STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

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GOVERNOR

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September 20, 2016

Jennifer Kostesich, Project Officer
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Dear Ms. Kostesich,

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

Enclosed is the quarterly report for Healthy Michigan Plan. It covers the third quarter of federal fiscal year 2016. The report provides operational information, program enrollment, and policy changes related to the waiver as specified in the Special Terms and Conditions.

Should you have any questions related to the information contained in this report, please contact Jacqueline Coleman. She may be reached by phone at (517) 241-7172, or by e-mail at colemanj@michigan.gov.

Sincerely,

Penny Rutledge, Director
Actuarial Division

cc: Ruth Hughes
Angela Garner

Enclosure (3)

Michigan Adult Coverage Demonstration
Section 1115 Quarterly Report

Demonstration Year: 7 (01/01/2016 – 12/31/2016)
Federal Fiscal Quarter: 3 (04/01/2016 – 06/30/2016)

Approval Period: December 30, 2013 through December 31, 2018

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Introduction

On April 1, 2014, Michigan expanded its Medicaid program to include adults with income up to 133 percent of the Federal Poverty Level (FPL). To accompany this expansion, the Michigan Adult Benefits Waiver (ABW) was amended and transformed to establish the Healthy Michigan Plan, through which the Michigan Department of Health & Human Services (MDHHS) will test innovative approaches to beneficiary cost sharing and financial responsibility for health care for the new adult eligibility group. Healthy Michigan Plan provides a full health care benefit package as required under the Affordable Care Act including all of the Essential Health Benefits as required by federal law and regulation. There will not be any limits on the number of individuals who can enroll. Beneficiaries who received coverage under the ABW program transitioned to the Healthy Michigan Plan on April 1, 2014.

The new adult population with incomes above 100 percent of the FPL are required to make contributions toward the cost of their health care. In addition, all newly eligible adults from 0 to 133 percent of the FPL are subject to copayments consistent with federal regulations. In October 2014, the MI Health Account was established for individuals enrolled in managed care plans to track beneficiaries' cost-sharing and service utilization. Beneficiaries have opportunities to reduce their cost-sharing amounts by agreeing to address or maintain certain healthy behaviors.

State law requires MDHHS to partner with the Michigan Department of Treasury to garnish state tax returns and lottery winnings for members consistently failing to meet payment obligations associated with the Healthy Michigan Plan. Prior to the initiation of the garnishment process, members are notified in writing of payment obligations and rights to a review. Debts associated with the MI Health Account are not reported to credit reporting agencies. Members non-compliant with cost-sharing requirements do not face loss of eligibility, denial of enrollment in a health plan, or denial of services. In July 2015, MDHHS initiated the MI Health Account garnishment process as described in the Special Terms and Conditions of this demonstration.

On December 17, 2015, CMS approved the state's September 1, 2015 request to amend the Healthy Michigan Section 1115 Demonstration. The state sought approval of this amendment to implement requirements of state law (MCL 400.105d(20)). With this approval, non-medically frail individuals above 100 percent of the FPL with 48 cumulative months of Healthy Michigan Plan coverage will have the choice of one of two coverage options:

1. Select a Qualified Health Plan offered on the Federal Marketplace. These individuals will pay premiums but can enroll in the Healthy Michigan Plan when a healthy behavior requirement is met; or

2. Remain in the Healthy Michigan Plan with increased cost-sharing and contribution obligations. These individuals are also required to meet a healthy behavior requirement.

Approval of the waiver request has allowed Michigan to continue coverage for approximately 600,000 members.

To reflect its expanded purpose, the name of the demonstration was changed to Healthy Michigan Plan. The overarching themes used in the benefit design will be:

- Increasing access to quality health care;

- Encouraging the utilization of high-value services; and

- Promoting beneficiary adoption of healthy behaviors and using evidence-based practice initiatives.

Organized service delivery systems will be utilized to improve coherence and overall program efficiency.

MDHHS's goals in amending the demonstration are to:

- Improve access to healthcare for uninsured or underinsured low-income Michigan citizens;
- Improve the quality of healthcare services delivered;
- Reduce uncompensated care;
- Encourage individuals to seek preventive care and encourage the adoption of healthy behaviors;
- Help uninsured or underinsured individuals manage their health care issues;
- Encourage quality, continuity, and appropriate medical care; and
- Study the effects of a demonstration model that infuses market-driven principles into a public healthcare insurance program by examining:
    - The extent to which the increased availability of health insurance reduces the costs of uncompensated care borne by hospitals;
    - The extent to which availability of affordable health insurance results in a reduction in the number of uninsured/underinsured individuals who reside in Michigan;
    - Whether the availability of affordable health insurance, which provides coverage for preventive and health and wellness activities, will increase healthy behaviors and improve health outcomes; and
    - The extent to which beneficiaries feel that the Healthy Michigan Plan has a positive impact on personal health outcomes and financial well-being.

Enrollment and Benefits Information

MDHHS began enrolling new beneficiaries into the program beginning April 1, 2014. Beneficiaries who were enrolled in the ABW were automatically transitioned into the Healthy Michigan Plan effective April 1, 2014. Potential enrollees can apply for the program via the MDHHS website, by calling a toll-free number or by visiting their local MDHHS office. At this time, MDHHS does not anticipate any changes in the population served or the benefits offered.

The following tables display new enrollments and disenrollments by month:

Table 1: Healthy Michigan Plan New Enrollments by Month			
April 2016	May 2016	June 2016	Total
31,410	30,394	30,469	92,273

Table 2: Healthy Michigan Plan Disenrollments by Month			
April 2016	May 2016	June 2016	Total
39,020	35,523	33,042	107,585

Most Healthy Michigan Plan beneficiaries elect to choose a health plan as opposed to automatic assignment to a health plan. As of July 21, 2016, 349,893 or, 72 percent, of the State's 484,937 Healthy Michigan Plan health plan enrollees selected a health plan. The remaining managed care enrolled beneficiaries were automatically assigned to a health plan. All Medicaid Health Plan members have an opportunity to change their plan within 90 days of enrollment into the plan. During this quarter, 6,748 of all Healthy Michigan Plan health plan enrollees changed health plans. This quarter, 3,309 or approximately 49 percent, of beneficiaries that changed plans were previously automatically assigned to a health plan. The remaining beneficiaries were those that changed plans after selecting a health plan.

Healthy Michigan Plan members have the opportunity to reduce cost-sharing requirements through the completion of Health Risk Assessments and engaging in healthy behaviors. MDHHS has developed a standard Health Risk Assessment form to be completed annually. Health Risk Assessment forms and reports are located on the MDHHS website. The Health Risk Assessment document is intended to be completed in two parts. The member typically completes the first sections of the form with the assistance of the Healthy Michigan Plan enrollment broker. Members that are automatically assigned to a health plan are not surveyed. The remainder of the form is completed at the member's initial primary care visit.

The initial assessment questions section of the Health Risk Assessments completed through the MDHHS enrollment broker had a completion rate of 95 percent this quarter. MDHHS is encouraged by the high level of participation by beneficiaries at the initial point of contact. The following table details the Health Risk Assessment data collected by the enrollment broker for the quarter:

Table 3: Health Risk Assessment Enrollment Broker Data					
Month	Number of Completed HRAs	Percent of Total	Number of Refused HRAs	Percent of Total	Total Enrollment Calls
April 2016	3,723	94%	237	6%	3,960
May 2016	2,756	95%	144	5%	2,900
June 2016	2,467	95%	125	5%	2,592
Total	8,946	95%	506	5%	9,452

Completion of the remaining Health Risk Assessment sections (beyond those completed through the State's enrollment broker) requires beneficiaries to schedule an annual appointment, select a Healthy Behavior, and have member results completed by their primary care provider. The primary care provider securely sends the completed Health Risk Assessment to the appropriate Medicaid Health Plan.

Healthy Michigan Plan members that successfully complete the Health Risk Assessment process and agree to address or maintain healthy behaviors may qualify for reduction in copayments and/or contributions and gift cards. The following opportunities are available to Healthy Michigan Plan beneficiaries:

- Reduction in copayments: A 50 percent reduction in copayments is available to members that have agreed to address or maintain healthy behaviors and have paid 2 percent of their income in copayments.

- Reduction in contributions: A 50 percent reduction in contributions can be earned by members that have agreed to address or maintain healthy behaviors and have completed a Health Risk Assessment with a Primary Care Practitioner attestation.

- Gift card incentives: A $50.00 gift card is available to beneficiaries at or below 100 percent FPL that have agreed to address or maintain healthy behaviors and have completed a Health Risk Assessment with a Primary Care Practitioner attestation.

This quarter, 9,480 Health Risk Assessments for Healthy Michigan Plan beneficiaries participating in the healthy behaviors incentive program were recorded by Medicaid Health Plans. Of these, health plans have reported that 7,612 of the earned incentives are gift card incentives. Additionally, 1,844 reductions in future contribution requirements have been earned. In this quarter, 2,333 reductions were applied. The remaining contribution reductions earned will be applied when those beneficiaries receive their first quarterly statement. The details of Health Risk Assessment completion can be found in the enclosed June 2016 Health Risk Assessment Report.

The following table details Health Risk Assessment data collected by the Medicaid Health Plans for the quarter:

Table 4: Health Risk Assessment Health Plan Data

	April 2016	May 2016	June 2016	Total
Health Risk Assessments Submitted	2,649	4,211	2,620	9,480
Gift Cards Earned	2,106	3,399	2,107	7,612
Reductions Earned	533	801	510	1,844
Reductions Applied	774	759	800	2,333

Enrollment Counts for Quarter and Year to Date

Enrollment counts below are for unique members for identified time periods. The unique enrollee count will differ from the June 2016 count from the Beneficiary Month Reporting section as a result of disenrollment that occurred during the quarter. Disenrollment can occur for a variety of reasons including change in eligibility status, such as an increase in income, or as part of a redetermination cycle, for example.

In addition to substantial Healthy Michigan Plan enrollment, MDHHS saw a significant number of disenrollments from the plan as reported in the Monthly Enrollment Reports to CMS. Healthy Michigan disenrollment reflects individuals who were disenrolled during a redetermination of eligibility or switched coverage due to eligibility for other Medicaid program benefits. In most cases beneficiaries disenrolled from the Healthy Michigan Plan due to eligibility for other Medicaid programs. This disenrollment can be a result of MDHHS's validation of self-attested information from the beneficiary. After a beneficiary is approved for Healthy Michigan Plan coverage, MDHHS performs authentication processes to determine the beneficiary is in fact eligible as attested in the application for benefits. MDHHS matches beneficiary information provided with that available through State and Federal databases. Movement between Medicaid

programs is not uncommon and MDHHS expects that beneficiaries will continue to shift between Healthy Michigan and other Medicaid programs as their eligibility changes.

Table 5: Enrollment Counts for Quarter and Year to Date			
Demonstration Population	Total Number of Demonstration Beneficiaries Quarter Ending – 06/2016	Current Enrollees (year to date)	Disenrolled in Current Quarter
ABW Childless Adults	N/A	N/A	N/A
Healthy Michigan Adults	697,490	794,641	108,021

Outreach/Innovation Activities to Assure Access

MDHHS utilizes the Healthy Michigan Program website to provider information to both beneficiaries and providers. The Healthy Michigan Plan website provides the public with information on eligibility, how to apply, services covered, cost sharing requirements, frequently asked questions, Health Risk Assessment completion, and provider information. The site also provides a link for members to make MI Health Account payments. MDHHS also has a mailbox, healthymichiganplan@michigan.gov, for questions or comments about the Healthy Michigan Plan.

MDHHS has worked closely with provider groups through meetings, Medicaid provider policy bulletins, and various interactions with community partners and provider trade associations. MDHHS continues to provide progress reports to the Medical Care Advisory Council (MCAC) at regularly scheduled quarterly meetings. These meetings provide an opportunity for attendees to provide program comments or suggestions. The May 10, 2016 MCAC meeting occurred during the quarter covered by this report. The minutes for this meeting have been attached as an enclosure. MCAC meeting agendas and minutes are also available on the MDHHS website.

Collection and Verification of Encounter Data and Enrollment Data

As a mature managed care state, all Medicaid Health Plans submit encounter data to MDHHS for the services provided to Healthy Michigan Plan beneficiaries following the existing MDHHS data submission requirements. MDHHS continues to utilize encounter data to prepare MI Health Account statements with a low volume of adjustments. MDHHS works closely with the plans in reviewing, monitoring and investigating encounter data anomalies. MDHHS and the Medicaid Health Plans work collaboratively to correct any issues discovered as part of the review process.

MDHHS staff effectively collaborate with the MI Health Account vendor to continue the garnishment process. As of August 4, 2016, MDHHS has successfully offset 2,067 individuals for a total of $201,452.80. A detailed breakdown is included in the following table:

Table 6: Healthy Michigan Plan Member Garnishments		
Garnishment Source	Individuals Garnished	Amount Garnished
Tax	2,063	$201,151.80
State Lottery	4	$301.00
Total	2,067	$201,452.80

Staff will continue to work with the MI Health Account vendor and the Michigan Department of Treasury to ensure data quality and accuracy.

Operational/Policy/Systems/Fiscal Developmental Issues

MDHHS regularly meets with the staff of Medicaid Health Plans to address operational issues, programmatic issues, and policy updates and clarifications. Updates and improvements to the Community Health Automated Medicaid Processing System (CHAMPS), the State's Medicaid Management Information System (MMIS) happen continually, and MDHHS strives to keep the health plans informed and functioning at the highest level. At these meetings, Medicaid policy bulletins and letters that impact the program are discussed, as are other operational issues. Additionally, these operational meetings include a segment of time dedicated to the oversight of the MI Health Account contactor. MDHHS and the health plans receive regular updates regarding MI Health Account activity and functionality.

The following policies with Healthy Michigan Plan impact were issued by the State during the quarter covered by this report:

Table 7: Medicaid Policy Bulletins with Healthy Michigan Plan Impact

Issue Date	Subject	Link
05/04/2016	Coverage of Targeted Case Management Services for Beneficiaries Who Were Served by the Flint Water System	MSA 16-10
05/19/2016	MI Care Team Implementation (Primary Care Health Home Benefit)	MSA 16-13
06/01/2016	Enrollment of Marriage and Family Therapists as Medicaid Providers	MSA 16-14
06/01/2016	New Form for Prior Authorization of Practitioner Services	MSA 16-15
06/01/2016	Ambulance Prior Authorization & Air Ambulance Enrollment Update	MSA 16-16
06/01/2016	Updates to the Medicaid Provider Manual; New Coverage of Existing Code; Clarification to Bulletin MSA 15-44	MSA 16-20

Financial/Budget Neutrality Development Issues

MDHHS did not experience budget neutrality issues this quarter. The completed budget neutrality table provided below reflects updates as expenditures are adjusted over time. For the purposes of completing the Healthy Michigan Plan Budget Neutrality Monitoring Table, MDHHS collects Healthy Michigan Plan expenditures from information included in the CMS 64.9VIII files submitted to CMS. Expenditures include those that both occurred and were paid in the same quarter in addition to adjustments to expenditures paid in quarters after the quarter of service. Expenditures for all eligible groups within the Healthy Michigan Plan were included. The State will continue to update data for each demonstration year as it becomes available.

Table 8: Healthy Michigan Plan Budget Neutrality Monitoring Table

	DY 5 - PMPM	DY 6 - PMPM	DY 7 - PMPM	DY 8 - PMPM	DY 9 - PMPM
Approved HMP PMPM	$667.36	$602.21	$569.80	$598.86	$629.40
Actual HMP PMPM (YTD)	$473.69	$463.04	$431.57	-	-
Total Expenditures (YTD)	$1,769,248,755.00	$3,364,828,796.00	$1,663,993,486.00	-	-
Total Member Months (YTD)	3,734,998	7,266,750	3,855,707	-	-

Beneficiary Month Reporting

The beneficiary counts below include information for each of the designated months during the quarter, and include retroactive eligibility through June 30, 2016.

Table 9: Healthy Michigan Plan Beneficiary Month Reporting				
Eligibility Group	April 2016	May 2016	June 2016	Total for Quarter Ending 06/16
Healthy Michigan Adults	639,569	633,807	630,775	1,904,151

Consumer Issues

This quarter, the total number of Healthy Michigan Plan complaints reported to MDHHS was 128. Issues obtaining prescriptions comprised 74 percent of total complaints received by MDHHS. This was largely due to other insurance showing on the beneficiary record. Beneficiaries experiencing issues obtaining transportation consisted of 6 percent of total complaints reported to MDHHS. Beneficiaries, especially in rural areas, can experience difficulty in utilizing transportation services due to a lack of drivers. This issue is one that preceded the implementation of the Healthy Michigan Plan. Complaints related to other covered services consisted of 19 percent of total complaints. Complaints on other issues comprised 1 percent of total complaints and included dental services. Overall, with over 1.9 million member months during the quarter, MDHHS is encouraged by its low rate of contacts related to Healthy Michigan Plan complaints. MDHHS will continue to monitor calls to the Beneficiary Helpline to identify problems or trends that need to be addressed.

