STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

July 2, 2015

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

Dear Ms. Ashkeboussi,

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

Enclosed is the quarterly report for Healthy Michigan Plan. It covers the second quarter of federal fiscal year 2015. 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,

[redacted]

Actuarial Division

cc: Ruth Hughes
Angela Garner

Enclosure (4)

Michigan Adult Coverage Demonstration
Section 1115 Quarterly Report

Demonstration Year: 6 (01/01/2015 – 12/31/2015)
Federal Fiscal Quarter: 2 (01/01/2015 – 03/31/2015)

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

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Introduction

In January 2004, the "Adult Benefits Waiver" (ABW) was approved and implemented as a Title XXI funded Section 1115 demonstration. The ABW provided a limited ambulatory benefit package to previously uninsured, low-income non-pregnant childless adults ages 19 through 64 years with incomes at or below 35 percent of the Federal poverty level (FPL) who are not eligible for Medicaid.

In December 2009, Michigan was granted approval by the Centers for Medicare and Medicaid Services (CMS) for a new Medicaid Section 1115 demonstration, entitled "Michigan Medicaid Nonpregnant Childless Adults Waiver (Adult Benefits Waiver)," to allow the continuation of the ABW health coverage program after December 31, 2009 through the use of Title XIX funds. The new ABW demonstration allowed Michigan to continue offering the ABW coverage program through September 30, 2014, under terms and conditions similar to those provided in the original Title XXI demonstration.

In December 2013, CMS approved Michigan's request to amend the Medicaid demonstration, entitled "Healthy Michigan Plan Section 1115 Demonstration (Project No. 11-W-00245/5)," formerly known as the Medicaid Nonpregnant Childless Adults Waiver [Adult Benefits Waiver (ABW)]. On April 1, 2014, Michigan expanded its Medicaid program to include adults with income up to 133 percent of the FPL. To accompany this expansion, the Michigan 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 will be 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 will be 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. Healthy Michigan Plan beneficiaries will receive quarterly statements that summarize the MI Health Account activity. Beneficiaries will also have opportunities to reduce their cost-sharing amounts by agreeing to address or maintain certain Healthy Behaviors.

To reflect its expanded purpose, the name of the demonstration is 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

Enrollment into the Healthy Michigan Plan, beginning April 1, 2014, happened two ways. First, beneficiaries who were enrolled in the ABW were automatically transitioned into the Healthy Michigan Plan effective April 1, 2014. Second, MDHHS began enrolling new beneficiaries into the new program beginning April 1, 2014. Potential enrollees can apply for the program in one of three ways. They can apply via the MDHHS website, call a toll-free number or visit their local MDHHS office. At this time, MDHHS does not anticipate any changes in the population served or the benefits offered. Enrollment has continued to grow during this quarter of the program with enrollment reaching over 600,000 by the end of the quarter. Michigan continues to see evidence of the high demand for services offered.

Table 1: Healthy Michigan Plan New Enrollments by Month			
January 2015	February 2015	March 2015	Total
54,627	52,328	36,589	143,544

Table 2: Healthy Michigan Plan Disenrollments by Month			
January 2015	February 2015	March 2015	Total
24,727	18,206	22,276	65,209

Most Healthy Michigan Plan beneficiaries have elected to choose a health plan rather than being automatically assigned to a health plan. As of March 10, 2015, 323,552 or, 73 percent, of the State's 443,319 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, 7,832 of all Healthy Michigan Plan health plan enrollees changed health plans. This quarter, 4,833, or 62 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: http://www.michigan.gov/mdch/0,4612,7-132-2943_66797-325070--,00.html. New members are informed that an annual preventative visit is a covered benefit of the Healthy Michigan Plan. 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 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 96 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
January 2015	12,602	96%	555	4%	13,157
February 2015	9,648	96%	377	4%	10,025
March 2015	13,099	96%	506	4%	13,605
Total	35,349	96%	1,438	4%	36,787

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 then securely sends the completed Health Risk Assessment to the appropriate Medicaid Health Plan. This quarter, 16,004 Health Risk Assessments for Healthy Michigan Plan beneficiaries participating in the healthy behaviors incentive program were submitted by Medicaid Health Plans. Of these, health plans have reported that 12,818 of the earned incentives are gift card incentives. Additionally, 3,104 reductions in future contribution requirements have been earned. Reductions earned were first applied to the MI Health Account Statements in November 2014. In this quarter, 3,183 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 March 2015 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				
	January 2015	February 2015	March 2015	Total
Health Risk Assessments Submitted	4,052	4,439	6,527	15,018
Gift Cards Earned	3,191	3,501	5,265	11,957
Reductions Earned	837	922	1,223	2,982
Reductions Applied	961	596	1,626	3,183

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 March 2015 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.

While Healthy Michigan Plan enrollment continued to demonstrate substantial growth, MDHHS saw a significant number of disenrollments from the plan as reported in the Monthly Enrollment Reports to CMS. Healthy Michigan disenrollments reflected individuals who were disenrolled during a redetermination of eligibility or switched coverage due to eligibility for other Medicaid program benefits. In most cases when beneficiaries were disenrolled from the Healthy Michigan Plan due to eligibility for other Medicaid programs. This 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 – 03/2015	Current Enrollees (year to date)	Disenrolled in Current Quarter
ABW Childless Adults	N/A	N/A	N/A
Healthy Michigan Adults	653,860	653,860	65,209

Outreach/Innovation Activities to Assure Access

On March 20, 2014, Governor Snyder announced to the public that the State would begin taking applications for the new Healthy Michigan Plan effective April 1, 2014. MDHHS developed a Healthy Michigan Program website with information available to both beneficiaries and providers (http://www.michigan.gov/healthymiplan/). 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. This quarter, MDHHS has engaged with numerous stakeholders. Community partners have requested MDHHS presentations on Healthy Michigan Plan updates as the program approaches one year after implementation. MDHHS partners also communicate with community stakeholders as Healthy Michigan Plan redeterminations draw near. This quarter, MDHHS has begun the process of annually reviewing its chronic conditions list. This annual review will be limited to additions to the list and will undoubtedly involve stakeholder input. Additionally, 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 February 2015 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 online at: http://michigan.gov/mdch/0,4612,7-132-2943_4860-55742--,00.html.

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 continues to work 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. As described in the Operational Protocol for the MI Health Accounts, state law requires consequences for Healthy Michigan Plan members that consistently fail to meet payment obligations. Currently, MDHHS is developing the MI Health Account garnishment process with the Michigan Department of Treasury.

Operational/Policy/Systems/Fiscal Developmental Issues

MDHHS holds bi-monthly meetings 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 Healthy Michigan Plan policies were issued by the State during the quarter covered by this report:

Table 6: Medicaid Policy Bulletins with Healthy Michigan Plan Impact

Issue Date	Subject	Link
01/29/2015	Changes to Prior Authorization Requirements for Pediatric-Related Overnight Stays	MSA 15-03
03/02/2015	Mobile Dental Facilities	MSA 15-04
03/02/2015	Updates to the Medicaid Provider Manual; ICD-10 Project Update; New Coverage of Existing Code; EPSDT/Habilitative Services Update; and Changes to the Michigan Department of Community Health and the Michigan Department of Human Services	MSA 15-05

The following Healthy Michigan Plan Medicaid Provider letters were issued by the State during the quarter covered by this report:

Table 7: Medicaid Provider Letters with Healthy Michigan Plan Impact		
Issue Date	Subject	Link
01/30/2015	Tribal Health Center (THC) All-Inclusive Rate for Managed Care Encounters	L 15-10
01/30/2015	Notice of Intent to Submit a State Plan Amendment on Cost-Sharing	L 15-11

Financial/Budget Neutrality Development Issues

CMS approved an increase in the Healthy Michigan Plan per member per month limit on January 13, 2015. 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 with 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	$542.15	$569.80	$598.86	$629.40
Actual HMP PMPM (YTD)	$406.38	$429.43	-	-	-
Total Expenditures (YTD)	$1,489,460,927	$764,828,526	-	-	-
Total Member Months (YTD)	3,665,184	1,781,026	-	-	-

Beneficiary Month Reporting

The beneficiary counts below include information for each of the designated months during the quarter, and include retroactive eligibility through March 31, 2015.

Table 9: Healthy Michigan Plan Beneficiary Month Reporting				
Eligibility Group	January 2015	February 2015	March 2015	Total for Quarter Ending 03/15
Healthy Michigan Adults	566,442	600,344	614,240	1,781,026

Consumer Issues

This quarter, the total number of Healthy Michigan Plan complaints reported to MDHHS was 81. Issues obtaining prescriptions comprised 37 percent of total complaints received by MDHHS. Beneficiaries experiencing issues obtaining transportation consisted of 23 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 22 percent of total complaints. Complaints on other issues comprised 18 percent of total complaints and included dental and behavioral health services. Of particular note, there were two complaints related to co-pays and one complaint related to contributions. Overall, with

over 1.7 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 January 2015 – March 2015

	Obtaining Prescriptions	Transportation	Other Covered Services	Other Issues	Total
Count	30	19	18	14	81
Percent	37%	23%	22%	18%	-

Quality Assurance/Monitoring Activity

MDHHS completes Performance Monitoring Reports (PMR) for the thirteen 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 report. The measures for the Healthy Michigan Plan population will mirror those used for the traditional Medicaid population. In addition, MDHHS will monitor 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 latest standards are expected to be published in July 2015. This quarter, the Bureau of Medicaid Program Operations & Quality Assurance published its most recent quarterly PMR. The table below includes a summary of Healthy Michigan Plan measures included in the January PMR. The complete PMR has been included with this report as an enclosure.

Table 11: January 2015 Performance Monitoring Report Healthy Michigan Plan Measures

Measure	Description	Measurement Period	Measurement Frequency	Percentage
Adults' Generic Drug Utilization	Percentage of generic prescriptions filled for adult members of health plans during the measurement period.	April – June 2014	Quarterly	84%
Timely Completion of Initial Health Risk Assessment	Percentage of Healthy Michigan Plan beneficiaries enrolled in a health plan who had a Health Risk Assessment (HRA) completed within 150 days of enrollment in a health plan.	April – June 2014	Quarterly	To be reported in April 2015 PMR
Outreach and Engagement to Facilitate Entry to Primary Care	Percentage of Healthy Michigan Plan health plan enrollees who have an ambulatory or preventive care visit within 150 days of enrollment into a health plan who had not previously had an ambulatory or preventive care visit since enrollment in Healthy Michigan Plan.	April – June 2014	Quarterly	To be reported in April 2015 PMR
Plan All-Cause Acute 30-Day Readmissions Measure	Percentage of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days.	January – December 2014	Annually	Not Reported
Adults' Access to Ambulatory Health Services	Percentage of adults 19 to 64 years old who had an ambulatory or preventive care visit during the measurement period	April – June 2014	Quarterly	57%

In the preceding quarter, MDHHS introduced the Fiscal Year 2016 – 2017 Focus Bonus Emergency Department Utilization Improvement Project to the Medicaid Health Plans. All Medicaid Health Plans participated this quarter by submitting a draft baseline analysis by the March 2015 due date. MDHHS has reviewed the health plans' submissions and have provided feedback. Final submissions are due for scoring and approval in April 2015.

This quarter, Medicaid Health Plans were required to submit a deliverable as a part of the Healthy Michigan Plan Pay for Performance process. In the Health Risk Assessment category, health plans submitted policies describing their process for identifying and reaching out to members that have identified health risk reduction goals on their Health Risk Assessments. Additionally, the health plans provided a report of members who received outreach and documentation of support provided by the health plans. Additionally, Medicaid Health Plans were required to perform a random member incentive check this quarter. MDHHS securely sent each plan the name and beneficiary identifications numbers of members whose incentives required verification.

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. MDHHS received reports this quarter from the contractor managing the MI Health Account Call Center. The call volumes for the months in this quarter are detailed in the following table:

Table 12: MI Health Account Call Center Activity

Month	Number of Calls	Percent Change from Previous Month	Change in Volume from Previous Month
January	1,565	+ 21%	+ 270
February	1,221	- 22%	- 344
March	1,724	+ 41%	+ 503

The MI Health Account Call Center handles questions regarding the MI Health Account welcome letters and MI Health Account quarterly statements. 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. Members that received a MI Health Account statement in January 2015 have a payment due date of April 15, 2015. For those that received their statement in February 2015, the payment due date is May 15, 2015. March 2015 statements have a payment due date of June 15, 2015.

The MI Health Account mailing and collection activity is detailed in the following tables:

Table 13: 2015 Quarterly MI Health Account Statement Mailings		
Month of Statement	Total Statements Mailed	Total Members Not Mailed Statement
January	69,830	20,538
February	26,226	6,729
March	72,706	51,982
Total	168,762	79,249

Table 14: 2015 MI Health Account Cost Sharing Data Payments up to 03/24/2015			
Month of Quarterly Statement	Number of Members with Cost Sharing Requirement	Total Amount Owed for the Quarter	Average Amount Owed for the Quarter
January	32,237	$774,671.85	$24.03
February	14,358	$334,731.72	$23.31
March	37,141	$876,862.45	$23.61
Total	83,736	$1,986,266.02	$23.65

Table 15: 2015 MI Health Account Payment Data by Source of Payment Payments up to 03/24/2015						
	Mail Payment			Online Payment		
Month of Quarterly Statement	Total Amount of Payments	Number of Members with Payments	Percent of Members with Payments	Total Amount of Payments	Number of Members with Payments	Percent of Members with Payments
January	$145,976.02	6,547	75%	$54,678.68	2,205	25%
February	$44,954.22	2,453	72%	$18,971.22	960	28%
March	$61,268.43	3,583	75%	$20,355.97	1,195	25%
Total	$252,198.67	12,583	74%	$94,005.87	4,360	26%

Table 16: 2015 MI Health Account Payment Data Payments up to 03/24/2015					
Month of Quarterly Statement	Total Amount of Payments	Total Number of Members with Payments	Total Payments as Percent of Total Amount Owed for the Quarter	Number of Members that Paid Entire Quarter	Number of Third Party Payers
January	$200,654.70	8,752	26%	4,326	1,011
February	$63,925.44	3,413	19%	1,544	320
March	$81,624.40	4,778	9%	1,576	457
Total	$346,204.54	16,943	17%	7,446	1,788

Cost sharing exemptions are applied to specific groups by law, regulation or program policy. The MI Health Account exemption activity is detailed in the following tables:

Table 17: 2015 MI Health Account Exemptions

Month of Statement	Number of Members	Total Adjustment Amount
January	33,803	($415,028.08)
February	11,041	($159,567.24)
March	32,619	($440,469.61)
Total	77,463	($1,015,064.93)

Table 18: 2015 MI Health Account Exemptions by Category

Month of Statement	5% Cost Share		Hospice		American Indian/ Alaskan Native	
	Number of Members	Total Amount of Adjustments	Number of Members	Total Amount of Adjustments	Number of Members	Total Amount of Adjustments
January	32,313	($365,171.96)	0	$0.00	39	($1,855.00)
February	10,149	($128,560.66)	0	$0.00	33	($1,970.00)
March	30,390	($361,033.16)	0	$0.00	51	($3,045.50)
Total	72,852	($854,765.78)	0	$0.00	123	($6,870.50)

Month of Statement	Pregnancy		Incorrectly Billed		FPL Not in Range	
	Number of Members	Total Amount of Adjustments	Number of Members	Total Amount of Adjustments	Number of Members	Total Amount of Adjustments
January	250	($4,847.51)	0	$0.00	0	$0.00
February	126	($2,499.55)	0	$0.00	0	$0.00
March	243	($5,351.16)	0	$0.00	0	$0.00
Total	619	($12,698.22)	0	$0.00	0	$0.00

Month of Statement	Healthy Behavior 2% Copay Cap		Healthy Behavior (1st Year Reduction at 50%)		Under 21	
	Number of Members	Total Amount of Adjustments	Number of Members	Total Amount of Adjustments	Number of Members	Total Amount of Adjustments
January	0	$0.00	961	($29,040.36)	240	($14,113.25)
February	0	$0.00	596	($18,418.78)	137	($8,118.25)
March	5	($17.04)	1,626	($53,540.75)	304	($17,482.00)
Total	5	($17.04)	3,183	($100,999.89)	681	($39,713.50)

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
January 2015 – March 2015

	Decision Upheld	Overturned	Total
Count	50	42	92
Percent	54%	46%	-

Table 20: Managed Care Organization Grievances
January 2015 – March 2015

	Access	Quality of Care	Administrative/Service	Billing	Transportation	Total
Count	173	41	124	17	104	459
Percent	38%	9%	27%	4%	23%	-

From January 2015 to March 2015, there were 92 total appeals among all the Medicaid Health Plans. Medicaid Health Plan decisions were upheld in 54 percent of the appeals. From January 2015 to March 2015 there were a total of 459 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. This quarter, MDHHS recognized the importance of the communication of system changes across the department. MDHHS unexpectedly experienced a system conflict resulting in unsuccessful payments. For the most part, Healthy Michigan Plan payments were not impacted. Systems staff were able to collaborate and remedy the limited conflicts that impacted the Healthy Michigan Plan. In the future, communication among systems staff across the department will be encouraged to prevent the conflict.

As the Healthy Michigan Plan has matured, MDHHS has closely monitored disenrollment from the plan. Initially, the level of disenrollments from the plan represented a concern to the department. MDHHS continues to query coverage information for members that disenroll from the Healthy Michigan Plan. The department has found that the majority of disenrolled members subsequently gain coverage through another Medicaid program. MDHHS has also seen disenrollments by month decrease retroactively over time. This indicates that Healthy Michigan Plan members are re-enrolling after disenrollment. MDHHS has learned to expect this pattern of disenrollment. The State continues to monitor disenrollment and is currently developing practices to get additional information about reasons for disenrollment.

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 five 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.

Activities for the evaluation have commenced, particularly with regards to Domain IV: Participant Beneficiary Views of the Healthy Michigan Plan. Other domain activities have also begun. A summary of the key activities for the fiscal year (FY) 2015 second quarterly report follow this paragraph:

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. In second quarter of 2015, IHPI has prepared extracts of Internal Revenue Service data for 2012 and updated extracts of Medicare cost report data. Ultimately, the activities will afford an assessment of Medicaid expansion on uncompensated care costs.

Domain II

Similar to Domain I, the Domain II interim report is not due until FY 2018. That being said, in the first quarter of FY 2015, IHPI has prepared extracts of Current Population Survey data and will subsequently prepare extracts of American Community Survey data to help ascertain the difference between these two US Census Bureau data sources. No further activity has been undertaken in the quarter covered by this report. This analysis will help to formulate a baseline uninsured rate in Michigan.

Domain III

Domain III will look at the impact of Healthy Michigan Plan on healthy behaviors and health outcomes. The interim report is due in FY 2017. IHPI activities in first quarter of FY 2015 included conducting preliminary feasibility assessments of key data fields relative to health behaviors, utilization, and outcomes. Those same feasibility assessments were re-ran in second quarter of 2015 and a list of data fields requiring further assessment was created, which will necessitate assistance from MDHHS. Additionally, IHPI is analyzing early utilization patterns to develop a targeted sample for the Domain IV beneficiary survey and participated in meetings to refine their sampling plan. In second quarter specifically, data was generated on Healthy Michigan Plan beneficiary demographic characteristics.

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 second quarter of FY 2015 have included the following:

Primary Care Practitioner (PCP) Survey

- Completed key informant interviews and began content analysis
- Created interview guides for other providers, navigators, PCP office staff, rural health system leaders, and managers
- Prepared PCP Survey for MDHHS review

Beneficiary Survey

- Cognitive interviews are in progress with beneficiaries to inform content of the beneficiary survey (referred to as the Healthy Michigan Voices Survey in the CMS Evaluation)
- Completed informant interviews with health plans, Michigan Department of Corrections, MDHHS Mental and Dental Health, and Community Mental Health Boards to help inform content of beneficiary survey
- Completed sampling strategy for the beneficiary survey
- Developing questions for the beneficiary survey
- Beneficiary interview guide developed
- Beneficiary interview guide for those eligible but not enrolled in the Healthy Michigan Plan developed

- Recruitment materials and plans developed and implemented for recruitment in the previously identified five communities where interviews will occur

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 second quarter of FY 2015 have built upon this first quarter's activities to further provide input into enrollee survey development and testing for questions related to cost sharing and consumer engagement/behavior. A sampling plan was created to ensure a target sample for the survey captures the population with contribution requirements.

Enclosures/Attachments

1. March 2015 Health Risk Assessment Report

2. February 2015 MCAC Minutes

3. January 2015 Performance Monitoring Report

State Contacts

If there are any questions about the contents of this report, please contact one of the following people listed below.

