STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

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April 7, 2016

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

Dear Ms. Kostesich,

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

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

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

Sincerely,

[redacted]

Penny Rutledge, Director
Actuarial Division

cc: Ruth Hughes
Angela Garner

Enclosure (5)

Michigan Adult Coverage Demonstration
Section 1115 Quarterly Report

Demonstration Year: 6 (01/01/2015 – 12/31/2015)
Federal Fiscal Quarter: 1 (10/01/2015 – 12/31/2015)

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 receive quarterly statements that summarize the MI Health Account activity. Beneficiaries also have opportunities to reduce their cost-sharing amounts by agreeing to address or maintain certain Healthy Behaviors.

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

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

- Increasing access to quality health care;
- Encouraging the utilization of high-value services; and

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

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

MDHHS's goals in amending the demonstration are to:

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

Enrollment and Benefits Information

Enrollment into the Healthy Michigan Plan began April 1, 2014. Beneficiaries who were enrolled in the ABW were automatically transitioned into the Healthy Michigan Plan effective April 1, 2014. MDHHS enrolled new beneficiaries into the program beginning April 1, 2014. Potential enrollees can apply for the program via the MDHHS website, by calling a toll-free number or by visiting their local MDHHS office. At this time, MDHHS does not anticipate any changes in the population served or the benefits offered. Program enrollment and disenrollment during this quarter has been similar to that of previous quarters. Michigan continues to see evidence of the high demand for services offered.

Table 1: Healthy Michigan Plan New Enrollments by Month

October 2015	November 2015	December 2015	Total
31,710	34,687	46,328	112,725

Table 2: Healthy Michigan Plan Disenrollments by Month			
October 2015	November 2015	December 2015	Total
32,230	29,636	32,916	94,782

Most Healthy Michigan Plan beneficiaries elect to choose a health plan as opposed to automatic assignment to a health plan. As of December 14, 2015, 350,358 or, 75 percent, of the State's 467,042 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, 8,798 of all Healthy Michigan Plan health plan enrollees changed health plans. This quarter, 4,768, or 54 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. 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 member's initial primary care visit.

The initial assessment questions section of the Health Risk Assessments completed through the MDHHS enrollment broker had a completion rate of 94 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
October 2015	7,053	95%	351	5%	7,404
November 2015	6,519	94%	393	6%	6,912
December 2015	7,398	93%	575	7%	7,973
Total	20,970	94%	1,319	6%	22,289

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, 9,847 Health Risk Assessments for Healthy Michigan Plan beneficiaries participating in the healthy behaviors incentive program were recorded by Medicaid Health Plans. Of these, health plans have reported that 7,878 of the earned incentives are gift card incentives. Additionally, 1,930 reductions in future contribution requirements have been earned. Earned reductions were first applied to the MI Health Account Statements in November 2014. In this quarter, 3,552 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 December 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				
	October 2015	November 2015	December 2015	Total
Health Risk Assessments Submitted	3,231	2,476	4,140	9,847
Gift Cards Earned	2,581	1,983	3,314	7,878
Reductions Earned	643	487	800	1,930
Reductions Applied	1,312	1,223	1,017	3,552

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 December 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.

In addition to substantial Healthy Michigan Plan enrollment, MDHHS saw a significant number of disenrollments from the plan as reported in the Monthly Enrollment Reports to CMS. Healthy Michigan disenrollment reflects individuals who were disenrolled during a redetermination of eligibility or switched coverage due to eligibility for other Medicaid program benefits. In most cases beneficiaries disenrolled from the Healthy Michigan Plan due to eligibility for other Medicaid programs. This disenrollment can be a result of MDHHS's validation of self-attested information from the beneficiary. After a beneficiary is approved for Healthy Michigan Plan coverage, MDHHS performs authentication processes to determine the beneficiary is in fact eligible as attested in the application for benefits. MDHHS matches beneficiary information provided with that available through State and Federal databases. Movement between Medicaid programs is not uncommon and MDHHS expects that beneficiaries will continue to shift between Healthy Michigan and other Medicaid programs as their eligibility changes.

Table 5: Enrollment Counts for Quarter and Year to Date			
Demonstration Population	Total Number of Demonstration Beneficiaries Quarter Ending – 12/2015	Current Enrollees (year to date)	Disenrolled in Current Quarter
ABW Childless Adults	N/A	N/A	N/A
Healthy Michigan Adults	686,644	883,965	94,782

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. The Healthy Michigan Plan website provides the public with information on eligibility, how to apply, services covered, cost sharing requirements, frequently asked questions, Health Risk Assessment completion, and provider information. The site also provides a link for members to make MI Health Account payments. MDHHS also has a mailbox,

healthymichiganplan@michigan.gov, for questions or comments about the Healthy Michigan Plan.

MDHHS has worked closely with provider groups through meetings, Medicaid provider policy bulletins, and various interactions with community partners and provider trade associations. MDHHS continues to provide progress reports to the Medical Care Advisory Council (MCAC) at regularly scheduled quarterly meetings. These meetings provide an opportunity for attendees to provide program comments or suggestions. The November 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 on the MDHHS website.

Collection and Verification of Encounter Data and Enrollment Data

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

MDHHS Encounter Data staff effectively collaborated with MI Health Account vendor to continue the garnishment process this quarter. As of March 1, 2016, MDHHS has successfully offset 607 individuals for a total of $63,525.34. A detailed breakdown is included in the following table:

Table 6: Healthy Michigan Plan Member Garnishments

Garnishment Source	Individuals Garnished	Amount Garnished
Tax	604	$63,288.34
State Lottery	3	$237.00
Total	607	$63,525.34

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

Operational/Policy/Systems/Fiscal Developmental Issues

MDHHS 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.

On December 17, 2015, CMS approved the State's September 1, 2015 request to amend the Healthy Michigan Section 1115 Demonstration. The State sought approval of this amendment to

implement requirements of State law (MCL 400.105d (20)). Individuals between 100 percent and 133 percent of the federal poverty level with 48 cumulative months of Healthy Michigan Plan coverage will be required to choose one of two options:

1. Purchase private insurance through the Federal Marketplace; or

2. Remain in the Healthy Michigan Plan with increased cost-sharing (up to 7 percent of income) and contributions (3.5 percent of income).

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

Table 7: Medicaid Policy Bulletins with Healthy Michigan Plan Impact

Issue Date	Subject	Link
10/01/2015	Affordable Care Act (ACA) Fingerprint Requirements	MSA 15-39
10/01/2015	Changes to Osteogenesis Stimulator Coverage Policy	MSA 15-40
10/30/2015	Revisions to the Mental Health/Substance Abuse Chapter of the Medicaid Provider Manual, Clubhouse Psychosocial Rehabilitation Programs Section	MSA 15-42
10/30/2015	Update of Maternal Infant Health Program Services	MSA 15-43
10/30/2015	Enrollment of Psychologists, Social Workers, and Professional Counselors as Medicaid Providers	MSA 15-44
12/01/2015	Medicaid Ambulance Policy Revisions	MSA 15-48
12/01/2015	Cost-Sharing Limits	MSA 15-49
12/01/2015	Changes to Non-Emergency Medical Transportation (NEMT) Medical Needs Verification and Minors Traveling Alone	MSA 15-50
12/01/2015	Updates to the Medicaid Provider Manual; Native American/Alaska Native Cost Sharing Exemption Modification; Healthy Michigan Plan Beneficiary Cost Sharing	MSA 15-53
12/01/2015	Medicaid Health Plan Common Formulary	MSA 15-55
12/01/2015	All-Inclusive Rate for Managed Care Encounters	MSA 15-57
12/02/2015	Coverage of Autism Services for Children Under 21 Years of Age	MSA 15-59
12/16/2015	Medicaid Hospice Reimbursement Changes	MSA 15-60
12/30/2015	Provider Enrollment Electronic Signature Form Submission Process	MSA 15-54
12/30/2015	Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) Code Updates	MSA 15-64

Financial/Budget Neutrality Development Issues

MDHHS did not experience budget neutrality issues this quarter. The completed budget neutrality table provided below reflects updates as expenditures are adjusted over time. For the purposes of completing the Healthy Michigan Plan Budget Neutrality Monitoring Table, MDHHS collects Healthy Michigan Plan expenditures from information included in the CMS 64.9VIII files submitted to CMS. Expenditures include those that both occurred and were paid in the same quarter in addition to adjustments to expenditures paid in quarters after the quarter of service. Expenditures for all eligible groups within the Healthy Michigan Plan were included. The State 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)	$460.12	432.01	-	-	-
Total Expenditures (YTD)	$1,716,998,659.00	$3,122,844,929.00	-	-	-
Total Member Months (YTD)	3,731,661	7,228,608	-	-	-

Beneficiary Month Reporting

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

Table 9: Healthy Michigan Plan Beneficiary Month Reporting				
Eligibility Group	October 2015	November 2015	December 2015	Total for Quarter Ending 12/15
Healthy Michigan Adults	607,413	612,464	625,875	1,845,752

Consumer Issues

This quarter, the total number of Healthy Michigan Plan complaints reported to MDHHS was 79. Issues obtaining prescriptions comprised 58 percent of total complaints received by MDHHS. Beneficiaries experiencing issues obtaining transportation consisted of 15 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 5 percent of total complaints and included dental and behavioral health services. Overall, with 1,845,752 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 October 2015 – December 2015					
	Obtaining Prescriptions	Transportation	Other Covered Services	Other Issues	Total
Count	46	12	17	4	79
Percent	58%	15%	22%	5%	

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 reports. 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 Bureau of Medicaid Program Operations & Quality Assurance published its most recent quarterly PMR with Healthy Michigan Plan specific measures. Performance areas specific to the Healthy Michigan Plan include:

- Adults' Generic Drug Utilization
- Timely Completion of Initial Health Risk Assessment
- Outreach and Engagement to Facilitate Entry to Primary Care
- Plan All-Cause Acute 30-Day Readmissions
- Adults' Access to Ambulatory Health Services

Managed Care Reporting Requirements

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

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

During this quarter, Healthy Michigan Plan members continued making payments for contributions and copays to the MI Health Account. Members that received a MI Health Account statement in October 2015 have a payment due date of January 15, 2015. For those that received their statement in November 2015, the payment due date is February 15, 2015. December 2015 statements have a payment due date of March 15, 2015.

Table 11 illustrates MI Health Account statement mailing activity for the current quarter. Additionally this table includes co-pay and contribution amounts owed when the statements were mailed.

Table 11: MI Health Account Statement Mailing

Month Statement Mailed	Statements Mailed	Statements Requiring a Copay Only	Statements Requiring a Contribution Only	Statements Requiring a Copay and Contribution	Total Copay Amount Owed	Total Contribution Amount Owed	Percent of Statements Requiring Payment
October 2015	95,337	20,085	8,920	9,259	$186,698.16	$993,375.77	40%
November 2015	62,459	26,447	8,602	6,791	$177,522.02	$841,134.41	67%
December 2015	74,326	27,792	10,747	6,083	$161,245.77	$917,954.67	60%
Total	232,122	74,324	28,269	22,133	$525,465.95	$2,752,464.85	54%

Table 12 contains statements mailed, amounts owed and amounts collected to date for the quarter covered in this report. The total amount owed in Table 12 will not equate the total amount owed reported in the Table 11 due to fluctuations in beneficiary circumstances that impact amounts owed to the MI Health Account. Table 11 reflects amounts owed when the statements were mailed and Table 12 reflects amounts owed to date. For example, a beneficiary may report a change in income since their statement was mailed that ultimately adjusted their contribution amount.

Table 12: MI Health Account Collection Amount Summary						
Month Statement Mailed	Beneficiaries Required to Pay	Number of Beneficiaries Paid	Percent of Beneficiaries Paid	Total Amount Owed	Amount Collected	Percent Collected
October 2015	38,264	10,512	27%	$1,180,073.93	$258,031.62	22%
November 2015	41,840	5,832	14%	$1,018,656.43	$134,432.66	13%
December 2015	44,622	5,077	11%	$1,079,200.44	$91,025.99	8%
Total	124,726	21,421	17%	$3,277,930.80	$483,490.27	15%

Table 13 displays the total amount collected by enrollment month and quarterly pay cycle since the implementation of the MI Health Account. For example, beneficiaries that enrolled in October 2014 received their first quarter statement in April 2015.

