of the measurement period. Include those reinstated due to the following: 1. Compliance 2. Determination of exemption or good cause circumstance 3. Successful appeal Step 4. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1, 2, and 3.
Required or recommended	Required if state has a suspension policy
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is equal to the sum of metrics CE_36, CE_37, CE_38, CE_39, and CE_40
Data source	Administrative records

Metric CE_36: Beneficiaries whose benefits were reinstated because their time-limited suspension period ended	
Metric element	**Description**
Description	The number of demonstration beneficiaries whose benefits were reinstated during the measurement period after suspension in a prior month triggered by noncompliance with community engagement requirements (if state has a suspension policy), because a defined suspension period ended
Counted variable	Step 1. Identify demonstration beneficiaries whose benefits were reinstated during the measurement period after being in suspended status for noncompliance (metric CE_35). Step 2. Retain beneficiaries whose benefits were reinstated during the measurement period because a defined suspension period ended. Include only beneficiaries whose benefits remained reinstated as of the last day of the month. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_35

Data source	Administrative records

Metric CE_37: Beneficiaries whose benefits were reinstated because they completed required community engagement activities

Metric element	Description
Description	The number of demonstration beneficiaries whose benefits were reinstated during the measurement period after suspension in a prior month triggered by noncompliance with community engagement requirements (if state has a suspension policy), because they completed qualifying activities
Counted variable	Step 1. Identify demonstration beneficiaries whose benefits were reinstated during the measurement period after being in suspended status for noncompliance (metric CE_35). Step 2. Retain beneficiaries whose benefits were reinstated during the measurement period because they completed qualifying activities. Include only beneficiaries whose benefits remained reinstated as of the last day of the month. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_35
Data source	Administrative records

Metric CE_38: Beneficiaries whose benefits were reinstated because they completed "on-ramp" activities other than qualifying community engagement activities

Metric element	Description
Description	The number of demonstration beneficiaries whose benefits were reinstated during the measurement period after suspension in a prior month triggered by noncompliance with community engagement requirements (if state has a suspension policy), because they used a special pathway for re-enrollment such as a state-approved educational course
Counted variable	Step 1. Identify demonstration beneficiaries whose benefits were reinstated during the measurement period after being in suspended status for noncompliance (metric CE_35). Step 2. Retain beneficiaries who were reinstated during the measurement period because they used a special pathway for re-enrollment such as a state-approved educational course. Include only beneficiaries whose benefits remained reinstated as of the last day of the month. Step 3. Count unique (deduplicated) beneficiaries that meet the criteria in Steps 1 and 2.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_35
Data source	Administrative records

Metric CE_39: Beneficiaries whose benefits were reinstated because they newly meet community engagement exemption criteria or had a good cause circumstance

Metric element	Description
Description	The number of demonstration beneficiaries whose benefits were reinstated during the measurement period after suspension in a prior month triggered by noncompliance with community engagement requirements (if state has a suspension policy) because they were newly determined exempt or had a good cause circumstance
Counted variable	Step 1. Identify demonstration beneficiaries whose benefits were reinstated during the measurement period after being in suspended status for noncompliance (metric CE_35). Step 2. Retain beneficiaries who were reinstated during the measurement period because they are newly determined exempt or to have a good cause circumstance. Include only beneficiaries whose benefits remained reinstated as of the last day of the month. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_35
Data source	Administrative records

Metric CE_40: Beneficiaries whose benefits were reinstated after successful appeal of suspension for noncompliance

Metric element	Description
Description	The number of demonstration beneficiaries whose benefits were reinstated during the measurement period after suspension in a prior month triggered by noncompliance with community engagement requirements (if state has a suspension policy) because they successfully appealed
Counted variable	Step 1. Identify demonstration beneficiaries whose benefits were reinstated during the measurement period after being in suspended status for noncompliance (metric CE_35). Step 2. Retain beneficiaries who were reinstated during the measurement period because they successfully appealed. Include only beneficiaries whose benefits remained reinstated as of the last day of the month. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_35
Data source	Administrative records

8. Re-entry after disenrollment

Metric CE_41: Total beneficiaries re-enrolling after disenrollment for noncompliance	
Metric element	**Description**
Description	Total number of beneficiaries re-enrolled in the demonstration during the measurement period after disenrollment in the last 12 months for noncompliance or because they were in suspended status on their redetermination date (depending on state policy), including those re-enrolling after being determined exempt or after successful appeal
Counted variable	Step 1. Identify beneficiaries enrolled in the demonstration who were subject to the community engagement requirement and met the requirement by engaging in qualifying activities (metric CE_5), exempt from (CE_2) the community engagement requirement, or who had a good cause circumstance (CE_3). Step 2. Retain beneficiaries who were disenrolled in the last 12 months for noncompliance or because they were in suspended status on their redetermination date. Step 3. Retain beneficiaries who re-enrolled in the demonstration (began a new enrollment spell) during the measurement period. Include beneficiaries who re-enrolled after being determined exempt or after successful appeal. Step 4. Count unique beneficiaries (unduplicated) that meet the criteria in Steps 1, 2, and 3.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is equal to the sum of metrics CE_42, CE_43, CE_44, CE_45, and CE_46
Data source	Administrative records

Metric CE_42: Beneficiaries re-enrolling after completing required community engagement activities	
Metric element	**Description**
Description	Total number of beneficiaries re-enrolled in the demonstration during the measurement period because they completed qualifying activities, subsequent to disenrollment in the last 12 months for noncompliance or because they were in suspended status on their redetermination date (depending on state policy)
Counted variable	Step 1. Identify beneficiaries who re-enrolled in the demonstration during the measurement period after disenrollment in the last 12 months for noncompliance or because they were in suspended status on their redetermination date (metric CE_41). Step 2. Retain beneficiaries who re-enrolled (began a new enrollment spell) during the measurement period because they completed qualifying activities. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_41
Data source	Administrative records

Metric CE_43: Beneficiaries re-enrolling after completing "on-ramp" activities other than qualifying community engagement activities

Metric element	Description
Description	Total number of demonstration beneficiaries re-enrolled during the measurement period because they used a special pathway for re-enrollment such as a state-approved educational course, subsequent to disenrollment in the last 12 months for noncompliance or because they were in suspended status on their redetermination date (depending on state policy)
Counted variable	Step 1. Identify beneficiaries who re-enrolled in the demonstration during the measurement period after disenrollment in the last 12 months for noncompliance or because they were in suspended status on their redetermination date (metric CE_41). Step 2. Retain beneficiaries who re-enrolled (began a new enrollment spell) during the measurement period because they used a special pathway for re-enrollment such as a state-approved educational course. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_41
Data source	Administrative records

Metric CE_44: Beneficiaries re-enrolling after re-applying, subsequent to being disenrolled for noncompliance with community engagement requirements

Metric element	Description
Description	The number of beneficiaries re-enrolled in the demonstration during the measurement period because they re-applied, subsequent to disenrollment in the last 12 months for noncompliance (or because they were in suspended status on their redetermination date). This includes those who re-applied immediately after disenrollment and those who did so after a disenrollment (non-eligibility) period.
Counted variable	Step 1. Identify beneficiaries who re-enrolled in the demonstration during the measurement period after disenrollment in the last 12 months for noncompliance or because they were in suspended status on their redetermination date (metric CE_41). Step 2. Retain beneficiaries who re-enrolled (began a new enrollment spell) during the measurement period after re-applying for coverage. Include those who re-applied immediately after disenrollment and those who did so after a disenrollment (non-eligibility) period. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_41
Data source	Administrative records

Metric CE_45: Beneficiaries re-enrolling because they newly met community engagement exemption criteria or had a good cause circumstance

Metric element	Description
Description	The number of beneficiaries re-enrolled in the demonstration during the measurement period because they were newly determined exempt, subsequent to disenrollment in the last 12 months for noncompliance (or because they were in suspended status on their redetermination date)
Counted variable	Step 1. Identify beneficiaries who re-enrolled in the demonstration during the measurement period after disenrollment in the last 12 months for noncompliance or because they were in suspended status on their redetermination date (metric CE_41). Step 2. Retain beneficiaries who re-enrolled (began a new enrollment spell) during the measurement period because they were newly determined exempt or had a good cause circumstance. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_41
Data source	Administrative records

Metric CE_46: Beneficiaries re-enrolling after successful appeal of disenrollment for noncompliance

Metric element	Description
Description	The number of beneficiaries re-enrolled in the demonstration during the measurement period after successful appeal (including retroactive determination of a good cause circumstance by the state), subsequent to disenrollment in the last 12 months for noncompliance (or because they were in suspended status on their redetermination date)
Counted variable	Step 1. Identify beneficiaries who re-enrolled in the demonstration during the measurement period after disenrollment in the last 12 months for noncompliance or because they were in suspended status on their redetermination date (metric CE_41). Step 2. Retain beneficiaries who re-enrolled (began a new enrollment spell) during the measurement period because they successfully appealed disenrollment. Exclude retroactive determination of an exemption or good cause circumstance by the state. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Required or recommended	Recommended
Measurement period (calculation lag)	Month (30 days)
Subpopulations	Specific demographic groups Specific eligibility groups (required)
Relationship to other metrics	This metric is a subset of metric CE_41
Data source	Administrative records