Jacqueline Coleman, Waiver Specialist

Phone: (517) 241-7172

Carly Todd, Analyst

Phone: (517) 241-8422

Jason Jorkasky, Federal Regulation & Hospital Reimbursement Section Manager

Phone: (517) 335-0215

Brian Keisling, Actuarial Division Director

Phone: (517) 241-7181

Actuarial Division

Bureau of Medicaid Policy and Health System Innovations

MSA, MDHHS, P.O. Box 30479

Lansing, MI 48909-7979

Fax: (517) 241-5112

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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

March 2015

Produced by the Quality Improvement and Program Development Section

Healthy Michigan Plan – Health Risk Assessment Report

Table of Contents

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 181,510 Health Risk Assessments were completed through Michigan ENROLLS as of March 2015. This represents a completion rate of 96.1%. 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

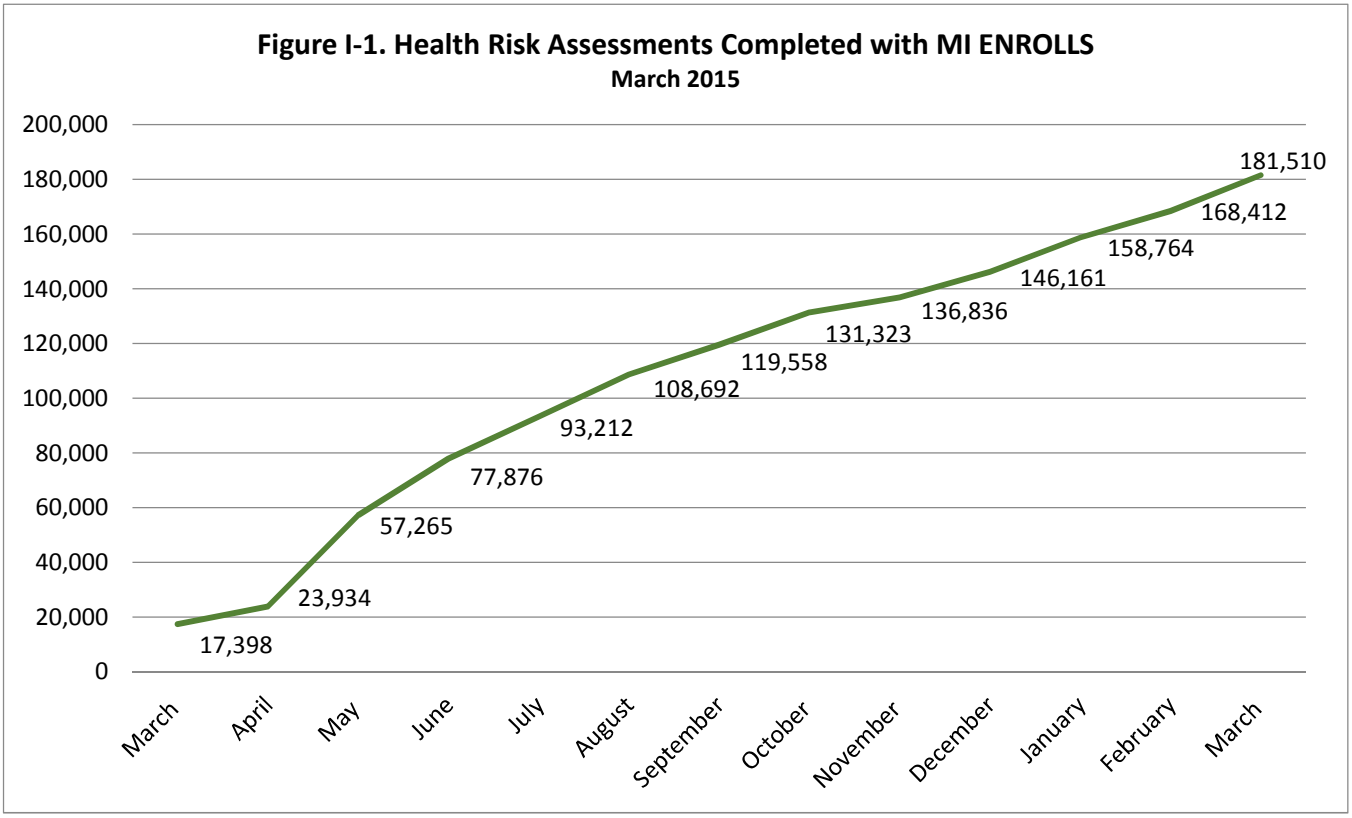
Table I. Count of Health Risk Assessments (HRA) Questions 1-9 Completed with MI Enrolls

MONTH	COMPLETE	DECLINED
March	17,398	482 (2.8%)
April	23,934	660 (2.8%)
May	57,265	1,832 (3.2%)
June	77,876	2,707 (3.4%)
July	93,212	3,289 (3.4%)
August	108,692	3,914 (3.5%)
September	119,558	4,372 (3.5%)
October	131,323	4,974 (3.8%)
November	136,836	5,292 (3.7%)
December	146,161	5,976 (3.9%)
January	158,764	6,530 (4.0%)
February	168,412	6,907 (3.9%)
March	181,510	7,413 (3.9%)

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

January 2015		
AGE GROUP	**COMPLETED HRA**	
19 - 29	45,431	25.0%
30 - 39	36,298	20.0%
40 - 49	40,269	22.2%
50 - 59	45,562	25.1%
60 +	13,950	7.7%
GENDER		
F	99,150	54.6%
M	82,360	45.4%
FPL		
< 100% FPL	150,246	82.8%
100 - 133% FPL	31,264	17.2%
TOTAL	**181,510**	**100.0%**

Figure I-1. Health Risk Assessments Completed with MI ENROLLS
March 2015

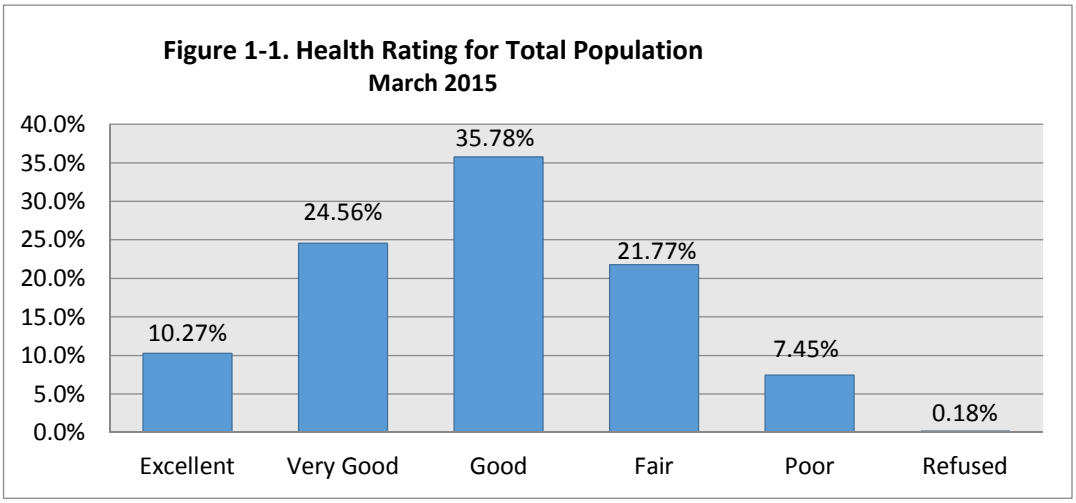


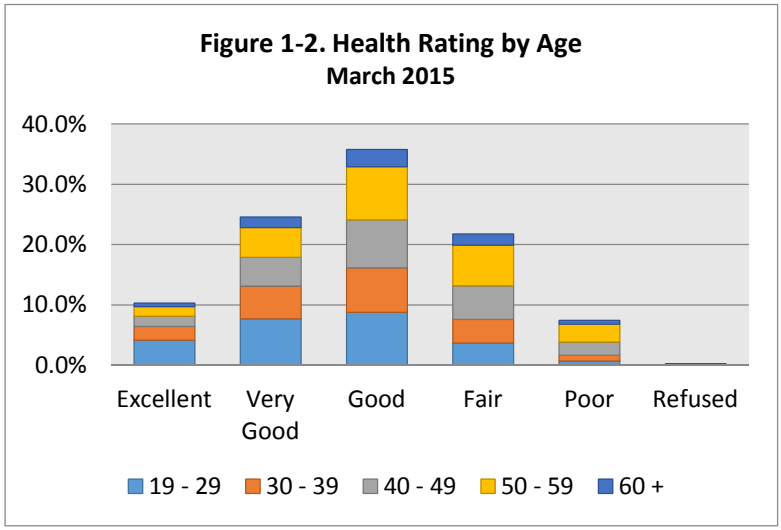
Question 1. General Health Rating

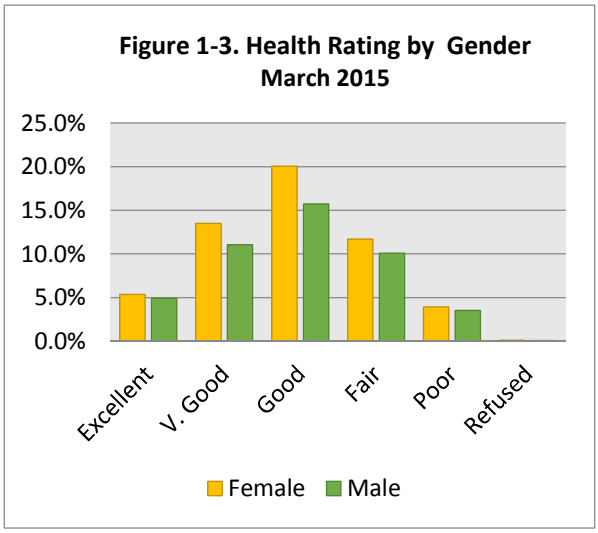
Question 1. In general, how would you rate your health? This question is used to assess self-reported health status. Healthy Michigan Plan enrollees were given the answer options of excellent, very good, good, fair or poor. Table 1 shows the overall answers to this question for March 2015. Among enrollees who completed the survey, this question had a 0.18% 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

March 2015		
HEALTH RATING	TOTAL	PERCENT
Excellent	18,644	10.27%
Very Good	44,570	24.56%
Good	64,943	35.78%
Fair	39,515	21.77%
Poor	13,521	7.45%
Refused	317	0.18%
TOTAL	181,510	100.00%





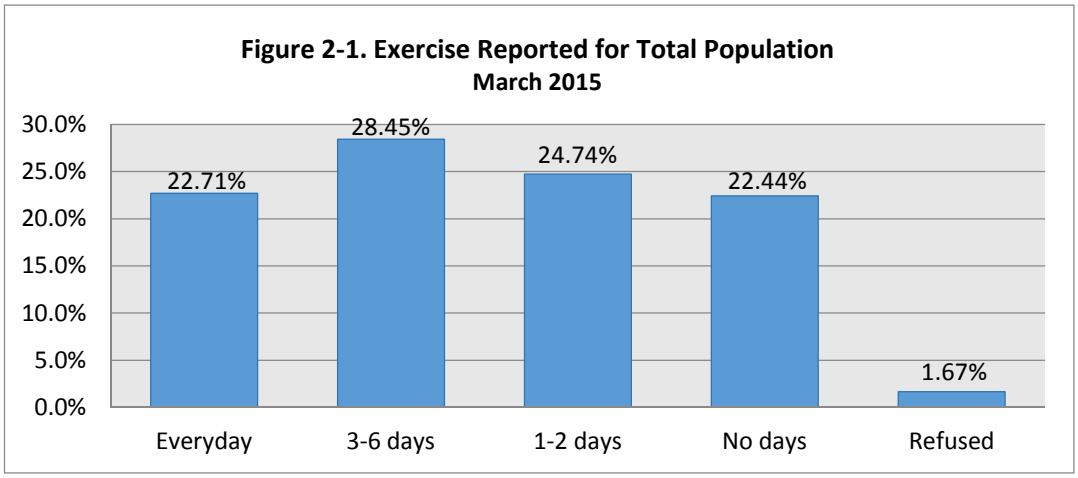


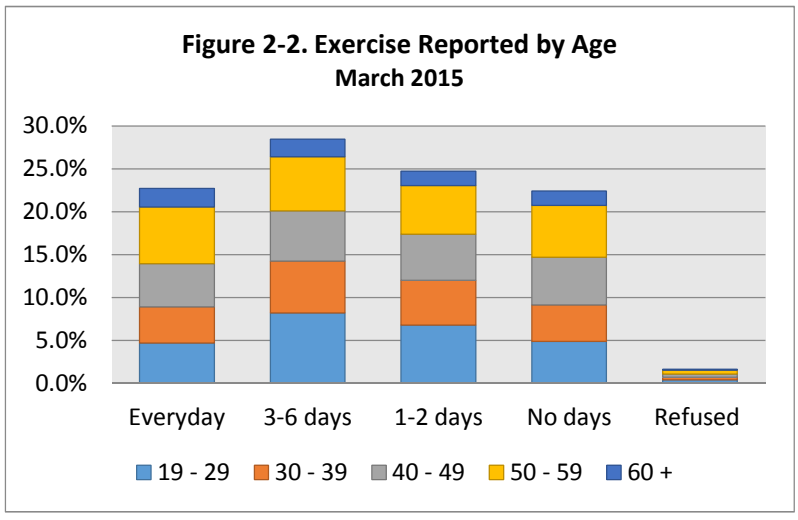
Question 2. Exercise

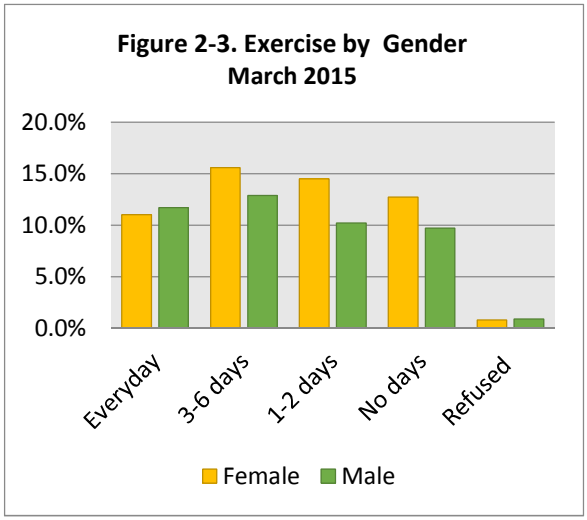
Question 2. In the last 7 days, how often did you exercise for at least 20 minutes a day? This question is used to assess self-reported exercise frequency as an important component of maintaining a healthy weight. Healthy Michigan Plan enrollees were given the answer options of every day, 3-6 days, 1-2 days or 0 days. Table 2 shows the overall answers to this question for March 2015. Among enrollees who participated in the survey, there was a 1.67% 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

March 2015		
EXERCISE	TOTAL	PERCENT
Everyday	41,217	22.71%
3-6 days	51,637	28.45%
1-2 days	44,899	24.74%
No days	40,733	22.44%
Refused	3,024	1.67%
TOTAL	181,510	100.00%





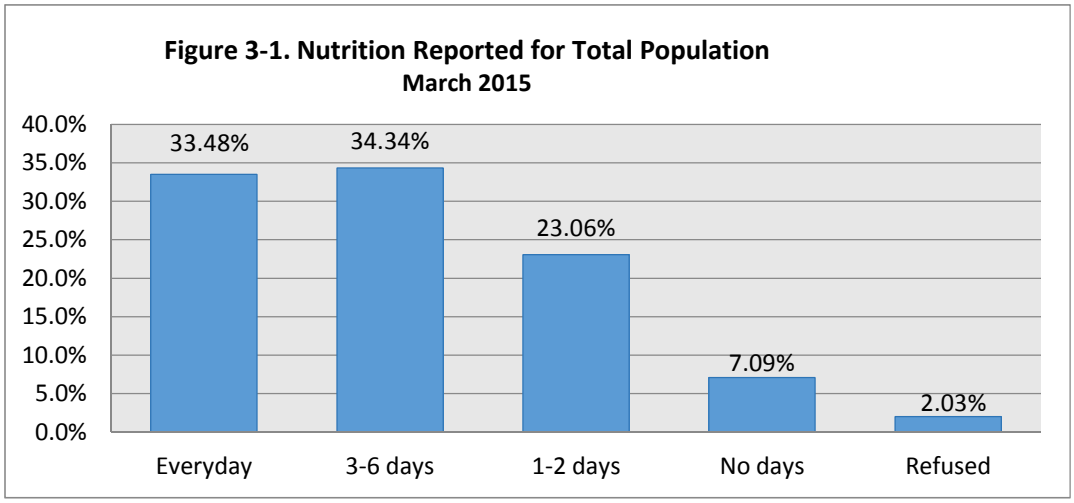


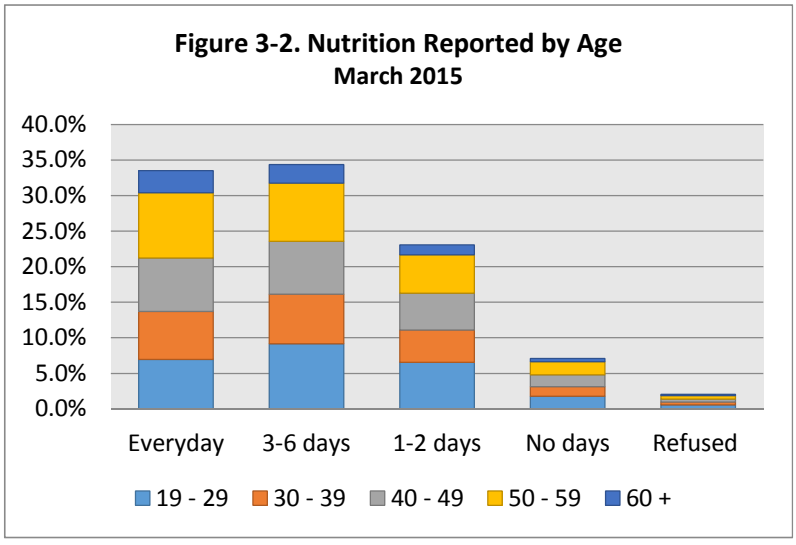
Question 3. Nutrition (fruits and vegetables)

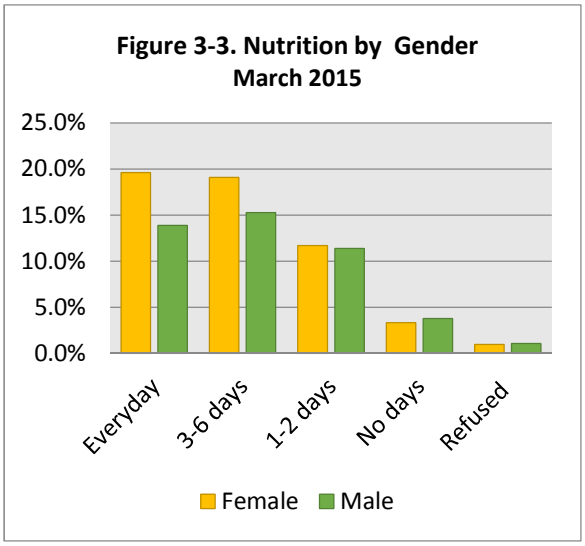
Question 3. In the last 7 days, how often did you eat 3 or more servings of fruits or vegetables in a day? This question is used to assess self-reported nutrition as an important component of maintaining a healthy weight. Healthy Michigan Plan enrollees were given the answer options of every day, 3-6 days, 1-2 days or 0 days. Table 3 shows the overall answers to this question for March 2015. Among enrollees who participated in the survey, there was a 2.03% 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

March 2015		
NUTRITION	TOTAL	PERCENT
Everyday	60,771	33.48%
3-6 days	62,331	34.34%
1-2 days	41,848	23.06%
No days	12,876	7.09%
Refused	3,684	2.03%
TOTAL	181,510	100.00%





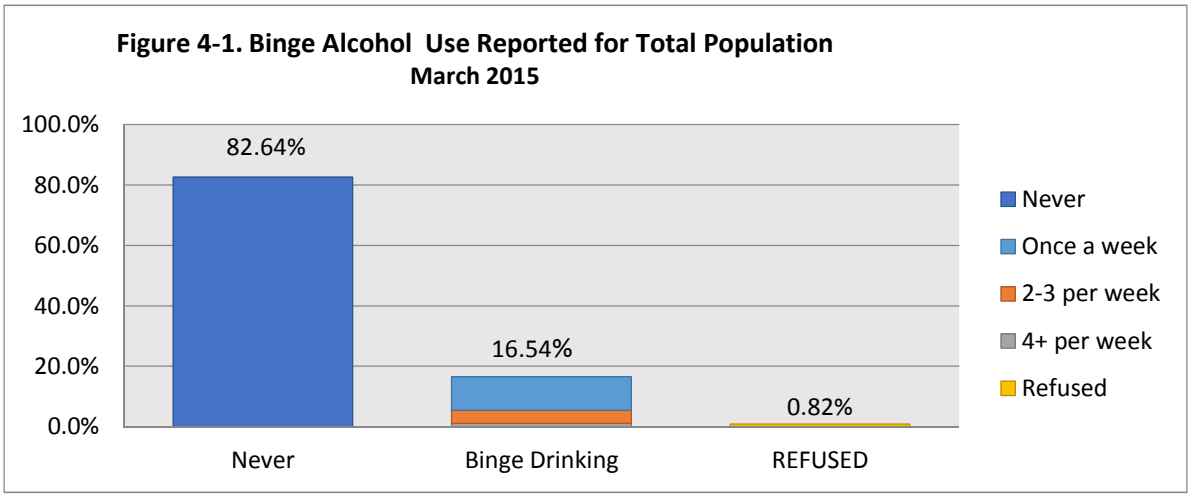


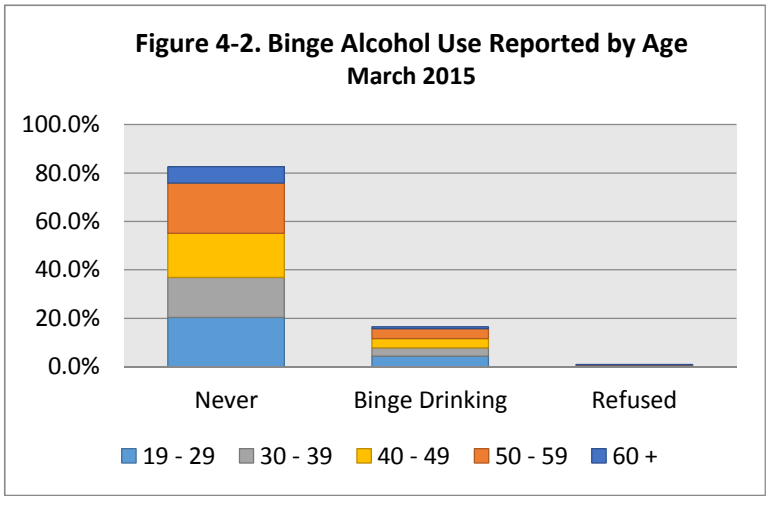
Question 4. Binge Alcohol Use

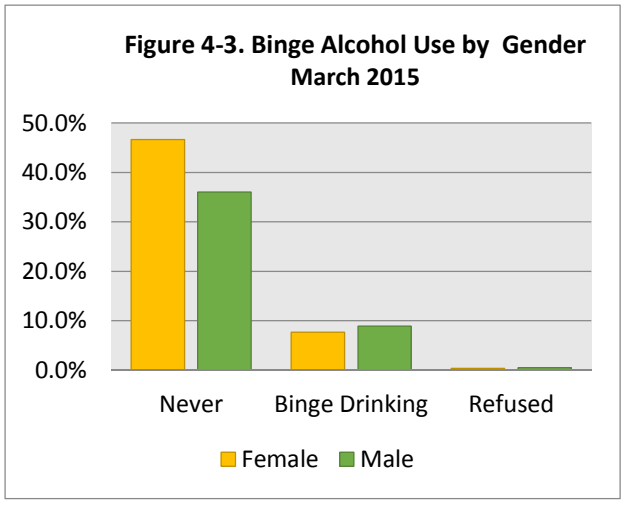
Question 4. In the last 7 days, how often did you have (5 or more for men, 4 or more for women) alcoholic drinks at one time? This question is used to assess self-reported binge alcohol use. Healthy Michigan Plan enrollees were given the answer options of never, once a week, 2-3 a week and more than 3 times during the week. Table 4 shows the combined overall answers to these questions for March 2015. 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

March 2015		
ALCOHOL	TOTAL	PERCENT
Never	150,002	82.64%
Once a week	20,111	11.08%
2-3 times a week	8,046	4.43%
More than 3	1,868	1.03%
Refused	1,483	0.82%
TOTAL	181,510	100.00%







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 March 2015. Question 5 had a 0.35% 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

March 2015		
TOBACCO USE	TOTAL	PERCENT
No Tobacco Use	104,873	57.78%
Quitting Now	29,994	16.52%
Wants to Quit	31,339	17.27%
Current Use	14,678	8.09%
Refused	642	0.35%
TOTAL	181,510	100.00%

Figure 5-1. Smoking/Tobacco Use for Total Population
March 2015

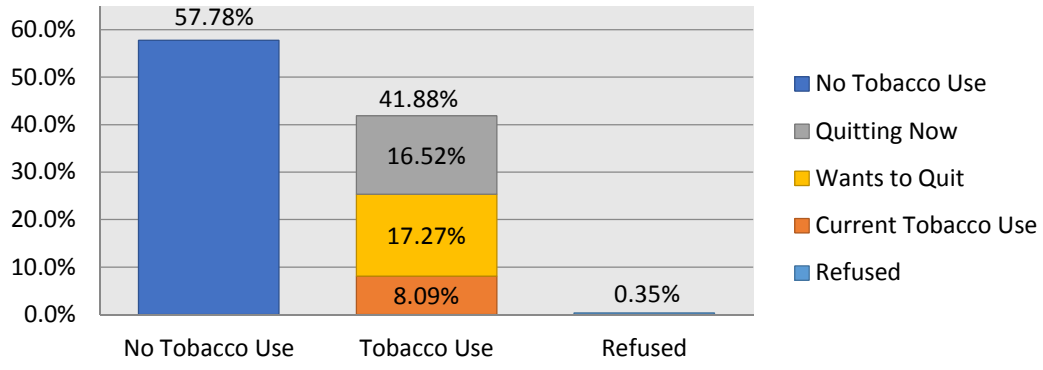


Figure 5-2. Smoking/Tobacco Use by Age
March 2015

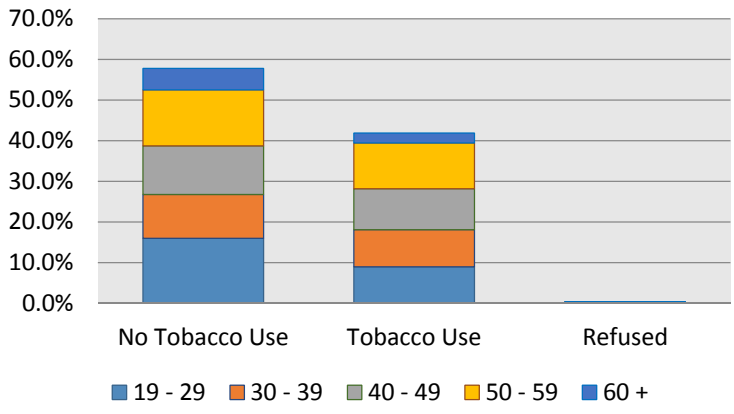
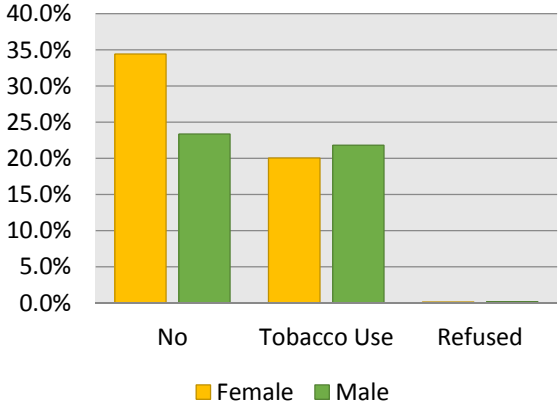