Table 13: MI Health Account Quarterly Collection				
Enrollment Month	Quarterly Pay Cycles	Amount Owed	Amount Collected	Percent Collected
April 2014	Oct 2014 - Dec 2014	$24,422.08	$13,218.07	54%
	Jan 2015 - Mar 2015	$204,384.25	$101,770.38	50%
	Apr 2015 – Jun 2015	$172,307.16	$72,039.38	42%
	Jul 2015 – Sept 2015	$149,375.35	$59,310.90	40%
May 2014	Nov 2014 - Jan 2015	$40,683.08	$22,309.02	55%
	Feb 2015 - Apr 2015	$62,935.61	$30,668.62	49%
	May 2015 – Jul 2015	$49,697.78	$22,854.77	46%
	Aug 2015 - Oct 2015	$33,661.49	$16,466.74	49%
June 2014	Dec 2014 - Feb 2015	$480,609.19	$273,276.04	57%
	Mar 2015 - May 2015	$357,508.85	$199,865.96	56%
	Jun 2015 - Aug 2015	$366,653.53	$179,289.86	49%
	Sept 2015 - Nov 2015	$232,149.14	$94,607.10	41%
July 2014	Jan 2015 - Mar 2015	$378,381.09	$174,115.39	46%
	Apr 2015 – Jun 2015	$284,107.28	$112,307.47	39%
	Jul 2015 – Sept 2015	$232,149.14	$94,607.10	41%
August 2014	Feb 2015 – Apr 2015	$185,369.45	$88,764.88	48%
	May 2015 – Jul 2015	$138,151.97	$53,074.88	38%
	Aug 2015 - Oct 2015	$94,987.99	$41,059.79	43%
September 2014	Mar 2015 – May 2015	$231,692.21	$94,245.06	41%
	Jun 2015 – Sept 2015	$167,281.87	$55,607.49	33%
	Sept 2015 - Nov 2015	$119,089.39	$44,044.47	37%
October 2014	Apr 2015 – Jun 2015	$191,718.43	$72,897.48	38%
	Jul 2015 – Sept 2015	$119,089.39	$44,044.47	37%
November 2014	May 2015 – Jul 2015	$216,014.51	$80,597.30	37%
	Aug 2015 – Oct 2015	$110,509.93	$40,508.03	37%
December 2014	Jun 2015 – Aug 2015	$117,077.63	$44,540.99	38%
	Sept 2015 – Nov 2015	$89,537.55	$24,207.55	27%
January 2015	Jul 2015 – Sept 2015	$223,560.85	$94,578.63	42%
February 2015	Aug 2015 - Oct 2015	$210,311.35	$79,884.51	38%
March 2015	Sept 2015 - Nov 2015	$229,536.89	$70,311.55	31%

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

Table 14: MI Health Account Methods of Payment			
	October 2015	November 2015	December 2015
Percent Paid Online	27%	28%	29%
Percent Paid by Mail	73%	72%	73%

Cost sharing exemptions are applied to specific groups by law, regulation and program policy. The MI Health Account adjustment activity is detailed in Table 15.

Table 15: MI Health Account Adjustment Activities						
	October 2015		November 2015		December 2015	
	Number of Beneficiaries	Total Amount	Number of Beneficiaries	Total Amount	Number of Beneficiaries	Total Amount
Beneficiary is Under Age 21	525	$27,198.05	452	$27,427.00	377	$19,179.40
Pregnancy	563	$19,419.28	403	$13,323.24	307	$10,964.98
Hospice	0	$0.00	0	$0.00	0	$0.00
Native American	50	$1,325.50	36	$1,983.50	52	$396.50
Five Percent Cost Share Limit Met	36,587	$457,714.47	5,102	$476,352.65	5,912	$453,071.82
FPL No Longer >100% - Contribution	0	$0.00	0	$0.00	0	$0.00
Healthy Behavior – Co-pay	301	$1,252.81	195	$582.07	203	$533.06
Healthy Behavior – Contribution	2,870	$95,815.35	2,057	$70,564.03	2,555	$91,372.69
Total	40,896	$602,725.46	8,245	$590,232.49	9,406	$575,518.45

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

Table 16: MI Health Account Past Due Collection Amounts		
Month	Number of Beneficiaries with Past Due Co-Pays/Contributions	Number of Beneficiaries with Past Due Co-Pays/Contributions that are Collectible Debt
October 2015	53,078	3,273
November 2015	59,458	1,706
December 2015	66,337	3,625

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

Table 17: MI Health Account Delinquent Co-pay and Contribution Amounts by Aging Category						
Days	0-30 Days	31-60 Days	61-90 Days	91-120 Days	>120 Days	Total
Amount Due	$612,379.17	$555,361.96	$485,822.44	$427,076.99	$2,118,911.88	$4,199,552.44
Number of Beneficiaries That Owe	53,487	49,650	46,156	41,195	58,402	95,668

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 18: Managed Care Organization Appeals			
October 2015 – December 2015			
	Decision Upheld	Overturned	Total
Count	65	38	103
Percent	63%	37%	

Table 19: Managed Care Organization Grievances						
October 2015 – December 2015						
	Access	Quality of Care	Administrative/Service	Billing	Transportation	Total
Count	192	41	110	26	225	594
Percent	32%	7%	19%	4%	38%	

From October to December 2015, there were 103 total appeals among all the Medicaid Health Plans. Medicaid Health Plan decisions were upheld in 63 percent of the appeals. From October 2015 to December 2015 there were a total of 594 grievances. The greatest number of grievances came from the Transportation category. Transportation grievances relate to issues with the transportation benefit and often mirror the complaints members directly reported to MDHHS. 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. 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 released the University of Michigan's evaluation of Healthy Michigan Plan member's experiences with the MI Health Account statements. The complete report is attached as an enclosure. MDHHS learned that there are significant opportunities to educate the Healthy Michigan Plan population on the purpose and functions of the MI Health Account. Specifically, members did not find the introductory MI Health Account letter memorable and found elements of the MI Health Account statements confusing. As a result, some members were unaware of payment obligations prior to receiving statements and were confused by the content when they did receive a statement. MDHHS is working with stakeholders and its health literacy team to make improvements to MI Health Account statements. Additionally, opportunities to increase awareness of the Health Risk Assessment and Healthy Behaviors were also identified. MDHHS is reviewing the recommendations included in the evaluation and strategies to increase participation in Healthy Behaviors.

Through the evaluation, MDHHS also gained insight to Healthy Michigan Plan member MI Health Account payment experiences. Many of the interviewed beneficiaries agreed that payments were reasonable. However, some members did report challenges associated with payment obligations. Barriers to making payments included lack of internet access, competing financial obligations, lack of a bank account, unemployment and disability. An additional barrier to making payments noted is the limited methods of payments. The evaluation recommended an expansion in payment mechanisms. MDHHS is currently reviewing the cost of expanded payment methods, such as allowing credit card payments, with stakeholders.

Demonstration Evaluation

MDHHS has commissioned the University of Michigan's Institute for Healthcare Policy and Innovation (IHPI) to serve as the Healthy Michigan Plan independent evaluator. The IHPI has developed a comprehensive plan to address the needs of the State and CMS. In accordance with paragraph 67 of the waiver special terms and conditions, the State submitted a draft of its

initial evaluation design to CMS on April 28, 2014 and, after a period of revisions, CMS formally approved the evaluation plan on October 22, 2014.

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

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

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. The following is a summary of the key activities for the current quarter:

Domain I
Although the interim report for Domain I isn't due until fiscal year (FY) 2018, IHPI has engaged in activities to find and compare baseline uncompensated care results from hospital cost reports and IRS filings to understand the distribution of uncompensated care in Michigan. This quarter, IHPI updated baseline uncompensated care results and submitted estimates to MDHHS. Additionally, IHPI began working with cost report data to ascertain changes in uncompensated care from 2013 to 2014, which will provide the foundation for comparing Michigan to other states.

Domain II
Similar to Domain I, the Domain II interim report is not due until FY 2018. IHPI continues to analyze extracts of Current Population Survey (CPS) data and American Community Survey (ACS) data to ascertain the difference between these two US Census Bureau data sources. In the current quarter, IHPI analyzed changes in insurance status in Michigan utilizing data in the 2014 ACS and the 2015 CPS. Added to that, IHPI analyzed the updated data to examine changes in Michigan (at both the statewide and geographic sub-unit levels) and elsewhere to ascertain appropriate comparison groups.

Domain III
The interim report for Domain III is due in FY 2017. The IHPI activities this quarter included pulling enrollment, income, and member contact data, conducting review of patterns to identify subgroups for analysis, and composing questions for MDHHS relating to Health Risk Assessment completion among fee-for-service enrollees – all of which will be used to help determine the rate of primary care visits and Health Risk Assessment completion among enrollees. In addition, enrollee data was pulled to help inform the Healthy Michigan Voices (HMV) survey, particularly with regards to the sampling strategy and to ascertain that enrollee utilization data could be utilized to validate HMV survey data.

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 current quarter included the following:

Primary Care Practitioner (PCP) Survey

- PCP Survey data collection completed with a 56 percent response rate
- PCP Survey analyses are underway

Beneficiary Survey

- HMV Survey development was completed and is scheduled to be fielded in early 2016
- Materials to inform and engage beneficiaries in the survey were developed and reviewed by MDHHS; informative materials will be sent out prior to fielding of the survey
- Qualitative interviews of 71 beneficiaries were completed and 4 individuals eligible but not enrolled in Healthy Michigan Plan were entered into qualitative analysis software (these interviews helped inform the HMV survey)

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 the current quarter included refining the aims of the analyses, specifying descriptive tables, and identifying needed variables to help select the treatment and control populations. In addition, IHPI Domain V/VI team members helped prioritize questions related to Domains V/VI on the HMV Survey. Domain V/VI team members also started their coordination planning with the Domain IV team to best analyze the HMV data when the responses are available.

Enclosures/Attachments

1. December 2015 Health Risk Assessment Report
2. November 2015 MCAC Meeting Minutes
3. January 2016 Performance Monitoring Report
4. Early Experiences of Beneficiaries Report Summary

State Contacts

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Medical Services Administration

Bureau of Medicaid Care Management and Quality Assurance

Healthy Michigan Plan - Health Risk Assessment Report

December 2015

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Produced by:

Quality Improvement and Program Development - Managed Care Plan Divison

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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 252,808 Health Risk Assessments were completed through Michigan ENROLLS as of December 2015. This represents a completion rate of 95.78%. 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
January 2015	158,763	6,531 (3.95%)
February 2015	168,411	6,908 (3.94%)
March 2015	181,510	7,414 (3.92%)
April 2015	192,208	7,839 (3.92%)
May 2015	201,861	8,222 (3.91%)
June 2015	209,090	8,618 (3.96%)
July 2015	216,850	8,996 (3.98%)
August 2015	224,671	9,413 (4.02%)
September 2015	231,838	9,810 (4.06%)
October 2015	238,891	10,161 (4.08%)
November 2015	245,410	10,554 (4.12%)
December 2015	252,808	11,129 (4.22%)

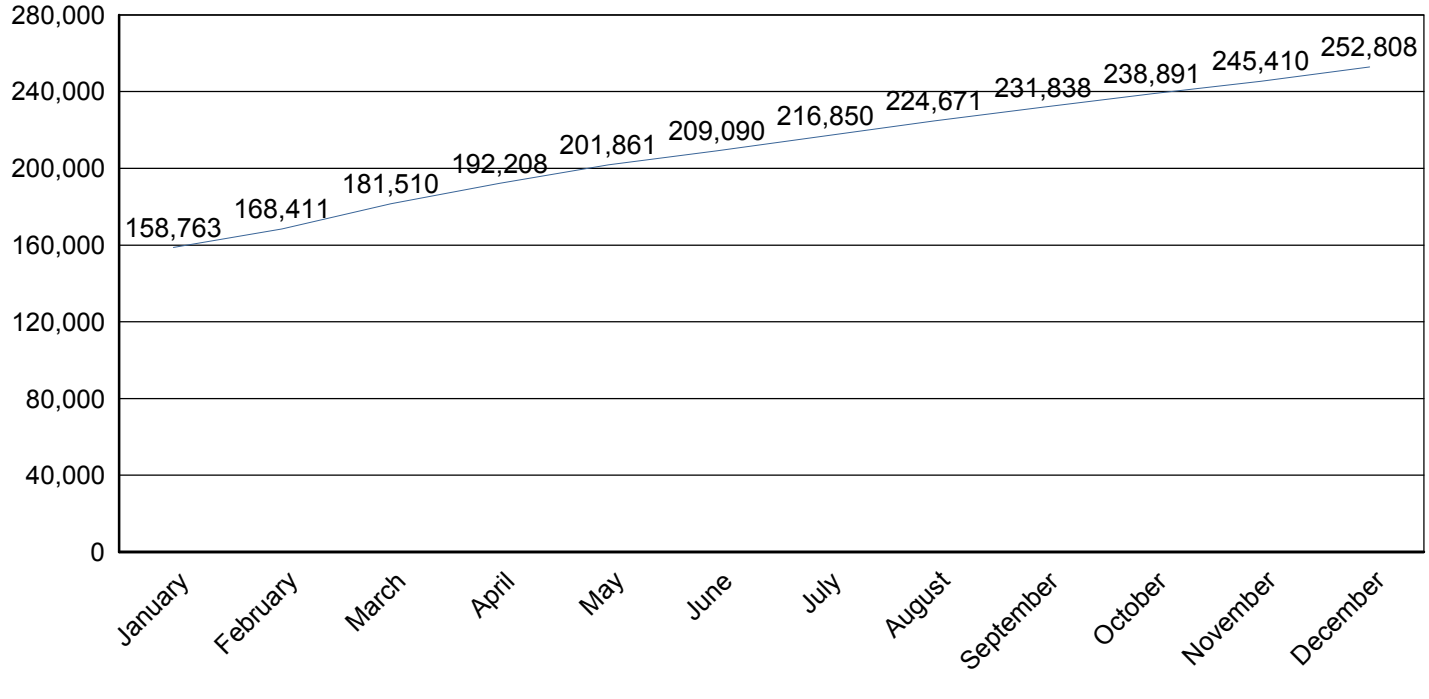
Table 11. Demographics of Population that Completed HRA Questions 1-9 with MI ENROLLS

January 2014 - December 2015

AGE GROUP	COMPLETED HRA	
19 - 29	62,302	24.64%
30 - 39	52,427	20.74%
40 - 49	53,334	21.10%
50 - 59	61,818	24.45%
60 +	22,927	9.07%
GENDER		
F	137,411	54.35%
M	115,397	45.65%
FPL		
< 100% FPL	207,660	82.14%
100 - 133% FPL	45,148	17.86%
TOTAL	**252,808**	**100.00%**

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

December 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 December 2015. Among enrollees who completed the survey, this question had a 0.17% refusal rate.