Table 10: Healthy Michigan Plan Complaints Reported to MDHHS April 2016 – June 2016					
	Obtaining Prescriptions	Other Covered Services	Transportation	Dental	Total
Count	95	24	8	1	128
Percent	74%	19%	6%	1%	

Quality Assurance/Monitoring Activity

MDHHS completes Performance Monitoring Reports (PMR) for the Medicaid Health Plans that are licensed and approved to provide coverage to Michigan's Medicaid beneficiaries. These reports are based on data submitted by the health plans. Information specific to the Healthy Michigan Plan are included in these reports. The measures for the Healthy Michigan Plan population mirrors those used for the traditional Medicaid population. In addition, MDHHS monitors trends specific to this new population over time. MDHHS continues to collect data for PMR purposes. All of the Healthy Michigan Plan measures are informational until standards are set. The most recently published Bureau of Medicaid Program Operations & Quality Assurance quarterly PMR with Healthy Michigan Plan specific measures was published in April 2016 and was included with the previous quarterly report. Future PMR reports will be provided as available.

Managed Care Reporting Requirements

MDHHS has established a variety of reporting requirements for the Medicaid Health Plans, many of which are compiled, analyzed and shared with the plans in the Performance Monitoring Reports described in the Quality Assurance/Monitoring Activity section of this report. This quarter, applicable Healthy Michigan Plan members received MI Health Account quarterly statements. Beneficiaries are able to make payments online and by mail.

The MI Health Account Call Center handles questions regarding the MI Health Account welcome letters and MI Health Account quarterly statements. MDHHS' Beneficiary Help Line number is listed on all MI Health Account letters. Staff are cross trained to provide assistance on a variety of topics. Commonly asked questions for callers contacting the MI Health Account Call Center relate to general MI Health Account information and payment amounts. Members calling regarding the quarterly statements have asked about amounts owed, requested clarification on the contents of the statement, and reported an inability to pay amounts owed.

During this quarter, Healthy Michigan Plan members continued making payments for contributions and copays to the MI Health Account. Detailed MI Health Account activity is documented in the following tables. The MI Health Account Executive Summary Report is currently under revision. For this reason, data available for this quarter is incomplete. Activity from the previous quarter that was not included in the previous quarterly report, due to report revisions and data lag, has also been included.

Table 11 illustrates MI Health Account statement mailing activity for the current quarter. Additionally this table includes co-pay and contribution amounts owed when the statements were mailed. The chart also shows total activity for the 2016 calendar year and from the time MI Health Account statements were first issued in October 2014.

Table 11: MI Health Account Statement Mailing

Month Statement Mailed	Statements Mailed	Statements Requiring a Copay Only	Statements Requiring a Contribution Only	Statements Requiring a Copay and Contribution	Percentage of Statements Requiring Payment
March 2016	80,639	16,737	6,347	8,604	39%
April 2016	95,279	21,381	7,713	10,673	42%
May 2016	-	-	-	-	-
June 2016	-	-	-	-	-
Calendar YTD	323,321	59,614	35,246	30,637	39%
Program Total	1,237,199	290,368	110,225	121,802	42%

Table 12 contains the collection history of the Healthy Michigan Plan members that have paid copayments and contributions. The chart also shows total activity for the 2016 calendar year and from the time MI Health Account statements were first issued in October 2014.

Table 12: MI Health Account Collection Summary					
Statement Month	Amount of copays owed	Amount of copays paid	Percentage of copays paid	Number of beneficiaries who owed copays	Number of beneficiaries who paid copays
Copays					
March 2016	$240,275.66	$88,124.25	37%	25,338	10,008
April 2016	$318,174.55	$99,414.47	31%	32,051	11,057
May 2016	-	-	-	-	-
June 2016	-	-	-	-	-
Calendar YTD	$713,482.07	$249,774.29	35%	90,302	34,597
Program Total	$2,915,443.18	$1,059,769.14	36%	411,141	150,752
Contributions					
Statement Month	Amount of contributions owed	Amount of contributions paid	Percentage of contributions paid	Number of beneficiaries who owed contributions	Number of beneficiaries who paid contributions
March 2016	$773,241.37	$222,385.19	29%	14,948	5,708
April 2016	$1,055,116.62	$277,266.82	26%	18,380	6,273
May 2016	-	-	-	-	-
June 2016	-	-	-	-	-
Calendar YTD	$3,513,670.42	$1,055,836.02	30%	65,874	25,012
Program Total	$12,643,423.97	$3,502,588.93	28%	232,014	86,590

Table 13 displays the total amount collected by enrollment month and quarterly pay cycle since the implementation of the MI Health Account. For example, beneficiaries that enrolled in October 2014 received their first quarter statement in April 2015. It should be noted that Percentage Collected can change even in complete quarters as payments are applied to the oldest invoice owed.

Table 13: MI Health Account Quarterly Collection				
Enrollment Month	Quarterly Pay Cycles	Amount Owed	Amount Collected	Percentage Collected
April 2014	Oct 2014 - Dec 2014	$24,297.41	$14,182.09	
	Jan 2015 - Mar 2015	$199,618.00	$104,719.77	52%
	Apr 2015 - Jun 2015	$168,701.60	$78,643.03	47%
	Jul 2015 - Sept 2015	$143,441.62	$73,116.73	51%
	Oct 2015 - Dec 2015	$151,243.40	$61,186.75	40%
	Jan 2016 - Mar 2016	$115,467.58	$48,523.09	42%
	Apr 2016 - Jun 2016	$145,108.94	$57,755.98	40%
May 2014	Nov 2014 - Jan 2015	$39,156.73	$22,077.47	56%
	Feb 2015 - Apr 2015	$60,934.96	$30,937.01	51%
	May 2015 - Jul 2015	$47,684.52	$24,017.84	50%
	Aug 2015 - Oct 2015	$31,015.38	$20,037.98	65%
	Nov 2015 - Jan 2016	$36,562.71	$18,136.65	50%
	Feb 2016 - Apr 2016	$36,215.61	$14,999.74	41%

Table 13: MI Health Account Quarterly Collection Continued				
Enrollment Month	Quarterly Pay Cycles	Amount Owed	Amount Collected	Percentage Collected
June 2014	Dec 2014 - Feb 2015	$442,707.82	$279,791.43	63%
	Mar 2015 - May 2015	$343,320.24	$205,902.00	60%
	Jun 2015 - Aug 2015	$351,778.20	$197,940.22	56%
	Sept 2015 - Nov 2015	$330,025.58	$171,781.21	52%
	Dec 2015 - Feb 2016	$235,607.15	$112,336.02	48%
	Mar 2016 - May 2016	$232,945.65	$118,300.38	51%
July 2014	Jan 2015 - Mar 2015	$366,046.34	$177,823.22	49%
	Apr 2015 - Jun 2015	$274,331.20	$120,247.19	44%
	Jul 2015 - Sept 2015	$221,549.40	$112,437.83	51%
	Oct 2015 - Dec 2015	$222,707.46	$91,694.09	41%
	Jan 2016 - Mar 2016	$162,002.06	$72,132.56	45%
	Apr 2016 - Jun 2016	$159,749.48	$66,498.82	42%
August 2014	Feb 2015 - Apr 2015	$180,742.29	$90,553.90	50%
	May 2015 - Jul 2015	$132,030.12	$57,808.68	44%
	Aug 2015 - Oct 2015	$89,940.84	$53,524.05	60%
	Nov 2015 - Jan 2016	$99,102.02	$46,387.21	47%
	Feb 2016 - Apr 2016	$97,378.60	$36,461.40	37%
September 2014	Mar 2015 - May 2015	$224,133.98	$98,990.94	44%
	Jun 2015 - Aug 2015	$158,672.05	$63,065.47	40%
	Sep 2015 - Nov 2015	$150,403.86	$59,772.42	40%
	Dec 2015 - Feb 2016	$120,631.58	$42,781.18	35%
	Mar 2016 May 2016	$124,171.62	$41,077.42	33%
October 2014	Apr 2015 - Jun 2015	$179,156.82	$79,930.35	45%
	Jul 2015 - Sept 2015	$107,685.57	$54,144.93	50%
	Oct 2015 - Dec 2015	$122,582.48	$49,124.77	40%
	Jan 2016 - Mar 2016	$100,815.62	$42,197.08	42%
	Apr 2016 Jun 2016	$105,123.28	$40,232.34	38%
November 2014	May 2015 - Jul 2015	$199,596.56	$86,370.41	43%
	Aug 2015 - Oct 2015	$95,265.66	$50,659.89	53%
	Nov 2015 - Jan 2016	$125,285.31	$53,825.39	43%
	Feb 2016 - Apr 2016	$136,635.63	$47,521.40	35%
December 2014	Jun 2015 - Aug 2015	$107,348.80	$50,460.75	47%
	Sept 2015 - Nov 2015	$82,905.72	$33,885.44	41%
	Dec 2015 - Feb 2016	$66,217.21	$25,705.32	39%
	Mar 2016 - May 2016	$72,789.87	$27,718.01	38%
January 2015	Jul 2015 - Sept 2015	$174,664.79	$107,164.27	61%
	Oct 2015 - Dec 2015	$165,362.65	$73,783.98	45%
	Jan 2016 - Mar 2016	$137,988.00	$67,941.45	49%
	Apr 2016 - Jun 2016	$144,420.51	$66,006.56	46%
February 2015	Aug 2015 - Oct 2015	$155,358.74	$94,772.80	61%
	Nov 2015 - Jan 2016	$119,831.23	$61,419.12	51%
	Feb 2016 - Apr 2016	$149,273.46	$66,263.22	44%
March 2015	Sept 2015 - Nov 2015	$213,649.46	$90,975.67	43%
	Dec 2015 - Feb 2016	$97,933.80	$39,107.95	40%
	Mar 2016 - May 2016	$85,657.59	$42,679.00	50%

Table 13: MI Health Account Quarterly Collection Continued				
Enrollment Month	Enrollment Month	Enrollment Month	Enrollment Month	Enrollment Month
April 2015	Oct 2015 - Dec 2015	$256,403.72	$110,454.09	43%
	Jan 2016 - Mar 2016	$77,489.54	$59,457.69	77%
	Apr 2016 - Jun 2016	$119,867.90	$69,203.66	58%
May 2015	Nov 2015 - Jan 2016	$155,930.66	$75,712.03	49%
	Feb 2016 - Apr 2016	$104,143.54	$52,149.25	50%
June 2015	Dec 2015 - Feb 2016	$142,468.62	$57,504.68	40%
	Mar 2016 - May 2016	$86,604.50	$38,655.14	45%
July 2015	Jan 2016 - Mar 2016	$106,974.27	$57,595.11	54%
	Apr 2016 - Jun 2016	$74,565.15	$35,944.12	48%
August 2015	Feb 2016 - Apr 2016	$149,325.14	$53,177.59	36%
September 2015	Mar 2016 - May 2016	$109,902.07	$42,079.49	38%
October 2015	Apr 2016 - Jun 2016	$102,187.33	$41,039.81	40%

Payments can be made to the MI Health Account by mail or online. Table 14 includes the current quarter's MI Health Account payments by payment method.

Table 14: MI Health Account Methods of Payment				
	March 2016	April 2016	May 2016	June 2016
Percent Paid Online	27%	27%	-	-
Percent Paid by Mail	73%	73%	-	-

Cost sharing exemptions are applied to specific groups by law, regulation and program policy. The MI Health Account adjustment activity is detailed in Table 15. The following table displays the number of members that met cost sharing exemption adjustments and adjustment amounts by month, for the current calendar year, and for the program in total.

Table 15: MI Health Account Adjustment Activities						
	March 2016		April 2016		May 2016	
	Number of Beneficiaries	Total Amount	Number of Beneficiaries	Total Amount	Number of Beneficiaries	Total Amount
Beneficiary is Under Age 21	429	$27,115.65	750	$43,269.00	-	-
Pregnancy	53	$7,213.24	508	$11,436.42	-	-
Hospice	0	$0.00	0	$0.00	-	-
Native American	50	$765.33	64	$980.00	-	-
Five Percent Cost Share Limit Met	31,949	$581,058.63	35,688	$582,816.97	-	-
FPL No Longer >100% - Contribution	0	$0.00	0	$0.00	-	-
Total	32,481	$616,152.85	37,010	$638,502.39	-	-

Table 15: MI Health Account Adjustment Activities Continued						
	June 2016		Calendar YTD		Program YTD	
	Number of Beneficiaries	Total Amount	Number of Beneficiaries	Total Amount	Number of Beneficiaries	Total Amount
Beneficiary is Under Age 21	-	-	2,161	$119,999.24	6,970	$384,254.74
Pregnancy	-	-	1,075	$37,325.50	5,352	$159,976.77
Hospice	-	-	0	$0.00	0	$0.00
Native American	-	-	210	$3,745.83	704	$27,983.83
Five Percent Cost Share Limit Met	-	-	105,838	$2,131,708.88	440,249	$6,550,245.76
FPL No longer >100% - Contribution	-	-	0	$0.00	20	$1,152.50
Total	-	-	109,284	$2,292,779.45	453,295	$7,123,613.60

Healthy Michigan Plan members may qualify for reductions in copayments and/or contributions after successful participation in the Healthy Behaviors program. Table 16 shows the number of qualified beneficiaries who have earned a reduction in copayments, contributions, and/or gift cards. The following table includes Healthy Behaviors rewards earned by month, current calendar year and for the program in total.

Table 16: Healthy Behaviors Incentive Activity						
	March 2016		April 2016		May 2016	
	Number of Beneficiaries	Total Amount	Number of Beneficiaries	Total Amount	Number of Beneficiaries	Total Amount
Copay	1,310	$9,301.02	2,289	$14,537.35	-	-
Contribution	2,677	$110,527.14	3,108	$133,044.98	-	-
Gift Cards	2,775	n/a	2,854	n/a	-	-
Total	6,762	$119,828.16	8,251	$147,582.33	-	-
	June 2016		Calendar YTD		Program YTD	
	Number of Beneficiaries	Total Amount	Number of Beneficiaries	Total Amount	Number of Beneficiaries	Total Amount
Copay	-	-	5,305	$31,392.82	6,552	$36,435.34
Contribution	-	-	11,092	$427,796.73	34,142	$1,180,958.42
Gift Cards	-	-	12,209	n/a	76,974	n/a
Total	-	-	28,606	$459,189.55	117,668	$1,217,393.76

Healthy Michigan Plan members that do not meet payment obligations for three consecutive months are deemed “consistently failing to pay.” Consequences for consistently failing to pay include healthy behavior reduction and garnishment of tax refunds and lottery winnings. Table 16 provides cumulative past due collection amounts and the number of members that have past due balances that are eligible for collection through the Michigan Department of Treasury for this reporting quarter.

Table 17: MI Health Account Past Due Collection Amounts		
Month	Number of Beneficiaries with Past Due Co-Pays/Contributions	Number of Beneficiaries with Past Due Co-Pays/Contributions that are Collectible Debt
March 2016	87,850	5,080
April 2016	92,342	7,220
May 2016	-	-
June 2016	-	-

Table 17 includes the total amount of past due balances by the length of time the account has been delinquent. The information below is cumulative and not limited to the current quarter.

Table 18: MI Health Account Delinquent Co-pay and Contribution Amounts by Aging Category						
Days	0-30 Days	31-60 Days	61-90 Days	91-120 Days	>120 Days	Total
Amount Due	$821,618.02	$746,314.07	$640,653.06	$579,300.71	$4,857,829.07	$7,645,714.93
Number of Beneficiaries That Owe	65,530	60,698	51,959	46,168	102,324	149,548

MDHHS has refined the Managed Care Organization grievance and appeal reporting process to collect Healthy Michigan Plan specific data. Grievances are defined in the MDHHS Medicaid Health Plan Grievance/Appeal Summary Reports as an expression of dissatisfaction about any matter other than an action subject to appeal. Appeals are defined as a request for review of the Health Plan's decision that results in any of the following actions:

- The denial or limited authorization of a requested service, including the type or level of service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of a payment for a properly authorized and covered service;
- The failure to provide services in a timely manner, as defined by the State; or
- The failure of the Health Plan to act within the established timeframes for grievance and appeal disposition.