Figure 5-3. Smoking by Gender
March 2015

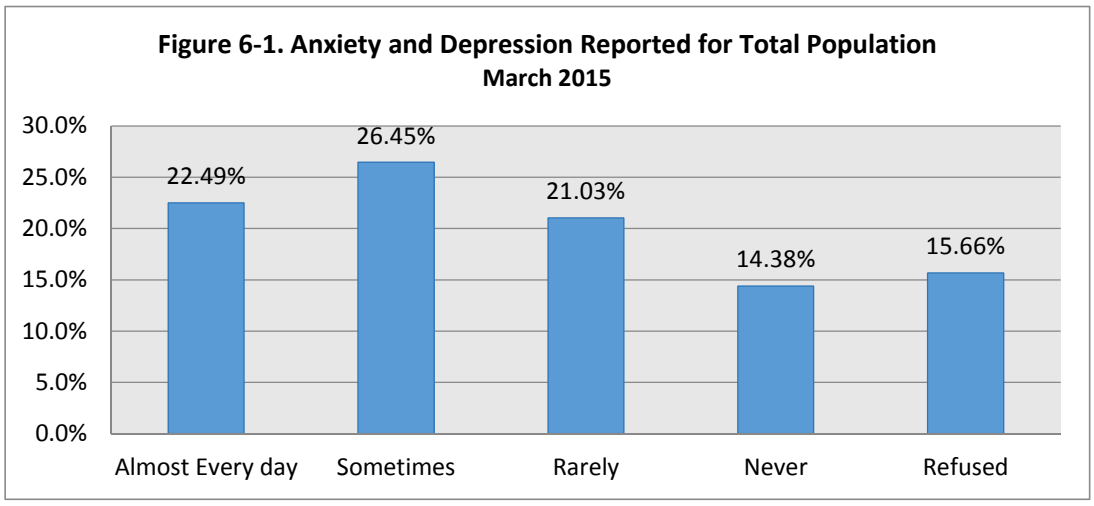


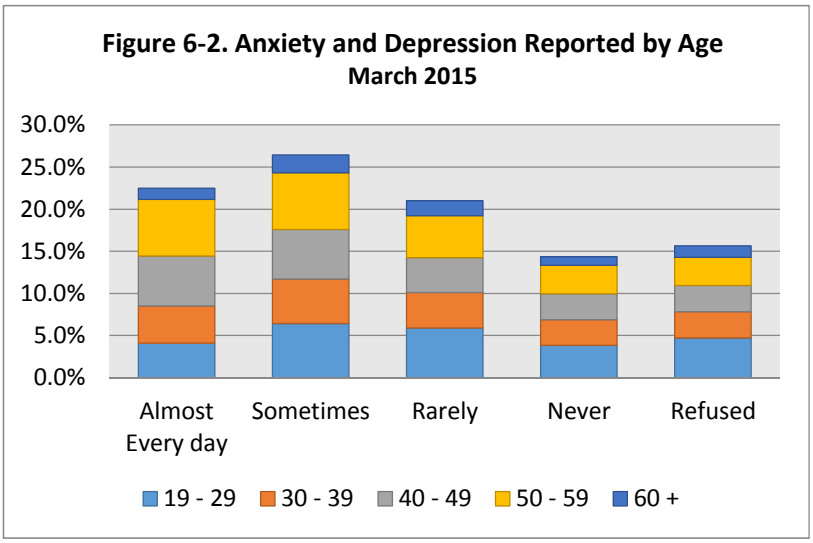
Question 6. Anxiety and Depression

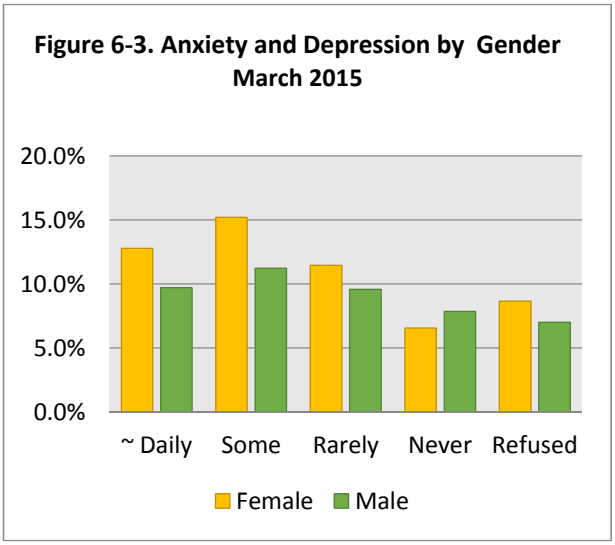
Question 6. In the last 30 days, how often have you felt tense, anxious or depressed? This question is used to assess self-reported mental health status. Healthy Michigan Plan enrollees were given the answer options of almost every day, sometimes, rarely and never. Table 6 shows the overall answers to this question for March 2015. Among enrollees who participated in the survey, there was a 15.66% 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

March 2015		
DEPRESSION	TOTAL	PERCENT
Almost Every day	40,813	22.49%
Sometimes	48,001	26.45%
Rarely	38,165	21.03%
Never	26,108	14.38%
Refused	28,423	15.66%
TOTAL	181,510	100.00%





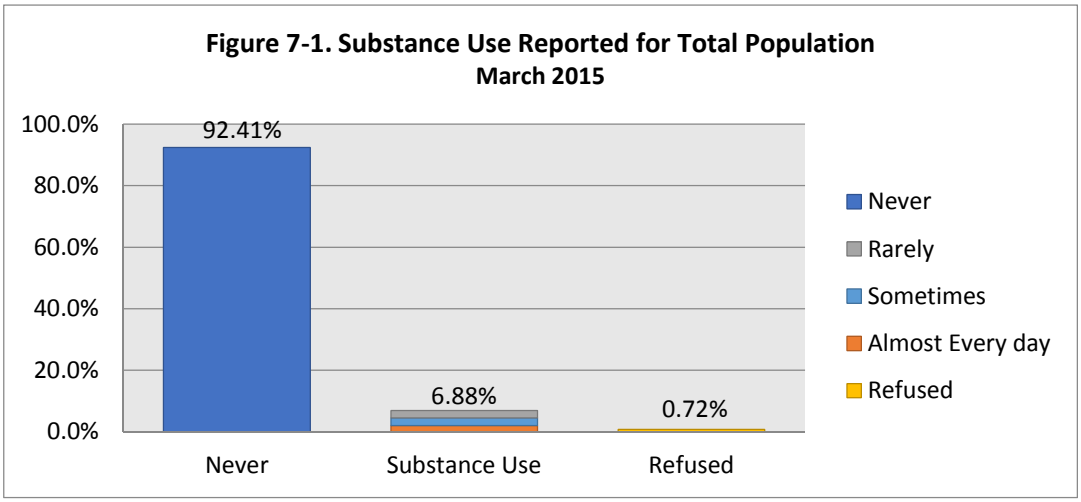


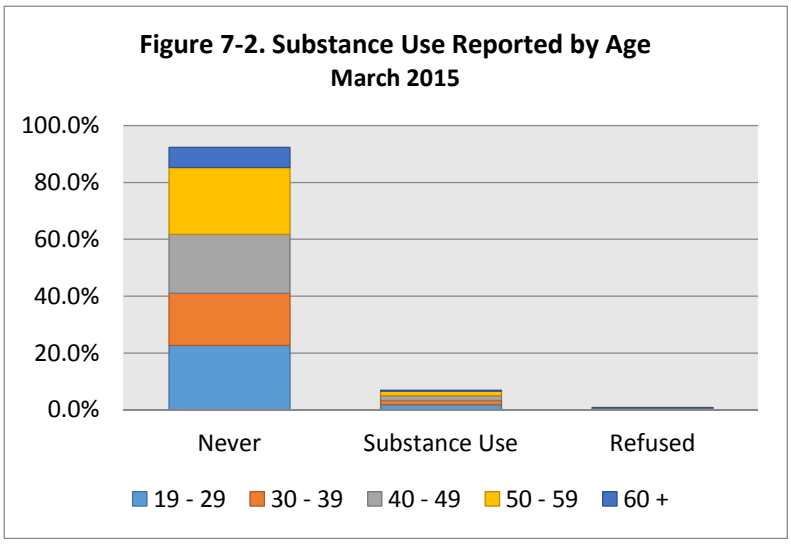
Question 7. Drugs and Substance Use

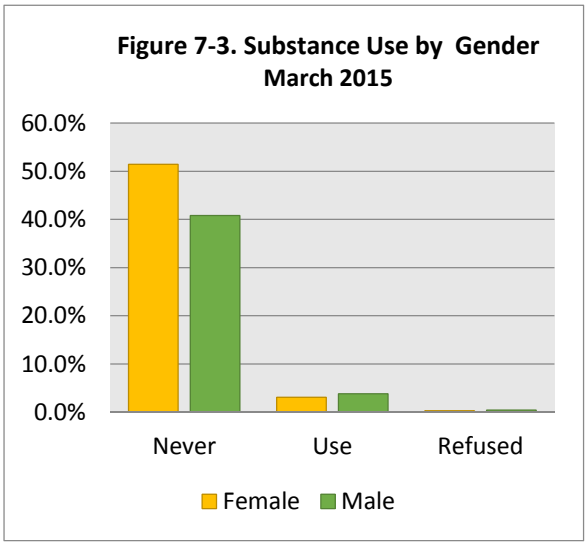
Question 7. Do you use drugs or medications (other than exactly as prescribed for you) which affect your mood or help you to relax? This question is used to assess self-reported substance use. Healthy Michigan Plan enrollees were given the answer options of almost every day, sometimes, rarely and never. Table 7 shows the overall answers to this question for March 2015. Among enrollees who participated in the survey, there was a 0.72% 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

March 2015		
SUBSTANCE USE	TOTAL	PERCENT
Almost Every day	3,515	1.94%
Sometimes	4,629	2.55%
Rarely	4,338	2.39%
Never	167,730	92.41%
Refused	1,298	0.72%
TOTAL	181,510	100.00%





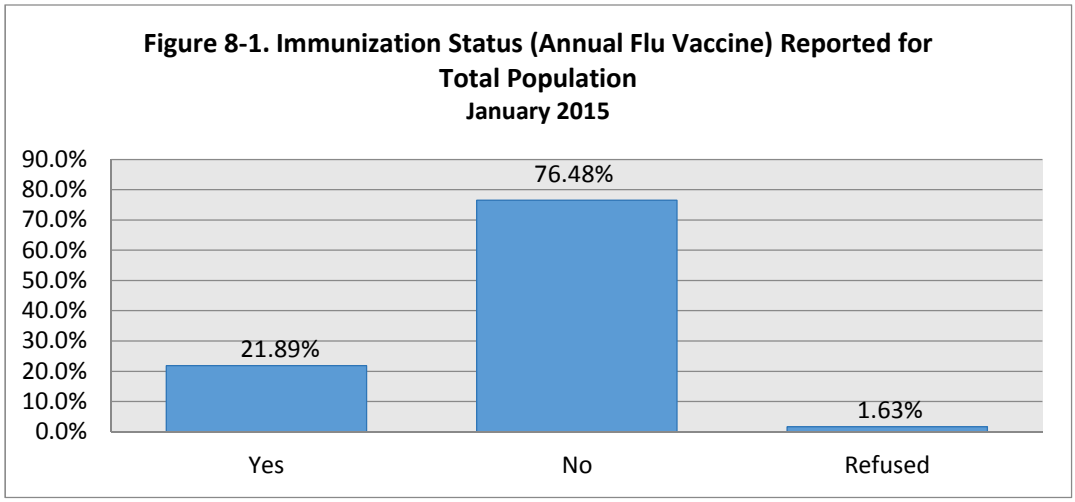


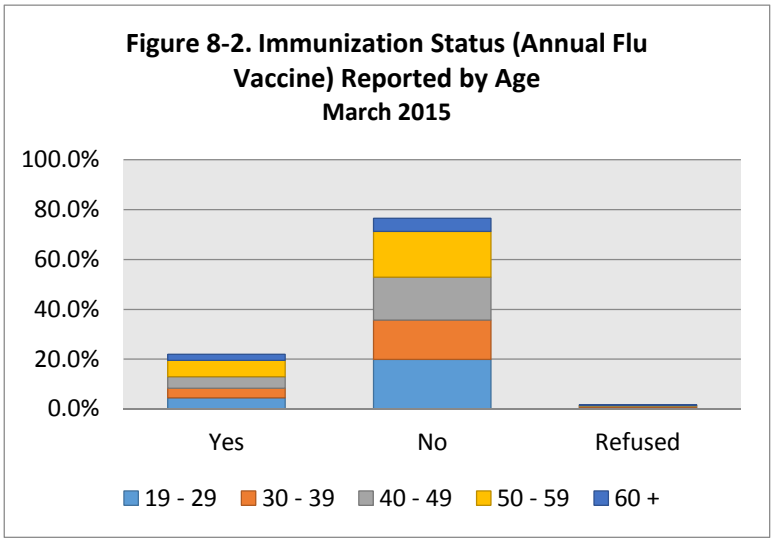
Question 8. Immunization Status (Annual Flu Vaccine)

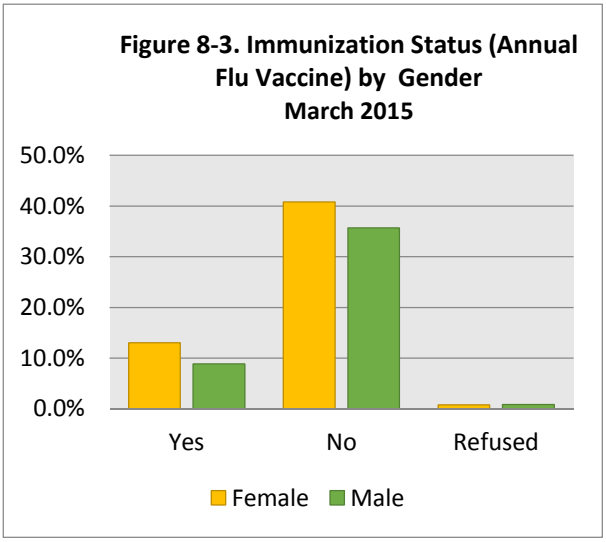
Question 8. The flu vaccine can be a shot in the arm or a spray in the nose. Have you had a flu shot or flu spray in the last year? This question is used to assess self-reported annual flu vaccine. Healthy Michigan Plan enrollees were given the answer options of yes or no. Table 8 shows the overall answers to this question for March 2015. Among enrollees who participated in the survey, there was a 1.63% refusal rate for this question. Figures 8-1 through 8-3 show annual flu vaccine reported for the total population, and by age and gender.

Table 8. Immunization Status (Flu Vaccine) Reported for Total Population

March 2015		
IMMUNIZATION	TOTAL	PERCENT
Yes	39,727	21.89%
No	138,821	76.48%
Refused	2,962	1.63%
TOTAL	181,510	100.00%





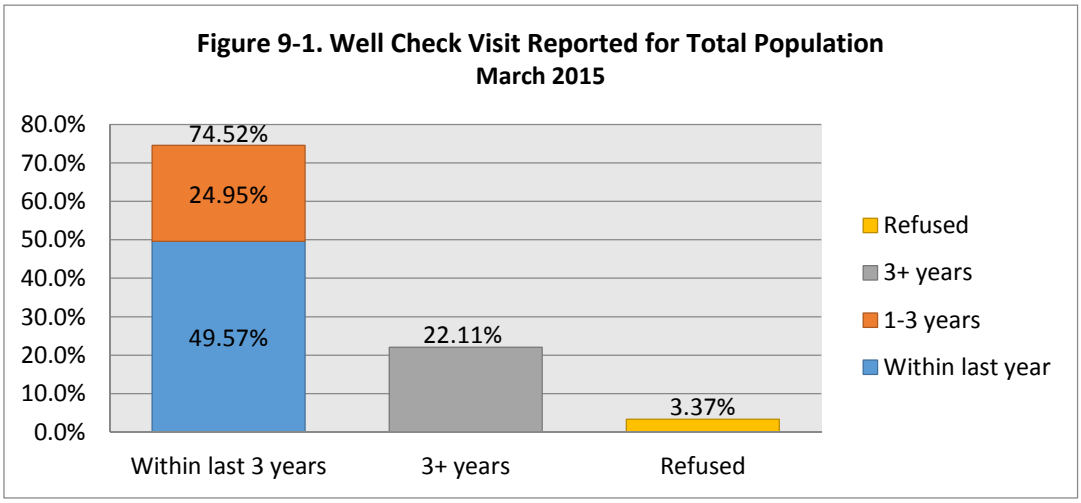


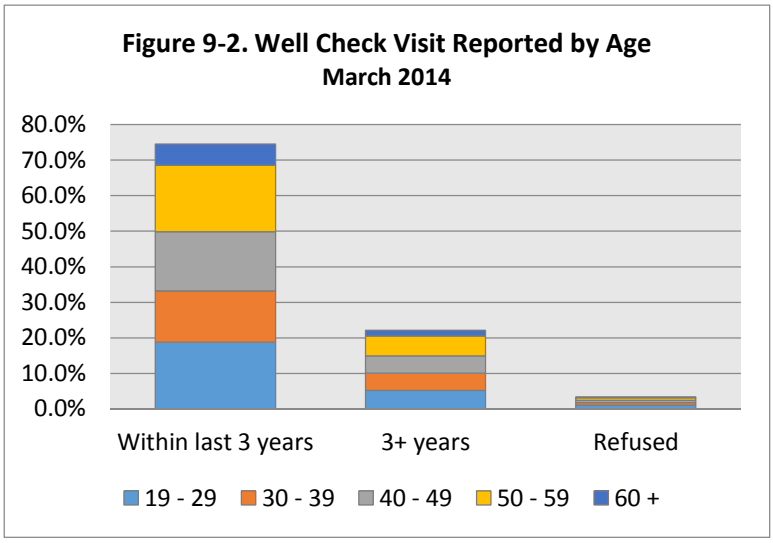
Question 9. Well Check Visit

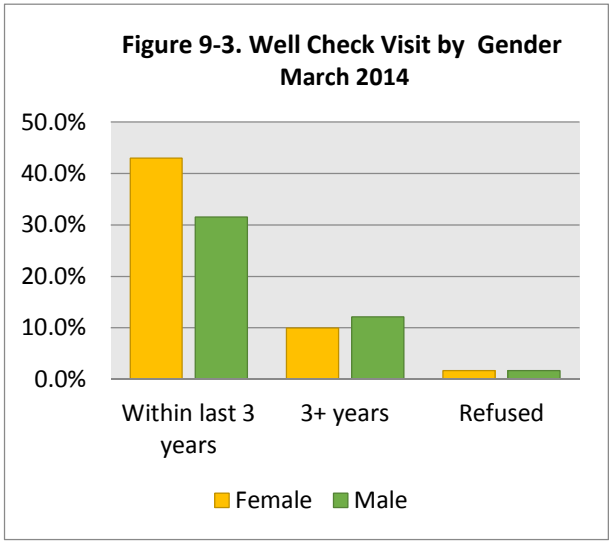
Question 9. A checkup is a visit to a doctor's office that is NOT for a specific problem. How long has it been since your last check-up? This question is used to assess self-reported well check visit. Healthy Michigan Plan enrollees were given the answer options of within the last year, between 1-3 years and more than 3 years. Table 9 shows the overall answers to this question for March 2015. Among enrollees who participated in the survey, there was a 3.37% 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

March 2015		
CHECK-UP	TOTAL	PERCENT
Within last year	89,977	49.57%
1-3 years	45,294	24.95%
3+ years	40,124	22.11%
Refused	6,115	3.37%
TOTAL	181,510	100.00%







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 with 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.

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 48,738 Health Risk Assessments were completed with primary care providers as of March 2015. Among beneficiaries who completed the Health Risk Assessment, 85.8% agreed to address health risk behaviors, and of those, 62.2% chose to address more than one healthy behavior. In addition, 13.0% of beneficiaries who completed the Health Risk Assessment chose to maintain current healthy behaviors, meaning that 98.8% of beneficiaries are choosing to address or maintain healthy behaviors. The healthy behaviors selected are reported in Tables 12-14. Healthy behavior goals are also reported by age and gender.

Health Risk Assessment Completion with Primary Care Provider

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

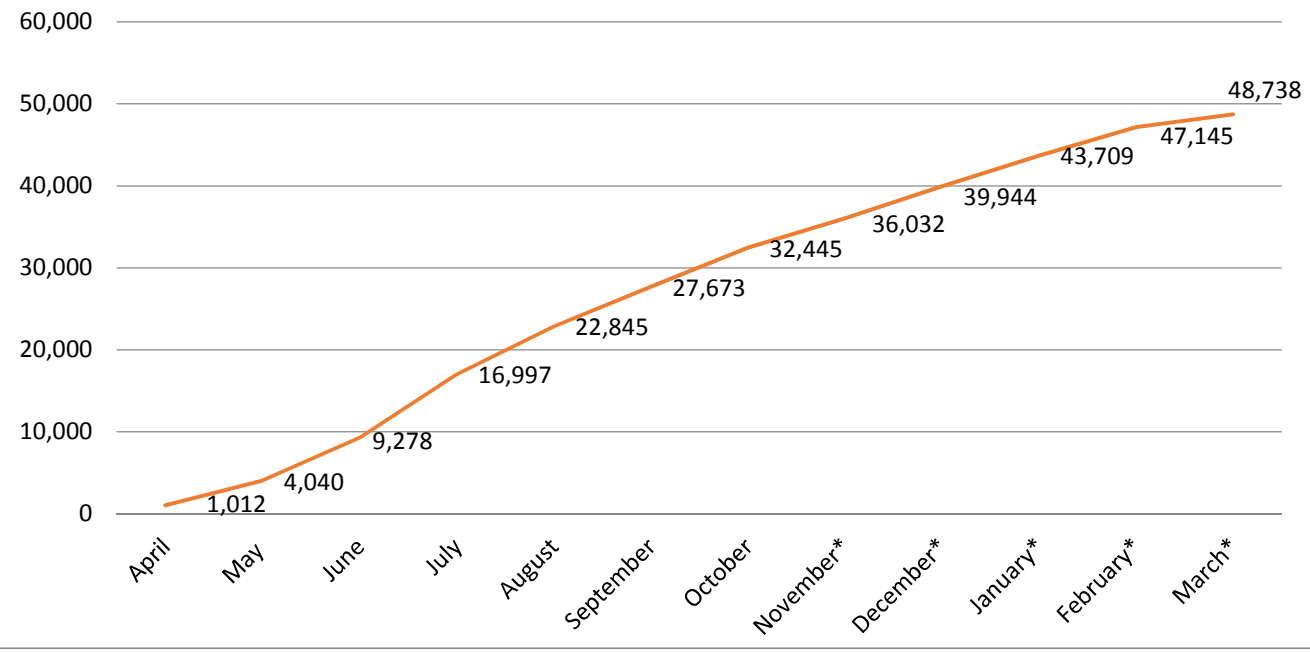
MONTH	COMPLETE	TOTAL
April	948	1,012
May	3,092	4,040
June	5,238	9,278
July	7,719	16,997
August	5,848	22,845
September	4,828	27,673
October	4,772	32,445
November*	3,587	36,032
December*	3,912	39,944
January*	3,765	43,709
February*	3,436	47,145
March*	1,593	48,738
TOTAL		**48,738**

* Many completed HRAs for these months have not yet been submitted

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

April 2014-March 2015		
AGE GROUP	**COMPLETED HRA**	
19 - 29	9,100	18.7%
30 - 39	8,087	16.6%
40 - 49	10,496	21.5%
50 - 59	15,606	32.0%
60 +	5,449	11.2%
GENDER		
F	28,031	57.5%
M	20,707	42.5%
FPL		
< 100% FPL	39,992	82.1%
100 - 133% FPL	8,746	17.9%
TOTAL	**48,738**	**100.00%**

Figure 10-1. Health Risk Assessments Completed with Primary Care Provider
March 2015



* Many completed HRAs for these months have not yet been submitted

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 time.