Table 1. Health Rating for Total Population

December 2015

HEALTH RATING	TOTAL	PERCENT
Excellent	27,762	10.98%
Very Good	64,262	25.42%
Good	90,369	35.75%
Fair	52,629	20.82%
Poor	17,369	6.87%
Refused	417	0.17%
TOTAL	**252,808**	**100.00%**

Figure 1-1. Health Rating for Total Population

December 2015

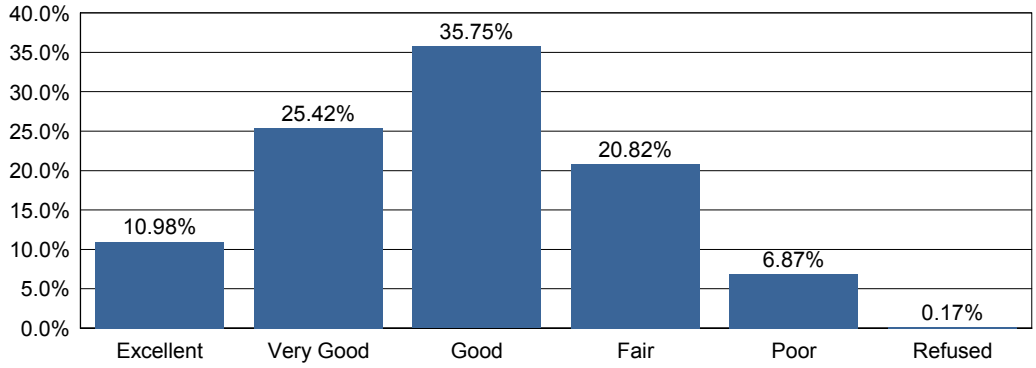


Figure 1-2. Health Rating by Age

December 2015

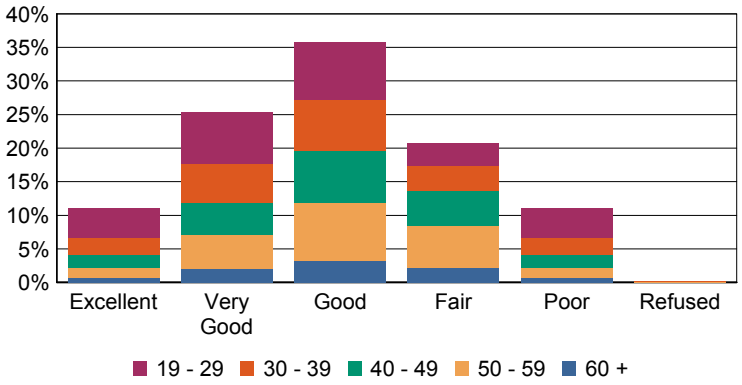
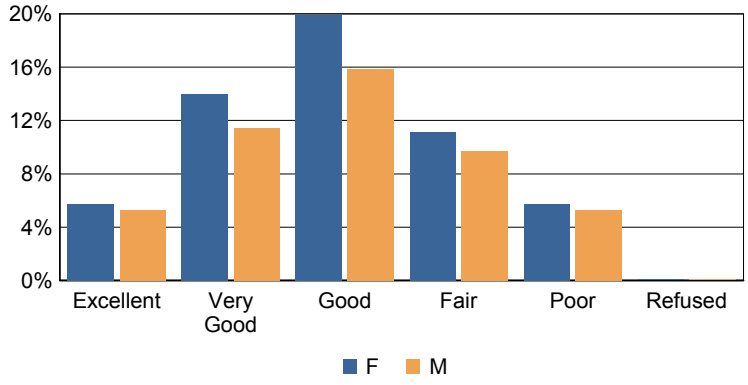


Figure 1-3. Health Rating by Gender

December 2015



Question 2. Exercise

Question 2. In the last 7 days, how often did you exercise for at least 20 minutes a day? This question is used to assess selfreported exercise frequency as an important component of maintaining a healthy weight. Healthy Michigan Plan enrollees were given the answer options of every day, 3-6 days, 1-2 days or 0 days. Table 2 shows the overall answers to this question for December 2015. Among enrollees who participated in the survey, there was a 1.55% 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

December 2015

EXERCISE	TOTAL	PERCENT
Every Day	58,142	23.00%
3-6 Days	73,217	28.96%
1-2 Days	62,327	24.65%
No Days	55,208	21.84%
Refused	3,914	1.55%
TOTAL	**252,808**	**100.00%**

Figure 2-1. Exercise Reported for Total Population

December 2015

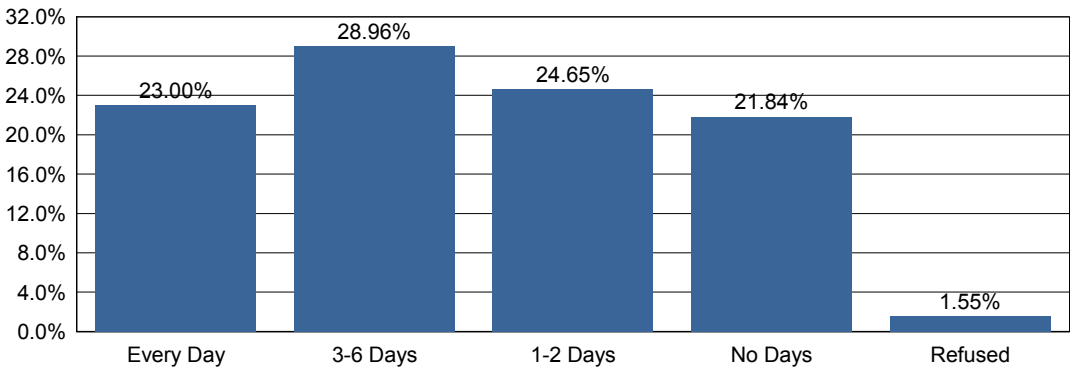


Figure 2-2. Exercise Reported by Age

December 2015

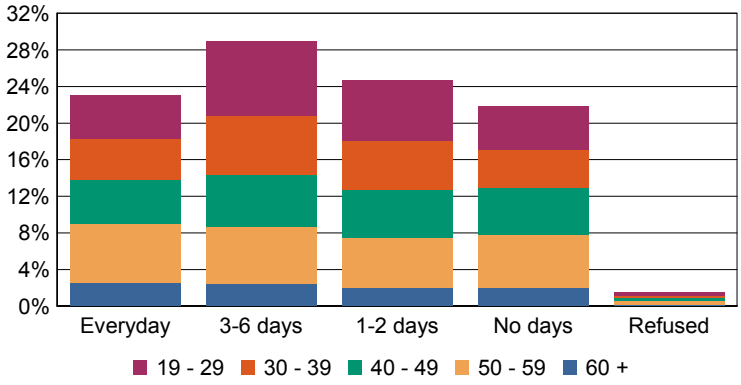
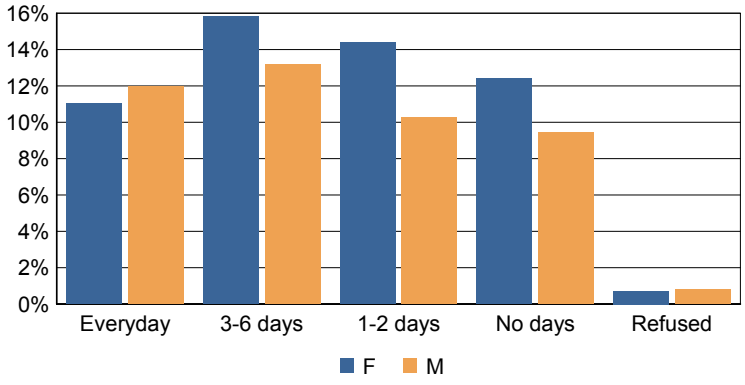


Figure 2-3. Exercise by Gender

December 2015



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 December 2015. Among enrollees who participated in the survey, there was a 1.90% 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

December 2015

NUTRITION	TOTAL	PERCENT
Every Day	85,210	33.71%
3-6 Days	87,361	34.56%
1-2 Days	57,814	22.87%
No Days	17,619	6.97%
Refused	4,804	1.90%
TOTAL	**252,808**	**100.00%**

Figure 3-1. Nutrition Reported for Total Population

December 2015

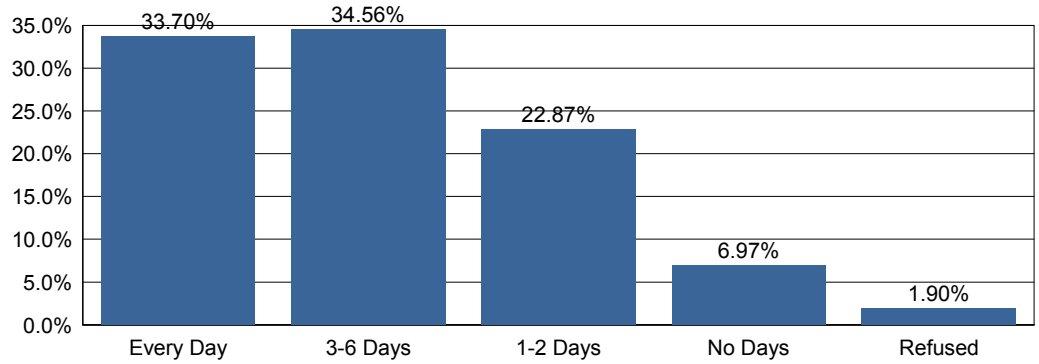


Figure 3-2. Nutrition Reported by Age

December 2015

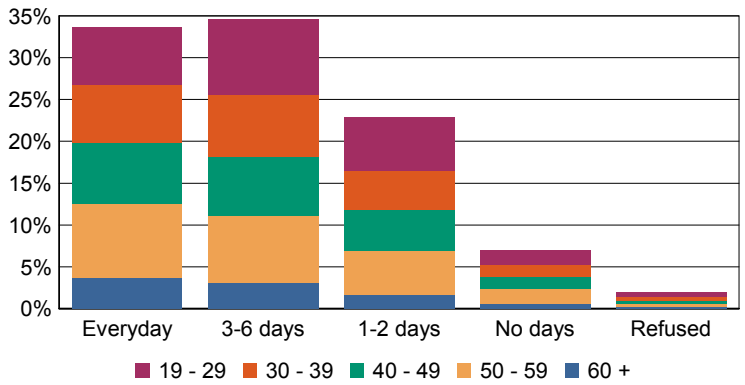
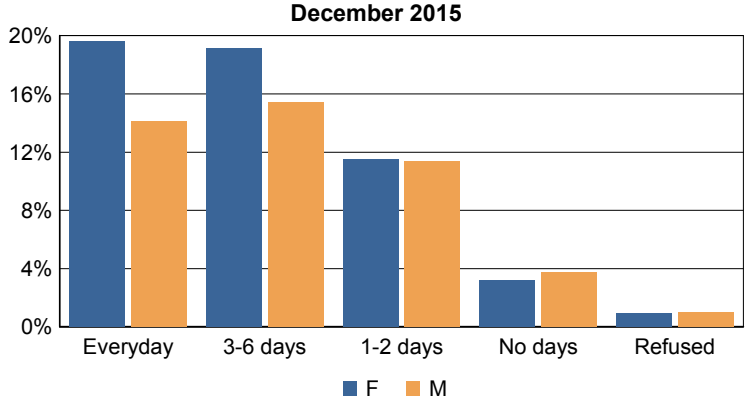