MDHHS has included grievance and appeals data reported by the Medicaid Health Plans from this quarter in the following tables:

Table 19: Managed Care Organization Appeals				
April 2016 – June 2016				
	Decision Upheld	Overturned	Undetermined/ Withdrawn	Total
Count	35	7	5	114
Percent	31%	65%	4%	

Table 20: Managed Care Organization Grievances						
April 2016 – June 2016						
	Access	Quality of Care	Administrative/Service	Billing	Transportation	Total
Count	173	51	119	22	77	442
Percent	39%	12%	27%	5%	17%	

From April to June 2016, there were 114 total appeals among all the Medicaid Health Plans. Medicaid Health Plan decisions were upheld in 31 percent of the appeals. From April to June 2016 there were a total of 442 grievances. The greatest number of grievances came from the Access category. Access grievances can include a primary care physician not accepting new patients, limited specialist availability, the refusal of a primary care physician to complete a referral or write a prescription, a lack of services provided by the primary care physician, long wait times for appointments and denied services. Grievances related to quality of care pertain to the level of care issues experienced by beneficiaries. Administrative/Service grievances can range from issues with claims, enrollment, eligibility, out-of-network providers and benefits not covered. Issues reported under the Billing category pertain to billing issues. Transportation grievances relate to issues with the transportation benefit and often mirror the complaints members directly reported to MDHHS. MDHHS will continue to monitor the Medicaid Health Plans Grievance/Appeal Summary Reports to ensure levels of grievances remain low and resolution of grievances is completed in a timely manner.

Lessons Learned

MDHHS continues to learn from the experience of launching a program the size and scope of the Healthy Michigan Plan. As the Healthy Michigan Plan program has matured, MDHHS has incorporated stakeholder feedback into program-related changes. For example, the MI Health Account statements are currently undergoing revision as a direct result of feedback received from members and stakeholders. MDHHS has learned through the revision experience how to incorporate the needs of the department with that of stakeholders in a single member-friendly statement. Additionally, MDHHS has learned through translating these changes into system enhancements that lags in associated reporting can occur. While still under revision, MDHHS continues to work toward a comprehensive and user-friendly MI Health Account statement format.

Demonstration Evaluation

MDHHS has commissioned the University of Michigan's Institute for Healthcare Policy and Innovation (IHPI) to serve as the Healthy Michigan Plan independent evaluator. The IHPI has developed a comprehensive plan to address the needs of the State and CMS. In accordance with paragraph 67 of the waiver special terms and conditions, the State submitted a draft of its initial evaluation design to CMS on April 28, 2014 and, after a period of revisions, CMS formally approved the evaluation plan on October 22, 2014.

Demonstration evaluation activities for the Healthy Michigan Plan are utilizing an interdisciplinary team of researchers from the IHPI. The activities of the evaluation will carry in six domains over the course of the 5 year evaluation period:

I. An analysis of the impact the Healthy Michigan Plan on uncompensated care costs borne by Michigan hospitals;
II. An analysis of the effect of Healthy Michigan Plan on the number of uninsured in Michigan;
III. The impact of Healthy Michigan Plan on increasing healthy behaviors and improving health outcomes;
IV. The viewpoints of beneficiaries and providers of the impact of Healthy Michigan Plan;
V. The impact of Healthy Michigan Plan's contribution requirements on beneficiary utilization, and;
VI. The impact of the MI Health Accounts on beneficiary healthcare utilization.

Domain I
Although the interim report for Domain I isn't due until FY 2018, IHPI has engaged in activities to find and compare baseline uncompensated care results from hospital cost reports and IRS filings to understand the distribution of uncompensated care in Michigan. This quarter continued with further analysis of Medicare cost report data, and specifically comparing changes in states that did and did not expand Medicaid.

Domain II
Similar to Domain I, the Domain II interim report is not due until FY 2018. That being said, IHPI continues to analyze extracts of Current Population Survey (CPS) data and American Community Survey (ACS) data to ascertain the difference between these two US Census Bureau data sources. This quarter, IHPI calculated the fraction of uninsured in Michigan using the publically available 2014 ACS data.

Domain III
The interim report for Domain III is due in FY 2017. IHPI activities in this quarter continued the assessment and extraction of health behavior (including chronic condition) data and Health Risk Assessment completion data. The Health Risk Assessment completion data in the MDHHS data warehouse will be juxtaposed to self-identified Health Risk Assessment completion data from the Healthy Michigan Voices Survey.

Domain IV
Domain IV will examine beneficiary and provider viewpoints of Healthy Michigan Plan through surveys. The interim report is due in FY 2016. Activities for the quarter included the following:

Primary Care Practitioner (PCP) Survey
- PCP Survey Report submitted to CMS
- Health Risk Assessment-specific data analyzed to facilitate understanding barriers and successes of Health Risk Assessment completion

Healthy Michigan Voices (HMV) Beneficiary Survey
- HMV Survey development fielded in January 2016 with over 2,000 responses as of the current quarter
- Finalized the specific HMV survey for Healthy Michigan Plan beneficiaries no longer enrolled (surveying will commence in late summer of 2016)

Domains V/VI
Domains V and VI entail analyzing data to assess the impact of contributions and the MI Health Account statements on beneficiary utilization of health care services, respectively. The interim reports are due in FY 2017. Activities in this quarter included further refining the analyses associated with Health Risk Assessment completion and incentives to select the control and treatment groups. In addition, with the HMV survey surpassing over 2,000 respondents, analyses will be completed related to the cost and cost-sharing elements of the Healthy Michigan Plan.

Enclosures/Attachments

1. June 2016 Health Risk Assessment Report

2. May 2016 MCAC Meeting Minutes

3. June 2016 MI Health Account Executive Summary Report

State Contacts

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September 20, 2016

Michigan Department of Health and Human Services

Medical Services Administration

Bureau of Medicaid Care Management and Quality Assurance

Healthy Michigan Plan - Health Risk Assessment Report

June 2016

Produced by:

Quality Improvement and Program Development - Managed Care Plan Divison

Table of Contents

Health Risk Assessment Part 1

Health Risk Assessment Part 2

Introduction

Pursuant to PA 107 of 2013, sections 105d(1)e and 105d(12), a Health Risk Assessment has been developed for the Healthy Michigan Plan (form DCH-1315). It is designed as a two part document, where the beneficiary completes the first three sections and the primary care provider completes the last section. It includes questions on a wide range of health issues, a readiness to change assessment, an annual physical exam and a discussion about behavior change with their primary care provider. The topics in the assessment cover all of the behaviors identified in PA 107 including alcohol use, substance use disorders, tobacco use, obesity and immunizations. It also includes the recommended healthy behaviors identified in the Michigan Health and Wellness 4X4 Plan, which are annual physicals, BMI, blood pressure, cholesterol and blood sugar monitoring, healthy diet, regular physical exercise and tobacco use.

Health Risk Assessment Part 1

Health Risk Assessments completion through Michigan ENROLLS

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

Completion of the Health Risk Assessment is voluntary; callers may refuse to answer some or all of the questions. Beneficiaries who are auto-assigned into a health plan are not surveyed. Survey results from Michigan ENROLLS are electronically transmitted to the appropriate health plan on a monthly basis to assist with outreach and care management.

The data displayed in Part 1 of this report reflect the responses to questions 1-9 of Section 1 of the Health Risk Assessment completed through Michigan ENROLLS. As shown in Table I, a total of 284,785 Health Risk Assessments were completed through Michigan ENROLLS as of June 2016. This represents a completion rate of 95.72%. Responses are reported in Tables 1 through 9. Beneficiaries who participated in the Health Risk Assessment but refused to answer specific questions are included in the total population and their answers are reported as “Refused”. Responses are also reported by age and gender.

Health Risk Assessment Completion through Michigan ENROLLS

Table I. Count of Health Risk Assessments (HRA) Questions 1-9 Completed with MI Enrolls

MONTH	COMPLETE	DECLINED
July 2015	216,850	8,996 (3.98%)
August 2015	224,671	9,413 (4.02%)
September 2015	231,838	9,810 (4.06%)
October 2015	238,891	10,161 (4.08%)
November 2015	245,410	10,554 (4.12%)
December 2015	252,808	11,129 (4.22%)
January 2016	261,417	11,585 (4.24%)
February 2016	269,644	11,983 (4.26%)
March 2016	275,839	12,239 (4.25%)
April 2016	279,562	12,476 (4.27%)
May 2016	282,318	12,620 (4.28%)
June 2016	284,785	12,745 (4.28%)

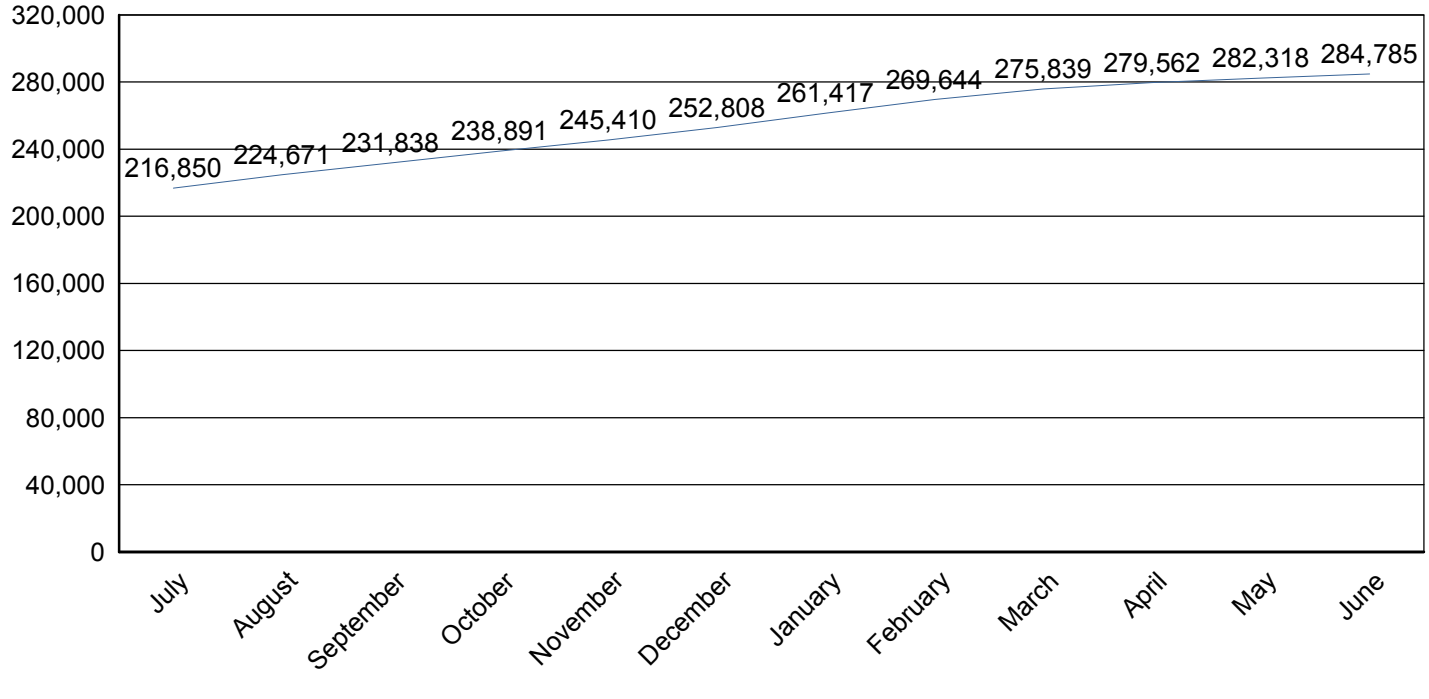
Table 11. Demographics of Population that Completed HRA Questions 1-9 with MI ENROLLS

January 2014 - June 2016

AGE GROUP	COMPLETED HRA	
19 - 29	70,399	24.72%
30 - 39	59,595	20.93%
40 - 49	59,169	20.78%
50 - 59	69,021	24.24%
60 +	26,601	9.34%
GENDER		
F	153,881	54.03%
M	130,904	45.97%
FPL		
< 100% FPL	233,910	82.14%
100 - 133% FPL	50,875	17.86%
TOTAL	**284,785**	**100.00%**

Figure I-1. Health Risk Assessments Completed with MI ENROLLS

June 2016



Question 1. General Health Rating

Question 1. In general, how would you rate your health? This question is used to assess self-reported health status. Healthy Michigan Plan enrollees were given the answer options of excellent, very good, good, fair or poor. Table 1 shows the overall answers to this question for June 2016. Among enrollees who completed the survey, this question had a 0.17% refusal rate. Figures 1-1 through 1-3 show the health rating reported for the total population, and by age and gender.

Table 1. Health Rating for Total Population

June 2016

HEALTH RATING	TOTAL	PERCENT
Excellent	31,991	11.23%
Very Good	73,495	25.81%
Good	101,771	35.74%
Fair	58,076	20.39%
Poor	18,977	6.66%
Refused	475	0.17%
TOTAL	**284,785**	**100.00%**

Figure 1-1. Health Rating for Total Population

June 2016

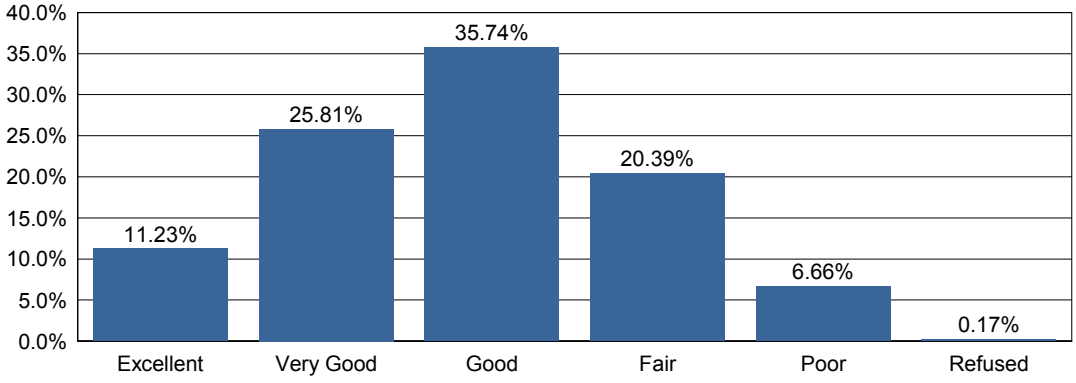


Figure 1-2. Health Rating by Age

June 2016

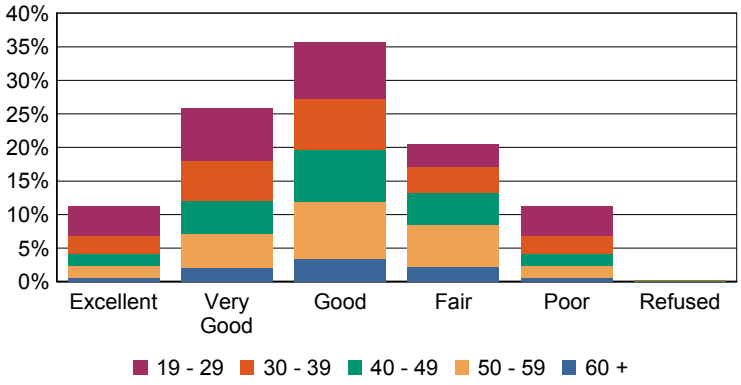
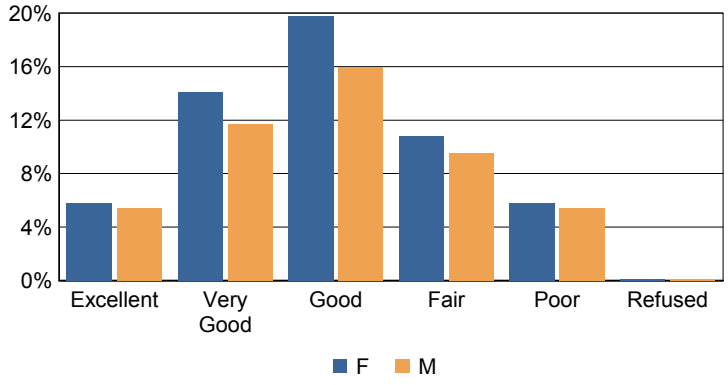


Figure 1-3. Health Rating by Gender

June 2016



Question 2. Exercise

Question 2. In the last 7 days, how often did you exercise for at least 20 minutes a day? This question is used to assess selfreported exercise frequency as an important component of maintaining a healthy weight. Healthy Michigan Plan enrollees were given the answer options of every day, 3-6 days, 1-2 days or 0 days. Table 2 shows the overall answers to this question for June 2016. Among enrollees who participated in the survey, there was a 1.53% refusal rate for this question. Figures 2-1 through 2-3 show the exercise frequency reported for the total population, by age and gender.