F. Additional metrics to be reported for demonstrations with retroactive eligibility waivers

1. At application

Metric RW_1: Beneficiaries who indicated that they had unpaid medical bills at the time of application	
Metric element	**Description**
Description	The number of demonstration beneficiaries in income and eligibility groups that were subject to the waiver of retroactive eligibility policy, who began a new enrollment period in the reporting month, and who indicated at the time of application for Medicaid that they had unpaid medical bills from the past three months
Counted variable	Step 1. Identify beneficiaries in the demonstration who began a new enrollment spell during the measurement period (metric AD_4). Step 2. Retain only those beneficiaries whose new enrollment spell resulted from a new application to Medicaid. Step 3. Retain beneficiaries who were subject to the waiver of retroactive eligibility policy. Step 4. Retain beneficiaries who indicated on their new application for Medicaid that they had unpaid medical bills from the past three months. Step 5. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1, 2, 3, and 4.
Required or recommended	Required
Measurement period (calculation lag)	Month (30 days)
Data source	Administrative records

2. At renewal

Metric RW_2: Beneficiaries who had a coverage gap at renewal	
Metric element	**Description**
Description	The number of demonstration beneficiaries in income and eligibility groups that were subject to the waiver of retroactive eligibility policy who re-enrolled in the demonstration within 90 days after a previous enrollment spell in the demonstration ended because the beneficiary did not comply with renewal processes on time
Counted variable	Step 1. Identify beneficiaries in the demonstration who began an enrollment spell during the measurement period. Step 2. Retain beneficiaries who had a previous spell of enrollment that ended within the prior 90 days (i.e., were enrolled at any time within the prior 90 days). Step 3. Retain beneficiaries who were subject to the waiver of retroactive eligibility policy. Step 4. Retain beneficiaries whose previous enrollment spell ended because beneficiary did not comply with the renewal process on time. Step 5. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1, 2, 3, and 4.
Required or recommended	Required
Measurement period (calculation lag)	Quarter (90 days)
Data source	Administrative records

Metric RW_3: Beneficiaries who had a coverage gap at renewal and had claims denied

Metric element	Description
Description	The number of demonstration beneficiaries in income and eligibility groups that were subject to the waiver of retroactive eligibility policy who re-enrolled in the demonstration within 90 days after a previous enrollment spell in the demonstration ended, and for whom claims were submitted for services rendered during the period of disenrollment that were denied by the state.
Counted variable	Step 1. Identify beneficiaries who had a coverage gap at renewal (RW_2). Step 2. Retain beneficiaries for whom claims were submitted for services rendered during the coverage gap that were denied by the state. Step 3. Count unique beneficiaries (deduplicated) who meet the criteria in Steps 1 and 2.
Additional guidance	The coverage gap is defined as the time between the end of the previous enrollment spell and the re-enrollment date.
Required or recommended	Required
Measurement period (calculation lag)	Quarter (90 days)
Relationship to other metrics	This metric is a subset of metric RW_2
Data source	Administrative records

APPENDIX A

ESTABLISHED MEASURES AND MEASURE SETS REFERENCED IN TECHNICAL SPECIFICATIONS

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Table A.1 defines the established measures, measure sets, and measure set versions referenced in the specifications for these metrics.

Table A.1 Established measures and measure sets referenced in metric specifications

Metric Number	Metric name	Measure set	Measure set version
AD_38A	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)	Adult Core Set	FFY 2019
AD_38B	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Merit-based Incentive Payment System (MIPS)	2018
AD_39-1	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA -AD)	Adult Core Set	FFY 2019
AD_39-2	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)	Adult Core Set	FFY 2019
AD_40	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)	Adult Core Set	FFY 2019
AD_41	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)	Adult Core Set	FFY 2019
AD_42	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)	Adult Core Set	FFY 2019
AD_43	PQI 08: Heart Failure Admission Rate (PQI08-AD)	Adult Core Set	FFY 2019
AD_44	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)	Adult Core Set	FFY 2019

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APPENDIX B

TECHNICAL SPECIFICATIONS FOR MEDICAID QUALITY MEASURES, ADAPTED FROM FFY 2019 ADULT CORE SET MEASURE SPECIFICATIONS

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This appendix provides the technical specifications for the Adult Core Set measures included in the monitoring metrics for section 1115 eligibility and coverage demonstrations. These specifications have been adapted from state-level specifications for use in section 1115 eligibility and coverage demonstrations.

B.I. MEASURE ELEMENT DEFINITIONS

Measurement period. The measurement period is the time frame for which the data should be collected (defined by start and end dates). The measurement period for each Adult Core Set measure included in the section 1115 eligibility and coverage monitoring metrics can be found in **Table B.1**. For many measures, the denominator measurement period for FFY 2019 corresponds to calendar year 2018 (January 1, 2018–December 31, 2018). However, for some measures, the measurement period begins before the calendar year. For example, Measure AD_40: Initiation and Engagement of Alcohol and Other Drug or Dependence Treatment (IET-AD) requires states to review utilization and continuous enrollment prior to January 1 when constructing the denominator. This is referred to as a "look-back period" or a negative review period.

Continuous enrollment. Continuous enrollment specifies the minimum amount of time that a beneficiary must be enrolled in the demonstration before becoming eligible for the measure. The continuous enrollment period is specified for each measure in **Table B.1**.

Allowable gap. The allowable gap specifies the maximum amount of time a beneficiary can be disenrolled from the demonstration and still qualify for inclusion in the measure. The allowable gap is specified for each measure in **Table B.1**.

Hospice exclusion. Some Adult Core Set measures included in the section 1115 eligibility and coverage monitoring metrics exclude beneficiaries who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These beneficiaries may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data. The Hospice Value Set is available to states upon request by contacting 1115MonitoringAndEvaluation@cms.hhs.gov. States should remove these beneficiaries prior to determining a measure's eligible population. Documentation that a beneficiary is near the end of life (e.g., comfort care, Do Not Resuscitate [DNR], Do Not Intubate [DNI]), or is in palliative care does not meet criteria for the hospice exclusion. This applies to the following measures: AD_39-1, AD_39-2, and AD_40.

Anchor date. Some measures include an anchor date, which is the date that an individual must be enrolled in the demonstration to be eligible for the measure. For example, if an enrollment gap includes the anchor date, the individual is not eligible for the measure. For several measures, the anchor date is the last day of the measure's FFY 2019 measurement period (December 31, 2018). States should use the specified anchor dates along with the continuous enrollment requirements and allowable gaps for each measure to determine the measure-eligible population.

CAHPS. CAHPS is a family of surveys designed to assess consumer experiences with care. Different versions of the survey are available for use among various populations, payers, and settings. The version of the CAHPS Survey specified in the Adult Core Set is the CAHPS Health Plan Survey 5.0H (Medicaid).

Table B.1. Measurement period for denominators and numerators for the FFY 2019 Adult Core Set section 1115 eligibility and coverage monitoring metrics

Measure	FFY 2019 Measurement Period[a]			
	Denominator	Numerator	Continuous Enrollment Period	Allowable Gap
AD_38A: Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)	January 1, 2018 – December 31, 2018	January 1, 2018 – December 31, 2018	July 1, 2018 – December 31, 2018	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (i.e., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
AD_39-1: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)	Emergency Department (ED) visit date: January 1, 2018 – December 1, 2018	7 Day Follow-up: January 1, 2018 – December 8, 2018 (ED visit date through 7 days after visit date) 30 Day Follow-up: January 1, 2018 – December 31, 2018 (ED visit date through 30 days after visit date)	January 1, 2018 – December 31, 2018 (ED visit date through 30 days after visit date)	None

Measure	FFY 2019 Measurement Period[a]			
	Denominator	Numerator	Continuous Enrollment Period	Allowable Gap
AD_39-2: Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)	ED visit date: January 1, 2018 – December 1, 2018	7 Day Follow-up: January 1, 2018 – December 8, 2018 (ED visit date through 7 days after visit date) 30 Day Follow-up: January 1, 2018 – December 31, 2018 (ED visit date through 30 days after visit date)	January 1, 2018 – December 31, 2018 (ED visit date through 30 days after visit date)	None
AD_40: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)	Index episode start date (IESD): January 1, 2018 – November 14, 2018 Negative diagnosis history review: November 2, 2017 – September 15, 2018 (60 days prior to IESD)	Initiation of AOD Treatment: January 1 , 2018 – November 28, 2018 (Within 14 days of the IESD)[b] Engagement of AOD Treatment: January 2, 2018 – January 1, 2019 (Day after initiation encounter through 34 days after the initiation date) [b]	November 2, 2017 – January 1, 2019 (60 days prior to IESD through 48 days after the IESD)	None
AD_41: PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)	January 1, 2018 – December 31, 2018	January 1, 2018 – December 31, 2018	None	None

Measure	FFY 2019 Measurement Period[a]			
	Denominator	Numerator	Continuous Enrollment Period	Allowable Gap
AD_42: PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults (PQI05-AD)	January 1, 2018 – December 31, 2018	January 1, 2018 – December 31, 2018	None	None
AD_43: PQI 08: Heart Failure Admission Rate (PQI08-AD)	January 1, 2018 – December 31, 2018	January 1, 2018 – December 31, 2018	None	None
AD_44: PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)	January 1, 2018 – December 31, 2018	January 1, 2018 – December 31, 2018	None	None

[a] For some measures, the measurement period for the numerator, denominator, or continuous enrollment period varies depending on a specified date for each enrollee (such as ED visit or the index episode start date). For these measures, two ranges are shown. The first date range identifies the full range of possible dates that states will need to use to calculate the measure for all measure-eligible enrollees. The text in parentheses describes the measurement period that should be used for each eligible enrollee.

b Applies to all rates: Alcohol abuse or dependence rate, Opioid abuse or dependence rate, Other drug abuse or dependence rate, and Total AOD abuse or dependence rate.