Figure 3-3. Nutrition by Gender

December 2015



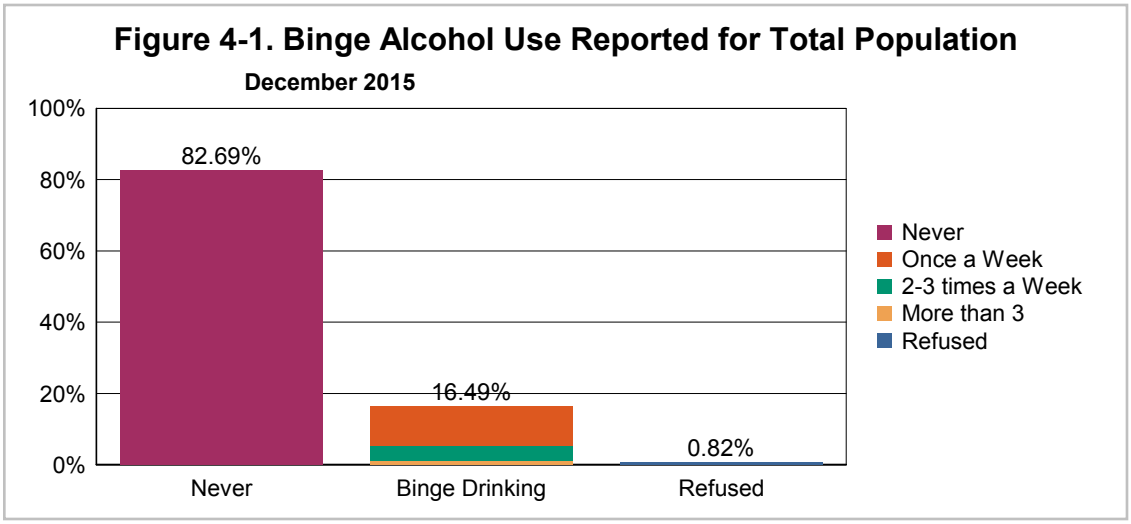
Question 4. Binge Alcohol Use

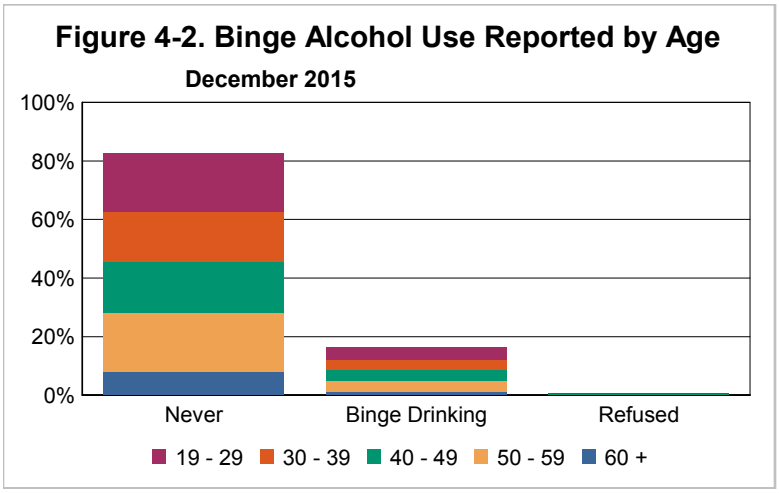
Question 4. In the last 7 days, how often did you have (5 or more for men, 4 or more for women) alcoholic drinks at one time?
This question is used to assess self-reported binge alcohol use. Healthy Michigan Plan enrollees were given the answer options of never, once a week, 2-3 a week and more than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

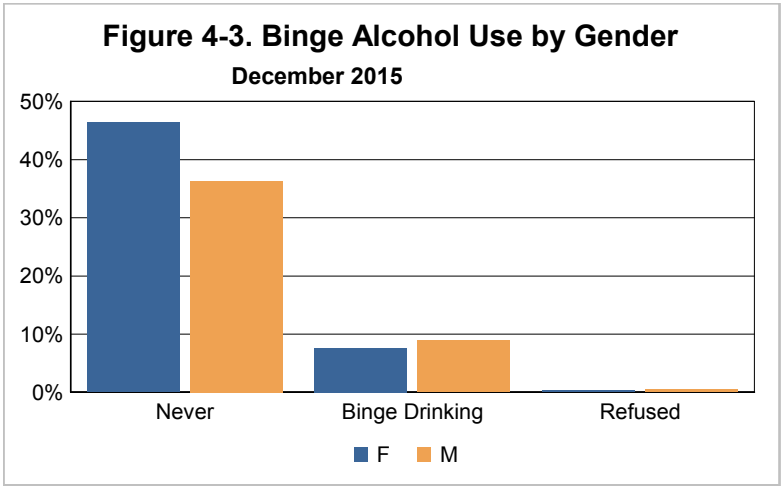
Table 4. Binge Alcohol Use Reported for Total Population

December 2015

ALCOHOL	TOTAL	PERCENT
Never	209,048	82.69%
Once a Week	28,033	11.09%
2-3 times a Week	11,024	4.36%
More than 3	2,629	1.04%
Refused	2,074	0.82%
TOTAL	**252,808**	**100.00%**







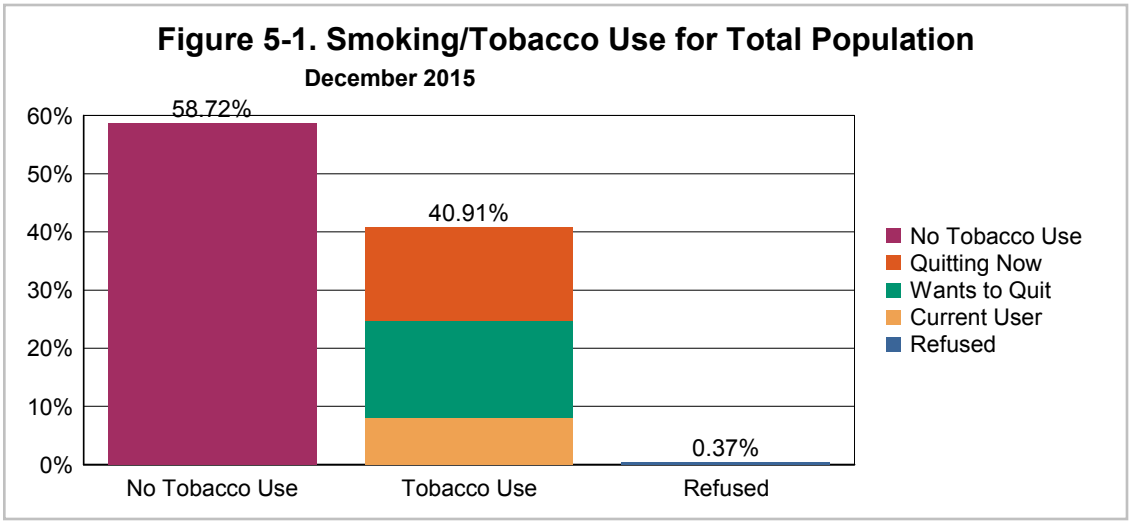
Question 5. Smoking/Tobacco Use

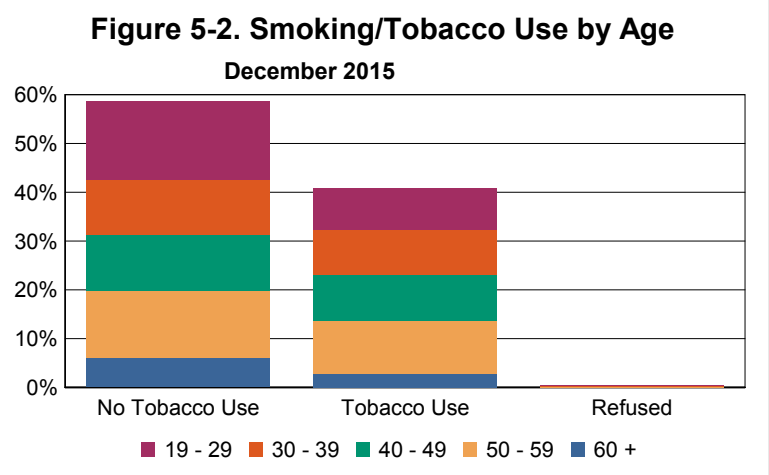
Question 5. In the last 30 days, have you smoked or used tobacco? This question is used to assess self-reported smoking/tobacco use. Healthy Michigan Plan enrollees were given the answer options of yes or no. Enrollees who answered yes, were asked a follow-up question: If YES, do you want to quit smoking 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 December 2015. Question 5 had a 0.37% refusal rate. Figures 5-1 through 5-3 show smoking/tobacco use reported for the total population, and by age and gender.

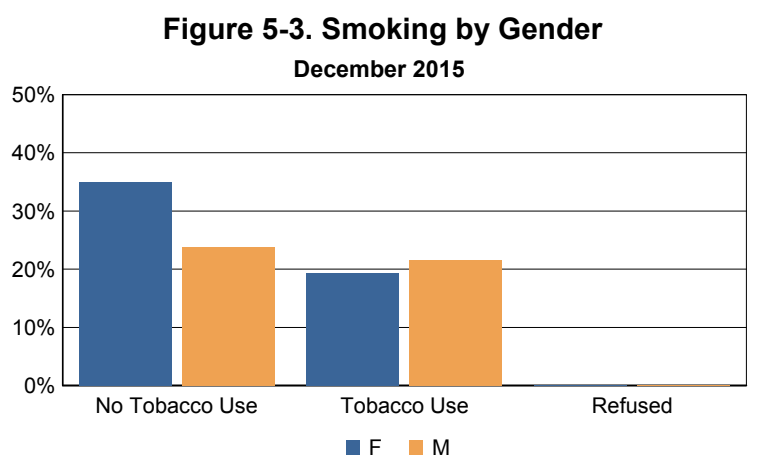
Table 5. Smoking/Tobacco Use Reported for Total Population

December 2015

TOBACCO USE	TOTAL	PERCENT
No Tobacco Use	148,448	58.72%
Quitting Now	40,785	16.13%
Wants to Quit	42,241	16.71%
Current User	20,403	8.07%
Refused	931	0.37%
TOTAL	**252,808**	**100.00%**







Question 6. Anxiety and Depression

Question 6. In the last 30 days, how often have you felt tense, anxious or depressed? This question is used to assess selfreported mental health status. Healthy Michigan Plan enrollees were given the answer options of almost every day, sometimes, rarely and never. Table 6 shows the overall answers to this question for December 2015. Among enrollees who participated in the survey, there was a 11.68% 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

December 2015

DEPRESSION	TOTAL	PERCENT
Almost Every day	53,949	21.34%
Sometimes	66,586	26.34%
Rarely	53,354	21.11%
Never	49,386	19.54%
Refused	29,533	11.68%
TOTAL	**252,808**	**100.00%**