Table 2. Exercise Reported for Total Population

June 2016

EXERCISE	TOTAL	PERCENT
Every Day	65,094	22.86%
3-6 Days	82,927	29.12%
1-2 Days	70,344	24.70%
No Days	62,076	21.80%
Refused	4,344	1.53%
TOTAL	**284,785**	**100.00%**

Figure 2-1. Exercise Reported for Total Population

June 2016

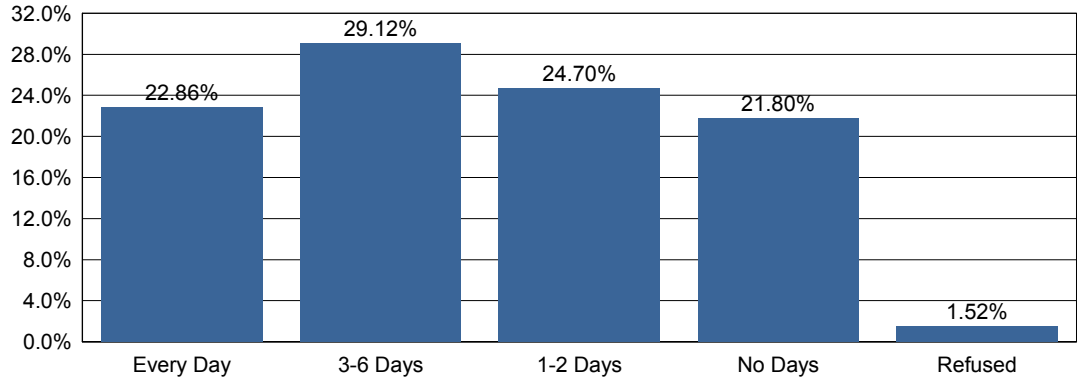


Figure 2-2. Exercise Reported by Age

June 2016

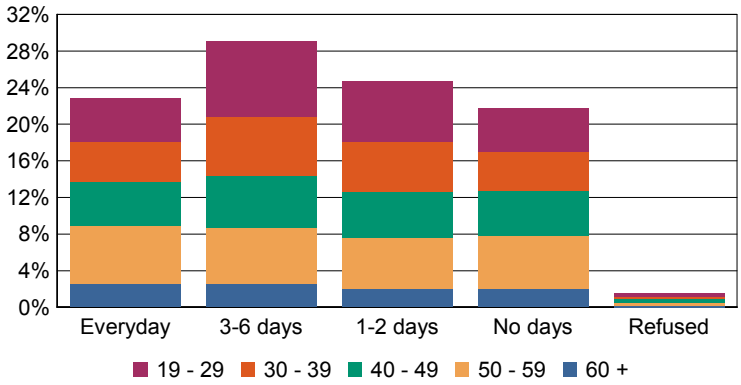
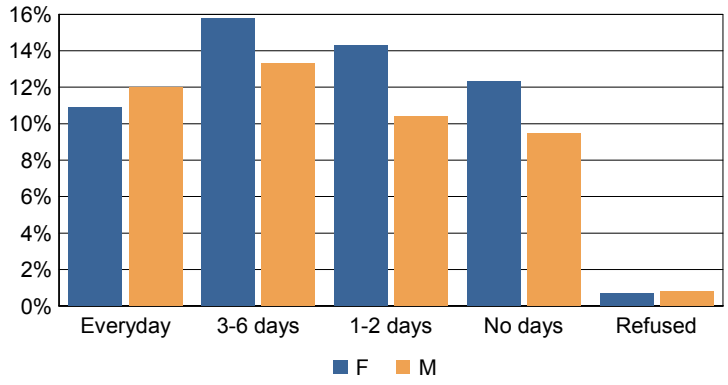


Figure 2-3. Exercise by Gender

June 2016



Question 3. Nutrition (Fruits and Vegetables)

Question 3. In the last 7 days, how often did you eat 3 or more servings of fruits or vegetables in a day? This question is used to assess self-reported nutrition as an important component of maintaining a healthy weight. Healthy Michigan Plan enrollees were given the answer options of every day, 3-6 days, 1-2 days or 0 days. Table 3 shows the overall answers to this question for June 2016. Among enrollees who participated in the survey, there was a 1.88% refusal rate for this question. Figures 3-1 through 3-3 show the nutrition reported for the total population, and by age and gender.

Table 3. Nutrition Reported for Total Population

June 2016

NUTRITION	TOTAL	PERCENT
Every Day	96,200	33.78%
3-6 Days	98,693	34.66%
1-2 Days	64,990	22.82%
No Days	19,541	6.86%
Refused	5,361	1.88%
TOTAL	**284,785**	**100.00%**

Figure 3-1. Nutrition Reported for Total Population

June 2016

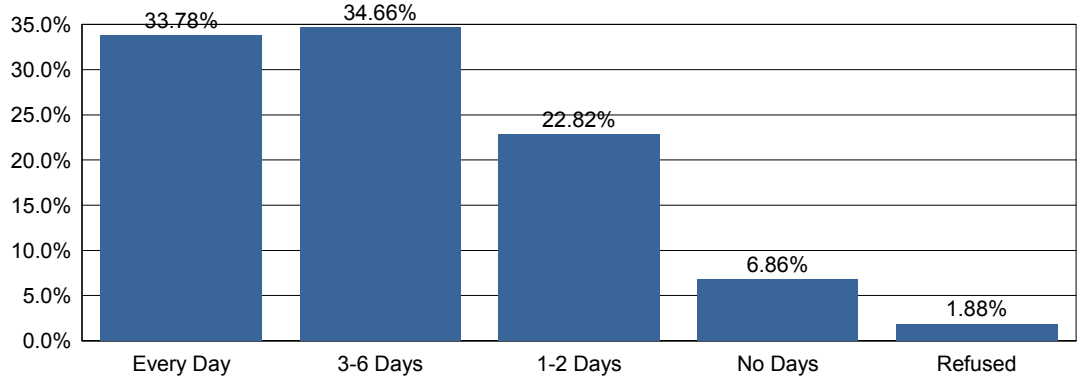


Figure 3-2. Nutrition Reported by Age

June 2016

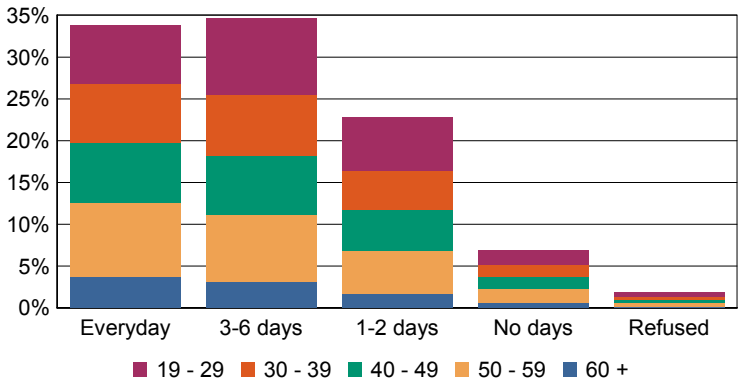
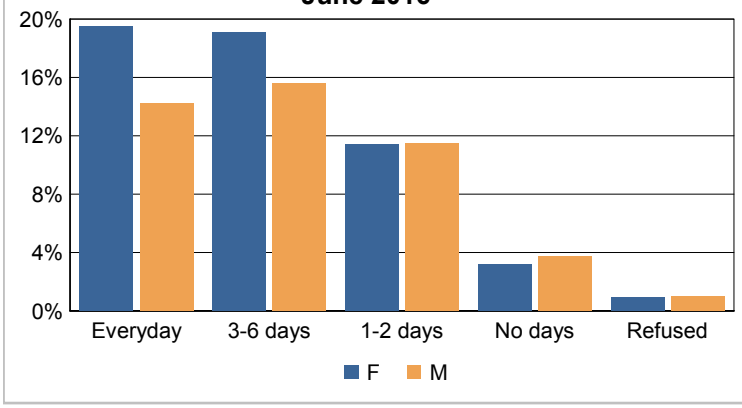


Figure 3-3. Nutrition by Gender

June 2016



Question 4. Binge Alcohol Use

Question 4. In the last 7 days, how often did you have (5 or more for men, 4 or more for women) alcoholic drinks at one time?
This question is used to assess self-reported binge alcohol use. Healthy Michigan Plan enrollees were given the answer options of never, once a week, 2-3 a week and more than 3 times during the week. Table 4 shows the combined overall answers to these questions for June 2016. Among enrollees who participated in the survey, there was a 0.82% refusal rate for this question. Figures 4-1 through 4-3 show binge alcohol use status reported for the total population, and by age and gender.

Table 4. Binge Alcohol Use Reported for Total Population

June 2016

ALCOHOL	TOTAL	PERCENT
Never	235,548	82.71%
Once a Week	31,641	11.11%
2-3 times a Week	12,351	4.34%
More than 3	2,910	1.02%
Refused	2,335	0.82%
TOTAL	**284,785**	**100.00%**

Figure 4-1. Binge Alcohol Use Reported for Total Population

June 2016

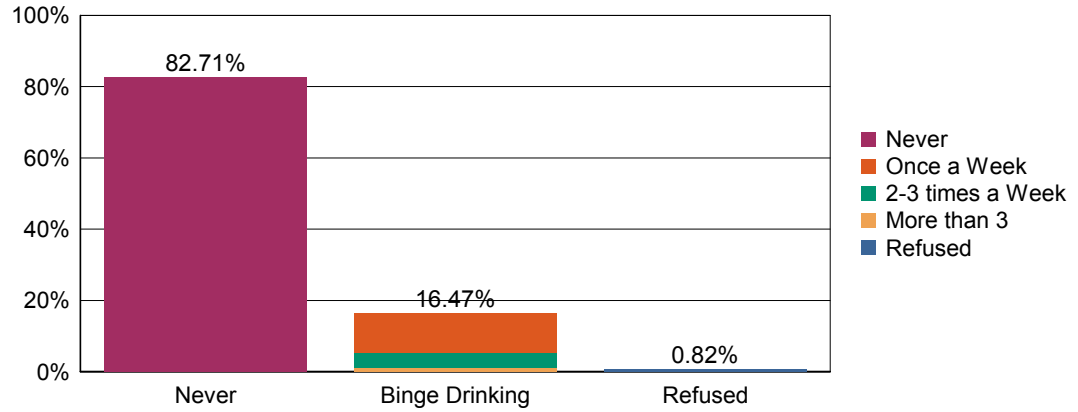


Figure 4-2. Binge Alcohol Use Reported by Age

June 2016

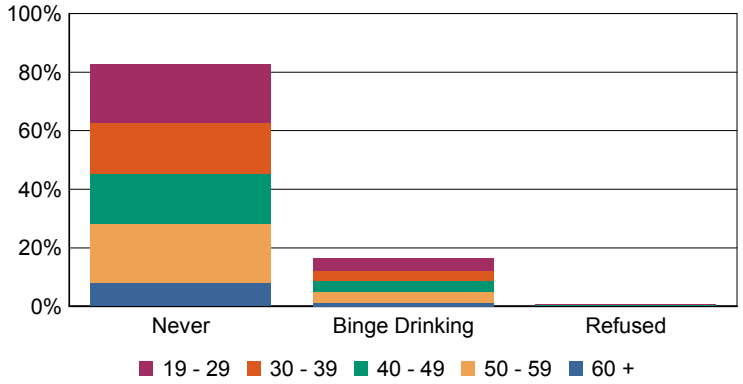
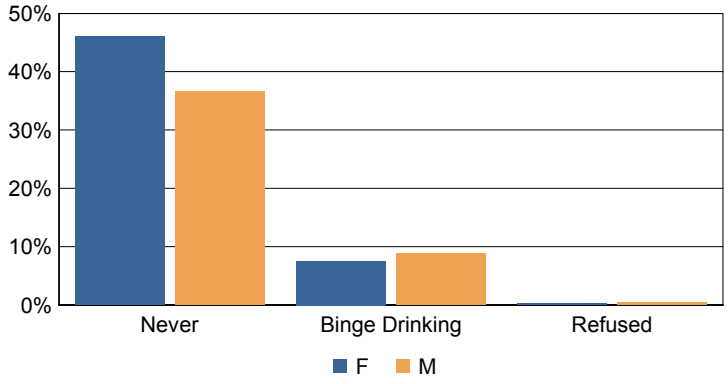


Figure 4-3. Binge Alcohol Use by Gender

June 2016



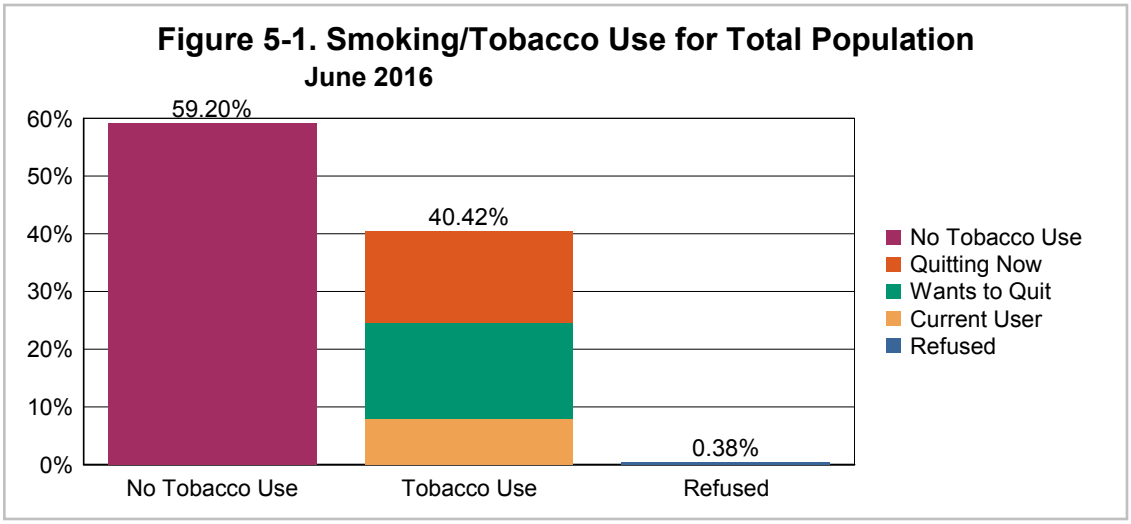
Question 5. Smoking/Tobacco Use

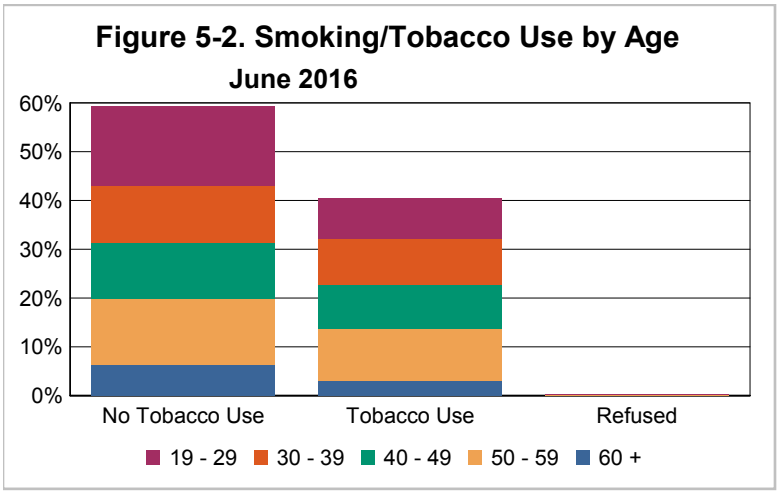
Question 5. In the last 30 days, have you smoked or used tobacco? This question is used to assess self-reported smoking/tobacco use. Healthy Michigan Plan enrollees were given the answer options of yes or no. Enrollees who answered yes, were asked a follow-up question: If YES, do you want to quit smoking or using tobacco? For this follow-up question, enrollees were given the answer options of yes, I am working on quitting or cutting back right now and no. Table 5 shows the combined overall answers to these questions for June 2016. Question 5 had a 0.38% refusal rate. Figures 5-1 through 5-3 show smoking/tobacco use reported for the total population, and by age and gender.