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

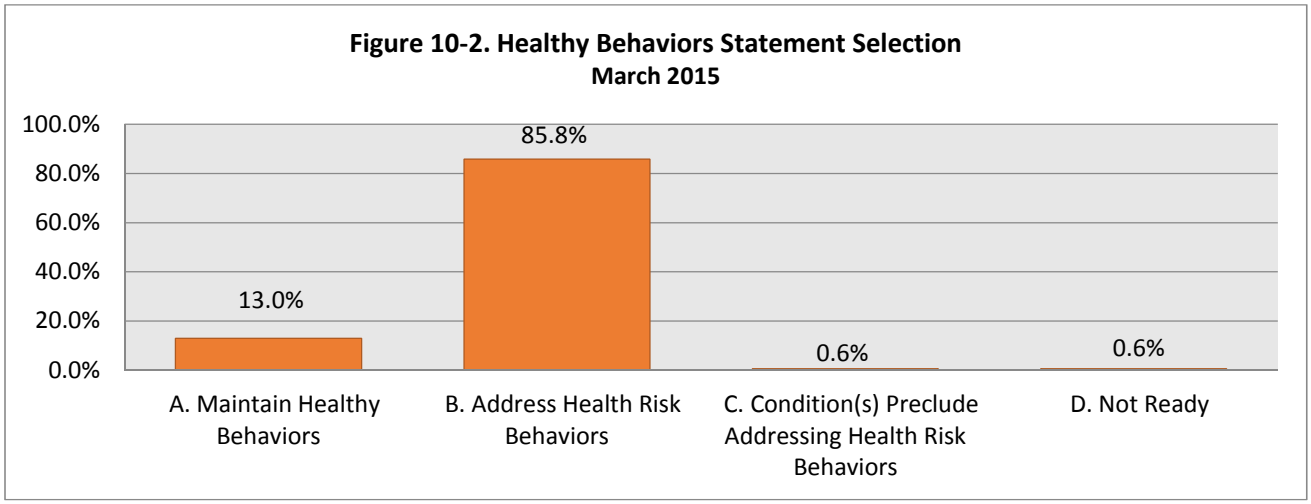
C. Patient has a serious medical, behavioral or social condition or conditions which precludes addressing unhealthy behaviors at this time.

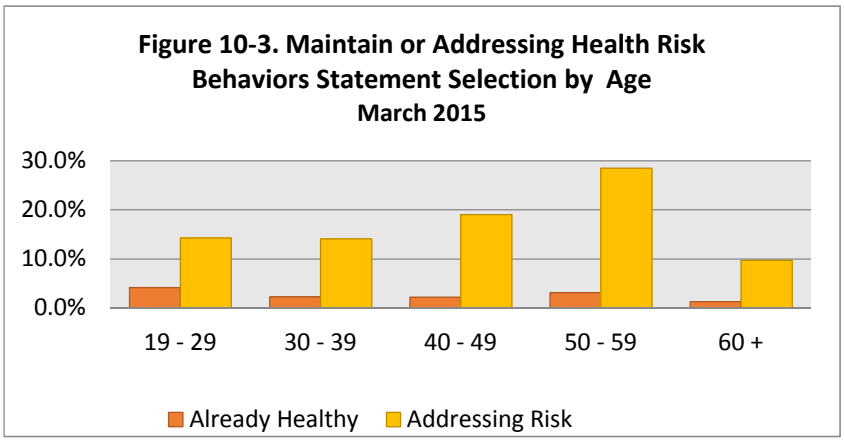
D. Unhealthy behaviors have been identified, patient's readiness to change has been assessed, and patient is not ready to make changes at this time.

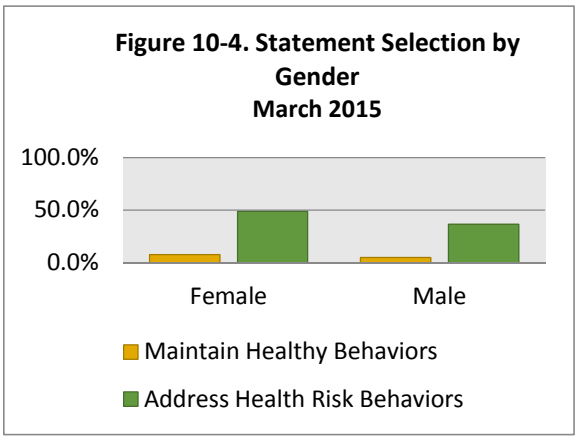
Figures 10-2 through 10-4 show Healthy Behaviors Statement Selections for the total population, and by age and gender.

Table 12. Healthy Behaviors Statement Selection

March 2015		
CHECK-UP	TOTAL	PERCENT
A. Maintain Healthy Behaviors	6,409	13.0%
B. Address Health Risk Behaviors	41,751	85.8%
C. Condition(s) Precludе Addressing Health Risk Behaviors	271	0.6%
D. Not Ready	307	0.6%
TOTAL	48,738	100.0%







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 30,500 HRAs submitted by December 2014 where the beneficiary chose to address health risk behaviors, 68.8% 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	7,144	17.1%
2. Tobacco Cessation Only	3,916	9.4%
3. Weight Loss, Follow-up for Chronic Conditions and Immunization Status	3,682	8.8%
4. Weight Loss and Follow-up for Chronic Conditions	3,669	8.8%
5. Weight Loss and Immunization Status	2,718	6.5%
6. Weight Loss, Tobacco Cessation, Follow-up for Chronic Conditions and Immunizations	2,412	5.8%
7. Follow-up for Chronic Conditions	2,400	5.7%
Total for Top 7	25,941	62.1%
Total for all other combinations	15,810	37.9%
Total	**41,751**	**100.0%**

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	65.3%	17.1%
Tobacco Cessation	41.3%	9.4%
Immunization Status (Annual Flu Vaccine)	41.1%	3.8%
Follow-up for Chronic Conditions	44.2%	5.8%
Addressing Alcohol Abuse	5.3%	0.4%
Addressing Substance Abuse	1.3%	0.1%
Other	4.7%	1.2%

Health Risk Assessment Completion with Primary Care Provider

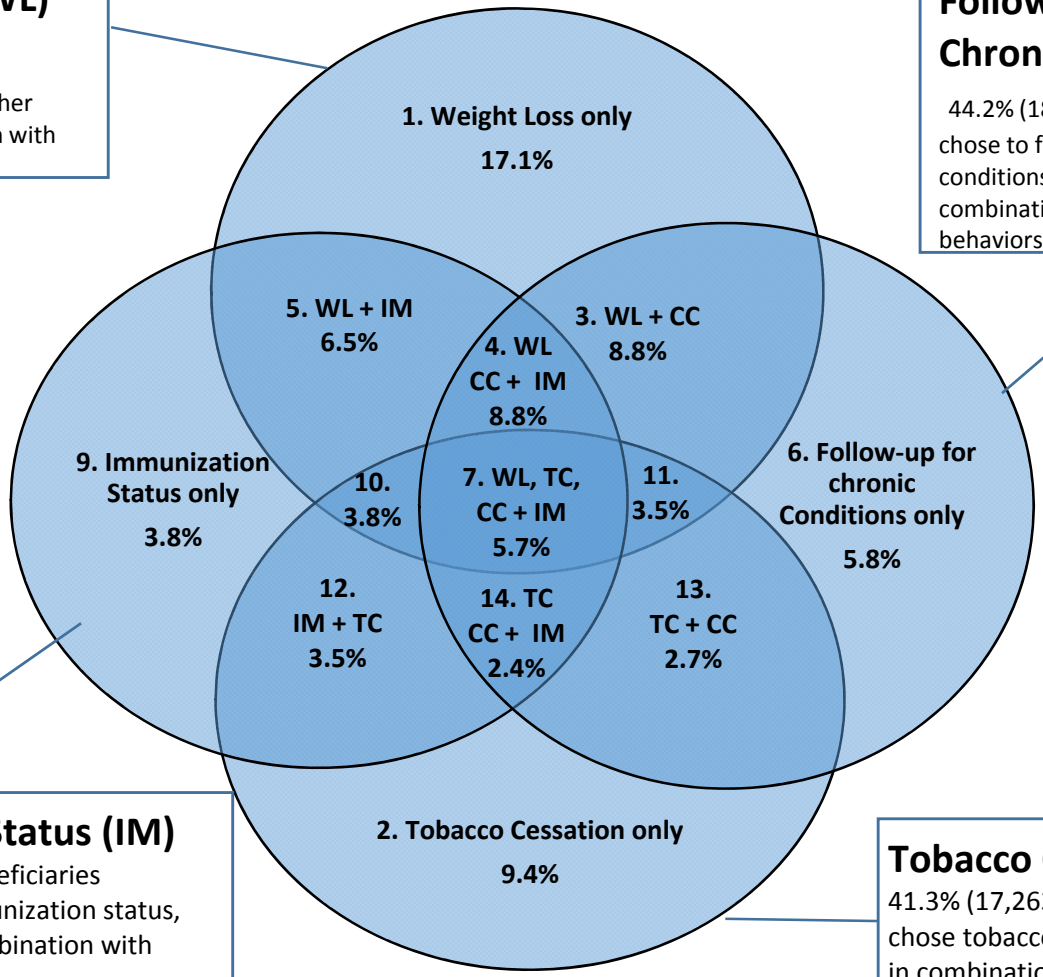
Representation of the overlapping nature of top 15 health risk behavior selections March 2015

Weight Loss (WL)

65.3% (27,247) of beneficiaries chose to address weight loss, either alone or in combination with other health behaviors

Follow-up for Chronic Conditions (CC)

44.2% (18,458) of beneficiaries chose to follow-up for chronic conditions, either alone or in combination with other health behaviors



More Middle Combinations

8. WL + TC 5.5%
10. WL + IM + TC 3.8%
11. WL + CC + TC 3.5%
15. IM + CC 2.3%

Immunization Status (IM)

41.1% (17,157) of beneficiaries chose to address immunization status, either alone or in combination with other health behaviors

Tobacco Cessation (TC)

41.3% (17,263) of beneficiaries chose tobacco cessation, either alone or in combination with other health behaviors

Michigan Department of Community Health

Rick Snyder, Governor
Nick Lyon, Director

Medical Services Administration

Medical Care Advisory Council

Minutes

Date: Thursday, February 19, 2015

Time: 1:00 pm – 4:30 pm

Where: Michigan Public Health Institute (MPHI)
2436 Woodlake Circle
Okemos, MI

Attendees: **Council Members:** Katie Linehan (for Elan Nichols), Cindy Schnetzler, Robin Reynolds, Cheryl Bupp, David Lalumia, Pam Lupo, Rebecca Blake, Amy Hundley, April Stopczynski, Roger Anderson, David Herbel, Dianne Haas, Jan Hudson, Barry Cargill, Vickie Kuhns (for Marilyn Litka-Klein), Larry Wagenknecht, Alison Hirschel, Amy Zaagman, Priscilla Cheever, Kim Sibilisky, Mark McWilliams (for Elmer Cerano) Bill Mayer, Mike Vizena

Staff: Steve Fitton, Charles Overbey, Dick Miles, Kathy Stiffler, Jackie Prokop, Pam Diebolt, Cindy Linn, Monica Kwasnik, Erin Emerson, Marie LaPres, Lynda Zeller

Welcome and Introductions

Jan Hudson opened the meeting and introductions were made.

Managed Care Rebid

The Michigan Department of Community Health (MDCH) has issued three press releases regarding the Managed Care Rebid since the previous Medical Care Advisory Council (MCAC) meeting in November 2014. In the first press release, issued January 6, 2015, it was announced that the coverage regions for the Medicaid Health Plans (MHPs) will be re-structured into Governor Snyder's ten "Prosperity Regions." Currently, MHPs operating within a region are not required to cover all counties within that region, but will be required to do so under the new contract. The first press release also discussed the planned conversion of MIChild, Michigan's Children's Health Insurance Program (CHIP), to a Medicaid expansion program with all current Medicaid benefits. Beneficiaries enrolled in this program will still have the same cost-sharing responsibilities currently required under MIChild ($10 per month per family). MDCH expects that this conversion will result in increased efficiency in the delivery of services to MIChild beneficiaries.

MDCH issued a second press release on January 26, 2015 to announce that the implementation date for the new MHP contracts would be delayed by a full quarter, to begin on January 1, 2016 instead of October 1, 2015. The Request for Proposal (RFP) is expected to be issued by May 1, 2015, and MHPs will have until early August to submit proposals.

The third press release, issued February 12, 2015, announced that pharmacy benefits would be carved out of the MHP benefit package. It was noted that many pharmaceuticals are currently carved-out of the existing MHP contracts. MDCH is also proposing a managed care adult dental benefit. An opportunity for public comment was given for each press release, and the questions and answers from the first two press releases have been posted to the MDCH website at www.michigan.gov/mdch. Interested parties were given until February 27, 2015 to comment on the most recent press release. No additional press releases on this topic are anticipated.

Budget

Charles Overbey provided the council with an update on MDCH budgets for Fiscal Year (FY) 2015 and FY 2016.

FY 2015 Adjustments

The State of Michigan has a $450 million budget shortfall for FY 2015. Of this amount, $250 million was due to tax credits awarded to businesses for job creation and job retention, and the future liability to the state for these tax credits is estimated at $500 million per year for the next ten years. As a result of the budget shortfall, the state reduced expenditures in FY 2015, including a $53 million reduction in MDCH spending. Some of the programs affected by the reduction include hospital Graduate Medical Education (GME), rural Disproportionate Share Hospital (DSH) payments, health and wellness initiatives, and local public health services. MDCH funding was reduced by $100 million due to a recent but unexplained decline in Medicaid caseloads.

FY 2016 Executive Budget

Governor Snyder's executive budget recommendation for FY 2016 calls for $260 million in total spending reductions and $300 million in new investments. The budget recommendation for MDCH totaled $19 billion gross, with $3 billion in General Fund (GF). The GF recommendation was reduced by $145 million from FY 2015, with $24 million in new investments. Investments for FY 2016 include a Healthy Kids Dental expansion into Oakland, Kent, and Wayne counties to cover children up to the age of nine years, a phase-in of adult dental managed care coverage in the fourth quarter of FY 2016, and new funding for the Mental Health Commission and university autism programs. Proposed GF reductions for FY 2016 include cuts in payments to hospitals, the conversion of GME and rural hospital payments to provider taxes as the match for the federal funds from GF, and savings from the carve-out of the pharmacy benefit from the MHP benefit package.

Steve Fitton clarified that adult dental services are currently covered by Medicaid, but that access to providers is limited due to low reimbursement rates. MDCH hopes to phase in new funding for adult dental coverage in the last quarter of FY 2016, with the goal of annualizing the funding in subsequent years.

Jan Hudson added that there was a $20 million increase to non-Medicaid mental health services from the GF for FY 2016, and that the FY 2015 costs to support primary care rates were annualized. (The FY 2015 primary care rates were set at 50% of the Affordable Care Act (ACA) mandated two year increase that expired.) Overall, the GF appropriation for Medicaid has remained relatively flat since 2001, despite a twofold increase in the caseload in that same time period.

The council discussed the potential impact of the FY 2016 budget proposal at length. Topics discussed include the proposed reduction of hospital payments, a potential GF shortfall in behavioral health programs, and legislation that is needed to implement various provisions of the MDCH budget. Among the needed legislation, the administration is requesting an increase in the Health Insurance Claims Assessment (HICA) tax from 0.75% to 1.3%. This increase is projected to preserve $450 million in Medicaid payments.

Merger of MDCH and DHS – Department of Health and Human Services

Governor Snyder signed Executive Order 2015-4 to merge the Department of Human Services (DHS) with MDCH to form the Michigan Department of Health and Human Services (MDHHS) effective April 10, 2015. The executive budget recommendation included separate budgets for MDCH and DHS, but those will be combined once the creation of MDHHS is effective for a total estimated gross appropriation of $25 billion, with $4 billion to come from the GF. Work groups have been established to decide how the two departments can best be combined. No budget reductions for the two current departments are planned as a direct result of the merger; Steve stressed that recent layoffs are due to FY 2015 spending reductions and are not related to the planned creation of MDHHS.

Healthy Michigan Plan

Eligibility Issues and Fixes

Although the process of enrolling beneficiaries into the Healthy Michigan Plan using the new Modified Adjusted Gross Income (MAGI) application has been largely successful, there were issues with implementation that resulted from the systems changes, and MDCH is continuing to work to correct them. Some of these issues include:

- Parents were incorrectly denied Medicaid or Healthy Michigan Plan coverage when they did not include dependent children who were already enrolled in Medicaid on their application. In December, MDCH suspended the logic in the system that caused these individuals to be denied coverage, and a permanent fix is scheduled in a future release.
- New Healthy Michigan Plan beneficiaries were incorrectly denied retroactive coverage at the time of enrollment; MDCH corrected this problem in October 2014. The Department will review and correct cases going back to January 2014.
- The Centers for Medicare and Medicaid Services (CMS) requires that, for individuals who are granted presumptive Medicaid eligibility, Medicaid benefits must be discontinued immediately when the individual is subsequently found to be ineligible for Medicaid coverage based on a full MAGI application. Currently, if an individual were to submit a presumptive eligibility application in Michigan, they would be granted Medicaid eligibility automatically through the end of the following month. MDCH systems will not have the ability to discontinue Medicaid benefits prior to the end of a month until a system change is implemented in October, 2015. MDCH has submitted a formal letter to CMS requesting to continue to receive federal matching funds for services provided to presumptively eligible beneficiaries through the end of the month following the submission of their MAGI application until the system change is implemented.
- MDCH is working to incorporate logic into the Community Health Automated Medicaid Processing System (CHAMPS) to end copays for services for beneficiaries once they contribute 5% of their income in cost-sharing, in order to comply with CMS rules. The 5% cap on contribution responsibilities is calculated on a per-household basis, rather than per individual.
- MDCH has experienced problems transitioning beneficiaries to the Transitional Medical Assistance (TMA) program when their eligibility ends for Family Independence Program payments. The system was transferring cases to other Medicaid program categories. A fix for this problem is scheduled for mid-March.

Healthy Behaviors Update

Monica Kwasnik provided an update on the Healthy Behaviors Incentive Program. When new Healthy Michigan Plan beneficiaries enroll in a MHP, they are encouraged to visit their primary care physician as soon as possible and complete a Health Risk Assessment (HRA) to address healthy behaviors that the beneficiary would like to engage in. Once the beneficiary and their physician submit a signed attestation to MDCH indicating the healthy behaviors to be addressed, the beneficiary's monthly income-related contribution requirement will be reduced (for those with incomes above 100% FPL). First-time completion of the HRA process will result in a 50% reduction in monthly contribution requirements, and beneficiaries above 100% FPL who complete the HRA process with their primary care physician for a second time within 11-15 months will have their contribution requirement reduced by 100%. Additionally, copayments may be reduced for beneficiaries who have completed the HRA process once their annual accumulated copayments reach 2% of their income. MDCH will also review the HRA form annually to assess the need for any changes.

If an individual calls Michigan ENROLLS to enroll in a MHP, Michigan ENROLLS staff will ask the beneficiary the first nine questions found on the HRA. MDCH has found that 96% of individuals who call Michigan ENROLLS to select a health plan are responding to those questions. The data gathered during these calls is sent directly to the new member's health plan.

To date, 35,000 Healthy Michigan Plan beneficiaries who enrolled in April, May and June of 2014 have completed the full HRA process. Many beneficiaries are selecting multiple behaviors to work on, such as weight loss, tobacco cessation, follow-up for a chronic illness, etc. Within five months of enrollment, 70% of new Healthy Michigan Plan beneficiaries were able to see their primary care physician. The HRA Report is available on the MDCH website at www.michigan.gov/healthymichiganplan.

Steve Fitton reported that as of February 19, 2015, approximately 567,000 beneficiaries had enrolled in the Healthy Michigan Plan. Roughly 75% of these individuals are currently enrolled in a health plan.

Data on Utilization

A handout was distributed to attendees containing data on Healthy Michigan Plan utilization, and key areas of interest were highlighted. A council member requested additional information on beneficiary utilization of dental benefits provided through the Healthy Michigan Plan, in order to assist with provider outreach and increase access to care for the newly-eligible Healthy Michigan Plan population.

MIHealth Account Statements and Payments

MDCH issued 53,000 MIHealth account statements in December, and 69,000 were sent out in January. The call center is receiving 10,000 calls per day, many of which are related to MIHealth account statements. Since beneficiaries do not receive their first statement until they have been enrolled in a health plan for six months, there has been some confusion among beneficiaries, who, until they received their first statement, did not believe they were responsible for contributions during that period. MIHealth account statements are mailed to all beneficiaries, including those who were not required to contribute copayments. MDCH is working to clarify language on the MIHealth account statements to eliminate confusion. Most payments (70% - 80%) are by mail.

Second Waiver Development

Public Act 107 of 2013 requires MDCH to submit a second waiver for the Healthy Michigan Plan to CMS by September 1, 2015. This waiver would require that beneficiaries who have had Healthy Michigan Plan coverage for 48 months and have incomes over 100% of the FPL to purchase insurance from the Federally Facilitated Marketplace (FFM) and receive a subsidy, or remain on the Healthy Michigan Plan and be required to contribute a higher rate for cost-sharing. Contribution responsibilities for beneficiaries who choose to remain in the Healthy Michigan Plan would increase from 2% of income to 3.5%, and the total cap on cost-sharing would be increased from 5% of income to 7%. If the new waiver is not approved by December 31, 2015, the law requires that the Healthy Michigan Plan be discontinued. Due to the uncertainty of such an increase in cost-sharing requirements receiving approval from CMS, Steve stressed the importance of educating Michigan legislators on the successes of the program. The Michigan House and Senate are scheduled to hear testimony on the Healthy Michigan Plan on March 3, 2015, and the council discussed coordinating a common message among providers and MDCH to share at the hearings.

High Emergency Room (ER) Utilizer Report

The final ER High Utilizer Report that was discussed at the November MCAC meeting was submitted to the Michigan Legislature at the end of 2014. The legislature is working with MDCH on a joint press release that should be issued within a month. The report will be made available to the public at that time, and will be posted on the MDCH website. Discussions are ongoing about incorporating recommendations made as a result of the findings in the report.