B.II. TECHNICAL SPECIFICATIONS

Metric AD_38A: Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)

Measure Steward: National Committee for Quality Assurance

A. DESCRIPTION

The following components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation:

- **Advising Smokers and Tobacco Users to Quit**. A rolling average represents the percentage of beneficiaries enrolled in the demonstration age 18 and older who were current smokers or tobacco users and who received advice to quit during the measurement year.
- **Discussing Cessation Medications**. A rolling average represents the percentage of beneficiaries enrolled in the demonstration age 18 and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.
- **Discussing Cessation Strategies**. A rolling average represents the percentage of beneficiaries enrolled in the demonstration age 18 and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.

Data Collection Method: Survey

Guidance for Reporting:

- If the denominator is less than 100, this measure is not reported. First-year data collection will generally not yield enough responses to be reportable. A rolling two-year average can be used to achieve a sufficient number of respondents for reporting. For additional guidance on calculating a two-year average, see Section E. Calculation of Measure.

B. ELIGIBLE POPULATION

Age	Age 18 and older as of December 31 of the measurement year.
Continuous enrollment	Enrolled in the demonstration for the last six months of the measurement period.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (i.e., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Current enrollment	Currently enrolled at the time the survey is completed.

Version of Specification: HEDIS 2019

C. PROTOCOL AND SURVEY INSTRUMENT

The data for this measure are collected annually as part of the CAHPS Health Plan Survey 5.0H, Adult Version. States must create a sample frame for the survey and contract with a NCQA certified HEDIS 2019 survey vendor that will administer the survey according to HEDIS protocols. The survey vendor draws the actual samples and fields the survey.

The sample size for the CAHPS Health Plan Survey should be 1,350, plus an oversample based on the state's prior experience with survey response rates, to yield at least 411 completed surveys. The required sample size is based on the average number of complete and valid surveys obtained by health plans during prior years; therefore, using the required sample size for a given survey does not guarantee that a state will achieve the goal of 411 completed surveys or the required denominator of 100 complete responses for each survey result. The state should work with its survey vendor to determine the number of complete and valid surveys it can expect to obtain without oversampling based on prior experience. Note that the sample size may need to be increased to yield at least 100 responses that meet the eligible population criteria for the section 1115 demonstration. Refer to Section E for more information on the denominator requirements for calculating the measure using a rolling average methodology.

NCQA maintains a list of survey vendors that have been trained and certified by NCQA to administer the CAHPS 5.0H survey. Each survey vendor is assigned a maximum capacity of samples. The capacity reflects the firm's and NCQA's projection of resources available to be dedicated to administer the survey. A current listing of NCQA-certified HEDIS 2019 survey vendors is available at https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/cahps-5-0h-survey-certification/vendor-directory/.

D. QUESTIONS INCLUDED IN THIS MEASURE

Questions		Response Choices
Q39	Do you now smoke cigarettes or use tobacco every day, some days, or not at all?	Every day Some days Not at all → If Not at all, Go to Question 43 Don't know → If Don't know, Go to Question 43
Q40	In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?	Never Sometimes Usually Always
Q41	In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.	Never Sometimes Usually Always

Questions		Response Choices
Q42	In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.	Never Sometimes Usually Always

E. CALCULATION OF MEASURE

Rolling averages are calculated using the formula below.

Rate = (Year 1 Numerator + Year 2 Numerator) / (Year 1 Denominator + Year 2 Denominator)

- If the denominator is less than 100, this measure is not reported.
- If the denominator is 100 or more, a rate is calculated.
- If the state did not report results for the current year (Year 2), this measure is not reported.
- If the state did not report results in the prior year (Year 1) but reports results for the current year and achieves a denominator of 100 or more, a rate is calculated; if the denominator is less than 100, this measure is not reported.

Component 1: Advising Smokers and Tobacco Users to Quit

Denominator

The number of beneficiaries who responded to the survey and indicated that they were current smokers or tobacco users. Beneficiary response choices must be as follows to be included in the denominator:

Q39 = “Every day” or “Some days.”

AND

Q40 = “Never” or “Sometimes” or “Usually” or “Always.”

Numerator

The number of beneficiaries in the denominator who indicated that they received advice to quit from a doctor or other health provider by answering “Sometimes” or “Usually” or “Always” to Q40.

Component 2: Discussing Cessation Medications

Denominator

The number of beneficiaries who responded to the survey and indicated that they were current smokers or tobacco users. Beneficiary response choices must be as follows to be included in the denominator:

Q39 = “Every day” or “Some days.”

AND

Q41 = “Never” or “Sometimes” or “Usually” or “Always.”

Numerator

The number of beneficiaries in the denominator who indicated that their doctor or health provider recommended or discussed cessation medications by answering “Sometimes” or “Usually” or “Always” to Q41.

Component 3: Discussing Cessation Strategies

Denominator

The number of beneficiaries who responded to the survey and indicated that they were current smokers or tobacco users. Beneficiary response choices must be as follows to be included in the denominator:

Q39 = “Every day” or “Some days.”

AND

Q42 = “Never” or “Sometimes” or “Usually” or “Always.”

Numerator

The number of beneficiaries in the denominator who indicated that their doctor or health provider discussed or provided cessation methods and strategies by answering “Sometimes” or “Usually” or “Always” to Q42.

Percentage of Current Smokers and Tobacco Users - Supplemental Calculation

This calculation is provided to support analysis of Medical Assistance with Smoking and Tobacco Use Cessation rates and provides additional context for unreportable results (that is, where the denominator is less than 100). A state with a small number of smokers or tobacco users may not be able to obtain a large enough denominator to achieve reportable rates (that is, where the denominator is less than 100).

The percentage of current smokers and tobacco users is calculated using data collected during the current reporting year only (not calculated as a rolling average).

Denominator

The number of beneficiaries who responded “Every day,” “Some days,” “Not at all,” or “Don’t know” to the question “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”

Numerator

The number of beneficiaries in the denominator who responded “Every day” or “Some days” to the question “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”

Metric AD_39-1: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA -AD)

Measure Steward: National Committee for Quality Assurance

A. DESCRIPTION

Percentage of emergency department (ED) visits for beneficiaries enrolled in the demonstration age 18 and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported:

- 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)
- 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)

Data Collection Method: Administrative

Guidance for Reporting:

- The denominator should be the same for the 30-day rate and the 7-day rate.
- The 30-day follow-up rate should be greater than or equal to the 7-day follow-up rate.
- When a visit code or procedure code must be used in conjunction with a diagnosis code, the codes must be on the same claim or be found on the same date of service.
    - If a value set includes codes used on professional claims (e.g., CPT, HCPCS) and includes codes used on facility claims (e.g., UB), use diagnosis and procedure codes from both facility and professional claims to identify services and diagnoses (the codes can be on the same claim or same date of service).
    - If a value set includes codes used only on facility claims (e.g., UB) then use only facility claims to identify services and diagnoses (the codes must be on the same claim).
- Include all paid, suspended, pending and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section I. Measure Element Definitions.

The following coding systems are used in this measure: CPT, HCPCS, ICD-10-CM, Modifier, POS, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Age 18 and older as of the ED visit.
Continuous enrollment	Enrolled in the demonstration on the date of the ED visit through 30 days after the ED visit (31 total days).
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	None.
Benefit	Medical and chemical dependency. Note: Beneficiaries with detoxification-only chemical dependency benefits do not meet these criteria.
Event/diagnosis	An ED visit (ED Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) on or between January 1 and December 1 of the measurement year where the beneficiary was age 18 or older on the date of the visit and enrolled in the demonstration. The denominator for this measure is based on ED visits, not on the number of beneficiaries enrolled in the demonstration. If a beneficiary has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below.
Multiple visits in a 31-day period	If a beneficiary has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a beneficiary has an ED visit on January 1, then include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically including only one per 31-day period. Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusion before removing multiple visits in a 31-day period.
ED visits followed by inpatient admission	Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay. An ED or observation visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay. These events are excluded from this measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

30-Day Follow-Up

A follow-up visit with any practitioner, with a principal diagnosis of AOD abuse or dependence within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.

7-Day Follow-Up

A follow-up visit with any practitioner, with a principal diagnosis of AOD abuse or dependence within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

For both indicators, any of the following meet criteria for a follow-up visit:

- IET Stand Alone Visits Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)
- An observation visit (Observation Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set)
- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set)
- An online assessment (Online Assessments Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set)

D. ADDITIONAL NOTES

There may be different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date, and units of service. Where billing methods are comparable to inpatient billing, each unit of service may be counted as an individual visit. The unit of service must have occurred during the required period for the rate (e.g., within 30 days after the ED visit or within 7 days after the ED visit).