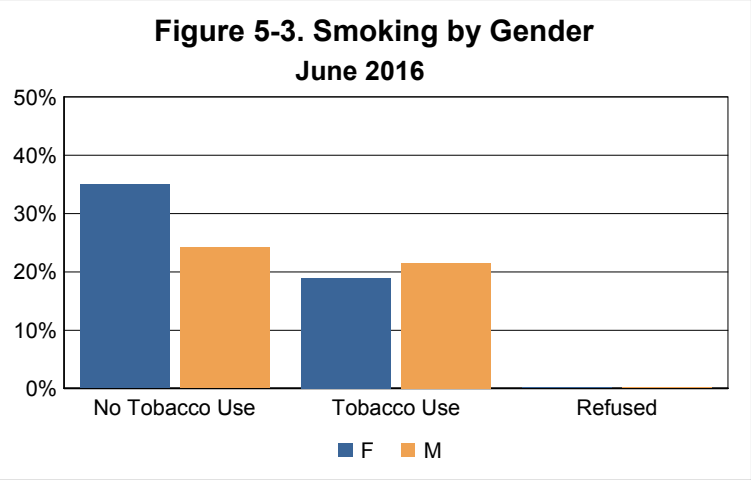
Table 5. Smoking/Tobacco Use Reported for Total Population

June 2016

TOBACCO USE	TOTAL	PERCENT
No Tobacco Use	168,586	59.20%
Quitting Now	45,326	15.92%
Wants to Quit	46,877	16.46%
Current User	22,916	8.05%
Refused	1,080	0.38%
TOTAL	**284,785**	**100.00%**







Question 6. Anxiety and Depression

Question 6. In the last 30 days, how often have you felt tense, anxious or depressed? This question is used to assess selfreported mental health status. Healthy Michigan Plan enrollees were given the answer options of almost every day, sometimes, rarely and never. Table 6 shows the overall answers to this question for June 2016. Among enrollees who participated in the survey, there was a 10.55% refusal rate for this question. Figures 6-1 through 6-3 show anxiety and depression reported for the total population, and by age and gender.

Table 6. Anxiety and Depression Reported for Total Population

June 2016

DEPRESSION	TOTAL	PERCENT
Almost Every day	59,304	20.82%
Sometimes	74,797	26.26%
Rarely	60,306	21.18%
Never	60,323	21.18%
Refused	30,055	10.55%
TOTAL	**284,785**	**100.00%**

Figure 6-1. Anxiety and Depression Reported for Total Population
June 2016

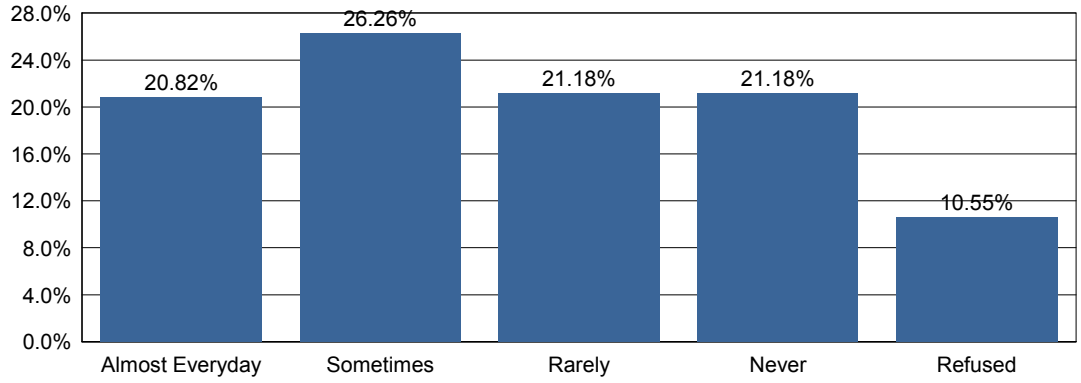


Figure 6-2. Anxiety and Depression Reported by Age
June 2016

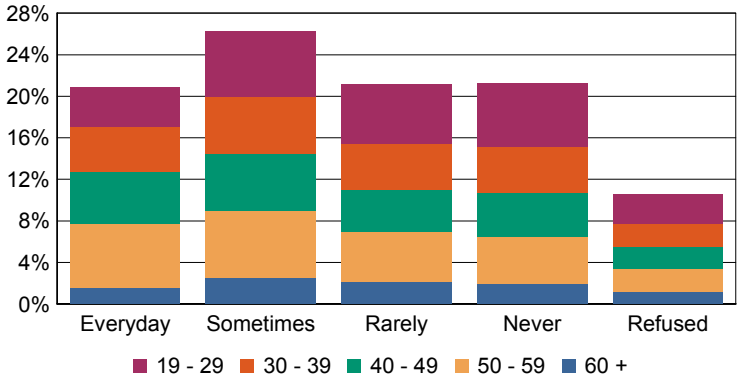
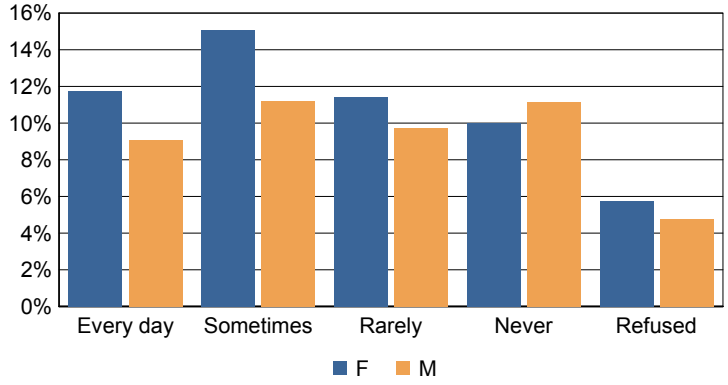


Figure 6-3. Anxiety and Depression by Gender
June 2016



Question 7. Drugs and Substance Use

Question 7. Do you use drugs or medications (other than exactly as prescribed for you) which affect your mood or help you to relax? This question is used to assess self-reported substance use. Healthy Michigan Plan enrollees were given the answer options of almost every day, sometimes, rarely and never. Table 7 shows the overall answers to this question for June 2016. Among enrollees who participated in the survey, there was a 0.73% refusal rate for this question. Figures 7-1 through 7-3 show substance use reported for the total population, and by age and gender.

Table 7. Substance Use Reported for Total Population

June 2016

SUBSTANCE USE	TOTAL	PERCENT
Almost Every Day	5,521	1.94%
Sometimes	7,280	2.56%
Rarely	6,671	2.34%
Never	263,248	92.44%
Refused	2,065	0.73%
TOTAL	**284,785**	**100.00%**

Figure 7-1. Substance Use Reported for Total Population

June 2016

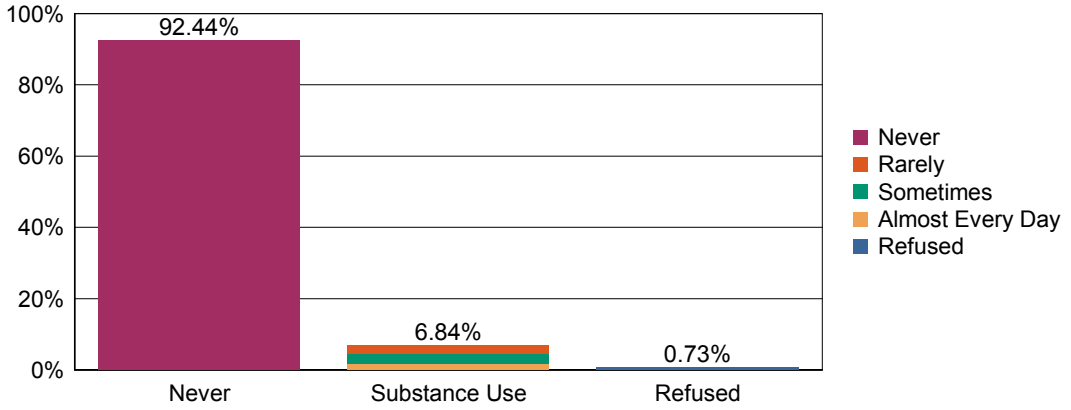


Figure 7-2. Substance Use Reported by Age

June 2016

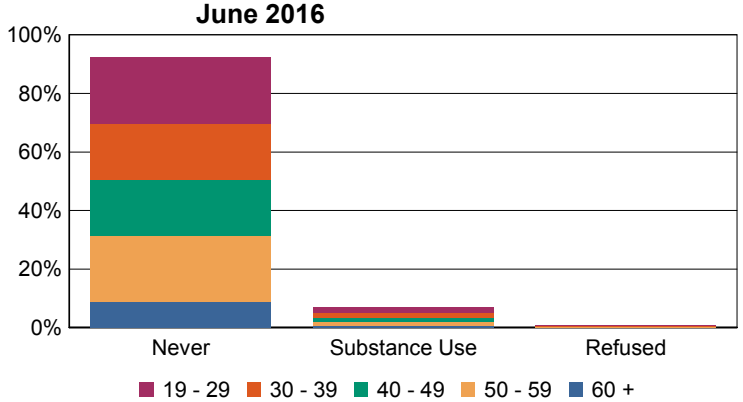
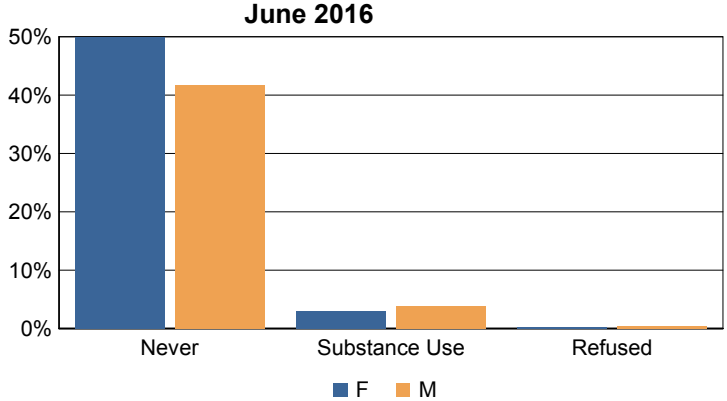


Figure 7-3. Substance Use by Gender

June 2016



Question 8. Immunization Status (Annual Flu Vaccine)

Question 8. The flu vaccine can be a shot in the arm or a spray in the nose. Have you had a flu shot or flu spray in the last year?
This question is used to assess self-reported annual flu vaccine as an indicator of immunization status. Healthy Michigan Plan enrollees were given the answer options of yes or no. Table 8 shows the overall answers to this question for June 2016. Among enrollees who participated in the survey, there was a 1.77% refusal rate for this question. Figures 8-1 through 8-3 show immunization status reported for the total population, and by age and gender.

Table 8. Immunization Status Reported for Total Population

June 2016

IMMUNIZATION	TOTAL	PERCENT
Yes	63,243	22.21%
No	216,503	76.02%
Refused	5,039	1.77%
TOTAL	**284,785**	**100.00%**

Figure 8-1. Immunization Status Reported for Total Population

June 2016

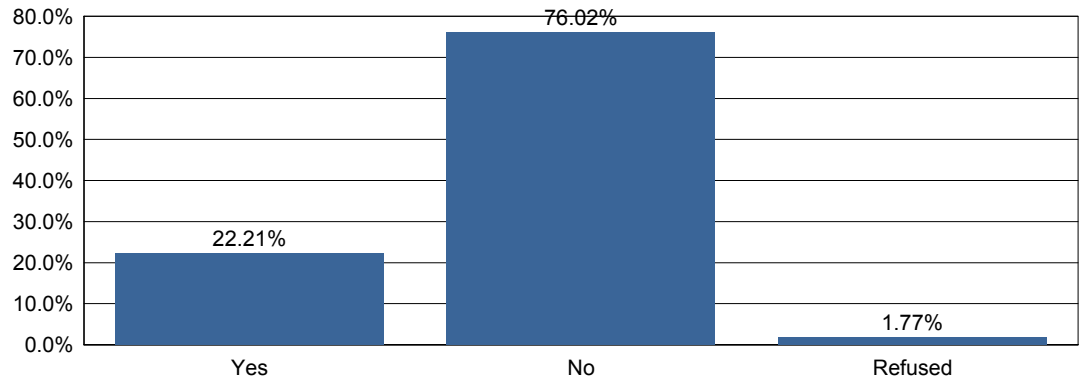


Figure 8-2. Immunization Status Reported by Age

June 2016

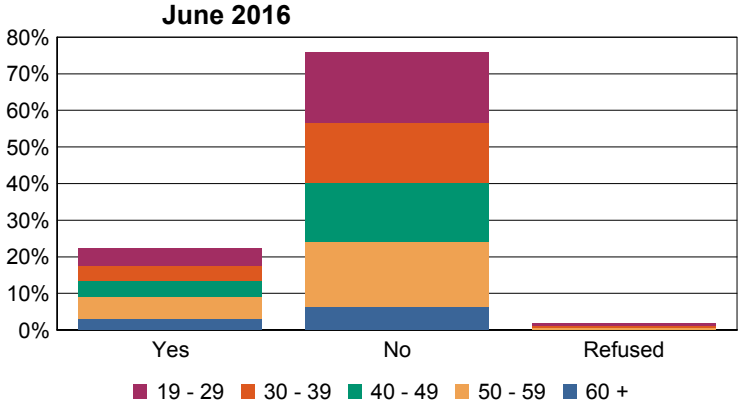
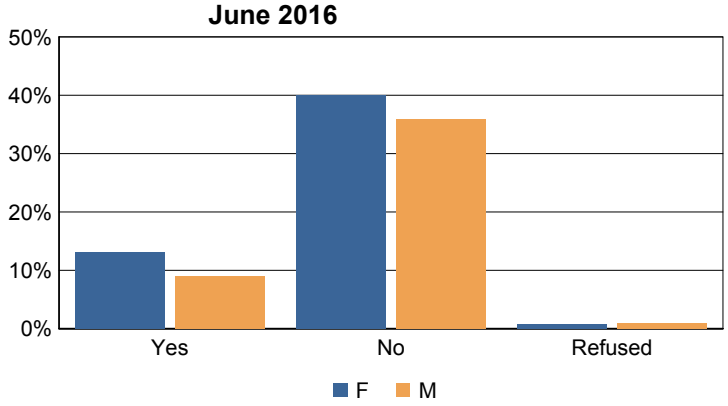


Figure 8-3. Immunization Status by Gender

June 2016



Question 9. Well Check Visit

Question 9. A checkup is a visit to a doctor's office that is NOT for a specific problem. How long has it been since your last check-up? This question is used to assess self-reported well check visit. Healthy Michigan Plan enrollees were given the answer options of within the last year, between 1-3 years and more than 3 years. Table 9 shows the overall answers to this question for June 2016. Among enrollees who participated in the survey, there was a 3.17% refusal rate for this question. Figures 9-1 through 9-3 show well check visit reported for the total population, and by age and gender.