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

December 2015

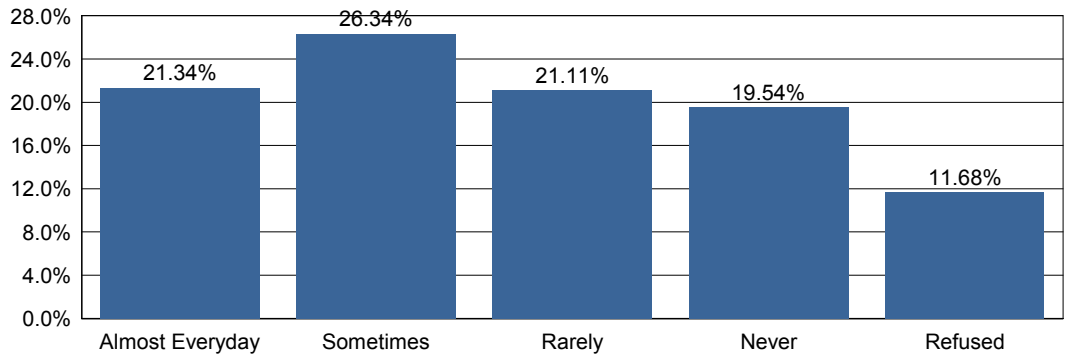


Figure 6-2. Anxiety and Depression Reported by Age

December 2015

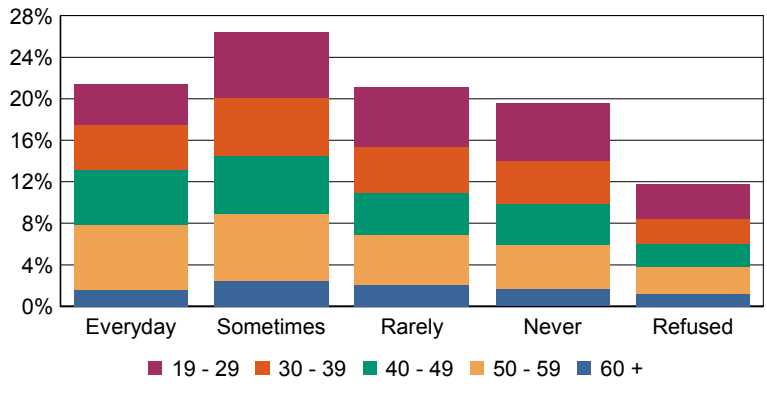
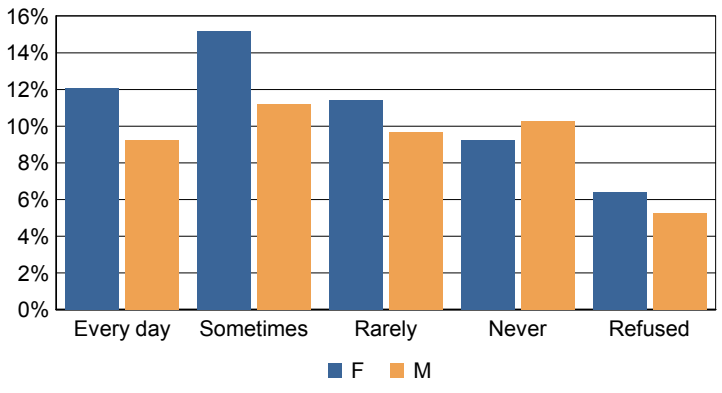


Figure 6-3. Anxiety and Depression by Gender

December 2015



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 December 2015. Among enrollees who participated in the survey, there was a 0.71% 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. Binge Alcohol Use Reported for Total Population

December 2015

SUBSTANCE USE	TOTAL	PERCENT
Almost Every Day	4,937	1.95%
Sometimes	6,458	2.56%
Rarely	5,971	2.36%
Never	233,636	92.42%
Refused	1,806	0.71%
TOTAL	**252,808**	**100.00%**

Figure 7-1. Substance Use Reported for Total Population

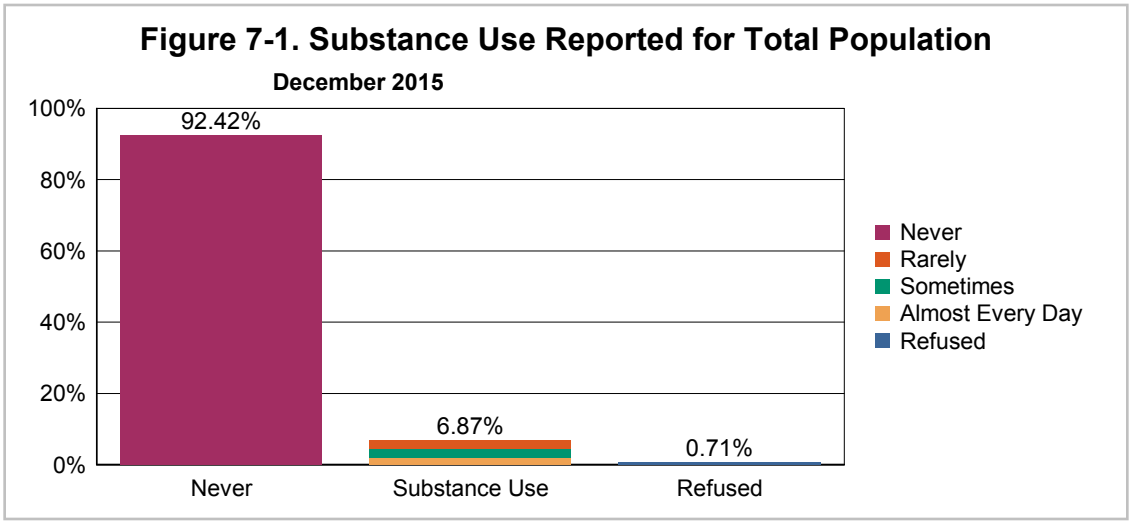


Figure 7-2. Substance Use Reported by Age

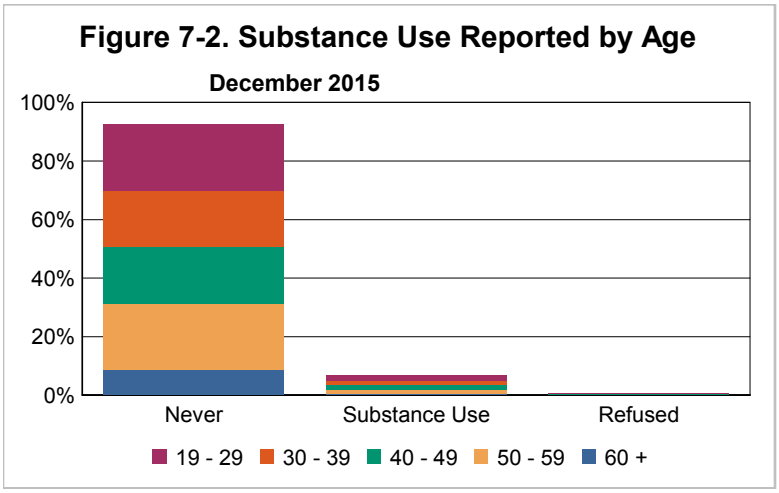
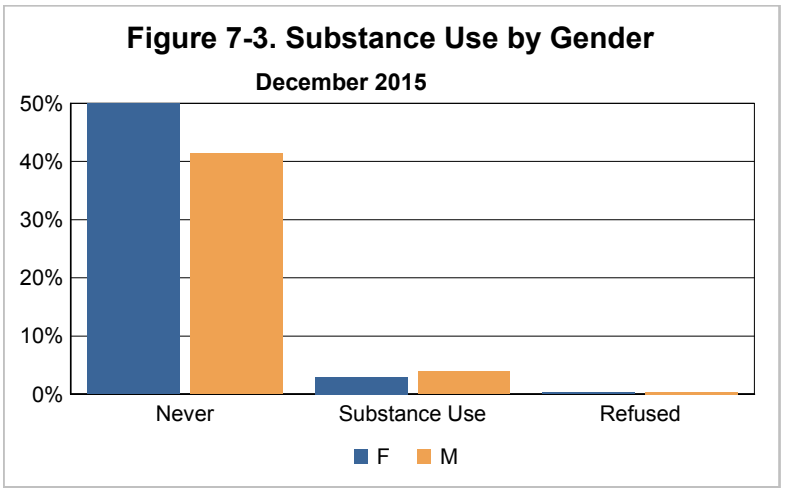


Figure 7-3. Substance Use by Gender



Question 8. Immunization Status (Annual Flu Vaccine)

Question 8. The flu vaccine can be a shot in the arm or a spray in the nose. Have you had a flu shot or flu spray in the last year?
This question is used to assess self-reported annual flu vaccine as an indicator of immunization status. Healthy Michigan Plan enrollees were given the answer options of yes or no. Table 8 shows the overall answers to this question for December 2015. Among enrollees who participated in the survey, there was a 1.74% refusal rate for this question. Figures 8-1 through 8-3 show immunization status reported for the total population, and by age and gender.

Table 8. Immunization Status Reported for Total Population

December 2015

IMMUNIZATION	TOTAL	PERCENT
Yes	56,096	22.19%
No	192,305	76.07%
Refused	4,407	1.74%
TOTAL	**252,808**	**100.00%**

Figure 8-1. Immunization Status Reported for Total Population

December 2015

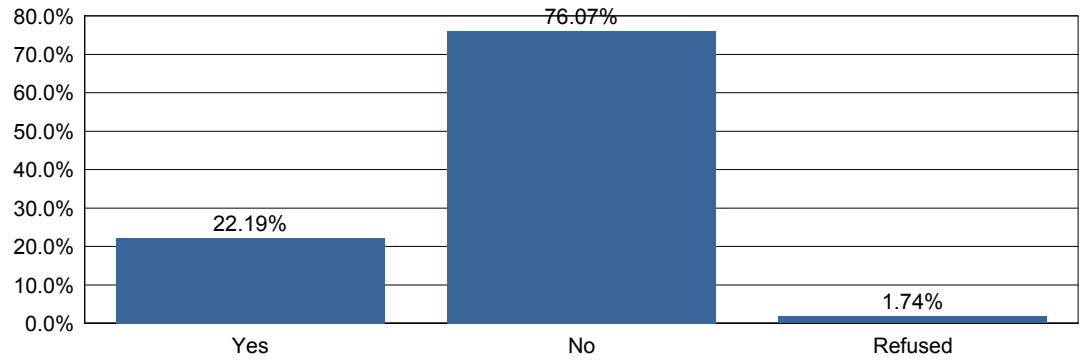


Figure 8-2. Immunization Status Reported by Age

December 2015

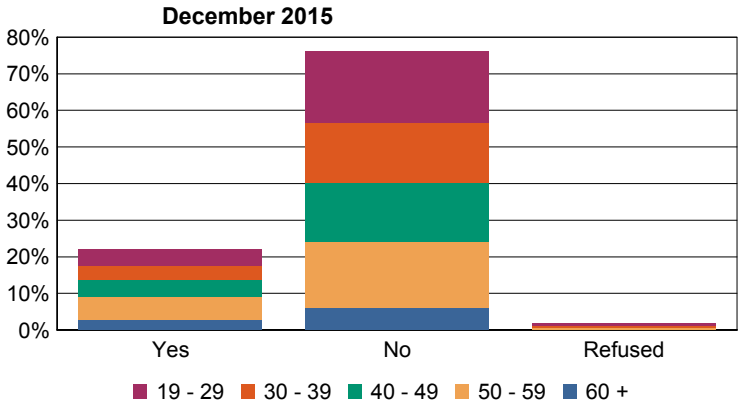
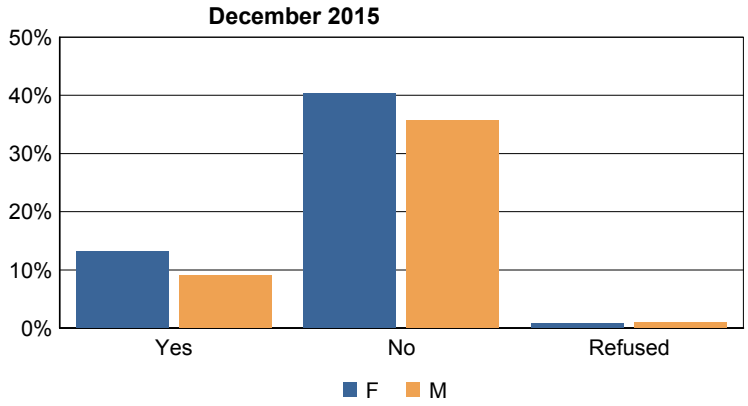