Integrated Care for Dual Eligibles

Services for beneficiaries enrolled in the MI Health Link program in Michigan's first two demonstration regions, Southwest Michigan and the Upper Peninsula, are scheduled to begin March 1, 2015 for those who opted into the program, while services for beneficiaries who are passively enrolled in MI Health Link will begin May 1, 2015. As of February 19, 2015, 63 individuals had already enrolled in these two regions. MDCH recently sent letters to 12,000 eligible individuals in the first two demonstration regions who can be passively enrolled May 1, 2015, and outreach efforts are ongoing to individuals in regions that are scheduled to begin MI Health Link at later dates.

MDCH has been experiencing some issues with MI Health Link implementation, including long wait times and dropped calls for individuals who have been calling Maximus, the MI Health Link enrollment broker, and some calls to the Medicare/Medicaid Assistance Program (MMAP) are not being answered due to staffing issues. MDCH also needs to receive approval for a separate Ombudsman program specific to MI Health Link, and there have been some verification issues related to guardianship over MI Health Link beneficiaries. While Dick Miles acknowledged that these issues present some concerns for MDCH, he expressed optimism that they will be resolved soon. Comments and questions related to the MI Health Link Program may be emailed to integratedcare@michigan.gov.

Behavioral Health Initiatives

MDCH is working to establish Health Homes to coordinate care for Medicaid beneficiaries with both behavioral health and physical health chronic conditions. The first of Michigan's planned Health Homes has been established in Grand Traverse, Manistee, and Washtenaw counties to address behavioral health needs. The local Community Mental Health (CMH) agencies are serving as providers, and are responsible for directing person-centered care and facilitating access to a full array of behavioral health and primary and acute physical health services. The target population for this health home demonstration is individuals with serious mental health conditions; they must also have chronic physical conditions as well (i.e., diabetes, congestive heart failure). Enrollment began July 1, 2014, and there are 361 beneficiaries currently being served in the three pilot counties. Within these three counties, it is expected that no more than 500 individuals will be enrolled in a Health Home at a single time. Additionally, funding has been allotted to begin another Health Home in Michigan to be run by the Federally Qualified Health Centers (FQHCs). MDCH is hoping to have the FQHC Health Home established by January 2016.

Policy Updates

A policy handout was distributed to each attendee.

MSA 15-01 – This policy was issued on January 2, 2015. It delays the implementation of Bulletin MSA 14-58, which provided guidelines for Electronic Services Verification for Home Help providers.

MSA 14-66 – This policy was issued December 29, 2014, and discusses removing Medicaid and Healthy Michigan Plan beneficiaries with a diagnosis of inherited diseases of metabolism who receive metabolic formula from their MHP and transitioning them to FFS Medicaid. The policy also establishes payment guidelines for enteral nutrition.

MSA 14-61 – This policy was issued December 1, 2014, and discusses an update to the Practitioner Services fee schedule and implementation of a rate adjustment for specified primary care practitioner services effective for dates of service on or after January 1, 2015

MSA 14-60 – This policy was issued December 1, 2014, and discusses expanded Medicaid coverage of breast pumps.

MSA 14-57 – This policy was issued December 29, 2015, and provides the beginning framework for the MI Health Link Program; MDCH plans to add a chapter specific to MI Health Link to the Medicaid Provider Manual at a later date.

Proposed Policy 1462-Dental – This proposed policy discusses registering mobile dental providers in CHAMPS effective April 1, 2015, and is being issued in response to a legislative mandate set forth in PA 100 of 2014.

Medicaid Enactment 50th Anniversary July 30, 2015

Jan discussed ideas for commemorating the 50th anniversary of Medicaid enactment, and recommended that the MCAC form a committee to plan activities for the occasion. Alison Hirschel, Priscilla Cheever, Cheryl Bupp, Dianne Haas and Katie Linehan/Elan Nichols volunteered to serve on the committee, and David Lalumia accepted the committee's nomination to serve as its chair.

4:30 – Adjourn

Next Meeting: May 4, 2015

Medical Services Administration
Bureau of Medicaid Care Management and Quality Assurance

PERFORMANCE MONITORING REPORT

MEDICAID MANAGED CARE
HEALTHY MICHIGAN PLAN
ADULT CORE SET MEASURES

January 2015

Produced by:

Quality Improvement and Program Development – Managed Care Plan Division

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Appendixes

Figures

Tables

Executive Summary

This Performance Monitoring Report represents a change in how the Managed Care Plan Division (MCPD) tracks quality, access, and utilization in the Michigan Medicaid program to better support high quality care for beneficiaries in the following ways:

- Allows for greater granularity in reporting. DCH now has the capacity to report data on the basis or program area (traditional Medicaid, Healthy Michigan Plan, FFS), by beneficiary demographic information (age, gender, race/ethnicity), or region
- Provides data in a more timely fashion

Some measures presented here are from the Adult Core Health Care Quality Measurement Set developed by the Centers for Medicare and Medicaid Services (CMS). The specifications published by CMS for these measures were used in the generation of the rates in this report with one exception; the measures reported here do NOT include data from medical record review or other administrative databases. The measures in this report have been generated using ONLY encounter data found in the Medicaid data warehouse. Therefore, the data here should not be compared to HEDIS measures or compared to HEDIS national benchmarks.

The Michigan Department of Community Health (MDCH) monitors the performance of the State's Medicaid Health Plans (MHPs) through twenty-eight (28) key performance measures, aimed at improving the quality and efficiency of health care services provided to the Michigan residents enrolled in a Medicaid program. FY 2015 Performance monitoring includes measures of the following categories:

Childhood Immunizations	*Elective Delivery*	*Postpartum Care*	*Blood Lead Testing*	*Developmental Screening*	*Well-Child Visits First 15 months*
Well-Child Visits 3-6 Years	*Complaints*	*Claims Processing*	*Encounter Data Reporting*	*Pharmacy Encounter Data*	*Provider File Reporting*
Adults Generic Drug Utilization	*Timely Completion of HRA*	*Outreach & Engagement to Facilitate Entry to Primary Care*	*Plan All-Cause Acute 30-Day Readmissions*	*Adults' Access to Ambulatory Health Services*	*Adult Body Mass Index Assessment*
Breast Cancer Screening	*Cervical Cancer Screening*	*Diabetes Short-Term Complications Admission Rate*	*COPD or Asthma in Older Adults Admission Rate*	*Heart Failure Admission Rate*	*Asthma in Younger Adults Admission Rate*
Chlamydia Screening in Women Age 21-24	*Comprehensive Diabetes Care: Hemoglobin A1c Testing*	*Antidepressant Medication Management*	*Annual Monitoring for Patients on Persistent Medications*		

Data for each of the twenty-eight (28) measures are represented in this report on a quarterly basis. The body of the report contains a cross-plan analysis of the most current data available for each performance measure. MDCH has established specific three letter codes identifying each Health Plan. These codes are listed in Appendix A. Appendix B contains the one-year plan specific analysis for each measure.

Measurement Frequency

The data for each performance measure vary in frequency. While most measures will be run on a quarterly basis, there are others that are run monthly. All monthly measures will be reported on a quarterly basis in the Performance Monitoring Report.

Measurement Periods for each measure may vary and are based on the specifications for that individual measure. In addition to this, Figures 3 through 25 depict only Managed Care Plan data, and not Fee-For-Service (FFS) data.

MHPs are contractually obligated to achieve specified standards for each measure. The following tables display the number of MHPs meeting or exceeding the standards for the performance measure versus total MHPs, as reported in the Performance Monitoring Report, during the listed month or quarter, for fiscal year 2015 unless otherwise noted.

Table 1: Fiscal Year 2015[1]

Quarterly Reported Measures	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Childhood Immunizations	N/A			
Elective Delivery	N/A			
Postpartum Care	N/A			
Well-Child Visits 3-6 Years	N/A			
Well-Child Visits 7-11 Years	N/A			
Complaints	5/13			
Adults' Generic Drug Utilization	N/A			
Timely Completion of Initial HRA	N/A			
Outreach & Engagement to Facilitate Entry to PCP	N/A			
Plan All-Cause Acute 30-Day Readmissions	N/A			
Adults' Access to Ambulatory Health Services	N/A			
Adult Body Mass Index Assessment	N/A			
Breast Cancer Screening	N/A			
Cervical Cancer Screening	N/A			
Diabetes Short-Term Complications Admission Rate	N/A			
COPD or Asthma in Older Adults Admission Rate	N/A			
Heart Failure Admission Rate	N/A			
Asthma in Younger Adults Admission Rate	N/A			
Chlamydia Screening in Women Ages 21-24	N/A			
Comprehensive Diabetes Care: Hemoglobin A1c Testing	N/A			

[1] Plans that show "N/A" have no minimum standard set and all published data for the measure is informational only.

Table 1: Fiscal Year 2015 (continued)

Antidepressant Medication Management	N/A			
Annual Monitoring for Patients on Persistent Medications	N/A			

Monthly Reported Measures	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Blood Lead Testing	5/13	4/13	4/13									
Developmental Screening	N/A	N/A	N/A									
Claims Processing	9/13	9/13	10/13									
Encounter Data Reporting	13/13	13/13	13/13									
Pharmacy Encounter Data	13/13	13/13	12/13									
Provider File Reporting	13/13	13/13	13/13									

Managed Care Enrollment

Michigan Medicaid managed care (MA-MC) enrollment has increased over the past year. In December 2014, enrollment was 1,495,735, up 241,245 enrollees (19.2%) from January 2014. A decrease of 34,570 enrollees (2.3%) was realized between November 2014 and December 2014.

The Healthy Michigan Plan (HMP-MC) enrollment has also increased. In December 2014, enrollment was 357,484, up 273,678 enrollees (326.6%) from its inception in April 2014. An increase of 6,009 enrollees (1.7%) was realized between November 2014 and December 2014.

Figure 1: MA-MC and HMP-MC Enrollment, January 2014 – December 2014

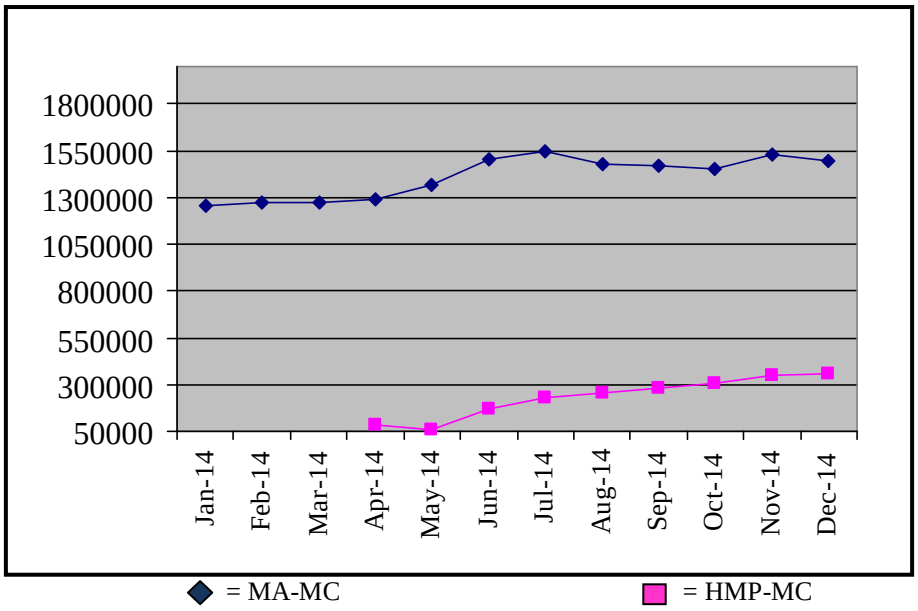
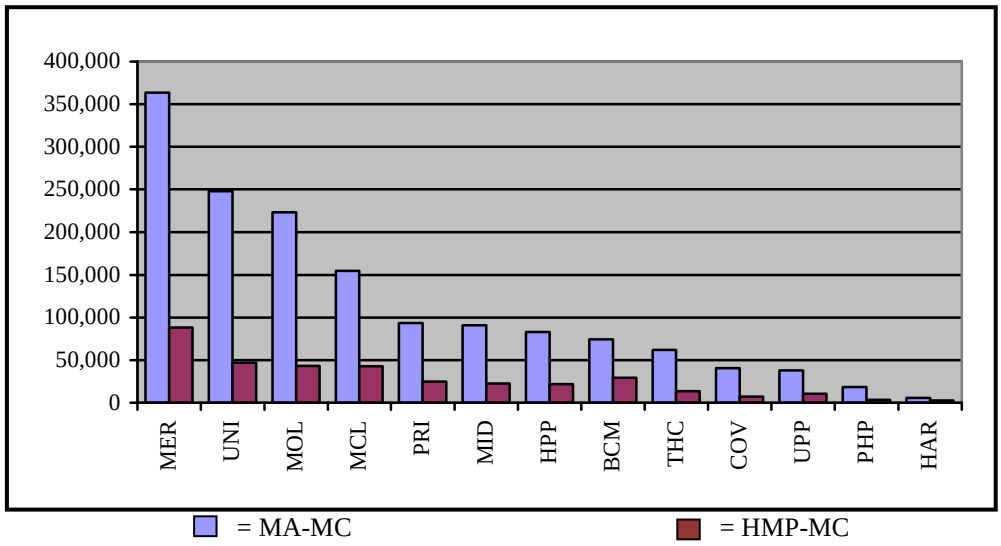


Figure 2: MA-MC and HMP-MC Enrollment, by Health Plan, December 2014



Medicaid Health Plan News

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

MDCH will be reporting data for the Healthy Michigan Plan measures as the data becomes available.

Cross-Plan Performance Monitoring Analyses

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

Childhood Immunizations

Measure
Percentage of children who turned two years old during the measurement period and received the complete Combination 3 childhood immunization series. The Combination 3 immunization series consists of 4 DtaP/DT, 3 IPV, 1 MMR, 3 Hib, 3 HEPB, 1 VZV, and 4 PCV.

Standard
N/A – This measure is informational only

Measurement Period
July 2013 – June 2014

Data Source
MDCH Data Warehouse

Measurement Frequency
Quarterly

Data for this measure will not be reported this quarter.

Elective Delivery

Measure
Percentage of pregnant women enrolled in a health plan with elective vaginal deliveries or elective cesarean sections greater than or equal to 37, and less than 39 weeks complete gestation during the measurement period.
NOTE: There is no continuous enrollment requirement for this measure.

Standard
N/A – This measure is informational only.

Measurement Period
July 2013 – June 2014

Data Source
MDCH Data Warehouse

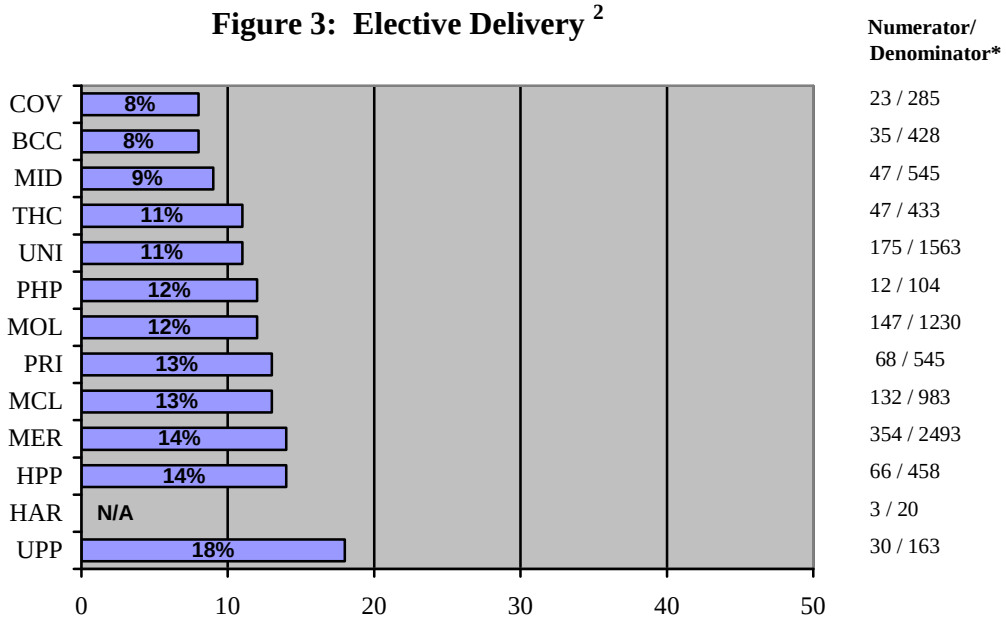
Measurement Frequency
Quarterly

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

Table 2: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	1297	10749	12%
Fee For Service (FFS) only	158	1499	11%
Managed Care only	1139	9250	12%
MA-MC	1136	9218	12%
HMP-MC	3	32	N/A

Figure 3: Elective Delivery [2]



Elective Delivery Percentages

*Numerator depicts the number of eligible beneficiaries who had an elective vaginal delivery or elective cesarean section ≥ 37 and ≤ 39 weeks complete gestation. Denominator depicts the total number of deliveries ≥ 37 and ≤ 39 weeks.

[2] A rate was not calculated for plans with a numerator under 5 or a denominator under 30.

Postpartum Care

Measure
Percentage of women who delivered live births between day one and day 309 of the measurement period that had a postpartum visit on or between 21 and 56 days after delivery.

Standard
N/A – This measure is informational only.

Measurement Period
July 2013 – June 2014

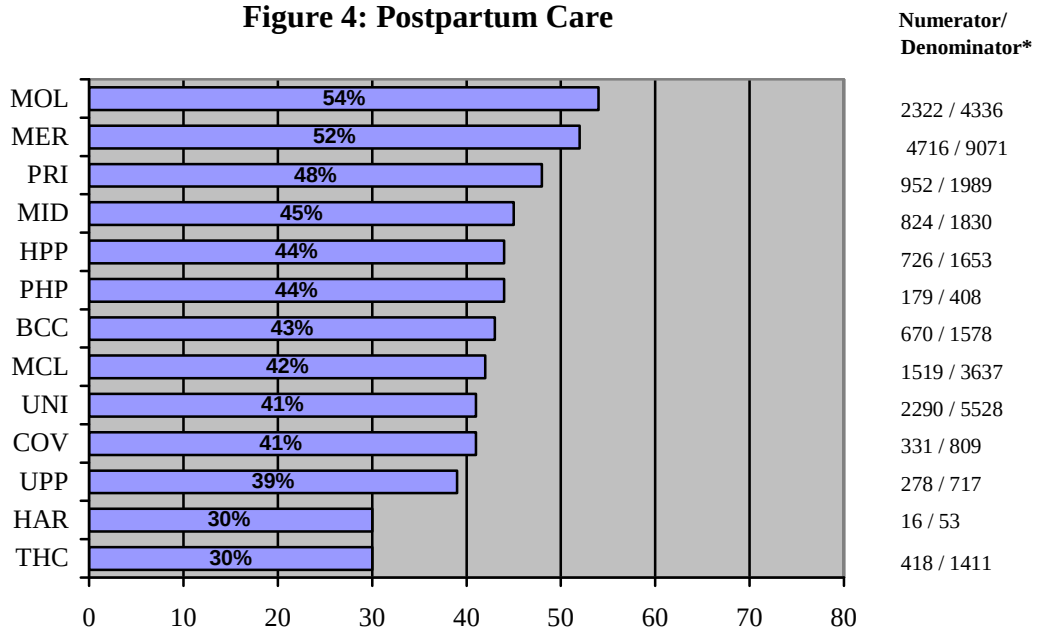
Data Source
MDCH Data Warehouse

Measurement Frequency
Quarterly

Table 3: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	18242	41790	44%
Fee For Service (FFS) only	423	1705	25%
Managed Care only	17819	40085	44%
MA-MC	17696	39665	45%
HMP-MC	5	60	8%

Figure 4: Postpartum Care



Postpartum Care Percentages

*Numerator depicts the number of eligible beneficiaries who delivered live births between day 1 and day 309 of the measurement period, and who also had a postpartum visit on or between 21 and 56 days after delivery. Denominator depicts the total number of eligible beneficiaries.

Blood Lead Testing for Two Year Olds

Measure
Percentage of two year old children that have had at least one blood lead test on or before their second birthday.

Standard
81% for continuously enrolled children

Measurement Period
October 2014 – December 2014

Data Source
MDCH Data Warehouse

Measurement Frequency
Monthly

Summary
The plan-wide weighted average was 77%, four percentage points below the standard for the measure. Five MHPs met or exceeded the standard in October, while eight plans did not; Four MHPs met or exceeded the standard in November and December, while nine plans did not.

Table 4: Blood Lead Testing for Two Year Olds

MHP	Standard	Cont. Enrolled Result			Standard Achieved		
		Oct	Nov	Dec	Oct	Nov	Dec
BCC	81%	71%	71%	71%	**No**	**No**	**No**
COV	81%	75%	75%	77%	**No**	**No**	**No**
HAR	81%	53%	55%	58%	**No**	**No**	**No**
HPP	81%	82%	82%	81%	Yes	Yes	Yes
MCL	81%	82%	82%	82%	Yes	Yes	Yes
MER	81%	79%	79%	79%	**No**	**No**	**No**
MID	81%	73%	73%	73%	**No**	**No**	**No**
MOL	81%	73%	73%	73%	**No**	**No**	**No**
PHP	81%	82%	80%	80%	Yes	**No**	**No**
PRI	81%	82%	82%	82%	Yes	Yes	Yes
THC	81%	67%	67%	66%	**No**	**No**	**No**
UNI	81%	77%	77%	77%	**No**	**No**	**No**
UPP	81%	84%	85%	86%	Yes	Yes	Yes

Developmental Screening

Measure
This measure includes three rates: The percentage of children less than one (1) year old who receive a developmental screening; the percentage of children between their 1st and 2nd birthday who receive a developmental screening; and the percentage of children between their 2nd and 3rd birthday who receive a developmental screening.

Standard
N/A – This measure is informational only.

Measurement Period
October 2014 – December 2014

Data Source
MDCH Data Warehouse

Measurement Frequency
Monthly

Table 5: Developmental Screening

MHP	First Year of Life			Second year of Life			Third Year of Life		
	Oct	Nov	Dec	Oct	Nov	Dec	Oct	Nov	Dec
BCC	17%	14%	11%	19%	16%	13%	12%	9%	7%
COV	20%	20%	21%	25%	24%	22%	15%	14%	15%
HAR	9%	9%	9%	12%	11%	6%	5%	4%	2%
HPP	21%	22%	23%	29%	29%	30%	22%	23%	24%
MCL	17%	18%	18%	19%	19%	20%	12%	13%	14%
MER	19%	19%	20%	22%	22%	22%	18%	18%	19%
MID	25%	26%	25%	30%	30%	31%	18%	20%	20%
MOL	21%	21%	22%	26%	26%	26%	19%	19%	20%
PHP	21%	22%	21%	20%	21%	22%	15%	16%	16%
PRI	20%	21%	22%	32%	33%	33%	25%	25%	25%
THC	14%	15%	15%	16%	15%	16%	10%	9%	9%
UNI	21%	21%	21%	26%	26%	26%	18%	18%	18%
UPP	21%	21%	21%	20%	19%	19%	17%	18%	17%

Well-Child Visits First 15 Months

Measure
Percentage of children who turned 15 months old during the measurement period, were continuously enrolled in the health plan from 31 days of age, and received at least six well-child visit(s) during their first 15 months of life.