Table 9. Well Check Visit Reported for Total Population

June 2016

CHECK-UP	TOTAL	PERCENT
Within the last year	145,608	51.13%
Between 1 & 3 years	70,801	24.86%
More than 3 years	59,347	20.84%
Refused	9,029	3.17%
TOTAL	**284,785**	**100.00%**

Figure 9-1. Well Check Visit Reported for Total Population

June 2016

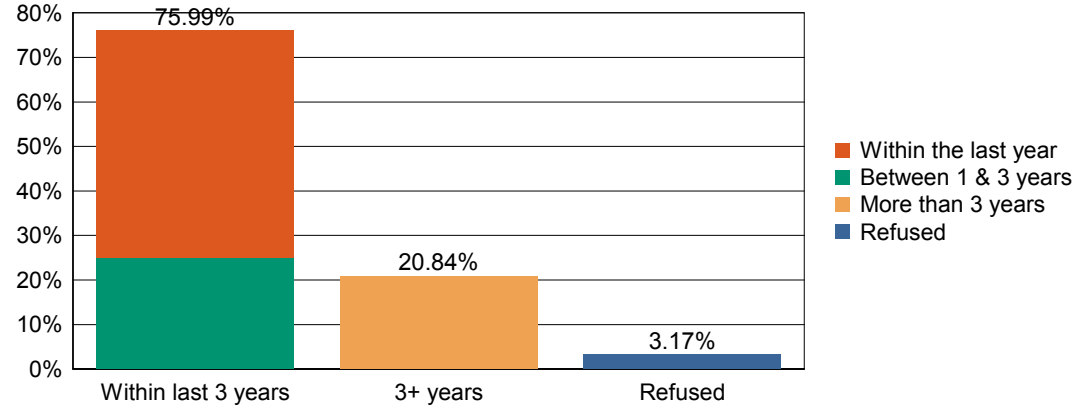


Figure 9-2. Well Check Visit Reported by Age

June 2016

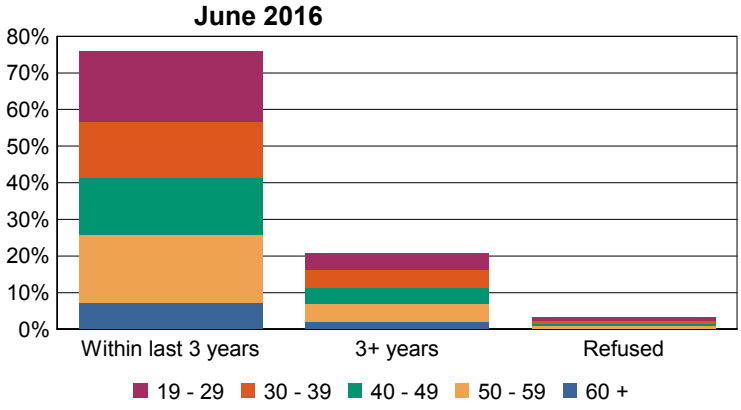
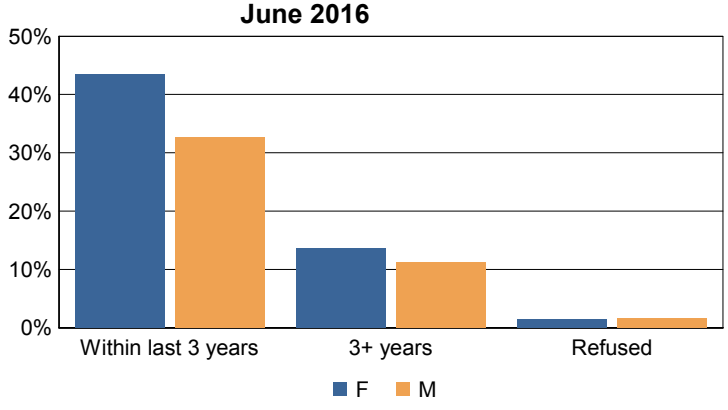


Figure 9-3. Well Check Visit by Gender

June 2016



Health Risk Assessment Part 2

Health Risk Assessments completion with Primary Care Provider

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

Completion of this section of the Health Risk Assessment is also voluntary. Healthy Michigan Plan Beneficiaries who complete a Health Risk Assessment with a primary care provider attestation and agree to maintain or address healthy behaviors are eligible for an incentive. Of the 659,464 beneficiaries who have been enrolled in a health plan for at least six months, 106,031 or 16.1% have completed the Health Risk Assessment with their primary care provider as of June 2016.

The data displayed in Part 2 of this report reflect the healthy behavior goals selected jointly by Healthy Michigan Plan beneficiaries and their primary care provider in the final section of the Health Risk Assessment. As shown in Table 10, a total of 127,432 Health Risk Assessments were completed with primary care providers as of June 2016. Health Risk Assessment completion is reported by age, gender and Federal Poverty Level in Table 11.

Among beneficiaries who completed the Health Risk Assessment, 109,494 or 85.9% of beneficiaries agreed to address health risk behaviors. In addition, 16,727 or 13.1% of beneficiaries who completed the Health Risk Assessment chose to maintain current healthy behaviors, meaning that 99.0% of beneficiaries are choosing to address or maintain healthy behaviors. The healthy behaviors goal statements selected are reported in Table 12. Healthy behavior goal statements are also reported by age and gender in Figures 10-3 and 10-4.

Of the 109,494 beneficiaries who agreed to address health risk behaviors, 60.1% chose to address more than one healthy behavior. Tables 13 and 14 report the most frequently selected health risk behaviors to address, alone and in combination. Figure 10-5 is a Venn diagram representing the overlapping nature of the multiple healthy behaviors selected.

Health Risk Assessment Completion with Primary Care Provider

Table 10. Count of Health Risk Assessments (HRA) Completed with Primary Care Provider by Attestation

MONTH	COMPLETE	TOTAL
July 2015	7,554	77,743
August 2015	6,545	84,299
September 2015	5,469	89,782
October 2015	5,269	95,066
November 2015	4,318	99,396
December 2015	4,405	103,813
January 2016	4,572	108,397
February 2016	5,377	113,778
March 2016	5,526	119,316
April 2016	4,470	123,796
May 2016	2,884	126,693
June 2016	738	127,432

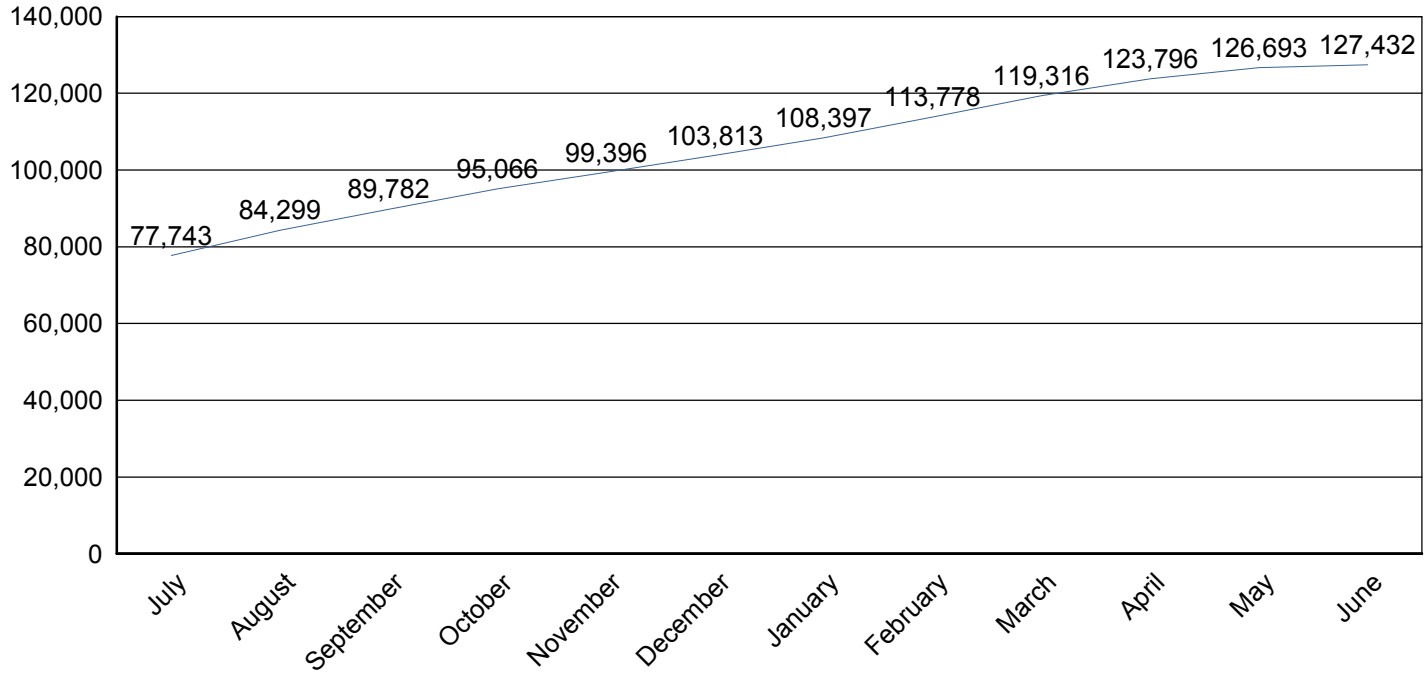
Table 11. Demographics of Population that Completed HRA with Primary Care Provider

September 2014 - June 2016

AGE GROUP	COMPLETED HRA	
19 - 29	25,654	20.13%
30 - 39	21,933	17.21%
40 - 49	25,169	19.75%
50 - 59	37,461	29.40%
60 +	17,215	13.51%
GENDER		
F	73,383	57.59%
M	54,049	42.41%
FPL		
< 100% FPL	102,421	80.37%
100 - 133% FPL	25,011	19.63%
TOTAL	**127,432**	**100.00%**

Figure 10-1. Health Risk Assessments Completed with Primary Care Provider

June 2016



Healthy Behaviors Statement Selection

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

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

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

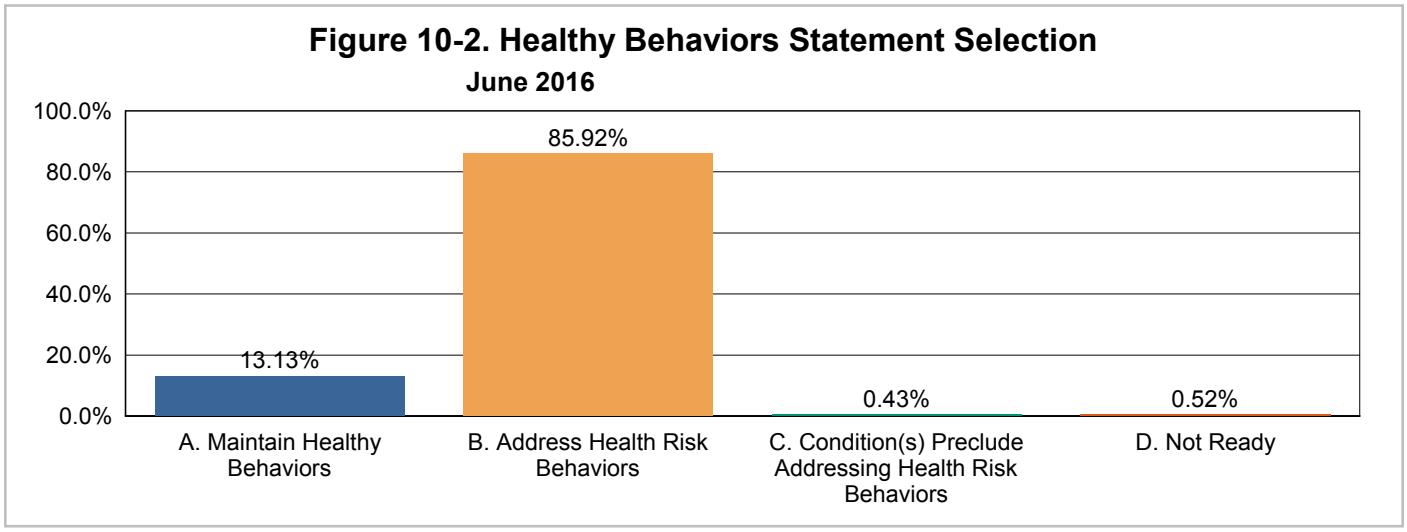
C. Patient has a serious medical, behavioral or social condition or conditions which precludes addressing unhealthy behaviors at this time.

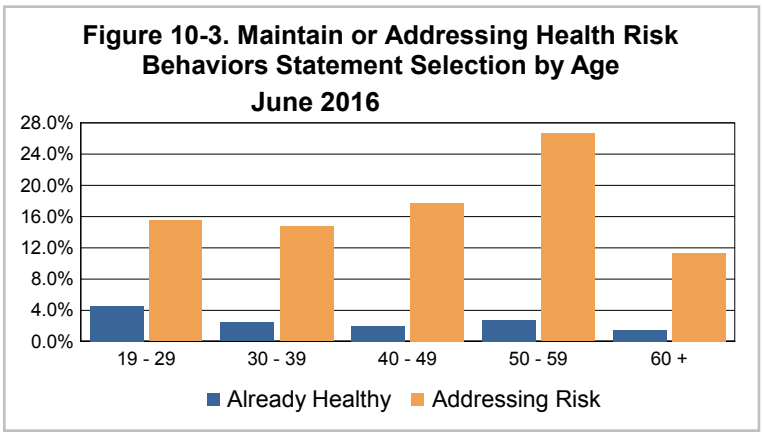
D. Unhealthy behaviors have been identified, patient's readiness to change has been assessed, and patient is not ready to make changes at this time.

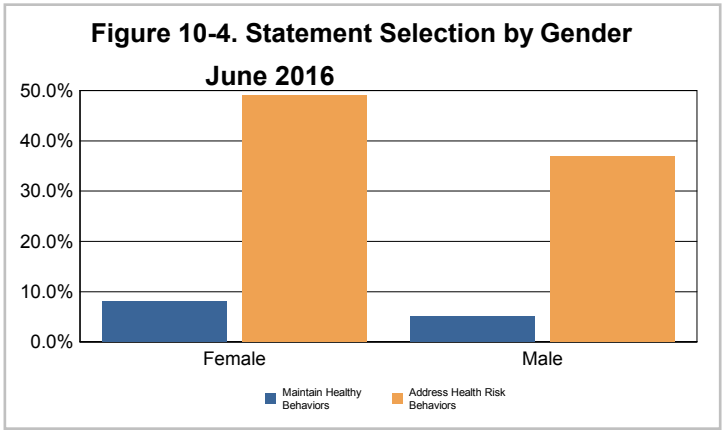
Figures 10-2 through 10-4 show Healthy Behaviors Statement Selections for the total population, and by age and gender.

Table 12. Healthy Behaviors Statement Selection
June 2016

CHECK-UP	TOTAL	PERCENT
A. Maintain Healthy Behaviors	16,727	13.13%
B. Address Health Risk Behaviors	109,494	85.92%
C. Condition(s) Preclude Addressing Health Risk Behaviors	550	0.43%
D. Not Ready	661	0.52%
TOTAL	**127,432**	**100.00%**







Selection of Health Risk Behaviors to Address

Section 4. Healthy Behaviors: In discussion with the beneficiary, when Statement B, "Patient has identified at least one behavior they intend to address over the next year to improve their health" is selected, providers choose one or more of the following 7 statements to identify the healthy behaviors the beneficiary has chosen to address for the year:

1. Increase physical activity, Learn more about nutrition and improve diet, and/or weight loss
2. Reduce/quit tobacco use
3. Annual Influenza vaccine
4. Agrees to follow-up appointment for screening or management (if necessary) of hypertension, cholesterol and/or diabetes
5. Reduce/quit alcohol consumption
6. Treatment for Substance Use Disorder
7. Other: explain _____

Of the 109,494 HRAs submitted through June 2016 where the beneficiary chose to address health risk behaviors, 60.12% of beneficiaries chose more than one healthy behavior to address. The top 7 most selected behavior combinations and the rate that each behavior was selected in combination and alone are presented in the tables below:

Table 13. Top 7 Most Selected Health Risk Behavior Combinations

Health Risk Behavior Combination	Count	Percent
1. Weight Loss ONLY	19,777	18.06%
2. Weight Loss, Follow-up for Chronic Conditions	10,197	9.31%
3. Weight Loss, Immunization Status, Follow-up for Chronic Conditions	9,716	8.87%
4. Tobacco Cessation ONLY	9,370	8.56%
5. Weight Loss, Immunization Status	7,633	6.97%
6. Follow-up for Chronic Conditions	6,614	6.04%
7. Weight Loss, Tobacco Cessation	5,987	5.47%
Total for Top 7	69,294	63.29%
Total for All Other Combinations	40,200	36.71%
Total	**109,494**	**100.00%**

Table 14. Health Risk Behaviors Selected in Combination and Alone

Health Risk Behavior	Chose this behavior and at least one more	Chose ONLY this behavior
Weight Loss	65.37%	18.06%
Tobacco Cessation	37.76%	8.56%
Immunization Status (Annual Flu Vaccine)	40.18%	4.40%
Follow-up for Chronic Conditions	42.89%	6.04%
Addressing Alcohol Abuse	4.56%	0.38%
Addressing Substance Abuse	1.17%	0.10%
Other	5.38%	2.35%