Figure 8-3. Immunization Status by Gender

December 2015



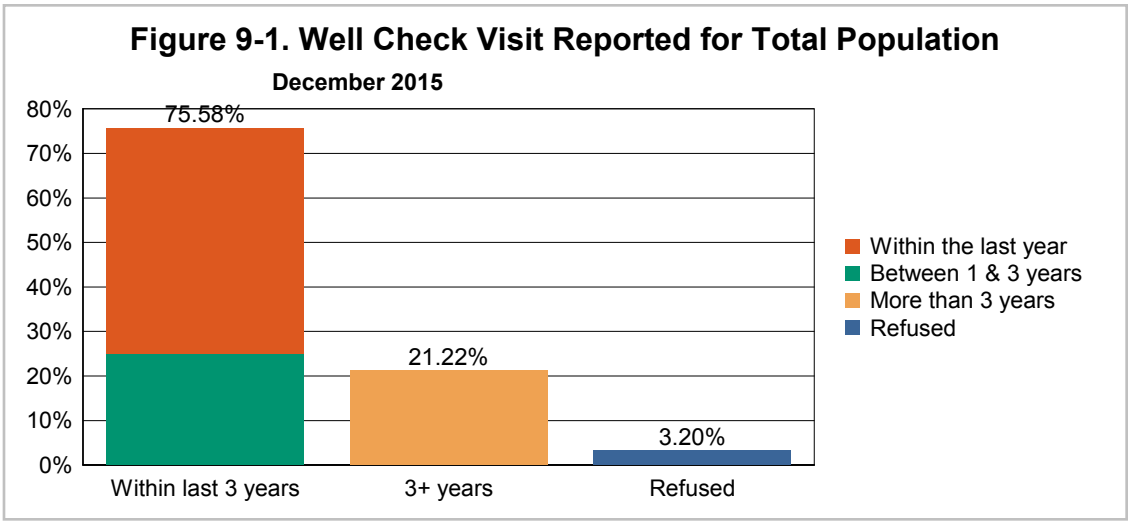
Question 9. Well Check Visit

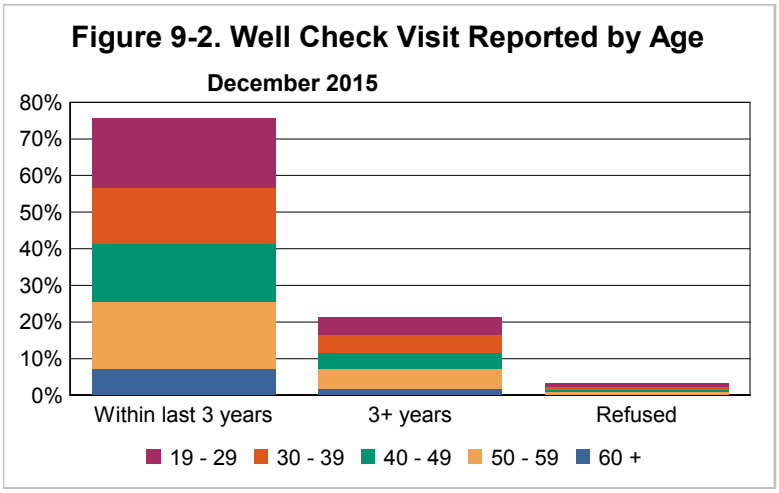
Question 9. A checkup is a visit to a doctor's office that is NOT for a specific problem. How long has it been since your last check-up? This question is used to assess self-reported well check visit. Healthy Michigan Plan enrollees were given the answer options of within the last year, between 1-3 years and more than 3 years. Table 9 shows the overall answers to this question for December 2015. Among enrollees who participated in the survey, there was a 3.20% 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.

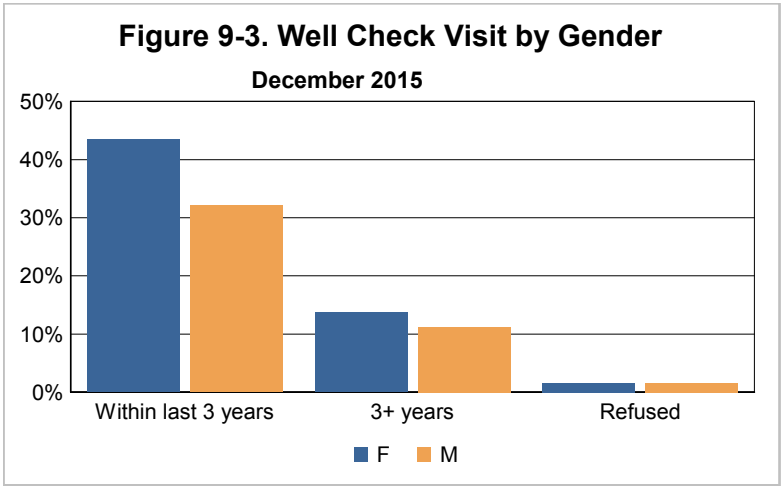
Table 9. Well Check Visit Reported for Total Population

December 2015

CHECK-UP	TOTAL	PERCENT
Within the last year	128,247	50.73%
Between 1 & 3 years	62,835	24.86%
More than 3 years	53,637	21.22%
Refused	8,089	3.20%
TOTAL	**252,808**	**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 to a primary care provider was promoted for all new beneficiaries. Beneficiaries were also encouraged to complete the last section of the Health Risk Assessment at this initial appointment. This final section of the Health Risk Assessment is completed jointly by beneficiaries and their primary care provider. It is designed as a tool for identifying annual health behavior goals.

Completion of this section of the Health Risk Assessment is also voluntary. Healthy Michigan Plan Beneficiaries who complete a Health Risk Assessment with a primary care provider attestation and agree to maintain or address healthy behaviors are eligible for an incentive. Of the 567,712 beneficiaries who have been enrolled in a health plan for at least six months, 84,383 or 14.9% have completed the Health Risk Assessment with their primary care provider as of December 2015.

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 96,394 Health Risk Assessments were completed with primary care providers as of December 2015. Health Risk Assessment completion is reported by age, gender and Federal Poverty Level in Table 11.

Among beneficiaries who completed the Health Risk Assessment, 82,584 or 85.7% of beneficiaries agreed to address health risk behaviors. In addition, 12,831 or 13.3% of beneficiaries who completed the Health Risk Assessment chose to maintain current healthy behaviors, meaning that 99.0% of beneficiaries are choosing to address or maintain healthy behaviors. The healthy behaviors goal statements selected are reported in Table 12. Healthy behavior goal statements are also reported by age and gender in Figures 10-3 and 10-4.

Of the 82,584 beneficiaries who agreed to address health risk behaviors, 61.1% chose to address more than one healthy behavior. Tables 13 and 14 report the most frequently selected health risk behaviors to address, alone and in combination. Figure 10-5 is a Venn diagram representing the overlapping nature of the multiple healthy behaviors selected.

Health Risk Assessment Completion with Primary Care Provider

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

MONTH	COMPLETE	TOTAL
January 2015	3,988	44,715
February 2015	4,147	48,879
March 2015	4,990	53,895
April 2015	4,948	58,860
May 2015	4,684	63,587
June 2015	5,643	69,265
July 2015	7,262	76,544
August 2015	6,148	82,702
September 2015	5,161	87,876
October 2015*	4,680	92,569
November 2015*	3,217	95,795
December 2015*	596	96,394

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

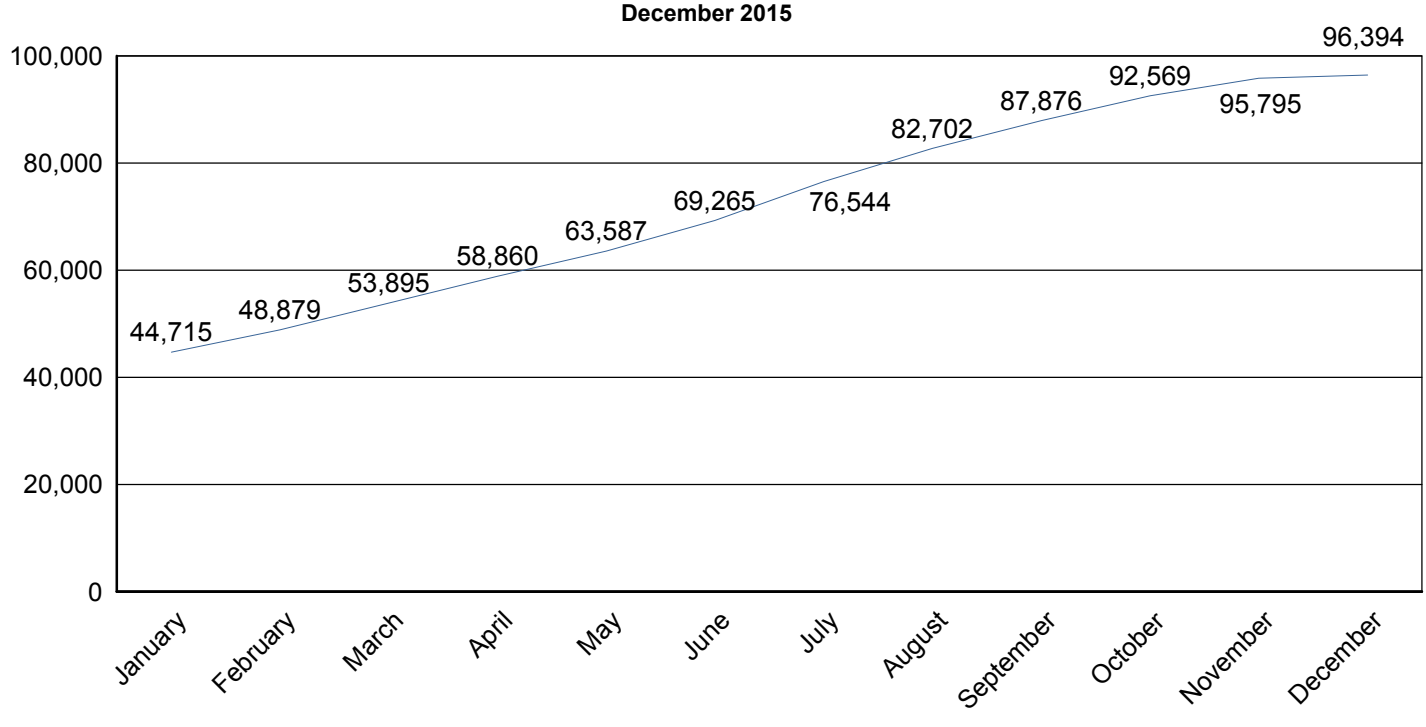
Table 11. Demographics of Population that Completed HRA with Primary Care Provider

September 2014 - December 2015

AGE GROUP	COMPLETED HRA	
19 - 29	19,143	19.86%
30 - 39	16,335	16.95%
40 - 49	19,441	20.17%
50 - 59	29,003	30.09%
60 +	12,472	12.94%
GENDER		
F	55,578	57.66%
M	40,816	42.34%
FPL		
< 100% FPL	77,000	79.88%
100 - 133% FPL	19,394	20.12%
TOTAL	**96,394**	**100.00%**

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

December 2015



Healthy Behaviors Statement Selection

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

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

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

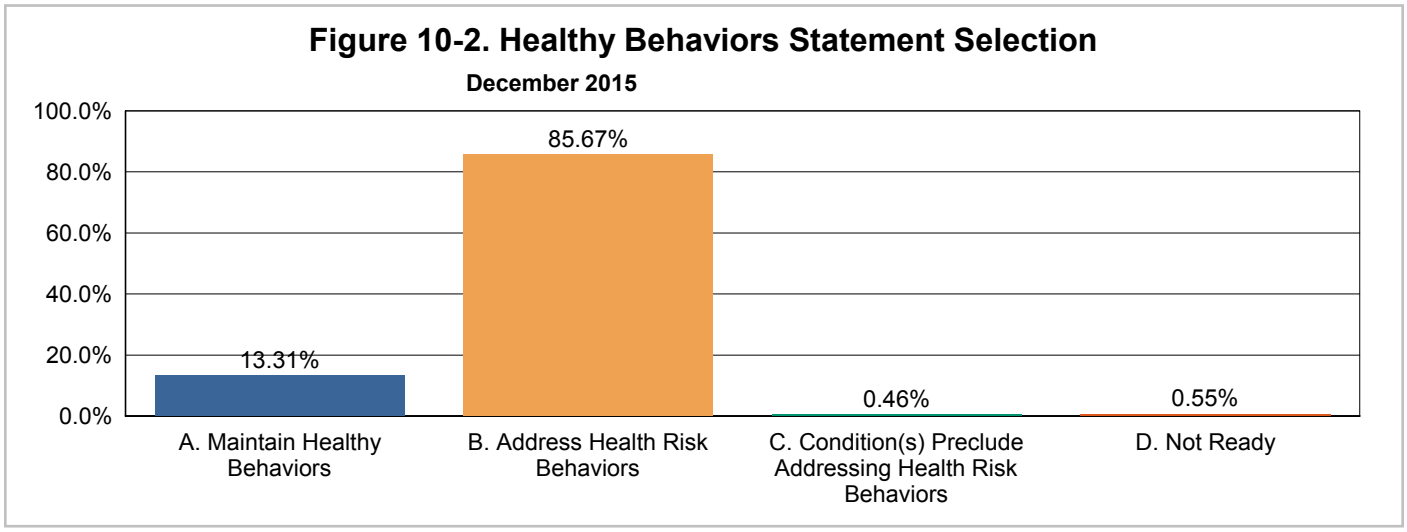
C. Patient has a serious medical, behavioral or social condition or conditions which precludes addressing unhealthy behaviors at this time.

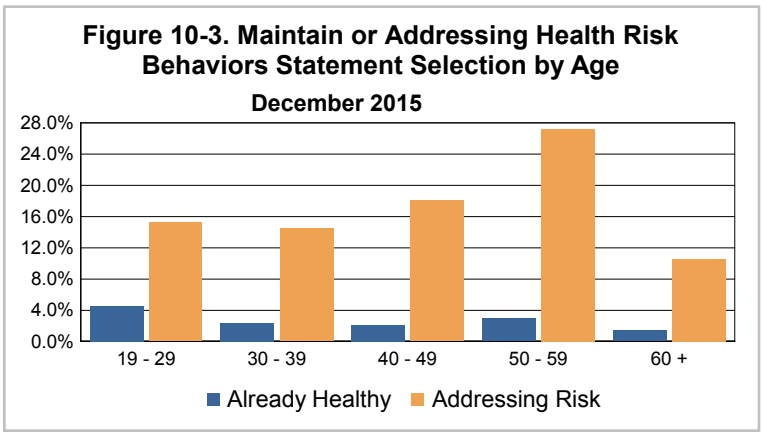
D. Unhealthy behaviors have been identified, patient's readiness to change has been assessed, and patient is not ready to make changes at this time.