Metric AD_39-2: Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)

Measure Steward: National Committee for Quality Assurance

A. DESCRIPTION

Percentage of emergency department (ED) visits for beneficiaries enrolled in the demonstration age 18 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported:

- 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)
- 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)

Data Collection Method: Administrative

Guidance for Reporting:

- The denominator should be the same for the 30-day rate and the 7-day rate.
- The 30-day follow-up rate should be greater than or equal to the 7-day follow-up rate.
- When a visit code or procedure code must be used in conjunction with a diagnosis code, the codes must be on the same claim or be found on the same date of service.
    - If a value set includes codes used on professional claims (e.g., CPT, HCPCS) and includes codes used on facility claims (e.g., UB), use diagnosis and procedure codes from both facility and professional claims to identify services and diagnoses (the codes can be on the same claim or same date of service).
    - If a value set includes codes used only on facility claims (e.g., UB) then only use facility claims to identify services and diagnoses (the codes must be on the same claim).
- Include all paid, suspended, pending and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section I. Measure Element Definitions.

The following coding systems are used in this measure: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, Modifier, POS, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Ages	Age 18 and older as of the date of the ED visit.
Continuous enrollment	Enrolled in the demonstration on the date of the ED visit through 30 days after the ED visit (31 total days).
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	None.
Benefit	Medical and mental health.
Event/diagnosis	An ED visit (ED Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on or between January 1 and December 1 of the measurement year where the beneficiary was age 18 or older on the date of the visit and enrolled in the demonstration. The denominator for this measure is based on ED visits, not on the number of beneficiaries enrolled in the demonstration. If a beneficiary has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below.
Multiple visits in a 31-day period	If a beneficiary has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a beneficiary has an ED visit on January 1, then include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically including only one per 31-day period. Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusion before removing multiple visits in a 31-day period.
ED visits followed by inpatient admission	Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay. An ED or observation visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay. These events are excluded from this measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

30-Day Follow-Up

A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of mental health disorder within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.

7-Day Follow-Up

A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

For both indicators, any of the following meet criteria for a follow-up visit.

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)
- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)
- An observation visit (Observation Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set) with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)
- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set)
- An observation visit (Observation Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)

D. ADDITIONAL NOTES

There may be different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date, and units of service. Where billing methods are comparable to inpatient billing, each unit of service may be counted as an individual visit. The unit of service must have occurred during the required period specified for the rate (e.g., within 30 days after discharge or within 7 days after discharge).

Metric AD_40: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)

Measure Steward: National Committee for Quality Assurance

A. DESCRIPTION

Percentage of beneficiaries enrolled in the demonstration age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:

- **Initiation of AOD Treatment**. Percentage of beneficiaries who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis
- **Engagement of AOD Treatment**. Percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or medication treatment within 34 days of the initiation visit

Data Collection Method: Administrative or EHR

Guidance for Reporting:

- Two rates are reported: initiation of AOD treatment and engagement of AOD treatment. For each rate, report the following AOD diagnosis cohorts:
  - Alcohol abuse or dependence
  - Opioid abuse or dependence
  - Other drug abuse or dependence
  - Total AOD abuse or dependence
- The total AOD abuse or dependence rate is not a sum of the diagnosis cohorts. Count beneficiaries in the total denominator rate if they had at least one alcohol, opioid, or other drug abuse or dependence diagnosis during the measurement period. Report beneficiaries with multiple diagnoses on the Index Episode claim only once for the total rate for the denominator.
- Exclude beneficiaries from the denominator for both rates (initiation of AOD treatment and engagement of AOD treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year.
- Include all paid, suspended, pending, and denied claims.
- Beneficiaries in hospice are excluded from the eligible population. For additional information, refer to the hospice exclusion guidance in Section I. Measure Element Definitions.
- NCQA's Medication List Directory (MLD) of NDC codes for Medication Treatment for Alcohol Abuse or Dependence Medications and Medication Treatment for Opioid Abuse or Dependence Medications can be found at https://www.ncqa.org/hedis/measures/hedis-2019-ndc-license/hedis-2019-final-ndc-lists.
- The electronic specification for FFY 2019 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/measures/cms137v6

The following coding systems are used in this measure: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, Modifier, NDC, POS, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Intake period	January 1 to November 14 of the measurement year. The Intake Period is used to capture new episodes of AOD abuse and dependence.
Index episode	The earliest eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence. The beneficiary must be enrolled in the demonstration during the index episode. For ED visits that result in an inpatient stay, the inpatient discharge is the Index Episode.
IESD	Index Episode Start Date (IESD). The earliest date of service for an eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence. For an outpatient, intensive outpatient, partial hospitalization, observation, telehealth, detoxification, or ED visit (not resulting in an inpatient stay), the IESD is the date of service. For an inpatient stay, the IESD is the date of discharge. For ED and observation visits that result in an inpatient stay, the IESD is the date of the inpatient discharge (an AOD diagnosis is not required for the inpatient stay; use the diagnosis from the ED or observation visit to determine the diagnosis cohort). When an ED or observation visit and an inpatient stay are billed on separate claims, the visit results in an inpatient stay when the ED/observation date of service occurs on the day prior to the admission date or any time during the admission (admission date through discharge date). An ED or observation visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay. For direct transfers, the IESD is the discharge date from the last admission (an AOD diagnosis is not required for the transfer; use the diagnosis from the initial admission to determine the diagnosis cohort).
Negative diagnosis history	A period of 60 days (2 months) before the IESD when the beneficiary had no claims/encounters with a diagnosis of AOD abuse or dependence. For an inpatient stay, use the admission date to determine the Negative Diagnosis History. For ED or observation visits that result in an inpatient stay, use the earliest date of service (either the ED/observation date of service or the inpatient admission date) to determine the Negative Diagnosis History. When an ED or observation visit and an inpatient stay are billed on separate claims, the visit results in an inpatient stay when the ED/observation date of service occurs on the day prior to the admission date or any time during the admission (admission date through discharge date). An ED or observation visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay. For direct transfers, use the first admission to determine the Negative Diagnosis History.

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Direct transfer	A direct transfer is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example: • An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer. • An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer. • An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays. Use the following method to identify admissions to and discharges from inpatient settings. 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission and discharge dates for the stay.

C. ELIGIBLE POPULATION

Age	Age 18 and older as of December 31 of the measurement year.
AOD diagnosis cohorts	Report the following diagnosis cohorts: • Alcohol abuse or dependence • Opioid abuse or dependence • Other drug abuse or dependence • Total AOD abuse or dependence
Continuous enrollment	Enrolled in Medicaid for 60 days (2 months) prior to the IESD and enrolled in the demonstration for 48 days after the IESD.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	None.
Benefits	Medical, pharmacy, and chemical dependency (inpatient and outpatient). Note: Beneficiaries with detoxification-only chemical dependency benefits do not meet these criteria.
Event/ diagnosis	New episode of AOD abuse or dependence during the Intake Period. Follow the steps below to identify the eligible population, which is the denominator for both rates. Step 1 Identify the Index Episode. Identify all beneficiaries in the specified age range who during the Intake Period had one of the following:

Event/ diagnosis (continued)	• An outpatient visit, telehealth, intensive outpatient visit, or partial hospitalization with a diagnosis of AOD abuse or dependence. Any of the following code combinations meet criteria: - IET Stand Alone Visits Value Set with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set) - IET Visits Group 1 Value Set with IET POS Group 1 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set) - IET Visits Group 2 Value Set with IET POS Group 2 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependency Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set) • A detoxification visit (Detoxification Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • An ED visit (ED Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • An observation visit (Observation Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • An acute or nonacute inpatient discharge with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. • A telephone visit (Telephone Visits Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • An online assessment (Online Assessments Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set For beneficiaries with more than one episode of AOD abuse or dependence, use the first episode.

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	For beneficiaries whose first episode was an ED or observation visit that resulted in an inpatient stay, use the diagnosis from the ED or observation visit to determine the diagnosis cohort and use the inpatient discharge date as the IESD. When an ED or observation visit and an inpatient stay are billed on separate claims, the visit results in an inpatient stay when the ED/observation date of service occurs on the day prior to the admission date or any time during the admission (admission date through discharge date). An ED or observation visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay. Step 2 Select the Index Episode and stratify based on age and AOD diagnosis cohort. • If the beneficiary has a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set), place the beneficiary in the alcohol cohort. • If the beneficiary has a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set), place the beneficiary in the opioid cohort. • If the beneficiary has a drug abuse or dependence that is neither for opioid or alcohol (Other Drug Abuse and Dependence Value Set), place the beneficiary in the other drug cohort. If the beneficiary has multiple substance use diagnoses for the visit, report the beneficiary in all AOD diagnosis stratifications for which they meet criteria. The total is not a sum of the diagnosis cohorts. Count beneficiaries in the total denominator rate if they had at least one alcohol, opioid, or other drug abuse or dependence diagnosis during the measurement period. Report beneficiaries with multiple diagnoses on the Index Episode only once for the total rate for the denominator. Step 3 Test for Negative Diagnosis History. Exclude beneficiaries who had a claim/encounter with a diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), AOD medication treatment (AOD Medication Treatment Value Set), or an alcohol or opioid dependency treatment medication dispensing event (Medication Treatment for Alcohol Abuse or Dependence Medications List; Medication Treatment for Opioid Abuse or Dependence Medications List, see link to Medication List Directory in Guidance for Reporting above) during the 60 days (2 months) before the IESD. For an inpatient IESD, use the admission date to determine the 60-day Negative Diagnosis History period. For an ED or observation visit that results in an inpatient stay, use the ED/observation date of service to determine the 60-day Negative Diagnosis History period. When an ED or observation visit and an inpatient stay are billed on separate claims, the visit results in an inpatient stay when the ED/observation date of service occurs on the day prior to the admission date or any time during the admission (admission date through discharge date). An ED or observation visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay.