Health Risk Assessment Completion with Primary Care Provider

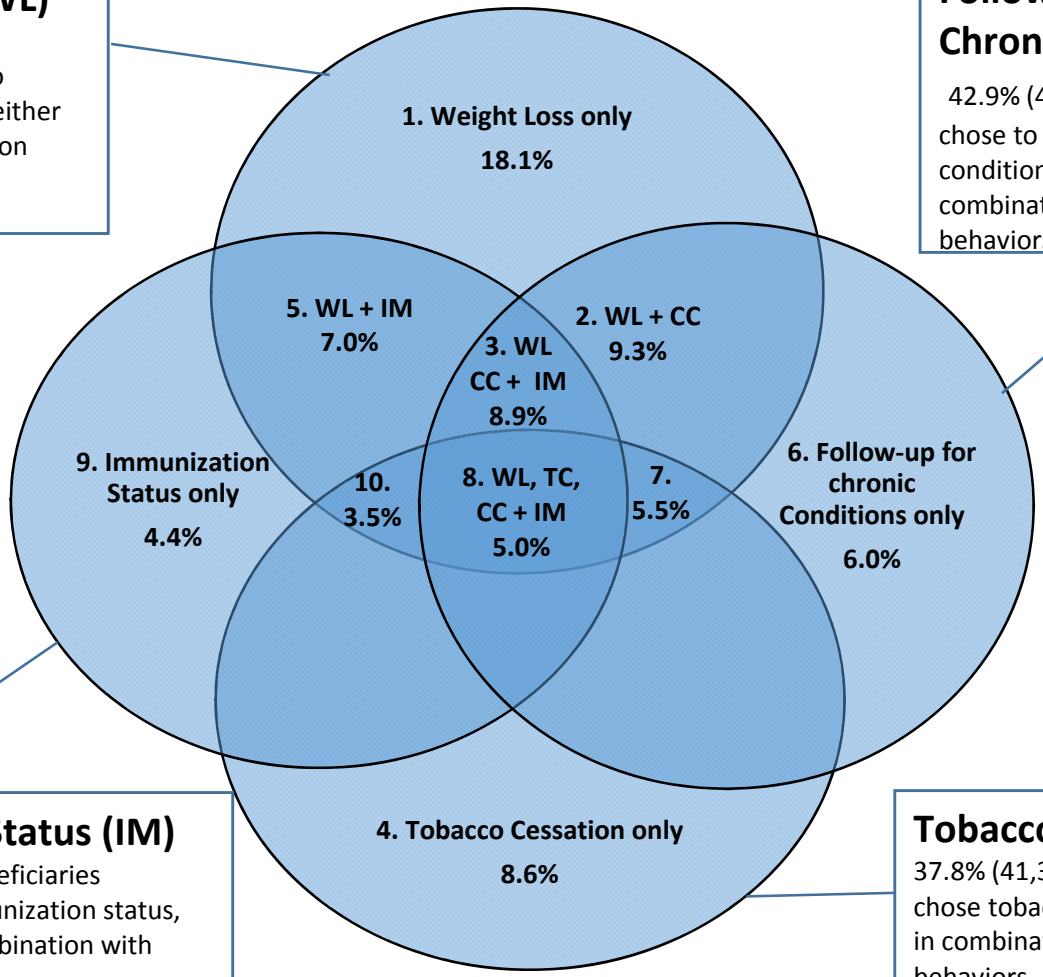
Representation of the overlapping nature of top 10 health risk behavior selections June 2016

Weight Loss (WL)

65.4% (71,575) of beneficiaries chose to address weight loss, either alone or in combination with other health behaviors

Follow-up for Chronic Conditions (CC)

42.9% (46,955) of beneficiaries chose to follow-up for chronic conditions, either alone or in combination with other health behaviors



More Middle Combinations
7. WL + TC 5.5%
10. WL + IM + TC 3.5%

Immunization Status (IM)

40.2% (43,987) of beneficiaries chose to address immunization status, either alone or in combination with other health behaviors

Tobacco Cessation (TC)

37.8% (41,344) of beneficiaries chose tobacco cessation, either alone or in combination with other health behaviors

Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Minutes

Date: Tuesday, May 10, 2016
Time: 1:00 pm – 4:30 pm
Where: Michigan Public Health Institute (MPHI)
2436 Woodlake Circle
Okemos, MI

Attendees: **Council Members:** Robin Reynolds, David Herbel, Cheryl Bupp, Cindy Schnetzler, Amy Zaagman, Marie DeFer, Dave LaLumia, Barry Cargill, Kimberly Singh, Marilyn Litka-Klein, Elmer Cerano, Alison Hirschel, Dianne Haas, Lisa Braddix (for Kate Kohn-Parrott), Eric Roath, Warren White, Rebecca Blake, April Stopczynski, Pam Lupo, Mark Klammer

Staff: Chris Priest, Kathy Stiffler, Dick Miles, Brian Keisling, Jackie Prokop, Pam Diebolt, Cindy Linn, Marie LaPres, Erin Emerson

Other Attendees: Dominic Pallone

Welcome and Introductions

Robin Reynolds opened the meeting and introductions were made.

Update on Flint

The Michigan Department of Health and Human Services (MDHHS) has received approval from the Centers for Medicare and Medicaid Services (CMS) to implement a waiver to provide coverage for children and pregnant women with incomes up to 400 percent of the federal poverty level (FPL) who were impacted by Flint water. The waiver became effective on May 9, 2016, and 94 people applied for coverage in the first day of implementation. All systems are operating smoothly, and MDHHS is focusing on outreach now that the waiver is operational. Eligible individuals may apply for coverage online at www.michigan.gov/mibridges, over the phone, or in person at any MDHHS County office. MDHHS is also working to implement a system for children and pregnant women over 400 percent of the FPL to buy unsubsidized coverage under the waiver by fall 2016.

Budget Update/Boilerplate

Chris Priest reported that the House of Representatives and the Senate have each passed a budget for fiscal year (FY) 2017, and the two bills are awaiting reconciliation in a conference committee before a final version is submitted to the governor for signature. Several differences in the two budgets were discussed, including the increase in the Private Duty Nursing (PDN)

rate (10 percent increase provided in the House budget, 20 percent increase in the Senate), and the expansion of the Healthy Kids Dental program (the Senate also allocated funds for expansion of adult dental services). The Senate also allocated funds for long-term care housing and outreach specialists in response to a reduction in the federal Money Follows the Person grant.

Healthy Michigan Plan

MDHHS has received CMS approval for a second waiver related to the Healthy Michigan Plan, and is now working to implement its provisions. Under the terms of the waiver beginning April 1, 2018, which is 48 months after the initial implementation of the Healthy Michigan Plan, individuals who have been enrolled in the Healthy Michigan Plan for at least 12 months and have incomes above 100 percent FPL may either:

- Complete a Health Risk Assessment (HRA) and choose to engage in one or more healthy behaviors, and remain on the Healthy Michigan Plan, or
- Leave the Healthy Michigan Plan and receive insurance from the Federally Facilitated Marketplace (FFM).

To implement the waiver, the Department will need to seek approval from CMS for revised Healthy Behavior Protocols, define "medically frail" for purposes of the demonstration, and provide plan guidance to the health plans on the FFM. The health plans must receive guidance by no later than fall 2016 in order to develop products to offer on the FFM beginning April 1, 2018. CMS also requires that at least two plans must be offered in each county. Approximately 120,000 Healthy Michigan Plan beneficiaries currently have incomes above 100 percent FPL, though MDHHS staff noted that the number of individuals who may move to the FFM after April 1, 2018 is difficult to project. A meeting attendee requested that Healthy Michigan Plan beneficiaries be permitted to submit their own paperwork related to Health Risk Assessments to the health plans instead of relying on the physician's office.

Behavioral Health Updates

Integration of Behavioral Health and Physical Health

Since release of the governor's FY 2017 executive budget recommendation in February 2016, which called for the integration of behavioral health and physical health services, the Lieutenant Governor has convened a stakeholder group to discuss the issue. The stakeholder group has met three times to date, with two additional meetings scheduled through June 2016. The group has defined a set of core concepts to make up the framework for a new system to integrate behavioral health and physical health services, and will discuss critical design elements for a new system and core concepts for boilerplate language at future meetings. The House and Senate budgets also propose language related to the integration of behavioral health and physical health services, and call for ongoing workgroups, as well. The stakeholder group has indicated a preference for the language proposed by the House. Additional information related

to the stakeholder group is available on the MDHHS website at www.michigan.gov/stakeholder298.

Certified Community Behavioral Health Clinics (CCBHCs)

In October 2015, Michigan became one of 25 states to receive a planning grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to establish CCBHCs. The planning grant will allow the State of Michigan to certify at least two clinics to provide intensive person-centered multi-disciplinary evidence-based screening, assessment, and diagnostic treatment and prevention services for individuals with mental health concerns. MDHHS released a request for certification in March 2016 for non-profit and government organizations, tribal health centers and federally qualified health centers to apply for certification as a CCBHC. Responses were due on May 5, 2016, and MDHHS received 28 requests for certification. The Department is now in the process of reviewing the applications to select the potential sites to participate in the planning grant, which it hopes to complete within three to four weeks. Once the sites are selected, MDHHS must conduct site visits and develop a prospective payment system. The Department must also submit an application by October 23, 2016 to be selected as one of eight states to participate in the SAMHSA demonstration grant for CCBHCs.

Eligibility Redetermination Update

MDHHS is in the process of implementing a system for passive redetermination of Medicaid eligibility for beneficiaries with a systems release scheduled in June 2016 for the Modified Adjusted Gross Income (MAGI) group. Passive redetermination for non-MAGI groups will be included in future Bridges releases. Beneficiaries who wish to be part of the passive redetermination process may provide their consent when applying for coverage. Once consent is given the Department will examine federal and state tax returns to determine subsequent eligibility for Medicaid programs without the need for additional action by the caseworker or beneficiary. In response to an inquiry, MDHHS staff and meeting attendees also discussed the income and asset limitations for Medicaid eligibility.

Federal Regulatory Guidance

Chris Priest reported on several pieces of federal regulatory guidance that have been issued by CMS recently, including:

- New rules related to Medicaid managed care with implications for MDHHS payment mechanisms, Prepaid Inpatient Health Plans (PIHPs), and many other areas;
- A new access regulation that requires MDHHS to develop a process by the end of 2016 to determine that access to care would not be harmed if Medicaid Fee-for-Service (FFS) rates are reduced;
- A new outpatient drug regulation that changes the reimbursement methodology for pharmacists as it relates to dispensing fees and ingredient costs; and
- New regulations related to mental health parity.

Chris encouraged meeting attendees to contact MDHHS with any concerns related to any new guidance from CMS, and noted that all federal rules for Medicaid are available on the CMS website at www.medicaid.gov >> Federal Policy Guidance.

Managed Care

Common RX Formulary Update

Kathy Stiffler reported that two stakeholder meetings have been held related to the implementation of a common formulary among all health plans to discuss coding changes that will need to be made as a result of the transition. The transition to a common formulary began on April 1, 2016, with a planned completion date of October 1, 2016.

Provider Surveys

MDHHS is working to develop a survey for primary care providers to give input to MDHHS related to their experience in working with the Medicaid health plans. When the survey is released, providers will be randomly assigned a health plan to evaluate, but may complete additional health plan evaluations as well.

Maternal Infant Health Program (MIHP) Transition

MDHHS has released project #1611-MIHP for public comment, which discusses the planned transition of MIHP services to the Medicaid health plans. This change will be effective October 1, 2016. In addition to accepting written comments on the proposed policy change, MDHHS has also planned meetings with MIHP providers, both in-person and through a webinar, to discuss its impact and help to ensure a smooth transition.

Long Term Care Services and Supports Updates

MI Health Link

Dick Miles announced that Pamela Gourwitz has been hired as the new director of the Integrated Care Division, which oversees the MI Health Link program for individuals who are dually eligible for Medicare and Medicaid, and provided an update on the program. Currently, 30,800 individuals total are enrolled in MI Health Link, including 1,800 individuals in nursing homes. Dick noted that enrollment has declined from 42,500 beneficiaries in September 2015, which is a result in part from beneficiaries losing Medicaid eligibility. As a solution to this problem, he reported that MDHHS is working to implement a new process known as deeming, in which MI Health Link beneficiaries who lose Medicaid eligibility may remain enrolled in MI Health Link for up to 90 days while their eligibility status is resolved. The next passive enrollment period for MI Health Link begins in June 2016, in which all individuals in the four demonstration regions (Upper Peninsula, Southwest Michigan, Wayne County and Macomb County) who are dually eligible for Medicare and Medicaid will be enrolled into MI Health Link if

they have not chosen to opt out. MDHHS is also working with its integrated care organization partners and provider groups to update its marketing strategy for the demonstration in order to encourage more eligible individuals to enroll voluntarily. A stakeholder meeting is planned for fall 2016.

A meeting attendee asked how the process of deeming within MI Health Link would affect PIHPs. In response, Dick noted that the Medical Services Administration has discussed the issue with the Behavioral Health and Developmental Disabilities Administration and determined that the PIHPs who participate with MI Health Link would continue use their own discretion regarding whether to provide services to an individual who has lost Medicaid eligibility. Unlike Integrated Care Organizations, PIHPs are not entitled to retroactive reimbursement for services rendered in the event that a beneficiary's Medicaid eligibility is restored.

A meeting attendee also requested information on why the individuals currently enrolled in MI Health Link chose to remain in the program while others disenrolled. In response, Dick reported that MDHHS is working with Michigan State University (MSU) to conduct a survey of MI Health Link beneficiaries regarding their experience with the demonstration.

Policy Updates

Revised Organizational Chart for MDHHS

MDHHS staff reported on organizational changes within the Department, including the migration of Children's Special Health Care Services (CSHCS) to the Medical Services Administration within the Bureau of Medicaid Care Management and Quality Assurance.

Health Homes/MI Care Team

MDHHS will implement a health home model known as MI Care Team for individuals with certain chronic conditions on July 1, 2016, with the goal of better integrating physical health and behavioral health treatment services. The Department has selected 10 federally qualified health centers in 18 counties throughout the State of Michigan to help implement the program, and expects to serve approximately 10,000-12,000 individuals per year based on available funding.

Other

MDHHS staff also discussed bulletin MSA 16-10, regarding targeted case management services for beneficiaries who were served by the Flint water system, and bulletin MSA 16-11, regarding Flint Water Group medical assistance. The public comment portion of the policy promulgation process for both bulletins is being conducted concurrently with their implementation, and interested parties may submit comments until June 8, 2016. A policy bulletin handout was also distributed to attendees.

A meeting attendee also requested clarification on eligibility requirements for the Women, Infants and Children (WIC) program. In response, MDHHS staff reported that women who are pregnant or nursing, infants and children under the age of five who are eligible for Medicaid are also eligible for WIC. The Department is also preparing to issue a press release to clarify WIC eligibility requirements.

The meeting was adjourned at 3:45 p.m.

Next Meeting: August 9, 2016

MI HEALTH ACCOUNT

EXECUTIVE SUMMARY REPORT

JUNE 2016

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: JUNE 2016

MAXIMUS contracts with each Healthy Michigan Plan health plan to operate the MI Health Account (MIHA). The MIHA documents health care costs and payments for health plan members eligible for the Healthy Michigan Plan. Any amount the beneficiary owes to the MIHA is reflected in the quarterly statement that is mailed to the beneficiary. The MIHA quarterly statement shows the total amount owed for co-pays and/or contributions.

A co-pay is a fixed amount beneficiaries pay for a health care service. Before a beneficiary is enrolled in managed care, the beneficiary will pay any co-pays directly to their provider at the time of service. Once enrolled in managed care, co-pays for health plan covered services will be paid into the MIHA.

A contribution is the amount of money that is paid toward health care coverage. **Beneficiaries with incomes at or below 100% of the Federal Poverty Level (FPL) will NOT have a contribution.** Beneficiaries above 100% FPL are required to pay contributions that are based on income and family size. The quarterly statement informs beneficiaries what to pay for co-pays and contributions each month for the next three months, includes payment coupons with instructions on how to make a payment, as well as tips on how to reduce costs (Healthy Behavior incentives). The statement lists the services the beneficiary has received, the amount the beneficiary has paid, what amount they still need to pay, and the amount the health plan has paid.

Quarterly Statement Mailing Guidelines

- The first quarterly statement is mailed six months after a beneficiary joins a health plan. After that, quarterly statements are sent every three months.
- A beneficiary follows his or her own enrollment quarter based on their enrollment effective date**.**
- Quarterly statements are mailed by the 15th calendar day of each month
- Statements are not mailed to beneficiaries if there are no health care services to display or payment due for a particular quarter.

Chart 1 displays the statement mailing activity for the past three months. It also displays the calendar year totals since January 2016 and the program totals from October 2014 to March 2016.

Chart 1: Account Statement Mailing

Month Statement Mailed	Statements Mailed	Statements Requiring a Copay Only	Statements Requiring a Contribution Only	Statements Requiring a Copay and Contribution	Percentage of Statements Requiring Payment
Jan-16	86,889	12,562	12,048	6,280	35.55%
Feb-16	60,514	8,991	9,138	5,080	38.26%
Mar-16	80,639	16,737	6,347	8,601	39.30%
Calendar YTD	**228,042**	**38,233**	**27,533**	**19,964**	**37.59%**
Program Total	**1,141,920**	**268,987**	**102,512**	**111,129**	**42.26%**

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Payments for the MIHA are due on the 15th of the month following the month they were billed.