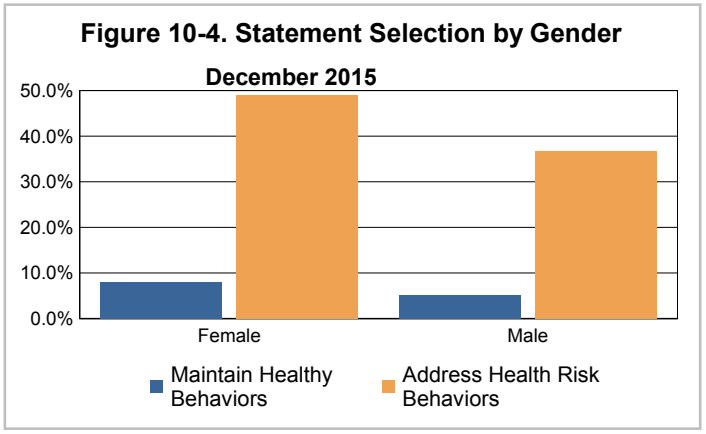
Figures 10-2 through 10-4 show Healthy Behaviors Statement Selections for the total population, and by age and gender.

Table 12. Healthy Behaviors Statement Selection
December 2015

CHECK-UP	TOTAL	PERCENT
A. Maintain Healthy Behaviors	12,831	13.31%
B. Address Health Risk Behaviors	82,584	85.67%
C. Condition(s) Preclude Addressing Health Risk Behaviors	446	0.46%
D. Not Ready	533	0.55%
TOTAL	**96,394**	**100.00%**







Selection of Health Risk Behaviors to Address

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

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

Of the 82,584 HRAs submitted through December 2015 where the beneficiary chose to address health risk behaviors, 61.12% of beneficiaries chose more than one healthy behavior to address. The top 7 most selected behavior combinations and the rate that each behavior was selected in combination and alone are presented in the tables below:

Table 13. Top 7 Most Selected Health Risk Behavior Combinations

Health Risk Behavior Combination	Count	Percent
1. Weight Loss ONLY	14,653	17.74%
2. Tobacco Cessation ONLY	7,497	9.08%
3. Weight Loss, Follow-up for Chronic Conditions	7,461	9.03%
4. Weight Loss, Immunization Status, Follow-up for Chronic Conditions	7,338	8.89%
5. Weight Loss, Immunization Status	5,799	7.02%
6. Follow-up for Chronic Conditions	4,926	5.97%
7. Weight Loss, Tobacco Cessation	4,527	5.48%
Total for Top 7	52,201	63.21%
Total for All Other Combinations	30,383	36.79%
Total	**82,584**	**100.00%**

Table 14. Health Risk Behaviors Selected in Combination and Alone

Health Risk Behavior	Chose this behavior and at least one more	Chose ONLY this behavior
Weight Loss	65.53%	17.74%
Tobacco Cessation	39.40%	9.08%
Immunization Status (Annual Flu Vaccine)	41.04%	4.31%
Follow-up for Chronic Conditions	43.30%	5.97%
Addressing Alcohol Abuse	4.80%	0.40%
Addressing Substance Abuse	1.21%	0.11%
Other	4.40%	1.27%

Health Risk Assessment Completion with Primary Care Provider

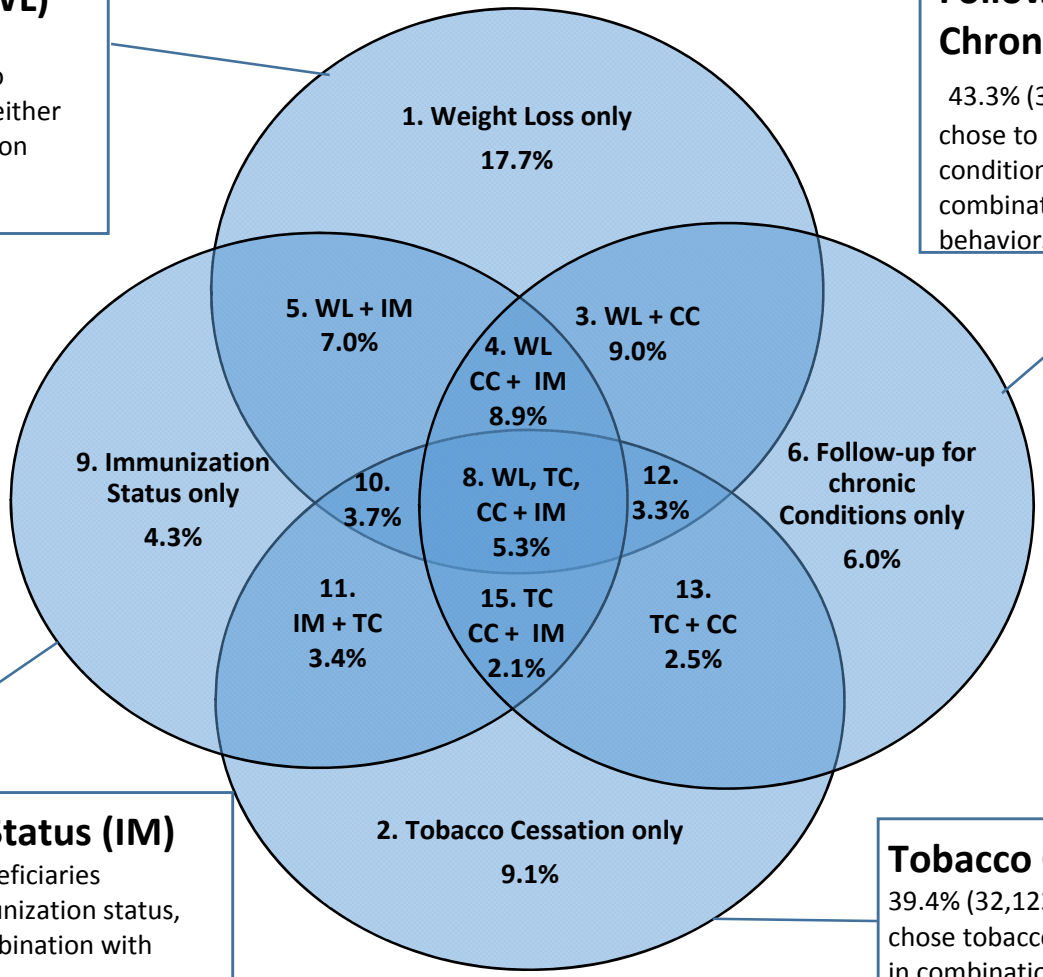
Representation of the overlapping nature of top 15 health risk behavior selections December 2015

Weight Loss (WL)

65.5% (54,123) of beneficiaries chose to address weight loss, either alone or in combination with other health behaviors

Follow-up for Chronic Conditions (CC)

43.3% (35,758) of beneficiaries chose to follow-up for chronic conditions, either alone or in combination with other health behaviors



More Middle Combinations

7. WL + TC 5.5%
10. WL + IM + TC 3.7%
12. WL + CC + TC 3.3%
14. IM + CC 2.3%

Immunization Status (IM)

41.0% (33,896) of beneficiaries chose to address immunization status, either alone or in combination with other health behaviors

Tobacco Cessation (TC)

39.4% (32,123) of beneficiaries chose tobacco cessation, either alone or in combination with other health behaviors

Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Minutes

Date: Wednesday, November 18, 2015

Time: 1:00 pm – 4:30 pm

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

Attendees: **Council Members:** Jan Hudson, Kim Singh, Pam Lupo, Dave Herbel, Warren White, Marion Owen, Linda Vail, Dave Lalumia, Robin Reynolds, Karlene Ketola, Cindy Schnetzler, Cheryl Bupp, April Stopczynski, Andrew Farmer, Roger Anderson, Alison Herschel, Robert Sheehan, Larry Wagenknecht, William Mayer, Joe Neller (for Rebecca Blake), Mark McWilliams (for Elmer Cerano), Vicki Kuhns (for Marilyn Litka-Klein), Amy Zaagman, Priscilla Cheever

Staff: Chris Priest, Dick Miles, Kathy Stiffler, Lynda Zeller, Leslie Asman, Jackie Prokop, Cindy Linn, Pam Diebolt, Marie LaPres, Matt Lori, Monica Kwasnik, Michelle Best, Denise Stark-Phillips, Elizabeth Hertel

Other Attendees: Mark Swan, Betsy Wile

Welcome and Introductions

Jan Hudson opened the meeting and introductions were made.

Welcome back to Chris Priest, Medicaid Director

Chris Priest was introduced to the council as the new director of the Medical Services Administration.

State Innovation Model (SIM) Update

The Michigan Department of Health and Human Services (MDHHS) has been working internally on the Blueprint for Health Innovation, which is the final product for Michigan's SIM planning process, and began reaching out to stakeholders once the bid period closed. Over 60 organizations interested in becoming an Accountable System of Care (ASC) or a Community Health Innovation Region completed the Department's assessment, and MDHHS is now communicating with many of these groups in addition to payers. A press release announcing a regional approach for the Blueprint for Health Innovation was issued on September 21, 2015. MDHHS expects to announce the names of the organizations that have been selected to participate in the SIM in early 2016, and is currently working with MPHI to develop an operational plan that must be submitted to the Centers for Medicare and Medicaid Services (CMS) by December 1, 2015. Jan Hudson offered to share with the council the PowerPoint presentation on the SIM project that Elizabeth Hertel prepared for another group.

Jan also requested that MDHHS take steps to ensure that patients are involved in the SIM development process. In response, MDHHS staff reported that the Department plans to engage with patients once the structure of the project is in place.

Healthy Michigan Plan

Waiver Amendment Progress

The second waiver for the Healthy Michigan Plan was submitted to CMS on September 1, 2015, and Jan and Chris both thanked the Council for drafting letters of support. Chris also reported that the feedback received by MDHHS during the public comment period for the waiver was overwhelmingly positive. MDHHS has been engaging in constructive discussions with CMS up to this point, and while Chris expressed optimism that the waiver would be approved, he cautioned that the process will take time. The waiver must be approved by December 31, 2015 for the Healthy Michigan Plan to continue after April 30, 2016.

Copay Increases for Enrollees with Incomes above 100% of the Federal Poverty Level (FPL)

Section 1631 of the State of Michigan appropriations bill for Fiscal Year (FY) 2016 requires that MDHHS must double most copayment amounts for Healthy Michigan Plan Enrollees with incomes above 100% of the FPL. The Department is currently in discussion with CMS to determine whether a waiver or State Plan Amendment will be needed to pursue approval for this requirement, but is awaiting a decision by CMS on the second waiver before taking action. Copays, by federal law, must be "nominal and not greater than 10% of the cost of the service." Beneficiaries may continue to reduce their copay amounts by completing a Health Risk Assessment (HRA) and engaging in one or more healthy behaviors.

MIHealth Account Report

MDHHS published a final MIHealth Account Executive Summary on November 18, 2015, which is available on the MDHHS website at www.michigan.gov/healthymichiganplan. Since Healthy Michigan Plan Enrollees have the option of paying their entire MIHealth Account balance at the end of each quarter, rather than making monthly payments, meeting attendees were advised that data for completed quarters most accurately reflects the amount of money collected by MDHHS as a percentage of the total amount owed by beneficiaries who received a MIHealth Account statement. MDHHS staff also encouraged attendees to share any suggestions for clarifying language in the summary with the Department, as it will be updated monthly.

Since the first MIHealth Account Statements were issued, MDHHS has collected no more than approximately 50% of the total amount owed in a single quarter. The Department is required by State law to garnish the State income tax returns and lottery winnings of Healthy Michigan Plan enrollees who consistently fail to pay their copayments and contributions, and MDHHS notified approximately 5,000 individuals in October 2015 that they met these criteria. Of this amount, 60 individuals requested a review of their account, and many others began making payments. Approximately 4,600 enrollees were reported to the Michigan Department of Treasury for garnishment. MDHHS staff and council members discussed ideas to increase the MIHealth Account payment rate among enrollees, such as the possibility of allowing payment by credit card.