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	Step 4 Calculate continuous enrollment. Beneficiaries must be continuously enrolled for 60 days (2 months) before the IESD through 48 days after the IESD (109 total days), with no gaps.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

Numerator 1: Initiation of AOD Treatment

Initiation of AOD treatment within 14 days of the IESD.

If the Index Episode was an inpatient discharge (or an ED/observation visit that resulted in an inpatient stay), the inpatient stay is considered initiation of treatment and the beneficiary is compliant.

If the Index Episode was not an inpatient discharge, the beneficiary must initiate the treatment on the start date of the Index Episode or in the 13 days after the Index Episode (14 total days). Any of the following code combinations meet criteria for initiation:

- An acute or nonacute inpatient admission with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient admissions:

  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

  2. Identify the admission date for the stay.

- IET Stand Alone Visits Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set)

- Observation Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set

- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set with or without a telehealth modifier (Telehealth Modifier Value Set)

- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set with or without a telehealth modifier (Telehealth Modifier Value Set)

- A telephone visit (Telephone Visits Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set

- An online assessment (Online Assessments Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- If the Index Episode was for a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set) a medication treatment dispensing event (Medication Treatment for Alcohol Abuse or Dependence Medications List, see link to Medication List Directory in Guidance for Reporting above) or medication treatment during a visit (AOD Medication Treatment Value Set)
    - If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) a medication treatment dispensing event (Medication Treatment for Opioid Abuse or Dependence Medications List, see link to Medication List Directory in Guidance for Reporting above) or medication treatment during a visit (AOD Medication Treatment Value Set)

For all initiation events except medication treatment (AOD Medication Treatment Value Set; Medication Treatment for Alcohol Abuse or Dependence Medications List; Medication Treatment for Opioid Abuse or Dependence Medications List, see link to Medication List Directory in Guidance for Reporting above), initiation on the same day as the IESD must be with different providers in order to count.

If a beneficiary is compliant for the Initiation numerator for any diagnosis cohort (i.e., alcohol, opioid, other drug), or for multiple cohorts, count the beneficiary once in the Total Initiation numerator. The "Total" column is not the sum of the diagnosis columns.

Exclude the beneficiary from the denominator for both indicators (Initiation of AOD Treatment and Engagement of AOD Treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year.

Numerator 2: Engagement of AOD Treatment

Step 1

Identify all beneficiaries compliant for the Initiation of AOD Treatment numerator.

For beneficiaries who initiated treatment via an inpatient admission, the 34-day period for the two engagement visits begins the day after discharge.

Step 2

Identify beneficiaries whose initiation of AOD treatment was a medication treatment event (Medication Treatment for Alcohol Abuse or Dependence Medications List; Medication Treatment for Opioid Abuse or Dependence Medications List; AOD Medication Treatment Value Set, see link to Medication List Directory in Guidance for Reporting above).

These beneficiaries are numerator compliant if they have two or more engagement events where only one can be an engagement medication treatment event.

Step 3

Identify the remaining beneficiaries whose initiation of AOD treatment was not a medication treatment event (beneficiaries not identified in step 2).

These beneficiaries are numerator compliant if they meet either of the following:

- At least two engagement visits
- At least one engagement medication treatment event

Two engagement visits can be on the same date of service but they must be with different providers in order to count as two events. An engagement visit on the same date of service as an engagement medication treatment event meets criteria (there is no requirement that they be with different providers).

Refer to the descriptions below to identify engagement visits and engagement medication treatment events.

Engagement Visits

Any of the following meet criteria for an engagement visit:

- An acute or nonacute inpatient admission with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission date for the stay.
- IET Stand Alone Visits Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set)
- Observation Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set)
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set)
- A telephone visit (Telephone Visits Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- An online assessment (Online Assessments Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set

Engagement Medication Treatment Events

Either of the following meets criteria for an engagement medication treatment event:

- If the IESD diagnosis was a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set), one or more medication treatment dispensing events (Medication Treatment for Alcohol Abuse or Dependence Medications List, see link to

Medication List Directory in Guidance for Reporting above) or medication treatment during a visit (AOD Medication Treatment Value Set), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Alcohol Abuse and Dependence Treatment.

- If the IESD diagnosis was a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set), one or more medication dispensing events (Medication Treatment for Opioid Abuse or Dependence Medications List, see link to Medication List Directory in Guidance for Reporting above) or medication treatment during a visit (AOD Medication Treatment Value Set), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Opioid Abuse and Dependence Treatment.

If a beneficiary enrolled in the demonstration is compliant for multiple cohorts, only count the beneficiary once for the Total Engagement numerator. The Total rate is not the sum of the diagnosis columns.

E. ADDITIONAL NOTES

- There may be different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date, and units of service. Where billing methods are comparable to inpatient billing, each unit of service may be counted as an individual visit. The unit of service must have occurred during the required time frame for the rate.
- For beneficiaries in the “other drug abuse or dependence” cohort, medication treatment does not meet numerator criteria for Initiation of AOD Treatment or Engagement of AOD Treatment.
- Methadone is not included in the medication lists for this measure. Methadone for opioid use disorder is only administered or dispensed by federally certified opioid treatment programs and does not show up in pharmacy claims data. The AOD Medication Treatment Value Set includes some codes that identify methadone treatment because these codes are used on medical claims, not pharmacy claims.

Metric AD_41: PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)

Measure Steward: Agency for Healthcare Research and Quality

A. DESCRIPTION

Number of inpatient hospital admissions for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 beneficiary months for beneficiaries enrolled in the demonstration age 18 and older.

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

Guidance for Reporting:

- States should report this measure as a rate per 100,000 beneficiary months as opposed to per 100,000 beneficiaries enrolled in the demonstration.
- A two-step process should be used to determine whether beneficiaries should be counted in this measure:
  - For each beneficiary month considered for the denominator, assess the beneficiary's age at either the 15th or 30th of the month (or the 28th of the month in February). If the beneficiary was age 18 or older by that date, the beneficiary month should be counted in the denominator. A consistent date should be used to assess age across all months. For example, if a state counts enrollment as of the 30th of the month and a beneficiary is over age 18 on the 30th but was disenrolled from the demonstration on the 27th, that month would not count toward the denominator. However, if a state counts enrollment as of the 15th, that month would count toward the denominator.
  - For each hospital admission representing a qualifying numerator event, assess the beneficiary's age on the date of admission. Only admissions for beneficiaries age 18 or older should be included in the numerator.
- This measure is designed to exclude transfers from other institutions from the numerator. However, the variables contained in the software to identify transfers, shown in Table PQI01-B, may not exist in all data sources. If that is the case, states should describe how transfers are identified and excluded in their calculations.
- Free software is available from the AHRQ Web site for calculation of this measure at http://www.qualityindicators.ahrq.gov/Software/Default.aspx. Use of the AHRQ software is optional for calculating the PQI measures.
- Include paid claims only.

The following coding systems are used in this measure: ICD-10-CM and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Beneficiary months	All beneficiary months for beneficiaries age 18 and older as of the 15th or the 30th day of the month and who are enrolled in the demonstration that month. Date for counting beneficiary months must be consistent across the reporting period.
Continuous enrollment	None.
Allowable gap	None.
Anchor date	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

Total number of months of demonstration enrollment for beneficiaries enrolled in the demonstration age 18 and older during the measurement period.

Numerator

All inpatient hospital admissions with ICD-10-CM principal diagnosis code for short-term complications of diabetes (ketoacidosis, hyperosmolarity, or coma) (Table PQI01-A, available at https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2019-adult-non-hedis-value-set-directory.zip).

Exclusions

- Transfer from a hospital (different facility), a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), or another health care facility (see Table PQI01-B below for admission codes for transfers)
- Admissions with missing age (AGE = missing), year (YEAR = missing), or principal diagnosis (DX1 = missing),
- Obstetric admissions (Note: By definition, admissions with a principal diagnosis of diabetes with short-term complications are precluded from assignment of MDC 14 by grouper software. Thus, obstetric admissions should not be considered in the PQI rate.)

Table PQI01-B. Admission Codes for Transfers

SID ASOURCE Codes	2 – Another hospital
	3 – Another facility, including long-term care
Point of Origin UB-04 Codes	4 – Transfer from a hospital
	5 – Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
	6 – Transfer from another health care facility

Metric AD_42: PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)

Measure Steward: Agency for Healthcare Research and Quality

A. DESCRIPTION

Number of inpatient hospital admissions for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 beneficiary months for beneficiaries enrolled in the demonstration age 40 and older.