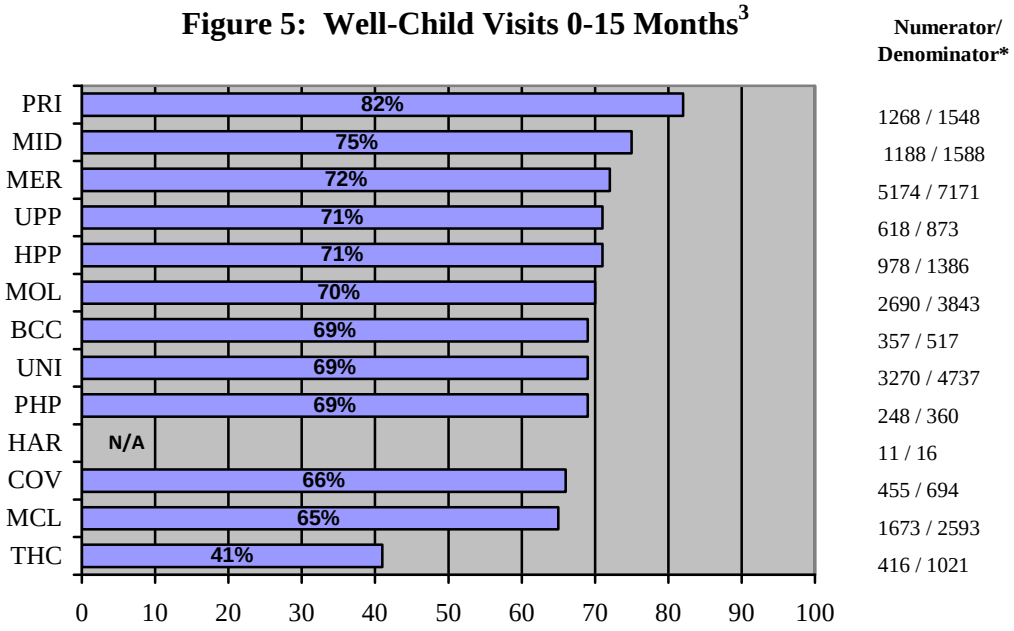
Standard
N/A – This measure is informational only.

Measurement Period
July 2013 – June 2014

Data Source
MDCH Data Warehouse

Measurement Frequency
Quarterly

Figure 5: Well-Child Visits 0-15 Months[3]



*Numerator depicts the number of eligible beneficiaries who had at least 6 well-child visits. Denominator depicts the total number of eligible beneficiaries.

[3] A rate was not calculated for plans with a numerator under 5 or a denominator under 30.

Well-Child Visits 3-6 Years Old

Measure
Percentage of children who were three, four, five, or six years old, were continuously enrolled in the health plan, and received one or more well-child visit(s) during the measurement period.

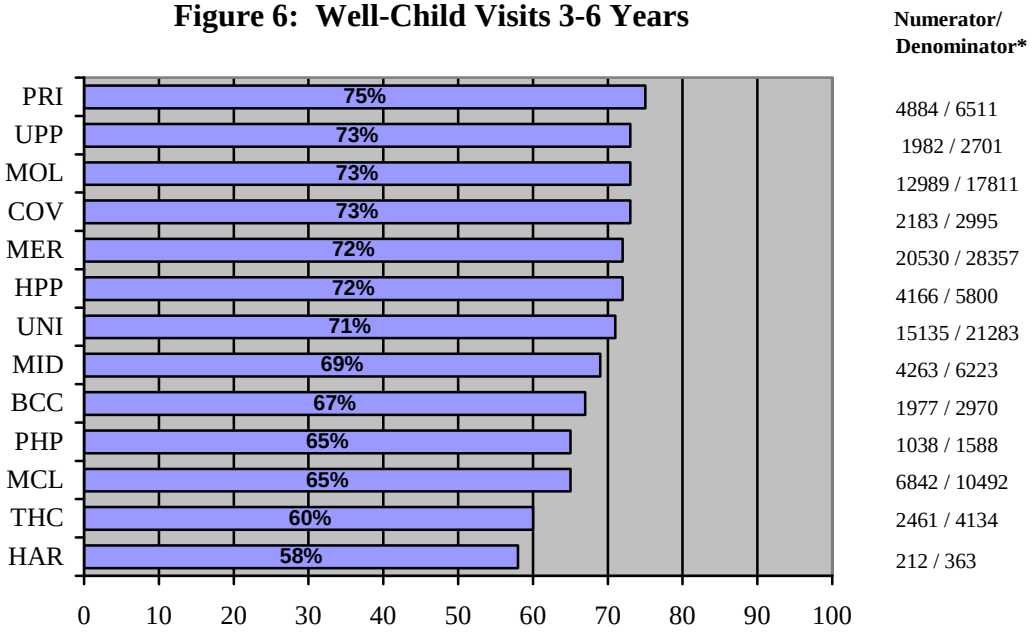
Standard
N/A – This measure is informational only.

Measurement Period
July 2013 – June 2014

Data Source
MDCH Data Warehouse

Measurement Frequency
Quarterly

Figure 6: Well-Child Visits 3-6 Years



Well-Child Visits 3-6 Years Percentage

*Numerator depicts the number of eligible beneficiaries who had at least one well-child visit. Denominator depicts the total number of eligible beneficiaries.

Complaints

Measure
Rate of complaints received by MDCH during the measurement period.

Standard
Less than 0.15 complaints per 1,000 member months

Measurement Period
July 2014 – September 2014

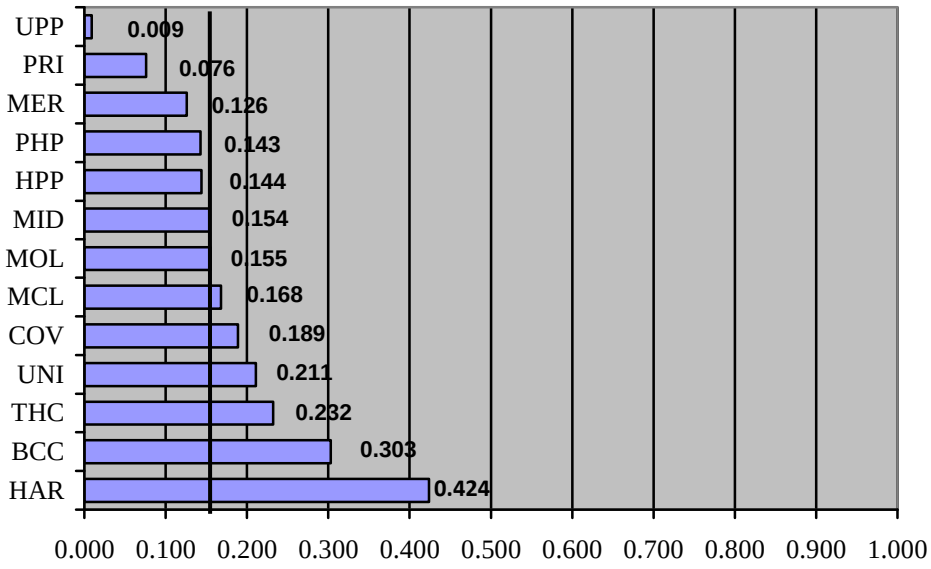
Data Source
Customer Relations System (CRM)

Measurement Frequency
Quarterly

Summary
Five MHPs met or exceeded the standard, while eight plans (BCC, COV, HAR, MCL, MID, MOL, THC, and UNI), did not. The results ranged from 0.009 to 0.424 complaints per 1,000 member months.

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

Figure 7: Complaints



Claims Processing

Measure
Rate of clean non-pharmacy claims processed within 30 days, rate of non-pharmacy claims in ending inventory greater than 45 days; percent of rejected claims.

Standard
Submission of accurate claims report within 30 days of the end of the report month; process ≥ 95% of clean claims within 30 days of receipt with ≤ 12% rejected claims; maintain ≤ 1% of ending inventory greater than 45 days.

Measurement Period
August 2014 – October 2014

Data Source
Claims report submitted by health plan

Measurement Frequency
Monthly

Summary
In August and September nine MHPs met the standard of submitting a claims report within 30 days; processing greater than or equal to 95% of clean non-pharmacy claims within 30 days of receipt with less than or equal to 12% rejected claims; and maintaining less than or equal to 1% of ending inventory greater than 45 days, while four plans did not.
In October ten MHPs met the standard of submitting a claims report within 30 days; processing greater than or equal to 95% of clean non-pharmacy claims within 30 days of receipt with less than or equal to 12% rejected claims; and maintaining less than or equal to 1% of ending inventory greater than 45 days, while three plans did not.

Table 6: Claims Processing August 2014

MHP	Timely	Accurate	≥95%	≤12%	≤0.01%	Standard Achieved
BCC	Yes	Yes	95%	4%	**11.85%**	**No**
COV	Yes	Yes	100%	3%	0.00%	Yes
HAR	Yes	Yes	**11%**	0%	0.00%	**No**
HPP	Yes	Yes	100%	2%	0.00%	Yes
MCL	Yes	Yes	100%	7%	0.00%	Yes
MER	Yes	Yes	99%	8%	0.00%	Yes
MID	Yes	Yes	98%	0%	0.00%	Yes
MOL	Yes	Yes	100%	4%	0.08%	Yes
PHP	**No**	**No**	N/A	N/A	N/A	**No**
PRI	Yes	Yes	99%	5%	0.00%	Yes
THC	Yes	Yes	100%	3%	0.00%	Yes
UNI	Yes	Yes	100%	10%	0.31%	Yes
UPP	Yes	Yes	99%	**15%**	0.00%	**No**

Table 7: Claims Processing September 2014

MHP	Timely	Accurate	≥95%	≤12%	≤0.01%	Standard Achieved
BCC	Yes	Yes	98%	4%	**21.70%**	**No**
COV	Yes	Yes	100%	3%	0.00%	Yes
HAR	Yes	Yes	100%	0%	0.07%	Yes
HPP	Yes	Yes	100%	2%	0.00%	Yes
MCL	Yes	Yes	**82%**	2%	11.88%	**No**
MER	Yes	Yes	99%	8%	0.00%	Yes
MID	Yes	Yes	98%	0%	0.00%	Yes
MOL	Yes	Yes	100%	3%	0.06%	Yes
PHP	Yes	Yes	**83%**	0%	0.00%	**No**
PRI	Yes	Yes	100%	5%	0.21%	Yes
THC	Yes	Yes	100%	4%	0.00%	Yes
UNI	Yes	Yes	100%	10%	0.51%	Yes
UPP	Yes	Yes	99%	**13%**	0.00%	**No**

Table 8: Claims Processing October 2014

MHP	Timely	Accurate	≥95%	≤12%	≤0.01%	Standard Achieved
BCC	Yes	Yes	98%	3%	**7.38%**	**No**
COV	Yes	Yes	100%	4%	0.00%	Yes
HAR	Yes	Yes	100%	0%	0.00%	Yes
HPP	Yes	Yes	100%	2%	0.01%	Yes
MCL	Yes	Yes	95%	3%	**1.69%**	**No**
MER	Yes	Yes	98%	8%	0.00%	Yes
MID	Yes	Yes	98%	0%	0.00%	Yes
MOL	Yes	Yes	100%	3%	0.03%	Yes
PHP	Yes	Yes	99%	0%	0.27%	Yes
PRI	Yes	Yes	100%	5%	0.03%	Yes
THC	Yes	Yes	100%	3%	0.00%	Yes
UNI	Yes	Yes	100%	9%	0.08%	Yes
UPP	Yes	Yes	100%	**13%**	0.00%	**No**

Encounter Data Reporting

Measure
Timely and complete encounter data submission

Standard
Submission of previous months adjudicated encounters by the 15th of the measurement month; include institutional and professional record types; and meet MDCH calculated minimum volume records accepted into the MDCH data warehouse

Measurement Period
October 2014 – December 2014

Data Source
MDCH Data Exchange Gateway, MDCH Data Warehouse

Measurement Frequency
Monthly

Summary
Thirteen of the MHPs met the standard of submitting a minimum volume of professional and institutional September 2014 – November 2014 adjudicated claims by the 15th of December 2014.

Table 9: Encounter Data Reporting October 2014

MHP	Standard	Timely	Complete		Standard Achieved
		15th of Month	Prof & Inst.	Min. Volume	
BCC	Timely, Complete	Yes	Yes	Yes	Yes
COV	Timely, Complete	Yes	Yes	Yes	Yes
HAR	Timely, Complete	Yes	Yes	Yes	Yes
HPP	Timely, Complete	Yes	Yes	Yes	Yes
MCL	Timely, Complete	Yes	Yes	Yes	Yes
MER	Timely, Complete	Yes	Yes	Yes	Yes
MID	Timely, Complete	Yes	Yes	Yes	Yes
MOL	Timely, Complete	Yes	Yes	Yes	Yes
PHP	Timely, Complete	Yes	Yes	Yes	Yes
PRI	Timely, Complete	Yes	Yes	Yes	Yes
THC	Timely, Complete	Yes	Yes	Yes	Yes
UNI	Timely, Complete	Yes	Yes	Yes	Yes
UPP	Timely, Complete	Yes	Yes	Yes	Yes

Table 10: Encounter Data Reporting November 2014

MHP	Standard	Timely	Complete		Standard Achieved
		15th of Month	Prof & Inst.	Min. Volume	
BCC	Timely, Complete	Yes	Yes	Yes	Yes
COV	Timely, Complete	Yes	Yes	Yes	Yes
HAR	Timely, Complete	Yes	Yes	Yes	Yes
HPP	Timely, Complete	Yes	Yes	Yes	Yes
MCL	Timely, Complete	Yes	Yes	Yes	Yes
MER	Timely, Complete	Yes	Yes	Yes	Yes
MID	Timely, Complete	Yes	Yes	Yes	Yes
MOL	Timely, Complete	Yes	Yes	Yes	Yes
PHP	Timely, Complete	Yes	Yes	Yes	Yes
PRI	Timely, Complete	Yes	Yes	Yes	Yes
THC	Timely, Complete	Yes	Yes	Yes	Yes
UNI	Timely, Complete	Yes	Yes	Yes	Yes
UPP	Timely, Complete	Yes	Yes	Yes	Yes

Table 11: Encounter Data Reporting December 2014

MHP	Standard	Timely	Complete		Standard Achieved
		15th of Month	Prof & Inst.	Min. Volume	
BCC	Timely, Complete	Yes	Yes	Yes	Yes
COV	Timely, Complete	Yes	Yes	Yes	Yes
HAR	Timely, Complete	Yes	Yes	Yes	Yes
HPP	Timely, Complete	Yes	Yes	Yes	Yes
MCL	Timely, Complete	Yes	Yes	Yes	Yes
MER	Timely, Complete	Yes	Yes	Yes	Yes
MID	Timely, Complete	Yes	Yes	Yes	Yes
MOL	Timely, Complete	Yes	Yes	Yes	Yes
PHP	Timely, Complete	Yes	Yes	Yes	Yes
PRI	Timely, Complete	Yes	Yes	Yes	Yes
THC	Timely, Complete	Yes	Yes	Yes	Yes
UNI	Timely, Complete	Yes	Yes	Yes	Yes
UPP	Timely, Complete	Yes	Yes	Yes	Yes

Pharmacy Encounter Data Reporting

Measure
Timely and complete pharmacy encounter data submission

Standard
Enrolled in the health plan within the designated period to the measurement month

Measurement Period
October 2014 – December 2014

Data Source
MDCH Data Exchange Gateway, Encounter Data

Measurement Frequency
Monthly

Summary
Twelve MHPs met the standard of submitting a minimum volume of pharmacy September 2014 – November 2014 adjudicated claims by the 15th of December 2014, while one plan (UPP) did not.

Table 12: Pharmacy Encounter Data Reporting October 2014

MHP	Standard	Timely	Complete	Standard Achieved
		15th of Month	Min. Volume	
BCC	Timely, Complete	Yes	Yes	Yes
COV	Timely, Complete	Yes	Yes	Yes
HAR	Timely, Complete	Yes	Yes	Yes
HPP	Timely, Complete	Yes	Yes	Yes
MCL	Timely, Complete	Yes	Yes	Yes
MER	Timely, Complete	Yes	Yes	Yes
MID	Timely, Complete	Yes	Yes	Yes
MOL	Timely, Complete	Yes	Yes	Yes
PHP	Timely, Complete	Yes	Yes	Yes
PRI	Timely, Complete	Yes	Yes	Yes
THC	Timely, Complete	Yes	Yes	Yes
UNI	Timely, Complete	Yes	Yes	Yes
UPP	Timely, Complete	Yes	Yes	Yes

Table 13: Pharmacy Encounter Data Reporting November 2014

MHP	Standard	Timely	Complete	Standard Achieved
		15th of Month	Min. Volume	
BCC	Timely, Complete	Yes	Yes	Yes
COV	Timely, Complete	Yes	Yes	Yes
HAR	Timely, Complete	Yes	Yes	Yes
HPP	Timely, Complete	Yes	Yes	Yes
MCL	Timely, Complete	Yes	Yes	Yes
MER	Timely, Complete	Yes	Yes	Yes
MID	Timely, Complete	Yes	Yes	Yes
MOL	Timely, Complete	Yes	Yes	Yes
PHP	Timely, Complete	Yes	Yes	Yes
PRI	Timely, Complete	Yes	Yes	Yes
THC	Timely, Complete	Yes	Yes	Yes
UNI	Timely, Complete	Yes	Yes	Yes
UPP	Timely, Complete	Yes	Yes	Yes

Table 14: Pharmacy Encounter Data Reporting December 2014

MHP	Standard	Timely	Complete	Standard Achieved
		15th of Month	Min. Volume	
BCC	Timely, Complete	Yes	Yes	Yes
COV	Timely, Complete	Yes	Yes	Yes
HAR	Timely, Complete	Yes	Yes	Yes
HPP	Timely, Complete	Yes	Yes	Yes
MCL	Timely, Complete	Yes	Yes	Yes
MER	Timely, Complete	Yes	Yes	Yes
MID	Timely, Complete	Yes	Yes	Yes
MOL	Timely, Complete	Yes	Yes	Yes
PHP	Timely, Complete	Yes	Yes	Yes
PRI	Timely, Complete	Yes	Yes	Yes
THC	Timely, Complete	Yes	Yes	Yes
UNI	Timely, Complete	Yes	Yes	Yes
UPP	Timely, Complete	Yes	**No**	**No**

Provider File Reporting

Measure
Monthly provider file submission.

Standard
Submission of an error free file, with an accurate list of primary care, specialist, hospital, and ancillary providers contracted with and credentialed by the health plan, to Michigan ENROLLS before the last Thursday of the month.

Measurement Period
October 2014 – December 2014

Data Source
MDCH Data Exchange Gateway, Encounter Data

Measurement Frequency
Monthly

Summary
Thirteen MHPs met the standard of submitting an error free provider file to Michigan ENROLLS for the months of October, November, and December 2014.

Table 15: Provider File Reporting

MHP	Standard	Timely			Accurate			Standard Achieved		
		Oct	Nov	Dec	Oct	Nov	Dec	Oct	Nov	Dec
BCC	Timely, Complete	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
COV	Timely, Complete	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
HAR	Timely, Complete	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
HPP	Timely, Complete	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
MCL	Timely, Complete	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
MER	Timely, Complete	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
MID	Timely, Complete	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
MOL	Timely, Complete	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
PHP	Timely, Complete	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
PRI	Timely, Complete	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
THC	Timely, Complete	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
UNI	Timely, Complete	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
UPP	Timely, Complete	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Adults' Generic Drug Utilization

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

Standard
N/A – This measure is informational only.

Measurement Period
April 2014 – June 2014

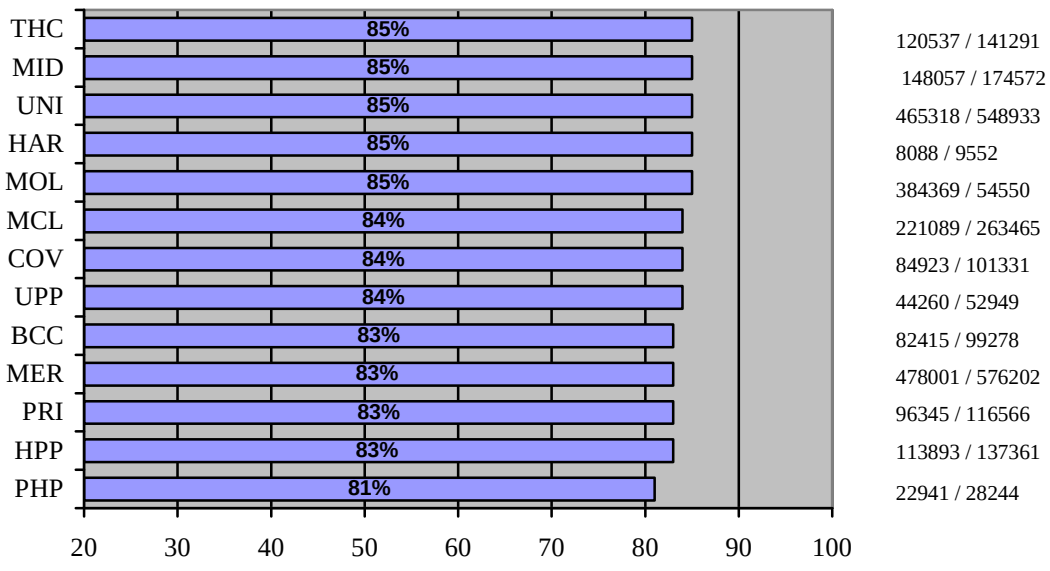
Data Source
MDCH Data Warehouse

Measurement Frequency
Quarterly

Table 16: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	2458710	2974299	83%
Fee For Service (FFS) only	46035	84714	54%
Managed Care only	2286637	2723892	84%
MA-MC	1986610	2368300	84%
HMP-MC	288806	342323	84%

Figure 8: Adults' Generic Drug Utilization



Adult's Generic Drug Utilization Percentages

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

Timely Completion of Initial Health Risk Assessment

Measure
Percentage of Healthy Michigan Plan beneficiaries enrolled in a health plan who had a Health Risk Assessment (HRA) completed within 150 days of enrollment in a health plan.

Standard
N/A – This measure is informational only.

Measurement Period
April 2014 – June 2014

Data Source
MDCH Data Warehouse

Measurement Frequency
Quarterly

Data for this measure will not be reported this quarter.

Outreach and Engagement to Facilitate Entry to Primary Care

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

Standard
N/A – This measure is informational only.

Measurement Period
April 2014 – June 2014

Data Source
MDCH Data Warehouse

Measurement Frequency
Quarterly

Data for this measure will not be reported this quarter.

Plan All-Cause Acute 30-Day Readmissions

Measure
The percentage of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days.

Standard
N/A – This measure is informational only.

Measurement Period
January 2014 – December 2014

Data Source
MDCH Data Warehouse

Measurement Frequency
Annually

Data for this measure will not be reported this quarter.

Adults' Access to Ambulatory Health Services

Measure
The percentage of adults 19 to 64 years old who had an ambulatory or preventive care visit during the measurement period.

Standard
N/A – This measure is informational only.

Measurement Period
April 2014 – June 2014

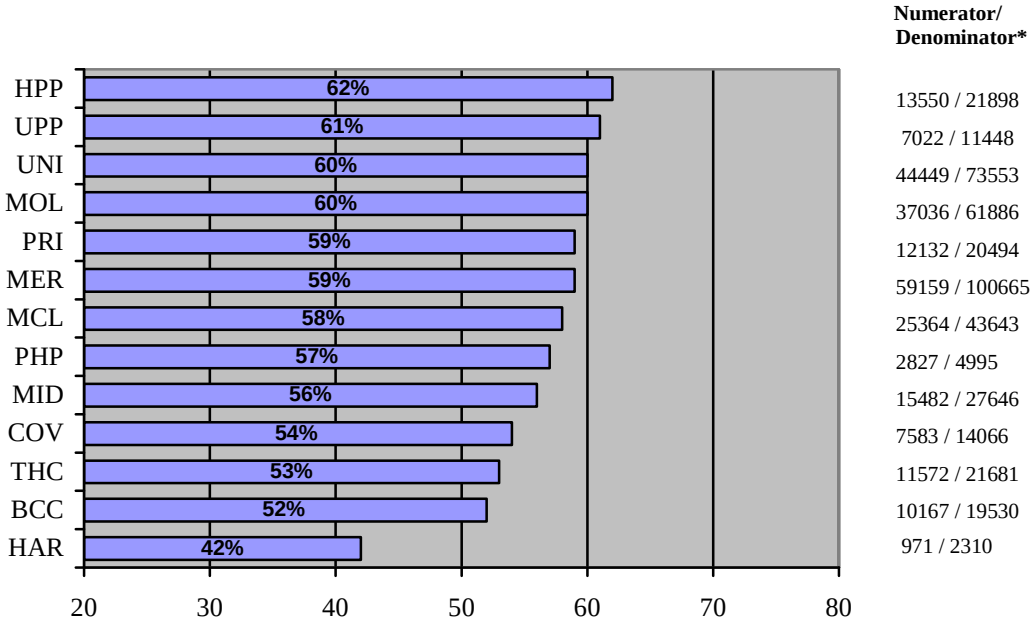
Data Source
MDCH Data Warehouse

Measurement Frequency
Quarterly

Table 17: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	363863	704911	52%
Fee For Service (FFS) only	45037	141792	32%
Managed Care only	249404	426912	58%
MA-MC	215216	366991	59%
HMP-MC	34081	59759	57%

Figure 9: Adults' Access to Ambulatory Health Services



Adult's Access to Ambulatory Health Services Percentages

*Numerator depicts the number of eligible beneficiaries who had an ambulatory or preventive care visit. Denominator depicts the total number of eligible beneficiaries.