Chart 2 displays a collection history of the number of beneficiaries that have paid co-pays and contributions. Completed quarterly payment cycles are explained and reflected in Chart 3. Calendar year totals are from January 2016. Program totals are from October 2014 through March 2016. Please note that beneficiaries that pay both co-pays and contributions will show in each chart.

Chart 2: Collection Amount by Copays/Contributions

Copays

Statement Month	Amount of copays owed	Amount of copays paid	Percentage of copays paid	Number of beneficiaries who owed copays	Number of beneficiaries who paid copays
Jan-16	$87,538.66	$32,906.62	38%	18,842	7,307
Feb-16	$67,493.20	$25,845.97	38%	14,071	5,577
Mar-16	$240,275.66	$81,598.84	34%	25,338	9,393
Calendar YTD	**$395,307.52**	**$140,351.43**	**36%**	**58,251**	**22,277**
Program Total	**$2,597,268.63**	**$938,624.71**	**36%**	**379,090**	**136,885**

Contributions

Statement Month	Amount of contributions owed	Amount of contributions paid	Percentage of contributions paid	Number of beneficiaries who owed contributions	Number of beneficiaries who paid contributions
Jan-16	$957,421.78	$293,058.60	31%	18,328	6,896
Feb-16	$727,890.65	$226,736.78	31%	14,218	5,575
Mar-16	$773,241.37	$201,205.53	26%	14,948	5,262
Calendar YTD	**$2,458,553.80**	**$721,000.91**	**29%**	**47,494**	**17,733**
Program Total	**$11,588,307.35**	**$3,502,588.93**	**30%**	**213,634**	**78,826**

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Chart 3 displays the total amount collected by completed quarter, by enrollment month. For example, beneficiaries who enrolled in May 2014 received their first quarterly statement in November 2014. These individuals had until February 2015 to pay in full, which constitutes a completed quarter. Please note that the Percentage Collected will change even in completed quarters because payments received are applied to the oldest invoice owed.

Chart 3: Quarterly Collection

Enrollment Month	Quarterly Pay Cycles	Amount Owed	Amount Collected	Percentage Collected
Apr-14	Oct 2014 - Dec 2014	$24,297.41	$14,014.18	57.68%
	Jan 2015 - Mar 2015	$201,864.83	$104,977.54	52.00%
	Apr 2015 - Jun 2015	$170,894.52	$77,999.83	45.64%
	Jul 2015 - Sep 2015	$163,070.66	$71,718.85	43.98%
	Oct 2015 - Dec 2015	$155,784.68	$58,995.73	37.87%
	Jan 2016 - Mar 2016	$127,668.02	$45,120.83	35.34%
May-14	Nov 2014 - Jan 2015	$40,293.73	$22,729.47	56.41%
	Feb 2015 - Apr 2015	$62,221.29	$31,456.01	50.56%
	May 2015 - Jul 2015	$48,835.94	$24,070.34	49.29%
	Aug 2015 - Oct 2015	$40,442.14	$19,820.50	49.01%
	Nov 2015 - Jan 2016	$40,040.89	$17,774.48	44.39%
	Feb 2016 - Apr 2016	$37,837.52	$14,047.40	37.13%
Jun-14	Dec 2014 - Feb 2015	$475,437.28	$280,096.49	58.91%
	Mar 2015 - May 2015	$376,765.97	$205,248.61	54.48%
	Jun 2015 - Aug 2015	$355,839.06	$197,020.94	55.37%
	Sep 2015 - Nov 2015	$335,608.69	$169,275.49	50.44%
	Dec 2015 - Feb 2016	$242,039.86	$107,484.51	44.41%
	Mar 2016 - May 2016	$272,432.96	$108,528.41	39.84%
Jul-14	Jan 2015 - Mar 2015	$370,037.92	$178,033.05	48.11%
	Apr 2015 - Jun 2015	$277,430.67	$119,571.84	43.10%
	Jul 2015 - Sep 2015	$249,231.82	$111,950.09	44.92%
	Oct 2015 - Dec 2015	$231,149.45	$89,667.24	38.79%
	Jan 2016 - Mar 2016	$183,973.38	$67,148.20	36.50%
Aug-14	Feb 2015 - Apr 2015	$182,457.95	$90,864.57	49.80%
	May 2015 - Jul 2015	$133,672.95	$57,621.13	43.11%
	Aug 2015 - Oct 2015	$109,152.47	$52,679.80	48.26%
	Nov 2015 - Jan 2016	$105,458.36	$43,960.09	41.68%
	Feb 2016 - Apr 2016	$100,991.58	$33,131.03	32.81%

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Enrollment Month	Quarterly Pay Cycles	Amount Owed	Amount Collected	Percentage Collected
Sep-14	Mar 2015 - May 2015	$227,455.21	$99,273.11	43.65%
	Jun 2015 - Aug 2015	$161,203.56	$62,431.28	38.73%
	Sep 2015 - Nov 2015	$153,547.38	$58,423.36	38.05%
	Dec 2015 - Feb 2016	$124,773.56	$40,944.39	32.81%
	Mar 2016 - May 2016	$141,081.94	$36,457.59	25.84%
Oct-14	Apr 2015 - Jun 2015	$186,496.55	$79,458.83	42.61%
	Jul 2015 - Sep 2015	$135,666.70	$53,293.50	39.28%
	Oct 2015 - Dec 2015	$129,677.15	$47,604.47	36.71%
	Jan 2016 - Mar 2016	$113,150.12	$39,287.99	34.72%
Nov-14	May 2015 - Jul 2015	$206,406.05	$86,008.87	41.67%
	Aug 2015 - Oct 2015	$135,961.12	$50,468.43	37.12%
	Nov 2015 - Jan 2016	$136,700.04	$52,525.21	38.42%
	Feb 2016 - Apr 2016	$142,242.82	$44,114.16	31.01%
Dec-14	Jun 2015 - Aug 2015	$112,068.61	$50,303.19	44.89%
	Sep 2015 - Nov 2015	$86,269.12	$32,987.15	38.24%
	Dec 2015 - Feb 2016	$68,945.13	$24,376.58	35.36%
	Mar 2016 - May 2016	$83,545.25	$24,541.26	29.37%
Jan-15	Jul 2015 - Sep 2015	$216,960.63	$106,581.82	49.12%
	Oct 2015 - Dec 2015	$177,622.45	$71,423.82	40.21%
	Jan 2016 - Mar 2016	$156,094.28	$64,082.23	41.05%
Feb-15	Aug 2015 - Oct 2015	$207,626.65	$93,133.46	44.86%
	Nov 2015 - Jan 2016	$138,081.48	$59,877.17	43.36%
	Feb 2016 - Apr 2016	$154,912.72	$61,385.33	39.63%
Mar-15	Sep 2015 - Nov 2015	$220,768.31	$88,812.21	40.23%
	Dec 2015 - Feb 2016	$103,573.30	$36,914.16	35.64%
	Mar 2016 - May 2016	$108,447.69	$39,058.24	36.02%
Apr-15	Oct 2015 - Dec 2015	$268,411.83	$108,935.60	40.59%
	Jan 2016 - Mar 2016	$110,163.16	$56,217.31	51.03%
May-15	Nov 2015 - Jan 2016	$175,422.45	$73,706.97	42.02%
	Feb 2016 - Apr 2016	$114,902.84	$49,147.03	42.77%
Jun-15	Dec 2015 - Feb 2016	$152,091.35	$55,346.94	36.39%
	Mar 2016 - May 2016	$108,813.08	$35,539.92	32.66%
Jul-15	Jan 2016 - Mar 2016	$128,232.13	$54,108.66	42.20%

Chart 3 continued on page 6

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Chart 3 continued from page 5

Enrollment Month	Quarterly Pay Cycles	Amount Owed	Amount Collected	Percentage Collected
Aug-15	Feb 2016 - Apr 2016	$155,487.22	$50,757.80	32.64%
Sep-15	Mar 2016 - May 2016	$126,809.57	$38,678.95	30.50%

Payments for the MIHA can be made one of two ways. Beneficiaries can mail a check or money order to the MIHA payment address. The payment coupon is not required to send in a payment by mail. Beneficiaries also have the option to pay online using a bank account.

Chart 4 displays a three month history of the percentage of payments made into the MIHA.

Chart 4: Methods of Payment

	Jan-16	Feb-16	Mar-16
Percent Paid Online	29.23%	31.14%	27.31%
Percent Paid by Mail	70.77%	68.86%	72.69%

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Adjustment Activities

Beneficiaries are not required to pay co-pays and/or contributions when specific criteria are met. In these cases, an adjustment is made to the beneficiary's quarterly statement.

This includes populations that are exempt; beneficiaries that are under age 21, pregnant, in hospice and Native American beneficiaries. It also includes beneficiaries who were not otherwise exempt, but have met their five percent maximum cost share and beneficiaries whose Federal Poverty Level is no longer in a range that requires a contribution.

Chart 5A shows the number of beneficiaries that met these adjustments for the specified month, calendar year since January 2016 and the cumulative total for the program from October 2014 through March 2016.

Chart 5A: Adjustment Activities

	Jan-16		Feb-16		Mar-16	
	#	Total $	#	Total $	#	Total $
Beneficiary is under age 21	467	$23,310.84	515	$26,303.75	429	$27,115.65
Pregnancy	482	$17,582.86	32	$1,092.68	53	$7,213.24
Hospice	0	$0.00	0	$0.00	0	$0.00
Native American	51	$1,097.00	45	$912.50	50	$765.33
Five Percent Cost Share Limit Met	22,665	$296,284.38	15,536	$236,078.64	31,949	$581,058.63
FPL No longer >100% - Contribution	0	$0.00	0	$0.00	0	$0.00
TOTAL	**23,665**	**$338,275.08**	**16,128**	**$264,387.57**	**32,481**	**$616,152.85**
	Jan-16 to Mar-16		**Calendar YTD**		**Program YTD**	
	#	Total $	#	Total $	#	Total $
Beneficiary is under age 21	1,411	$76,730.24	1,411	$76,730.24	6,220	$313,870.09
Pregnancy	567	$25,888.78	567	$25,888.78	4,844	$148,540.35
Hospice	0	$0.00	0	$0.00	0	$0.00
Native American	146	$2,774.83	146	$2,774.83	640	$26,993.83
Five Percent Cost Share Limit Met	70,150	$1,113,421.65	70,150	$1,113,421.65	404,561	$5,967,428.79
FPL No longer >100% - Contribution	0	$0.00	0	$0.00	20	$1,152.50
TOTAL	**72,274**	**$1,218,815.50**	**72,274**	**$1,218,815.50**	**416,285**	**$6,457,985.56**

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Healthy Behavior Incentives

Beneficiaries may qualify for reductions in co-pays and/or contributions due to Healthy Behavior incentives. All health plans offer enrolled beneficiaries financial incentives that reward healthy behaviors and personal responsibility. To be eligible for incentives a beneficiary must first complete a health risk assessment (HRA) with their primary care provider (PCP) and agree to address or maintain health behaviors.

Co-pays – Beneficiaries can receive a 50% reduction in co-pays once they have paid 2% of their income in co-pays AND agree to address or maintain healthy behaviors.

Contributions - Beneficiaries can receive a 50% reduction in contributions if they complete an HRA with a PCP attestation AND agree to address or maintain healthy behaviors.

Gift Cards – Beneficiaries at or below 100% FPL receive a $50.00 gift card if they complete an HRA with a PCP attestation AND agree to address or maintain healthy behaviors.

Chart 5B shows the number of beneficiaries that qualified for a reduction in co-pays and/or contributions due to Healthy Behavior incentives for the specified month, calendar year since January 2016 and the cumulative total for the program from October 2014 through March 2016.

Chart 5B: Healthy Behaviors

	Jan-16		Feb-16		Mar-16	
	#	Total $	#	Total $	#	Total $
Co-pay	983	$5,736.61	723	$1,817.84	1,310	$9,301.02
Contribution	2,891	$101,650.78	2,416	$82,573.83	2,677	$110,527.14
Gift Cards	3,786	n/a	2,794	n/a	2,775	n/a
TOTAL	**7,660**	**$107,387.39**	**5,933**	**$84,391.67**	**6,762**	**$119,828.16**
	Jan-16 to Mar-16		**Calendar YTD**		**Program YTD**	
	#	Total $	#	Total $	#	Total $
Co-pay	3,016	$16,855.47	3,016	$16,855.47	4,263	$21,897.99
Contribution	7,984	$294,751.75	7,984	$294,751.75	31,034	$1,047,913.44
Gift Cards	9,355	n/a	9,355	n/a	74,120	n/a
TOTAL	**20,355**	**$311,607.22**	**20,355**	**$311,607.22**	**109,417**	**$1,069,811.43**

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Beneficiaries that do not pay three consecutive months they have been billed co-pays or contributions are considered “consistently failing to pay (CFP)” status. Once a beneficiary is in CFP status, the following language is added to the quarterly statement: “If your account is overdue, you may have a penalty. For example, if you have a healthy behavior reduction, you could lose it. Your information may also be sent to the Michigan Department of Treasury. They can take your overdue amount from your tax refund or future lottery winnings. Your doctor cannot refuse to see you because of an overdue amount.” Beneficiaries that are in CFP status and have a total amount owed of at least $50 can be referred to the Department of Treasury for collection. Beneficiaries that have not paid at least 50% of their total contributions and co-pays billed to them in the past 12 months can also be referred to the Department of Treasury for collection.

Chart 6 displays the past due collection history and the number of beneficiaries that have past due balances that can be collected through the Department of Treasury. These numbers are cumulative from quarter to quarter.

Chart 6: Past Due Collection Amounts

Month	# of Beneficiaries with Past Due Co-pays/Contributions	# of Beneficiaries with Past Due Co-pays/Contributions that Can be Sent to Treasury
Jan-16	74,026	4,948
Feb-16	82,216	2,984
Mar-16	87,850	5,080

Chart 7 displays the total amount of past due invoices according to the length of time the invoice has been outstanding. Each length of time displays the unique number of beneficiaries for that time period. The total number of delinquent beneficiaries is also listed along with the corresponding delinquent amount owed.

Chart 7: Delinquent Copay and Contribution Amounts by Aging Category

Days	0-30 Days	31-60 Days	61-90 Days	91-120 Days	>120 Days	TOTAL
Amount Due	$791,261.23	$662,441.40	$595,857.71	$520,936.37	$4,387,630.35	**$6,958,127.06**
Number of Beneficiaries That Owe	64,087	53,723	47,521	39,589	95,801	**140,064**

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Beneficiaries are mailed a letter that informs them of the amount that could be garnished by the Department of Treasury. This pre-garnishment notice is mailed each year in July. Beneficiaries are given 30 days from the date of the letter to make a payment or file a dispute with the Department of Health and Human Services (DHHS) for the amount owed.

Chart 8 displays the beneficiary payment activity as a result of the pre-garnishment notice.

Chart 8: Pre-Garnishment Notices

Month/Year	# of Beneficiaries that Received a Garnishment Notice	Total Amount Owed	# of Beneficiaries that Paid Following Pre-Garnishment Notice	Total Amount Collected
Jul-15	5,893	$589,770.20	2,981	$78,670.02
Jul-16	0	$0.00	0	$0.00
Calendar YTD	0	$0.00	0	$0.00
Program Total	**5,893**	**$589,770.20**	**2,981**	**$78,670.02**

Beneficiaries are referred to the Department of Treasury each year in November if they still owe at least $50 following the pre-garnishment notice.

Chart 9 displays the number of beneficiaries that were referred to Treasury.

Chart 9: Garnishments Sent to Treasury

Month	# of Beneficiaries Sent to Treasury for Garnishment	Total Amount Sent to Treasury for Garnishment
Nov-15	4,635	$460,231.19

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The Department of Treasury may garnish tax refunds or lottery winnings up to the amount referred to them from the MI Health Account.

Chart 10 displays collection activities by the Department of Treasury.

Chart 10: Garnishments Collected by Treasury

Tax Year	# of Garnishments Collected By Taxes	# of Garnishments Collected By Lottery	Total # of Garnishments Collected	Total Amount of Garnishments Collected By Taxes	Total Amount of Garnishments Collected By Lottery	Total Amount of Garnishments Collected
2015	2,018	4	2,022	$196,063.40	$301.00	$196,364.40
2016	0	0	0	$0	$0	$0
Calendar YTD	**2,018**	**4**	**2,022**	**$196,063.40**	**$301.00**	**$196,364.40**
Program Total	**2,018**	**4**	**2,022**	**$196,063.40**	**$301.00**	**$196,364.40**