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

Guidance for Reporting:

- States should report this measure as a rate per 100,000 beneficiary months as opposed to per 100,000 beneficiaries enrolled in the demonstration.
- A two-step process should be used to determine whether beneficiaries should be counted in this measure:
  - For each beneficiary month considered for the denominator, assess the beneficiary's age at either the 15th or 30th of the month (or the 28th of the month in February). If the beneficiary was age 40 or older by that date, the beneficiary month should be counted in the denominator. A consistent date should be used to assess age across all months. For example, if a state counts enrollment as of the 30th of the month and a beneficiary is over age 18 on the 30th but was disenrolled from the demonstration on the 27th, that month would not count toward the denominator. However, if a state counts enrollment as of the 15th, that month would count toward the denominator.
  - For each hospital admission representing a qualifying numerator event, assess the beneficiary's age on the date of admission. Only admissions for beneficiaries age 40 or older should be included in the numerator.
- This measure is designed to exclude transfers from other institutions from the numerator. However, the variables contained in the software to identify transfers, shown in Table PQI05-C, may not exist in all data sources. If that is the case, states should describe how transfers are identified and excluded in their calculations.
- Free software is available from the AHRQ Web site for calculation of this measure at http://www.qualityindicators.ahrq.gov/Software/Default.aspx. Use of the AHRQ software is optional for calculating the PQI measures.
- Include paid claims only.

The following coding systems are used in this measure: ICD-10-CM and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Beneficiary months	All beneficiary months for beneficiaries age 40 and older as of the 15th or the 30th day of the month and who are enrolled in the demonstration that month. Date for counting beneficiary months must be consistent across the reporting period.
Continuous enrollment	None.
Allowable gap	None.
Anchor date	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

Total number of months of demonstration enrollment for beneficiaries enrolled in the demonstration age 40 and older during the measurement period.

Numerator

All inpatient hospital admissions with an ICD-10-CM principal diagnosis code for:

- COPD (Table PQI05-A), available at https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2019-adult-non-hedis-value-set-directory.zip or
- Asthma (Table PQI05-B), available at https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2019-adult-non-hedis-value-set-directory.zip

Exclusions

- Transfer from a hospital (different facility), a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), or another health care facility (see Table PQI05-C below for admission codes for transfers)
- Admissions with missing age (AGE = missing), year (YEAR = missing), or principal diagnosis (DX1 = missing)
- Obstetric admissions (Note: By definition, admissions with a principal diagnosis of COPD, asthma, or acute bronchitis are precluded from assignment of MDC 14 by grouper software. Thus, obstetric admissions should not be considered in the PQI rate.)
- ICD-10-CM diagnosis codes for cystic fibrosis and anomalies of the respiratory system (Table PQI05-D, available at https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2019-adult-non-hedis-value-set-directory.zip)

Table PQI05-C. Admission Codes for Transfers

SID ASOURCE Codes	2 – Another hospital
	3 – Another facility, including long-term care
Point of Origin UB-04 Codes	4 – Transfer from a hospital
	5 – Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
	6 – Transfer from another health care facility

Metric AD_43: PQI 08: Heart Failure Admission Rate (PQI08-AD)

Measure Steward: Agency for Healthcare Research and Quality

A. DESCRIPTION

Number of inpatient hospital admissions for heart failure per 100,000 beneficiary months for beneficiaries enrolled in the demonstration age 18 and older.

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

Guidance for Reporting:

- States should report this measure as a rate per 100,000 beneficiary months as opposed to per 100,000 beneficiaries enrolled in the demonstration.
- A two-step process should be used to determine whether beneficiaries should be counted in this measure:
  - For each beneficiary month considered for the denominator, assess the beneficiary's age at either the 15th or 30th of the month (or the 28th of the month in February). If the beneficiary was age 18 or older by that date, the beneficiary month should be counted in the denominator. A consistent date should be used to assess age across all months. For example, if a state counts enrollment as of the 30th of the month and a beneficiary is over age 18 on the 30th but was disenrolled from the demonstration on the 27th, that month would not count toward the denominator. However, if a state counts enrollment as of the 15th, that month would count toward the denominator.
  - For each hospital admission representing a qualifying numerator event, assess the beneficiary's age on the date of admission. Only admissions for beneficiaries age 18 or older should be included in the numerator.
- This measure is designed to exclude transfers from other institutions from the numerator. However, the variables contained in the software to identify transfers, shown in Table PQI08-B, may not exist in all data sources. If that is the case, states should describe how transfers are identified and excluded in their calculations.
- Free software is available from the AHRQ Web site for calculation of this measure at http://www.qualityindicators.ahrq.gov/Software/Default.aspx. Use of the AHRQ software is optional for calculating the PQI measures.
- Include paid claims only.

The following coding systems are used in this measure: ICD-10-CM, ICD-10-PCS, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Beneficiary months	All beneficiary months for beneficiaries age 18 and older as of the 15th or the 30th day of the month and who are enrolled in the demonstration that month. Date for counting beneficiary months must be consistent across the reporting period.
Continuous enrollment	None.
Allowable gap	None.
Anchor date	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

Total number of months of demonstration enrollment for beneficiaries enrolled in the demonstration age 18 and older during the measurement period.

Numerator

All inpatient hospital admissions with ICD-10-CM principal diagnosis code for heart failure (Table PQI08-A, available at https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2019-adult-non-hedis-value-set-directory.zip).

Exclusions

- Transfer from a hospital (different facility), a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), or another health care facility (see Table PQI08-B below for admission codes for transfers)
- Admissions with missing age (AGE = missing), year (YEAR = missing), or principal diagnosis (DX1 = missing)
- Obstetric admissions (Note: By definition, admissions with a principal diagnosis of heart failure are precluded from assignment of MDC 14 by grouper software. Thus, obstetric admissions should not be considered in the PQI rate.)
- With any listed ICD-10-PCS procedure codes for cardiac procedure (Table PQI08-C, available at https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2019-adult-non-hedis-value-set-directory.zip)

Table PQI08-B. Admission Codes for Transfers

SID ASOURCE Codes	2 – Another hospital
	3 – Another facility, including long-term care
Point of Origin UB-04 Codes	4 – Transfer from a hospital
	5 – Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
	6 – Transfer from another health care facility

http://www.qualityindicators.ahrq.gov/Modules/pqi_resources.aspx

Metric AD_44: PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)

Measure Steward: Agency for Healthcare Research and Quality

A. DESCRIPTION

Number of inpatient hospital admissions for asthma per 100,000 beneficiary months for beneficiaries enrolled in the demonstration ages 18 to 39.

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

Guidance for Reporting:

- States should report this measure as a rate per 100,000 beneficiary months as opposed to per 100,000 beneficiaries enrolled in the demonstration.
- A two-step process should be used to determine whether beneficiaries should be counted in this measure:
  - For each beneficiary month considered for the denominator, assess the beneficiary's age at either the 15th or 30th of the month (or the 28th of the month in February). If the beneficiary was ages 18 to 39 on that date, the beneficiary month should be counted in the denominator. A consistent date should be used to assess age across all months. For example, if a state counts enrollment as of the 30th of the month and a beneficiary is over age 18 on the 30th but was disenrolled from the demonstration on the 27th, that month would not count toward the denominator. However, if a state counts enrollment as of the 15th, that month would count toward the denominator.
  - For each hospital admission representing a qualifying numerator event, assess the beneficiary's age on the date of admission. Only admissions for beneficiaries ages 18 to 39 should be included in the numerator.
- This measure is designed to exclude transfers from other institutions from the numerator. However, the variables contained in the software to identify transfers, shown in Table PQI15-B, may not exist in all data sources. If that is the case, states should describe how transfers are identified and excluded in their calculations.
- Free software is available from the AHRQ Web site for calculation of this measure at http://www.qualityindicators.ahrq.gov/Software/Default.aspx. Use of the AHRQ software is optional for calculating the PQI measures.
- Include paid claims only.

The following coding systems are used in this measure: ICD-10-CM and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Beneficiary months	All beneficiary months for beneficiaries ages 18 to 39 as of the 15th or the 30th day of the month and who are enrolled in the demonstration that month. Date for counting beneficiary months must be consistent across the reporting period.
Continuous enrollment	None.
Allowable gap	None.
Anchor date	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

Total number of months of demonstration enrollment for beneficiaries enrolled in the demonstration ages 18 to 39 during the measurement period.

Numerator

All inpatient hospital admissions for beneficiaries ages 18 to 39 with an ICD-10-CM principal diagnosis code of asthma (Table PQI15-A, available at https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2019-adult-non-hedis-value-set-directory.zip).