Adult Body Mass Index (BMI) Assessment

Measure
The percentage of adults enrolled in a health plan between the ages of 18 and 74 who had an outpatient visit and whose body mass index (BMI) was documented during the measurement period or the year prior to the measurement period.

Standard
N/A – This measure is informational only.

Measurement Period
July 2013 – June 2014

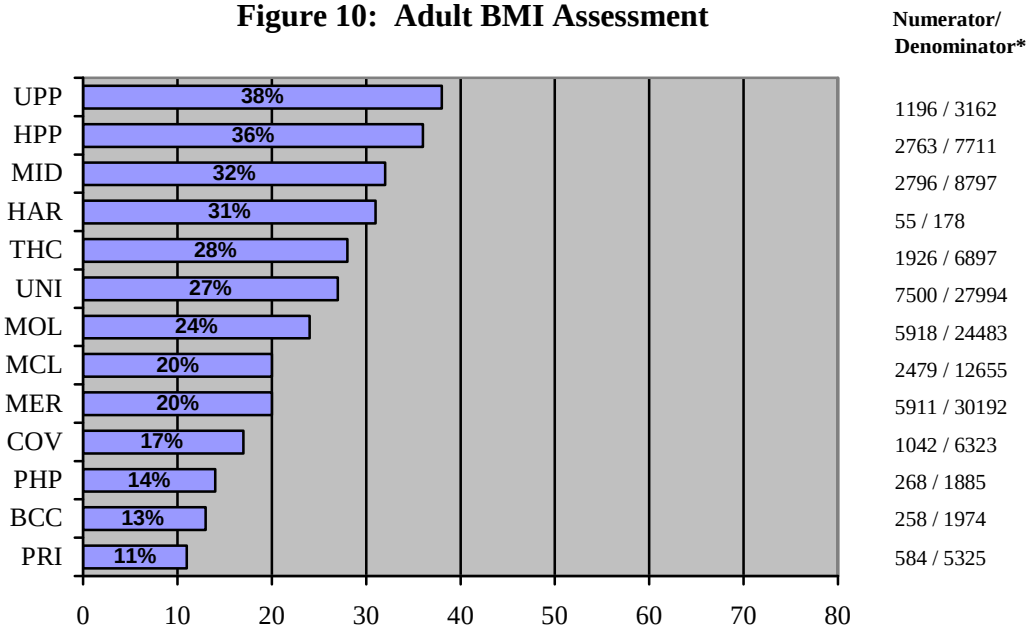
Data Source
MDCH Data Warehouse

Measurement Frequency
Quarterly

Table 18: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	45162	192620	23%
Fee For Service (FFS) only	608	2907	21%
Managed Care only	34668	145032	24%
MA-MC	34068	141829	24%
HMP-MC	N/A	N/A	N/A

Figure 10: Adult BMI Assessment



Adult BMI Assessment Percentages

*Numerator depicts the number of eligible beneficiaries who had an outpatient visit and whose BMI was documented. Denominator depicts the total number of eligible beneficiaries.

Breast Cancer Screening

Measure
The percentage of women enrolled in a health plan between the ages of 50 and 74 who received a mammogram to screen for breast cancer during the measurement period or the two (2) years prior to the measurement period.

Standard
N/A – This measure is informational only.

Measurement Period
July 2013 – June 2014

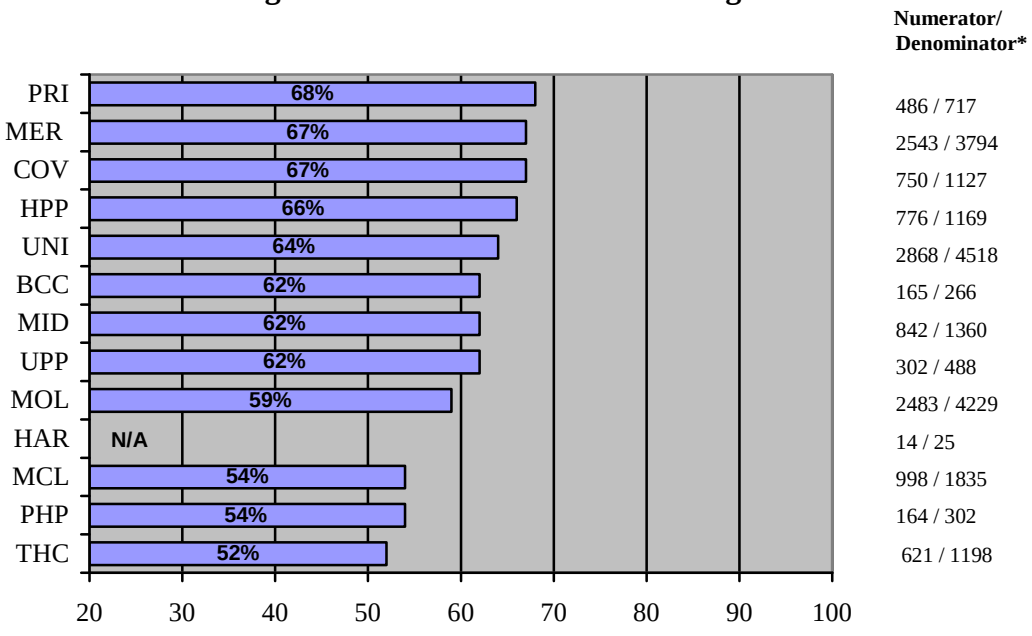
Data Source
MDCH Data Warehouse

Measurement Frequency
Quarterly

Table 19: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	16475	27315	60%
Fee For Service (FFS) only	519	1012	51%
Managed Care only	13952	22672	62%
MA-MC	13861	22535	62%
HMP-MC	N/A	N/A	N/A

Figure 11: Breast Cancer Screening[4]



Breast Cancer Screening Percentages

*Numerator depicts the number of eligible beneficiaries who were screened for breast cancer. Denominator depicts the total number of eligible beneficiaries.

[4] A rate was not calculated for plans with a numerator under 5 or a denominator under 30.

Cervical Cancer Screening

Measure
The percentage of women enrolled in a health plan between the ages of 21 and 64 who were screened for cervical cancer using either of the following criteria:

- Women ages 21 to 64 who had cervical cytology performed every three (3) years.
- Women ages 30 to 64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every five (5) years.

Standard
N/A – This measure is informational only.

Measurement Period
July 2013 – June 2014

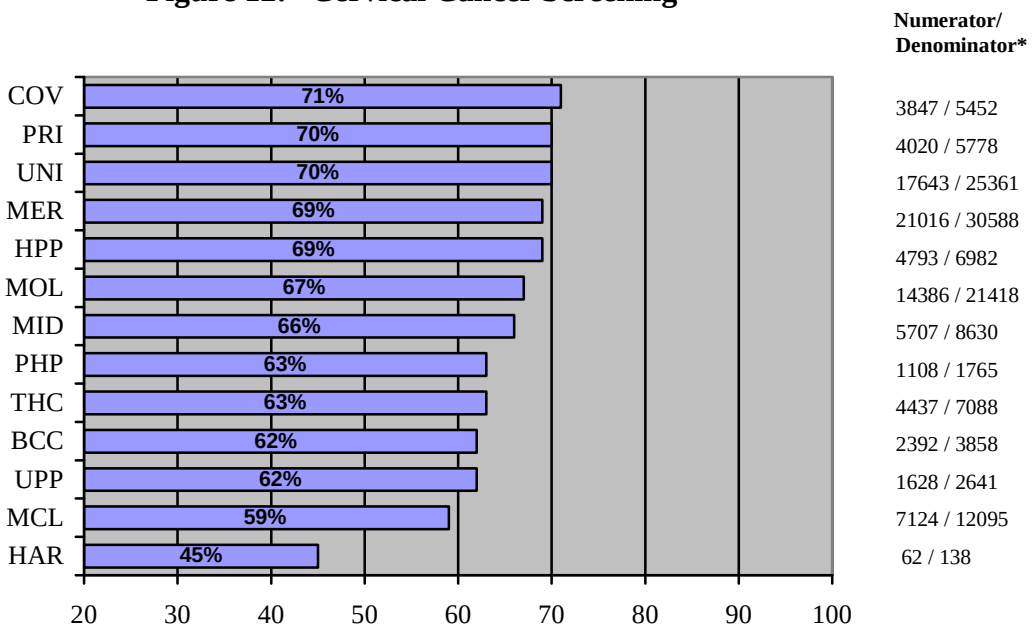
Data Source
MDCH Data Warehouse

Measurement Frequency
Quarterly

Table 20: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	114637	175336	65%
Fee For Service (FFS) only	1406	3576	39%
Managed Care only	90963	135844	67%
MA-MC	88723	132689	67%
HMP-MC	N/A	N/A	N/A

Figure 12: Cervical Cancer Screening



Cervical Cancer Screening Percentages

*Numerator depicts the number of eligible beneficiaries who were screened for cervical cancer. Denominator depicts the total number of eligible beneficiaries.

Diabetes Short-Term Complications Admission Rate

Measure
The rate of adults enrolled in a health plan age 18 and older who were discharged for diabetes short-term complications per 100,000 member months.

Standard
N/A – This measure is informational only.

Measurement Period
July 2013 – June 2014

Data Source
MDCH Data Warehouse

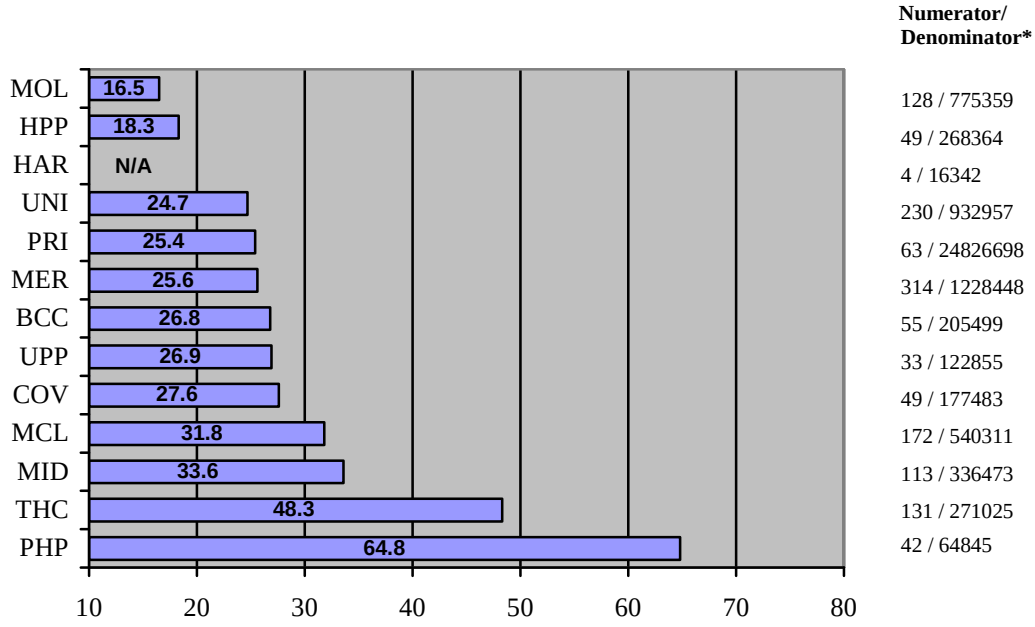
Measurement Frequency
Quarterly

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

Table 21: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Rate
Michigan Medicaid All	1910	6578751	29
Fee For Service (FFS) only	527	1390015	37.9
Managed Care only	1383	5188736	26.7
MA-MC	1300	4849664	26.8
HMP-MC	83	339072	24.5

Figure 13: Diabetes Short-Term Complications Admission Rate



Diabetes Short-Term Complications Admission Rate

*Numerator depicts the number of eligible beneficiaries who were discharged for diabetes short-term complications per 100,000 member months. Denominator depicts the total number of eligible beneficiaries.

Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate

Measure
The rate of adults enrolled in a health plan age 40 and older who were discharged for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 member months.

Standard
N/A – This measure is informational only.

Measurement Period
July 2013 – June 2014

Data Source
MDCH Data Warehouse

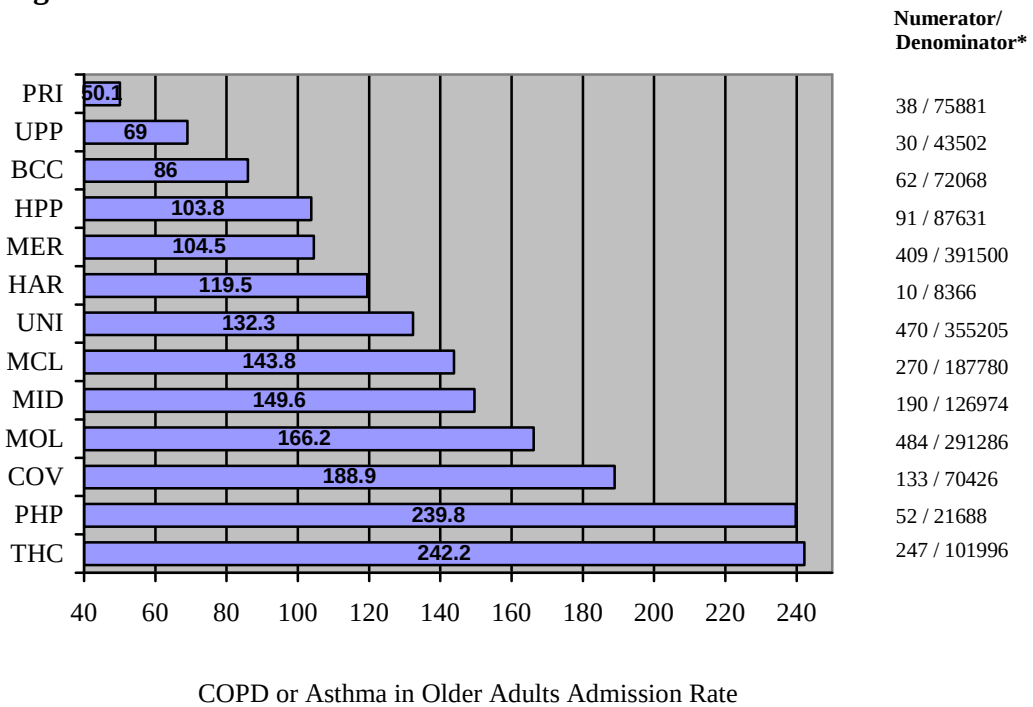
Measurement Frequency
Quarterly

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

Table 22: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	3111	236748	131.6
Fee For Service (FFS) only	625	529283	118.1
Managed Care only	2486	1834465	135.5
MA-MC	2400	1654536	145.1
HMP-MC	86	179929	47.8

Figure 14: COPD or Asthma in Older Adults Admission Rate



COPD or Asthma in Older Adults Admission Rate

*Numerator depicts the number of eligible beneficiaries who were discharged for COPD or asthma per 100,000 member months. Denominator depicts the total number of eligible beneficiaries.

Heart Failure Admission Rate

Measure
The rate of adults enrolled in a health plan age 18 and older who were discharged for heart failure per 100,000 member months.

Standard
N/A – This measure is informational only.

Measurement Period
July 2013 – June 2014

Data Source
MDCH Data Warehouse

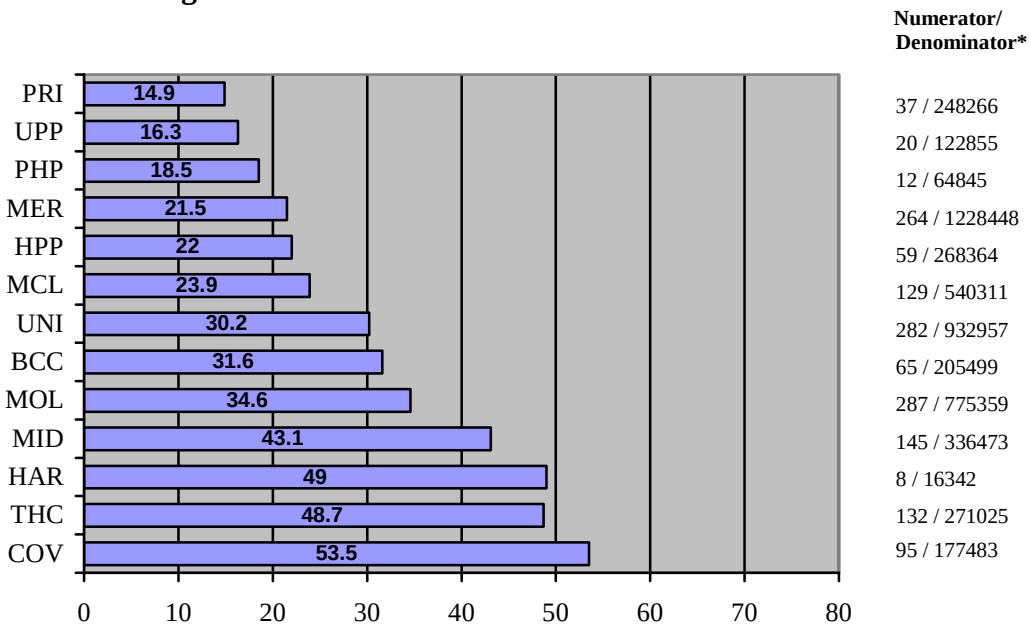
Measurement Frequency
Quarterly

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

Table 23: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	2127	6578751	32.3
Fee For Service (FFS) only	611	1390015	44
Managed Care only	1516	5188736	29.2
MA-MC	1475	4849664	30.4
HMP-MC	41	339072	12.1

Figure 15: Heart Failure Admission Rate



*Numerator depicts the number of eligible beneficiaries who were discharged for heart failure 100,000 member months. Denominator depicts the total number of eligible beneficiaries.

Asthma in Younger Adults Admission Rate

Measure
The rate of adults enrolled in a health plan between the ages of 18 and 39 who were discharged for asthma per 100,000 member months.

Standard
N/A – This measure is informational only.

Measurement Period
July 2013 – June 2014

Data Source
MDCH Data Warehouse

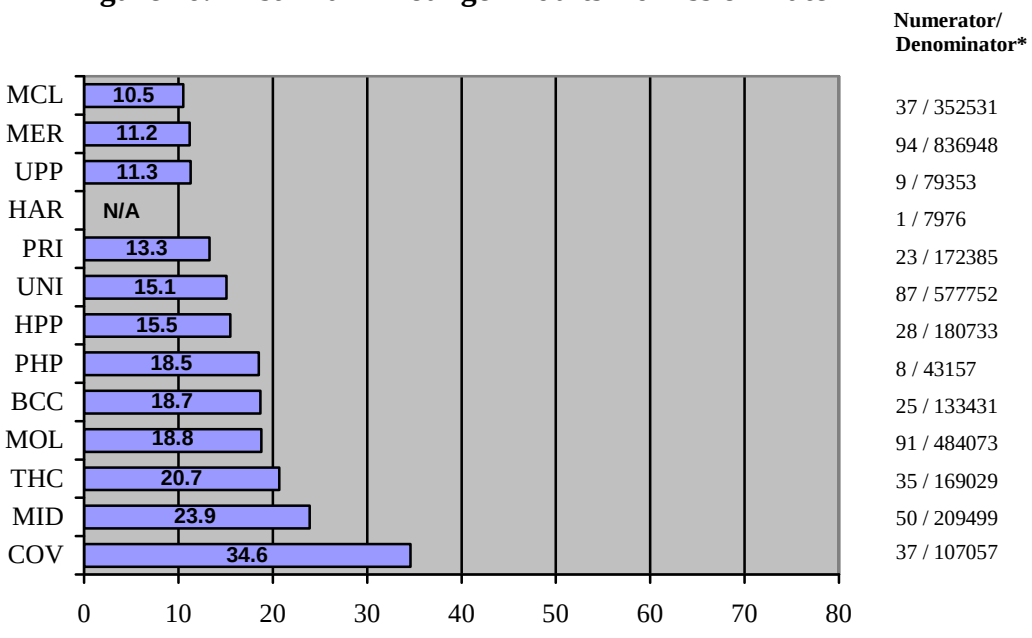
Measurement Frequency
Quarterly

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

Table 24: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	651	4215003	15.4
Fee For Service (FFS) only	126	860732	14.6
Managed Care only	525	3354271	15.7
MA-MC	504	3195128	15.8
HMP-MC	21	159143	13.2

Figure 16: Asthma in Younger Adults Admission Rate



*Numerator depicts the number of eligible beneficiaries who were discharged for asthma 100,000 member months. Denominator depicts the total number of eligible beneficiaries.

Chlamydia Screening in Women Ages 21 to 24

Measure
The percentage of women enrolled in a health plan between the ages of 21 and 24 who were identified as sexually active and who had at least one (1) test for chlamydia during the measurement period.

Standard
N/A – This measure is informational only.

Measurement Period
July 2013 – June 2014

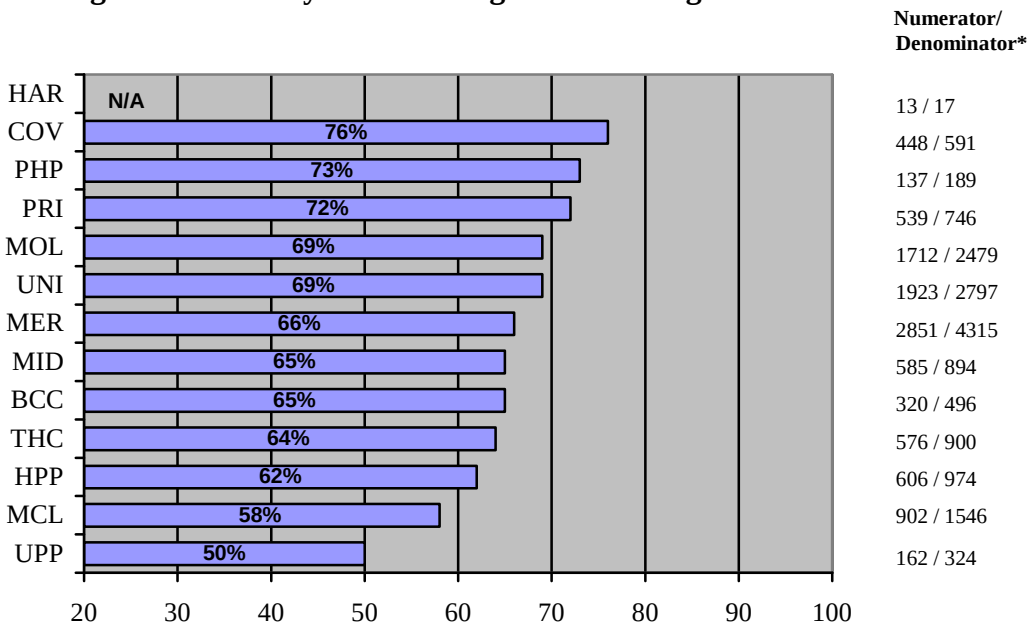
Data Source
MDCH Data Warehouse

Measurement Frequency
Quarterly

Table 25: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	17157	25396	68%
Fee For Service (FFS) only	169	338	50%
Managed Care only	11172	16862	66%
MA-MC	10800	16262	66%
HMP-MC	N/A	N/A	N/A

Figure 17: Chlamydia Screening in Women Ages 21 to 24[5]



Chlamydia Screening in Women Ages 21 to 24 Percentages

*Numerator depicts the number of eligible beneficiaries who were screened for chlamydia. Denominator depicts the total number of eligible beneficiaries.