Exclusions

- Transfer from a hospital (different facility), a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), or another health care facility (see Table PQI15-B below for admission codes for transfers)
- Admissions with missing age (AGE = missing), year (YEAR = missing), or principal diagnosis (DX1 = missing)
- Obstetric admissions (Note: By definition, admissions with a principal diagnosis of asthma are precluded from assignment of MDC 14 by grouper software. Thus, obstetric admissions should not be considered in the PQI rate.)
- With any listed ICD-10-CM diagnosis code for cystic fibrosis and anomalies of the respiratory system (Table PQI15-C, available at https://www.medicaid.gov/license-agreement.html?file=%2Fmedicaid%2Fquality-of-care%2Fdownloads%2F2019-adult-non-hedis-value-set-directory.zip)

Table PQI15-B. Admission Codes for Transfers

SID ASOURCE Codes	2 – Another hospital
	3 – Another facility, including long-term care
Point of Origin UB-04 Codes	4 – Transfer from a hospital
	5 – Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
	6 – Transfer from another health care facility

http://www.qualityindicators.ahrq.gov/Modules/pqi_resources.aspx

APPENDIX C

VALUE SETS REFERENCED IN METRIC SPECIFICATIONS

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Table C.1. HEDIS value sets referenced in metric specifications

Value Set Name	Relevant Metrics
Ambulatory Visits	AD_33: Preventive care and office visit utilization
ED	AD_35: Emergency department utilization AD_36: Emergency department utilization, non-emergency
ED Procedure Code	AD_35: Emergency department utilization AD_36: Emergency department utilization, non-emergency
ED POS	AD_35: Emergency department utilization AD_36: Emergency department utilization, non-emergency
Inpatient Stay	AD_36: Emergency department utilization, non-emergency AD_37: Inpatient admissions
Other Ambulatory Visits	AD_33: Preventive care and office visit utilization
Well-Care	AD_33: Preventive care and office visit utilization

Instructions for accessing the supporting value sets

- Step 1: Open "1115 EandC Monitoring Metrics HEDIS Value Set Directory v1.xls" (available upon request by contacting 1115MonitoringAndEvaluation@cms.hhs.gov).
- Step 2: Filter the "Value Sets to Codes" tab to select value set names (column A) identified in metric specification
- Step 3: Include listed codes (column D) when calculating metric

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APPENDIX D

REFERENCE LIST OF RELATIONSHIPS AMONG METRICS

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Table D.1. Reference list of relationships among metrics for any demonstration with premiums, premium assistance, health behaviors, community engagement requirements, or retroactive eligibility waivers

Metric Number	Metric name	Relationship to other metrics
Enrollment		
AD_1	Total enrollment in the demonstration	Not applicable
AD_2	Beneficiaries in suspension status for noncompliance	Beneficiaries in this metric are not included in AD_1
AD_3	Beneficiaries in a non-eligibility period who are prevented from re-enrolling for a defined period of time	Not applicable
AD_4	New enrollees	Not applicable
AD_5	Re-enrollments or re-instatements using defined pathways after disenrollment or suspension of benefits for noncompliance with demonstration policies	Not applicable
AD_6	Re-enrollments or re-instatements for beneficiaries not using defined pathways after disenrollment or suspension of benefits for noncompliance	Not applicable
Mid-year loss of demonstration eligibility		
AD_7	Beneficiaries determined ineligible for Medicaid, any reason, other than at renewal	Metric AD_7 is the sum of metrics AD_12, AD_13, and AD_14
AD_8	Beneficiaries no longer eligible for Medicaid, failure to provide timely change in circumstance information	This metric is a subset of Metric AD_7
AD_9	Beneficiaries determined ineligible for Medicaid after state processes a change in circumstance reported by a beneficiary	This metric is a subset of Metric AD_7
AD_10	Beneficiaries no longer eligible for the demonstration due to transfer to another Medicaid eligibility group	Not applicable
AD_11	Beneficiaries no longer eligible for the demonstration due to transfer to CHIP	This metric is a subset of Metric AD_7
Cumulative metrics: Enrollment duration at time of disenrollment		
AD_12	Enrollment duration 0-3 months	This metric is a subset of Metric AD_7
AD_13	Enrollment duration 4-6 months	This metric is a subset of Metric AD_7
AD_14	Enrollment duration 6-12 months	This metric is a subset of Metric AD_7
Renewal		
AD_15	Beneficiaries due for renewal	This metric is equal to the sum of metrics AD_16, AD_17, AD_18, AD_19, AD_20, AD_21, and AD_22
AD _16	Beneficiaries determined ineligible for the demonstration at renewal, disenrolled from Medicaid	This metric is a subset of metric AD_15
AD_17	Beneficiaries determined ineligible for the demonstration at renewal, transfer to another Medicaid eligibility category	This metric is a subset of metric AD_15
AD_18	Beneficiaries determined ineligible for the demonstration at renewal, transferred to CHIP	This metric is a subset of metric AD_15
AD_19	Beneficiaries who did not complete renewal, disenrolled from Medicaid	This metric is a subset of metric AD_15
AD_20	Beneficiaries who had pending/ uncompleted renewals and were still enrolled	This metric is a subset of metric AD_15

Table D.1 (continued)

Metric Number	Metric name	Relationship to other metrics
AD_21	Beneficiaries who retained eligibility for the demonstration after completing renewal forms	This metric is a subset of metric AD_15
AD_22	Beneficiaries who renewed ex parte	This metric is a subset of metric AD_15
Cost sharing limit		
AD_23	Beneficiaries who reached 5% limit	Not applicable
Appeals and grievances		
AD_24	Appeals, eligibility	Not applicable
AD_25	Appeals, denial of benefits	Not applicable
AD_26	Grievances, care quality	Not applicable
AD_27	Grievances, provider or managed care organization (MCO)	Not applicable
AD_28	Grievances, other	Not applicable
Access to care		
AD_29	Primary care provider availability	Not applicable
AD_30	Primary care provider active participation	Not applicable
AD_31	Specialist provider availability	Not applicable
AD_32	Specialist provider active participation	Not applicable
AD_33	Preventive care and office visit utilization	Not applicable
AD_34	Prescription drug use	Not applicable
AD_35	Emergency department utilization, total	Not applicable
AD_36	Emergency department utilization, non-emergency	Not applicable
AD_37	Inpatient admissions	Not applicable
Quality of care and health outcomes		
AD_38A	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)	Not applicable
AD_38B	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Not applicable
AD_39-1	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA -AD)	Not applicable
AD_39-2	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)	Not applicable
AD_40	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)	Not applicable
AD_41	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)	Not applicable
AD_42	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)	Not applicable
AD_43	PQI 08: Heart Failure Admission Rate (PQI08-AD)	Not applicable
AD_44	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)	Not applicable
Administrative cost		
AD_45	Administrative cost of demonstration operation	Not applicable

Table D.2. Reference list of relationships among metrics for demonstrations that require premiums or account payments

Metric	Metric name	Relationship to other metrics
Enrollment by premium payment status		
PR_1	Beneficiaries subject to premium policy (or account contribution) during the month, not exempt	This metric is equal to the sum of metrics PR_3, PR_4, PR_5, and PR_6
PR_2	Beneficiaries who were exempt from premiums for that month	Not applicable
PR_3	Beneficiaries who paid a premium during the month	This metric is a subset of metric PR_1
PR_4	Beneficiaries who were subject to premium policy but declare hardship for that month	This metric is a subset of metric PR_1
PR_5	Beneficiaries in short-term arrears (grace period)	This metric is a subset of metric PR_1
PR_6	Beneficiaries in long-term arrears	This metric is a subset of metric PR_1
PR_7	Beneficiaries with collectible debt	This metric is a subset of metric PR_1. This metric could include beneficiaries who are counted in metrics PR_2, PR_3, PR_4, PR_5, or PR_6, depending on state debt and enrollment policies.
Cumulative enrollment duration in states with time-variant premium policies		
PR_8	Beneficiaries in enrollment duration tier 1	Not applicable
PR_9	Beneficiaries in enrollment duration tier 2	Not applicable
PR_10	Beneficiaries in enrollment duration tiers 3+	Not applicable
Mid-year change in circumstance by premium amount		
PR_11	Beneficiaries for whom the state processed a mid-year change in circumstance in household or income information and who remained enrolled in the demonstration	This metric is equal to the sum of metrics PR_12, PR_13, and PR_14.
PR_12	No premium change following mid-year processing of a change in household or income information	This metric is a subset of metric PR_11.
PR_13	Premium increase following mid-year processing of change in household or income information	This metric is a subset of metric PR_11.
PR_14	Premium decrease following mid-year processing of change in household or income information	This metric is a subset of metric PR_11.
Disenrollment or suspension for failure to pay		
PR_15	Beneficiaries disenrolled from the demonstration for failure to pay and therefore disenrolled from Medicaid	This metric is a subset of metric AD_7, relevant only for demonstrations with monthly payment requirements.
PR_16	Beneficiaries in a non-eligibility period who were disenrolled for failure to pay and are prevented from re-enrolling for a defined period of time	Not applicable
PR_17	Beneficiaries whose benefits are suspended for failure to pay	This metric is a subset of metric AD_2
Renewal		
PR_18	No premium change	The sum of metrics PR_18, PR_19, and PR_20 should equal the sum of metrics AD_21 and AD_22 among beneficiaries required to pay premiums
PR_19	Premium increase	The sum of metrics PR_18, PR_19, and PR_20 should equal the sum of metrics AD_21 and AD_22 among beneficiaries required to pay premiums
PR_20	Premium decrease	The sum of metrics PR_18, PR_19, and PR_20 should equal the sum of metrics AD_21 and AD_22 among beneficiaries required to pay premiums
Third party premium payment		
PR_21	Third-party premium payment	Not applicable

Table D.3. Reference list of relationships among metrics for demonstrations with Marketplace-focused premium assistance programs

Metric	Metric name	Relationship to other metrics
Enrollment by premium payment status		
PA_1	Beneficiaries who lost Medicaid eligibility due to mid-year change in circumstance, and transitioned to a qualified health plan offered in the Marketplace	This metric is a subset of metric AD_9
PA_2	Beneficiaries who lost Medicaid eligibility at renewal, and transitioned to a qualified health plan offered in the Marketplace	This metric is a subset of metric AD_16
Access to care		
PA_3	Wraparound service utilization, by service	Not applicable