[5] A rate was not calculated for plans with a numerator under 5 or a denominator under 30.

Comprehensive Diabetes Care: Hemoglobin A1c Testing

Measure
The percentage of adults enrolled in a health plan between the ages of 18 and 75 with type 1 or type 2 diabetes who had a hemoglobin A1c (HbA1c) test.

Standard
N/A – This measure is informational only.

Measurement Period
July 2013 – June 2014

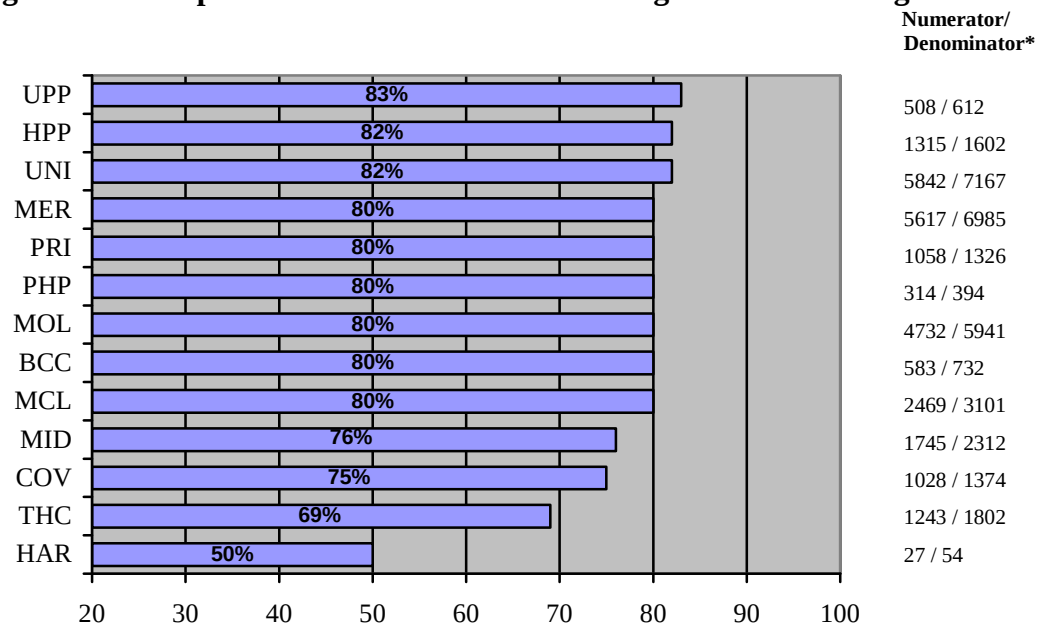
Data Source
MDCH Data Warehouse

Measurement Frequency
Quarterly

Table 26: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	32799	41973	78%
Fee For Service (FFS) only	1141	1575	72%
Managed Care only	27342	34473	79%
MA-MC	26972	33991	79%
HMP-MC	N/A	N/A	N/A

Figure 18: Comprehensive Diabetes Care: Hemoglobin A1c Testing



Comprehensive Diabetes Care: Hemoglobin A1c Testing Percentages
*Numerator depicts the number of eligible beneficiaries who had an HbA1c test. Denominator depicts the total number of eligible beneficiaries.

Antidepressant Medication Management

Measure
The percentage of adults enrolled in a health plan age 18 and older with a diagnosis of major depression and who were treated with antidepressant medication, who remained on an antidepressant medication treatment. Two rates are reported:

• Effective Acute Phase Treatment. The percentage of diagnosed and treated Medicaid enrollees who remained on an antidepressant medication for at least 84 days (12 weeks).
• Effective Continuation Phase Treatment. The percentage of diagnosed and treated Medicaid enrollees who remained on an antidepressant medication for at least 180 days (6 months).

Standard
N/A – This measure is informational only.

Measurement Period
July 2013 – June 2014

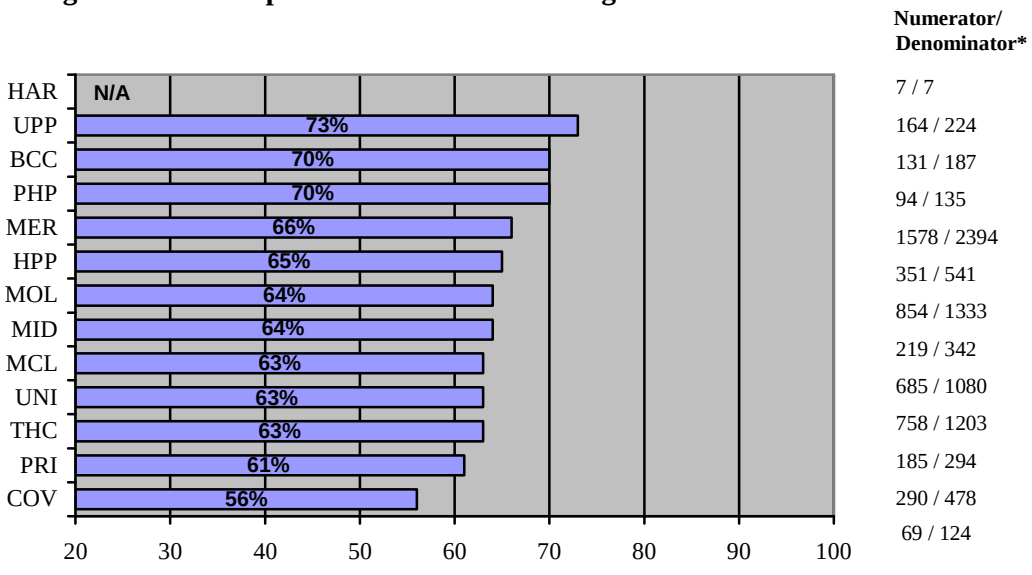
Data Source
MDCH Data Warehouse

Measurement Frequency
Quarterly

Table 27: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	8168	12439	66%
Fee For Service (FFS) only	202	285	71%
Managed Care only	5602	8673	65%
MA-MC	5436	8390	65%
HMP-MC	N/A	N/A	N/A

Figure 19: Antidepressant Medication Management – Acute



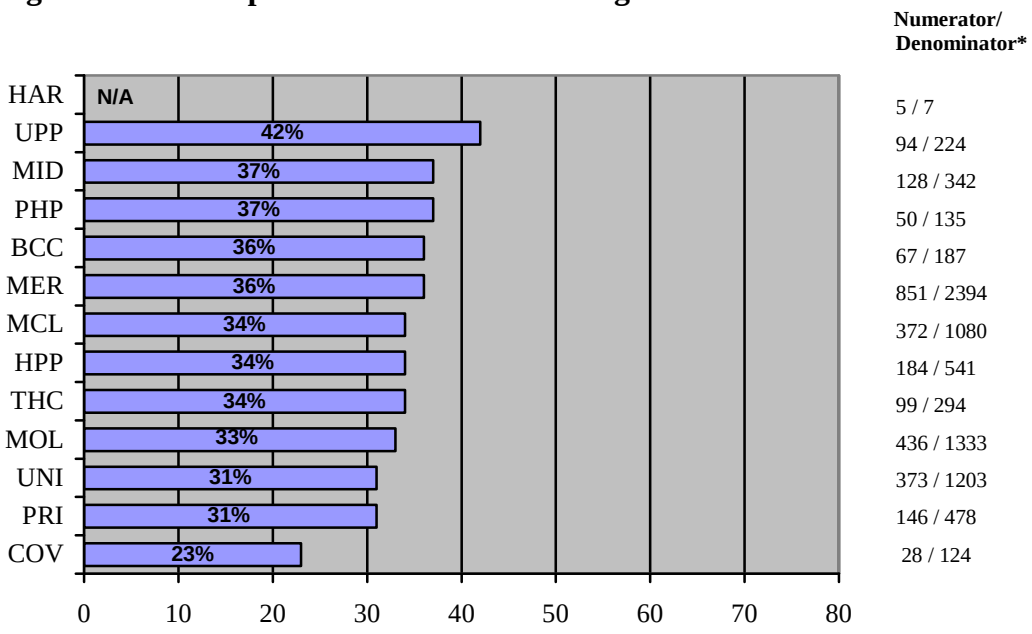
Antidepressant Medication Management – Acute Percentages

*Numerator depicts the number of eligible beneficiaries who remained on an antidepressant medication for at least 84 days (12 weeks). Denominator depicts the total number of eligible beneficiaries.

Table 28: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	4439	12439	36%
Fee For Service (FFS) only	132	285	46%
Managed Care only	2946	8673	34%
MA-MC	2866	8390	34%
HMP-MC	N/A	N/A	N/A

Figure 20: Antidepressant Medication Management – Continuous



Antidepressant Medication Management – Continuous Percentages

*Numerator depicts the number of eligible beneficiaries who remained on an antidepressant medication for at least 180 days (6 months). Denominator depicts the total number of eligible beneficiaries.

Annual Monitoring for Patients on Persistent Medications

Measure
The percentage of adults enrolled in a health plan age 18 and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent and who received annual monitoring for the therapeutic agent in the measurement period. The following four (4) rates will be calculated:

- Annual monitoring for enrollees on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)
- Annual monitoring for enrollees on digoxin
- Annual monitoring for enrollees on diuretic
- Annual monitoring for enrollees on anticonvulsants
- Total rate for annual monitoring for enrollees on persistent medications

Standard
N/A – This measure is informational only.

Measurement Period
July 2013 – June 2014

Data Source
MDCH Data Exchange Gateway, Encounter Data

Measurement Frequency
Quarterly

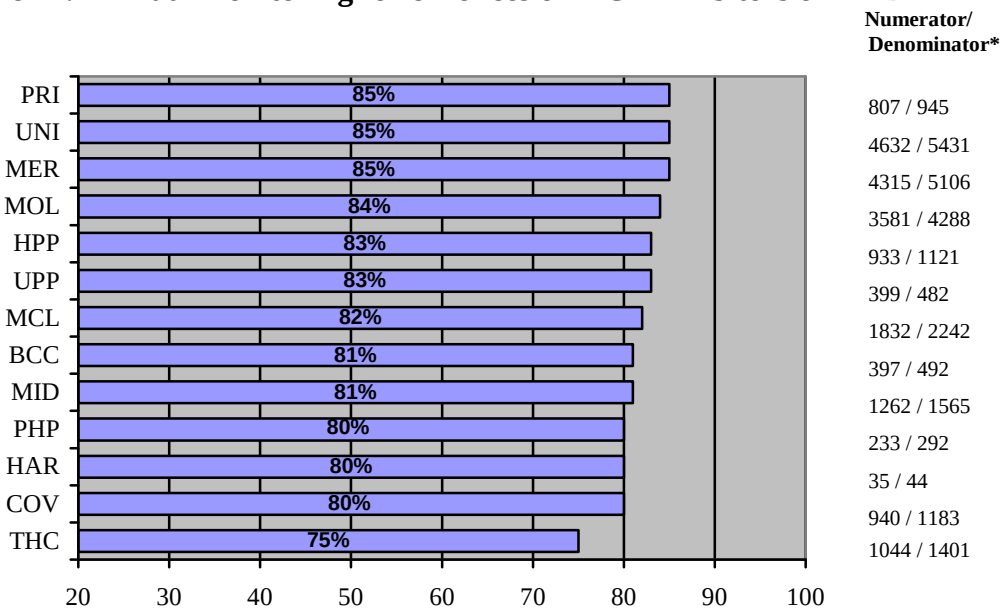
See next page for tables and figures

Annual monitoring for enrollees on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB):

Table 29: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	23872	28693	83%
Fee For Service (FFS) only	459	514	89%
Managed Care only	20983	25253	83%
MA-MC	20671	24861	83%
HMP-MC	N/A	N/A	N/A

Figure 21: Annual monitoring for enrollees on ACE inhibitors or ARB



Annual monitoring for enrollees on ACE inhibitors or ARB Percentages

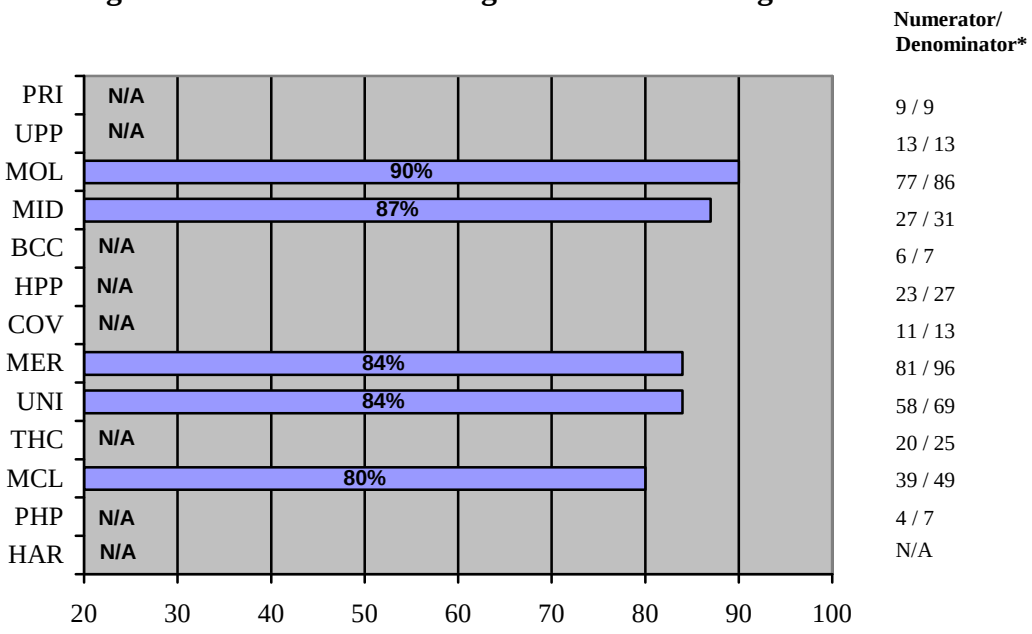
*Numerator depicts the number of eligible beneficiaries who received annual monitoring while on ACE inhibitors or ARB. Denominator depicts the total number of eligible beneficiaries.

Annual monitoring for enrollees on digoxin:

Table 30: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	414	490	85%
Fee For Service (FFS) only	7	7	N/A
Managed Care only	379	446	85%
MA-MC	377	443	85%
HMP-MC	N/A	N/A	N/A

Figure 22: Annual monitoring for enrollees on Digoxin[6]



Annual monitoring for enrollees on Digoxin Percentages

*Numerator depicts the number of eligible beneficiaries who received annual monitoring while on digoxin. Denominator depicts the total number of eligible beneficiaries.

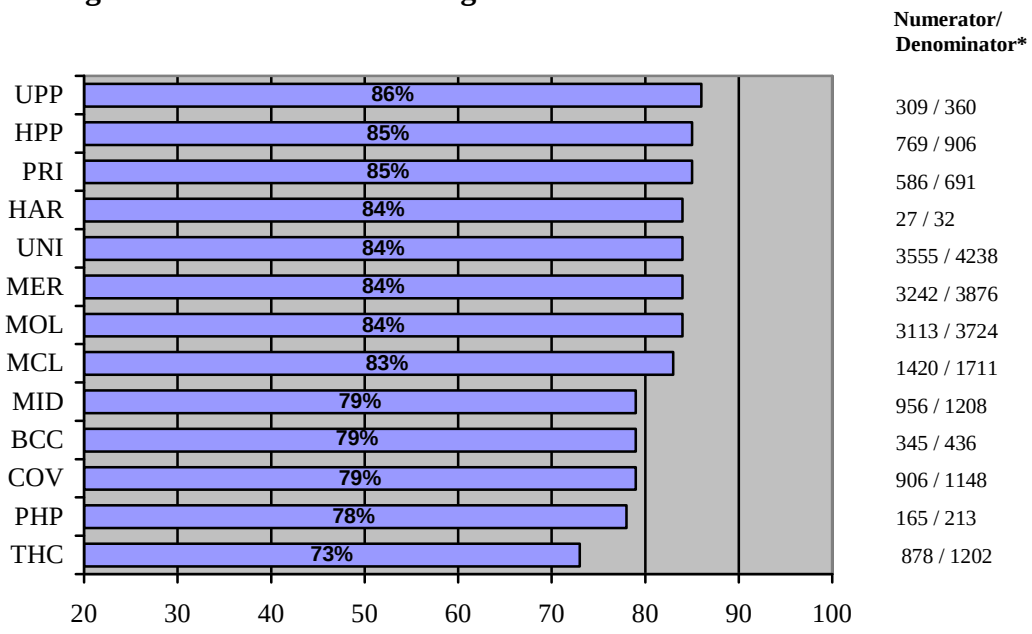
[6] A rate was not calculated for plans with a numerator under 5 or a denominator under 30. HAR was not included in this measure as they had no members who met this criterion.

Annual monitoring for enrollees on diuretic:

Table 31: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	18943	22962	83%
Fee For Service (FFS) only	330	375	88%
Managed Care only	16743	20304	83%
MA-MC	16503	19990	83%
HMP-MC	N/A	N/A	N/A

Figure 23: Annual monitoring for enrollees on diuretics



Annual monitoring for enrollees on diuretics Percentages

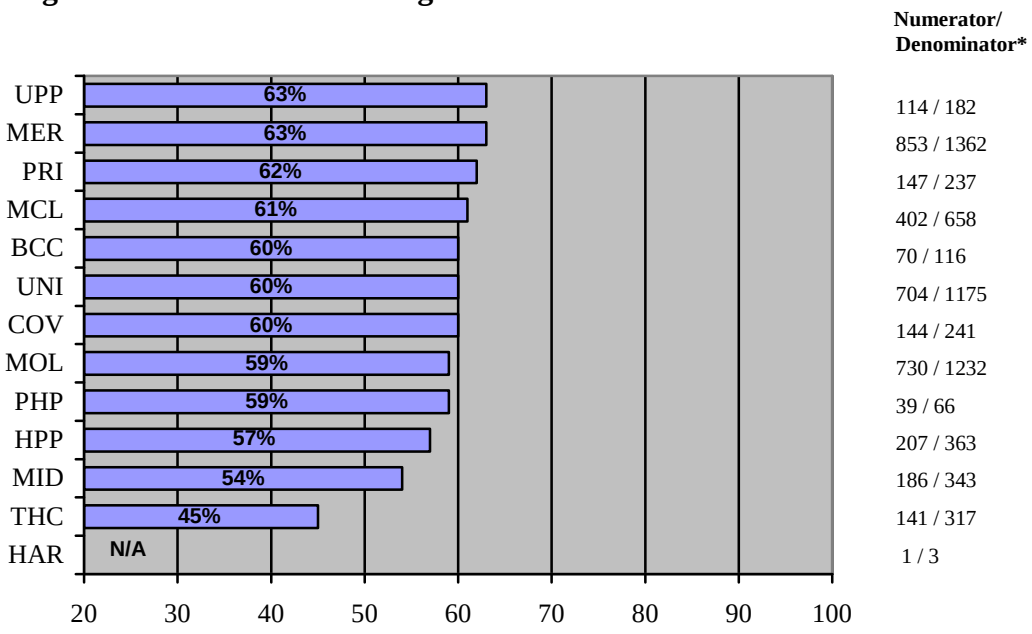
*Numerator depicts the number of eligible beneficiaries who received annual monitoring while on diuretics. Denominator depicts the total number of eligible beneficiaries.

Annual monitoring for enrollees on anticonvulsants:

Table 32: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	4236	6675	64%
Fee For Service (FFS) only	107	140	76%
Managed Care only	3820	6021	63%
MA-MC	3793	5973	64%
HMP-MC	N/A	N/A	N/A

Figure 24: Annual monitoring for enrollees on anticonvulsants



Annual monitoring for enrollees on anticonvulsants Percentages

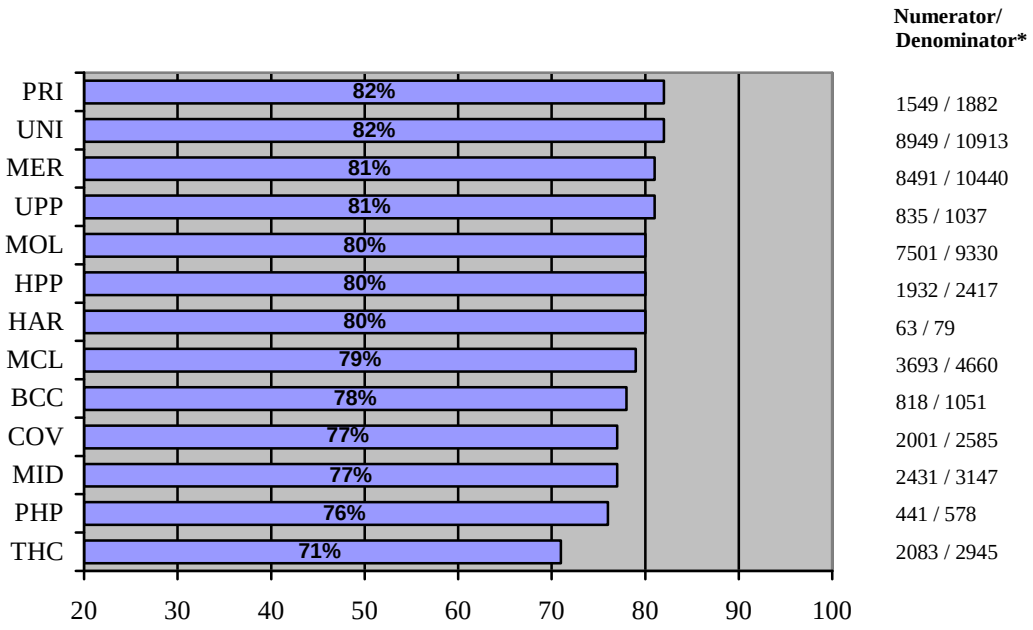
*Numerator depicts the number of eligible beneficiaries who received annual monitoring while on anticonvulsants. Denominator depicts the total number of eligible beneficiaries.

A total rate will also be calculated:

Table 33: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	47465	58820	81%
Fee For Service (FFS) only	903	1036	87%
Managed Care only	41925	52024	81%
MA-MC	41344	51267	81%
HMP-MC	N/A	N/A	N/A

Figure 25: Total rate for annual monitoring for enrollees on persistent medications



Total rate for annual monitoring for enrollees on persistent medications Percentages

*Numerator depicts the number of eligible beneficiaries who received annual monitoring while on persistent medications. Denominator depicts the total number of eligible beneficiaries.

Appendix A: Three Letter MHP Codes

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

BCC	Blue Cross Complete of Michigan, Inc.
COV	CoventryCares of Michigan, Inc.
HAR	Harbor Health Plan, Inc.
HPP	HealthPlus Partners, Inc.
MER	Meridian Health Plan
MCL	McLaren Health Plan
MID	HAP Midwest Health Plan, Inc.
MOL	Molina Healthcare of Michigan
PHP	Sparrow PHP
PRI	Priority Health Choice
THC	Total Health Care
UNI	UnitedHealthcare Community Plan
UPP	Upper Peninsula Health Plan