Table D.4. Reference list of relationships among metrics for demonstrations with health behavior incentives

Metric	Metric name	Relationship to other metrics
Enrollment		
HB_1	Total enrollment among beneficiaries subject to health behavior incentives	This metric serves as a denominator to pair with metrics HB_2, HB_3, and HB_4 to create rates
Use of incentivized services: claims-based analysis		
HB_2	Beneficiaries using incentivized services that can be documented through claims, by service	Not applicable
Other incentivized behaviors not documented through claims-based analysis		
HB_3	Completion of incentivized health behavior(s) not documented through claims analysis (i.e. health risk assessments), by health behavior	Not applicable
HB_4	Completion of all incentivized health behaviors (both claims-based and other), if there are multiple	Not applicable
Rewards granted for completion of incentivized health behaviors		
HB_5	Beneficiaries granted a premium reduction for completion of incentivized health behaviors	This metric can be compared to numbers in metrics HB_2, HB_3, and/or HB_4, to understand whether behavior completions are resulting in accrual of rewards, depending on state policy
HB_6	Beneficiaries granted a financial reward other than a premium reduction for completion of incentivized health behaviors	This metric can be compared to numbers in metrics HB_2, HB_3, and/or HB_4 to understand whether behavior completions are resulting in accrual of rewards, depending on state policy
HB_7	Beneficiaries granted a reward in the form of additional covered benefits for completion of incentivized health behaviors	This metric can be compared to numbers in metrics HB_2, HB_3, and/or HB_4, to understand whether behavior completions are resulting in accrual of rewards, depending on state policy

Table D.5. Reference list of relationships among metrics relevant for demonstrations with community engagement requirements

Metric	Metric name	Relationship to other metrics
Community engagement enrollment counts		
CE_1	Total beneficiaries subject to the community engagement requirement, not exempt	Metrics CE_1, CE_2, and CE_3 should sum to the total number of enrolled beneficiaries in income and eligibility groups subject to community engagement requirements
CE_2	Total beneficiaries who were exempt from community engagement requirements in the month	Metrics CE_1, CE_2, and CE_3 should sum to the total number of enrolled beneficiaries in income and eligibility groups subject to community engagement requirements
CE_3	Beneficiaries with approved good cause circumstances	Metrics CE_1, CE_2, and CE_3 should sum to the total number of enrolled beneficiaries in income and eligibility groups subject to community engagement requirements
CE_4	Beneficiaries subject to community engagement requirement and in suspension status due to failure to meet requirement	This metric is a subset of metric AD_2
CE_5	Beneficiaries subject to the community engagement requirement and receiving benefits who met the requirement for qualifying activities	This metric is a subset of metric CE_1
CE_6	Beneficiaries subject to the community engagement requirement and receiving benefits but in a grace period or allowable month of noncompliance	This metric is a subset of metric CE_1
CE_7	Beneficiaries who successfully completed make-up hours or other activities to retain active benefit status after failing to meet community engagement requirements in a previous month	This metric is a subset of metric CE_1 for states with an "opportunity to cure" policy
CE_8	Beneficiaries in a non-eligibility period who were disenrolled for noncompliance with community engagement requirement and are prevented from re-enrolling for a defined period of time	Not applicable
Community engagement requirement qualifying activities		
CE_9	Beneficiaries who met the community engagement requirement by satisfying requirements of other programs	This metric is a subset of metric CE_5
CE_10	Beneficiaries who met the community engagement requirement through employment for the majority of their required hours	This metric is a subset of metric CE_5
CE_11	Beneficiaries who met the community engagement requirement through job training or job search for the majority of their required hours	This metric is a subset of metric CE_5
CE_12	Beneficiaries who met the community engagement requirement through educational activity for the majority of their required hours	This metric is a subset of metric CE_5
CE_13	Beneficiaries who met the community engagement requirement who were engaged in other qualifying activity for the majority of their required hours	This metric is a subset of metric CE_5
CE_14	Beneficiaries who met the community engagement requirement by combining two or more activities	This metric is a subset of metric CE_5
Basis of beneficiary exemptions from community engagement requirement		
CE_15	Beneficiaries exempt from Medicaid community engagement requirements because they were exempt from requirements of SNAP and/or TANF	This metric is a subset of metric CE_2
CE_16	Beneficiaries exempt from Medicaid community engagement requirements on the basis of pregnancy	This metric is a subset of metric CE_2

Table D.5 (continued)

Metric	Metric name	Relationship to other metrics
CE_17	Beneficiaries exempt from community engagement requirements due to former foster youth status	This metric is a subset of metric CE_2
CE_18	Beneficiaries exempt from Medicaid community engagement requirements due to medical frailty	This metric is a subset of metric CE_2
CE_19	Beneficiaries exempt from Medicaid community engagement requirements on the basis of caretaker status	This metric is a subset of metric CE_2
CE_20	Beneficiaries exempt from Medicaid community engagement requirements due to unemployment insurance compensation	This metric is a subset of metric CE_2
CE_21	Beneficiaries exempt from Medicaid community engagement requirements due to substance abuse treatment status	This metric is a subset of metric CE_2
CE_22	Beneficiaries exempt from Medicaid community engagement requirements due to student status	This metric is a subset of metric CE_2
CE_23	Beneficiaries exempt from community engagement requirements because they were excused by a medical professional	This metric is a subset of metric CE_2
CE_24	Beneficiaries exempt from Medicaid community engagement requirements, other	This metric is a subset of metric CE_2
Supports and assistance		
CE_25	Beneficiaries receiving supports to participate and placement assistance	This metric includes individuals counted in metrics CE_26 through CE_30. Beneficiaries may be counted more in more than one of metrics CE_26 through CE_30, but should only be counted once in metric CE_25, regardless of the number of different types of supports received.
CE_26	Beneficiaries provided with transportation assistance	This metric is a subset of metric CE_25
CE_27	Beneficiaries provided with childcare assistance	This metric is a subset of metric CE_25
CE_28	Beneficiaries provided with language supports	This metric is a subset of metric CE_25
CE_29	Beneficiaries assisted with placement in community engagement activities	This metric is a subset of metric CE_25
CE_30	Beneficiaries provided with other non-Medicaid assistance	This metric is a subset of metric CE_25
Reasonable modifications for beneficiaries with disabilities		
CE_31	Beneficiaries who requested reasonable modifications to community engagement processes or requirements due to disability	Not applicable
CE_32	Beneficiaries granted reasonable modifications to community engagement processes or requirements due to disability	Not applicable
New suspensions and disenrollments during the measurement period		
CE_33	Beneficiaries newly suspended for failure to complete community engagement requirements	This metric is a subset of metric CE_4
CE_34	Beneficiaries newly disenrolled for noncompliance with community engagement requirement	Not applicable
Reinstatement of benefits after suspension		
CE_35	Total beneficiaries whose benefits were reinstated after being in suspended status for noncompliance	This metric is equal to the sum of metrics CE_36, CE_37, CE_38, CE_39, and CE_40
CE_36	Beneficiaries whose benefits were reinstated because their time-limited suspension period ended	This metric is a subset of metric CE_35
CE_37	Beneficiaries whose benefits were reinstated because they completed required community engagement activities	This metric is a subset of metric CE_35

Table D.5 (continued)

Metric	Metric name	Relationship to other metrics
CE_38	Beneficiaries whose benefits were reinstated because they completed “on-ramp” activities other than qualifying community engagement activities	This metric is a subset of metric CE_35
CE_39	Beneficiaries whose benefits were reinstated because they newly meet community engagement exemption criteria or had a good cause circumstance	This metric is a subset of metric CE_35
CE_40	Beneficiaries whose benefits were reinstated after successful appeal of suspension for noncompliance	This metric is a subset of metric CE_35
Re-entry after disenrollment		
CE_41	Total beneficiaries re-enrolling after disenrollment for noncompliance	This metric is equal to the sum of metrics CE_42, CE_43, CE_44, CE_45, and CE_46
CE_42	Beneficiaries re-enrolling after completing required community engagement activities	This metric is a subset of metric CE_41
CE_43	Beneficiaries re-enrolling after completing “on-ramp” activities other than qualifying community engagement activities	This metric is a subset of metric CE_41
CE_44	Beneficiaries re-enrolling after re-applying, subsequent to being disenrolled for noncompliance with community engagement requirements	This metric is a subset of metric CE_41
CE_45	Beneficiaries re-enrolling because they newly met community engagement exemption criteria or had a good cause circumstance	This metric is a subset of metric CE_41
CE_46	Beneficiaries re-enrolling after successful appeal of disenrollment for noncompliance	This metric is a subset of metric CE_41

Table D.6. Reference list of relationships among metrics relevant for demonstrations with retroactive eligibility waivers

Metric	Metric name	Relationship to other metrics
At application		
RW_1	Beneficiaries who indicated that they had unpaid medical bills at the time of application	Not applicable
At renewal		
RW_2	Beneficiaries who had a coverage gap at renewal	Not applicable
RW_3	Beneficiaries who had a coverage gap at renewal and had claims denied	This metric is a subset of metric RW_2

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