U of M Evaluation of MIHealth Account Statements

MDHHS commissioned the University of Michigan to conduct a review of the MIHealth Account Statements, which has now been completed. The University spoke with over 50 enrollees who received a MIHealth Account Statement, and submitted recommendations to the Department for changes to the Statements to address the findings of their review. A council member offered to share a report, The Power of Prompts, submitted to the U.S. Department of Health and Human Services in August that detailed recommendations for increasing beneficiary participation in the programs in which they are enrolled, and noted that President Obama issued an executive order requiring all federal agencies to implement the report's recommendations. MDHHS staff also offered to share a redacted MIHealth Account Statement with the council.

Fiscal Year (FY) 2016 Budget Implementation and FY 2017 Development

Chris Priest reported that the MDHHS budget for FY 2016 went into effect on October 1, 2015, and the Department is beginning to develop the FY 2017 budget. Several areas of concern related to the development of the FY 2017 budget were discussed, including:

- MDHHS is anticipating a loss of approximately $60 million related to a reduction in the Federal Medical Assistance Percentage (FMAP) rate for FY 2017.
- The State's "clawback" payment for Medicare Part D will increase by 11%.
- The State will be required to contribute matching funds for the Healthy Michigan Plan.
- The use tax on Medicaid Health Plans (MHPs) is scheduled to phase out on December 31, 2016, which will activate an increase in the Health Insurance Claims Assessment (HICA) rate from 0.75 % to 1%. Despite the increase in the HICA rate, the State is expecting a loss of revenue as a result of the expiration of the use tax. Legislation has been introduced in the State legislature to extend the HICA, which is scheduled to sunset on December 31, 2017.

Autism Services Expansion through Age 21 (Currently 18 Months to Age 5)

MDHHS is on track to expand autism services through age 21 effective January 1, 2016.

Specialty Drugs

Chris reported that many new high-cost specialty drugs are becoming available on the market for treatment of hepatitis C, cystic fibrosis, etc., which may contribute to budget challenges in the future for MDHHS. The Department is currently in the process of working internally to identify budget priorities for FY 2017.

Managed Care Rebid

Recommendations for Contract Awards

MDHHS issued a press release on November 13, 2015 announcing the final recommendations for the MHPs to receive contract awards at the conclusion of an allotted protest period. A final synopsis of the results of the bid is posted online at www.buy4michigan.com. The recommended MHPs have received approval from the State Administrative board, and the Department is on track to implement the new MHP contracts on January 1, 2016. After the implementation of the new MHP contracts, 125,000 beneficiaries will no longer be served by their current health plan in their county of residence. Of these affected beneficiaries, 112,500 have already been transferred to other plans, while MDHHS has notified the remaining beneficiaries that they have 90 days to select a new MHP covering their area. In response to an inquiry regarding the impact of the new MHP contracts on provider networks, MDHHS staff noted that a statewide analysis found 94% of providers to be contracted with more than one health plan, so the Department expects network coverage gaps to be minimal. A meeting attendee also recommended that MDHHS take a proactive approach toward implementing performance metrics for the MHPs in order to address potential problems before complaints are filed. In response, MDHHS staff agreed to consider the suggestion, and reminded meeting attendees that providers should first discuss problems with the MHPs directly before contacting the Department.

Common Formulary Update

MDHHS held a stakeholder meeting on August 11, 2015 to discuss the implementation of a MHP common formulary for drug coverage, and incorporated many suggested changes into the final common formulary. The Department is now on track to implement the common formulary on January 1, 2016, and will be holding a second stakeholder meeting on November 19, 2015 at Lansing Community College West for the purpose of describing changes made and to answer questions. Once the common formulary is finalized, providers will have the opportunity to submit feedback each quarter.

Quality Strategy

MDHHS staff provided meeting attendees with a copy of the MDHHS managed care quality strategy, and discussed several areas of the document. The Department has incorporated several changes requested by CMS and intends to submit the final document to CMS by November 25, 2015. Attendees were advised that comments must be submitted by November 24, 2015 to be considered for incorporation into the final document.

MIChild Conversion

On January 1, 2016, the MIChild program will be converted to a Medicaid expansion program. MDHHS has distributed two proposed policies for public comment related to the MIChild conversion: project #1541-Eligibility, which discusses eligibility requirements for MIChild as a Medicaid expansion program, and project #1554-Eligibility, which discusses covered services. Both policies will be issued as final bulletins on December 1, 2015, and current MIChild beneficiaries have been notified of the change. MDHHS staff discussed the changes outlined in the proposed policies with meeting attendees. A number of Medicaid services will become available to these children, including EPSDT, comprehensive behavioral health services, Healthy Kids dental, non-emergency medical transportation as well as retroactive coverage. Enrollment will be through Bridges, not Maximus as in the past, but Maximus will continue to collect the $10/family monthly premium.

National Governor's Association (NGA) Emergency Room (ER) High Utilizer Project

Matt Lori reported that MDHHS was awarded a grant by the National Governors Association from July 2015 – October 2016 to participate in the NGA ER High Utilizer Project, and provided meeting attendees with an update on its progress. The five goals for the project include: data-driven decision making; use payment to leverage best practices and models of care; revise and/or add services to address gaps identified by data analysis to strengthen the system or provide clinical teams with data and support tools that enable the right care at the right time within the right setting; and use the progress from the above goals to make a case for sustainability. The project's data have shown that one of the contributing factors to high ER utilization is homelessness, and the council discussed ideas to address this problem at length, including specific projects in Kent and Kalamazoo counties.

Integrated Care for Dual Eligibles (MI Health Link)

The MDHHS Integrated Care Demonstration, known as MI Health Link, is now operational in the four demonstration regions (Upper Peninsula, Southwest Michigan, Wayne County and Macomb County) to provide integrated services to beneficiaries who are dually eligible for Medicare and Medicaid. Enrollment as of September 2015 was 42,500; it has dropped to 36,200 in November. If dually eligible individuals do not voluntarily enroll in MI Health Link during an "active" enrollment period, then they are automatically enrolled into the program by MDHHS during a "passive" enrollment period unless they choose to opt out. The number of individuals who choose to enroll voluntarily has not met Department expectations. MI Health Link has also experienced issues with enrollment related to yearly Medicaid redetermination, systems changes and personal care services. The council discussed possible changes to the Medicaid redetermination process, which included the prospective implementation of a passive redetermination process.

MDHHS has established an ombudsman program specific to the MI Health Link Program to address problems experienced by enrollees.

A public forum to discuss MI Health Link was held in the Upper Peninsula in October, and a forum is also scheduled for December 9, 2015 in Benton Harbor.

Implementation of Home Help Program Changes

MDHHS is in the process of implementing changes to the Home Help program to address the findings of a program audit that were released in 2014, as well as the findings of an internal department business process review. These changes include conducting criminal background checks of home help providers and moving to an electronic services verification system. In October 2014, MDHHS implemented a process to enroll new providers in the

Community Health Automated Medicaid Processing System (CHAMPS) and began conducting criminal background checks on home help providers. Providers who have been convicted of a Mandatory Exclusion, as outlined in Bulletin MSA 14-31, are prohibited from participating in the Home Help Program, while providers who have been convicted of a Permissive Exclusion, as outlined in Bulletin MSA 14-40, may continue to provide services with a signed acknowledgement form from the beneficiary. MDHHS is now in the process of enforcing these provisions. Continuity of care remains a concern. The Department also implemented a process for electronic services verification in June 2015, which included a parallel paper verification process for home help providers who do not have access to a computer. The compliance rate for the new electronic services verification system among providers is lower than expected, and MDHHS is working to find solutions to this problem.

Behavioral Health Issues

Certified Community Behavioral Health Clinics (CCBHCs)

Lynda Zeller announced that the State of Michigan has received a planning grant for CCBHCs, and is working with the Medical Care Advisory Council (MCAC) and the Behavioral Health Advisory Committee (BHAC) to form a steering committee to advise the department as the planning for CCBHCs proceeds. CCBHCs provide more comprehensive health care services than are currently offered through a Community Mental Health (CMH) clinic, and accept all beneficiaries. The focus will be population health, specifically improvements in physical health/behavioral health outcomes. All clinics established prior to April 1, 2014 are eligible to become CCBHCs in the eight states that will be awarded final implementation grants. The State of Michigan plans to establish no more than 10 CCBHCs if selected. In response to an inquiry regarding how the CCBHCs would coordinate with the State Innovation Model (SIM) Grant, Lynda explained that the CCBHCs are classified as specialty providers, and would be able to belong to multiple Accountable Systems of Care (ASCs) within a SIM region and easily share information with the Community Health Innovation Region.

Common Consent Form

MDHHS is working to develop a common consent form to better integrate behavioral health and physical health services, and has been meeting with stakeholder groups for input. Current federal law creates barriers.

Michigan Prescription Drug and Opioid Abuse Task Force Report of Findings and Recommendations for Action

The Michigan Prescription Drug and Opioid Abuse Task Force Report recommended action in five areas, which include prevention, treatment, regulation, policy enforcement and outcomes. The Behavioral Health and Developmental Disabilities Administration will be working to address the recommended changes in the areas of prevention and treatment, while the Governor's office will work with the MDHHS director's policy office and others to address changes to regulation, policy enforcement and outcomes. The Task Force identified numerous issues for which solutions will be very challenging.

Policy Updates

A policy bulletin handout was distributed to attendees, and several items were discussed.

Chairperson and Consumer Representation for 2016

Since Jan Hudson will be stepping down as chairperson of the MCAC at the end of this year, Chris Priest announced that Robin Reynolds has accepted his invitation to take over the role beginning in 2016. The council also continued to discuss ideas for finding individuals to provide consumer representation on the MCAC.

4:30 – Adjourn

Next Meeting: February 29, 2016

Medical Services Administration
Bureau of Medicaid Care Management and Quality Assurance

PERFORMANCE MONITORING REPORT

MEDICAID MANAGED CARE
HEALTHY MICHIGAN PLAN
ADULT CORE SET MEASURES

Composite – All Plans

January 2016

Revised March 16, 2016

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

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Executive Summary

This Performance Monitoring Report is produced by the Quality Improvement and Program Development (QIPD) Section of the Managed Care Plan Division (MCPD) to track quality, access, and utilization in the Michigan Medicaid program to better support high quality care for beneficiaries. In addition to this, the Department now has the capacity to report data on the basis of program area (traditional Medicaid, Healthy Michigan Plan, FFS), by beneficiary demographic information (age, gender, race/ethnicity), or region

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. Other HEDIS rates published by the Michigan Department of Health and Human Services (MDHHS) include rates derived using hybrid methodology that allows for sampling and medical record abstraction.

MDHHS monitors the performance of the State's 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 2016 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. MDHHS 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 4 through 25 depict only Managed Care Plan data, and not Fee-For-Service (FFS) data.

MHPs are contractually obligated to achieve specified standards for most measures. 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 2016 unless otherwise noted.

Table 1: Fiscal Year 2016[1]

Quarterly Reported Measures	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Childhood Immunizations	N/A			
Elective Delivery	N/A			
Postpartum Care	0/13			
Well-Child Visits 0-15 Months	6/12			
Well-Child Visits 3-6 Years	0/13			
Complaints	7/13			
Adults' Generic Drug Utilization	13/13			
Timely Completion of Initial HRA	1/13			
Outreach & Engagement to Facilitate Entry to PCP	0/13			
Plan All-Cause Acute 30-Day Readmissions	5/13			
Adults' Access to Ambulatory Health Services	2/13			
Adult Body Mass Index Assessment	0/13			
Breast Cancer Screening	9/12			
Cervical Cancer Screening	0/13			
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	1/13			
Comprehensive Diabetes Care: Hemoglobin A1c Testing	2/13			

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

Table 1: Fiscal Year 2016 (continued)

Antidepressant Medication Management	N/A			
Annual Monitoring for Patients on Persistent Medications	0/13			

Monthly Reported Measures	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Blood Lead Testing	3/12	3/12	3/12									
Developmental Screening First Year of Life	11/13	11/13	11/13									
Developmental Screening Second Year of Life	10/13	10/13	10/13									
Developmental Screening Third Year of Life	8/13	8/13	9/13									
Claims Processing	12/13	12/13	12/13									
Encounter Data Reporting	13/13	12/13	12/13									
Pharmacy Encounter Data	13/13	13/13	13/13									
Provider File Reporting	13/13	13/13	13/13									

Managed Care Enrollment

Michigan Medicaid Managed Care (MA-MC) enrollment has remained steady over the past year. In January 2016, enrollment was 1,650,824, up 64,495 enrollees (4.1%) from February 2015. An increase of 24,172 enrollees (1.5%) was realized between December 2015 and January 2016.

The Healthy Michigan Plan (HMP-MC) enrollment has also remained steady over the past year. In January 2016, enrollment was 467,688, up 44,089 enrollees (10.4%) from February 2015. An increase of 646 enrollees (0.1%) was realized between December 2015 and January 2016.

Figure 1: MA-MC and HMP-MC Enrollment, February 2015 – January 2016

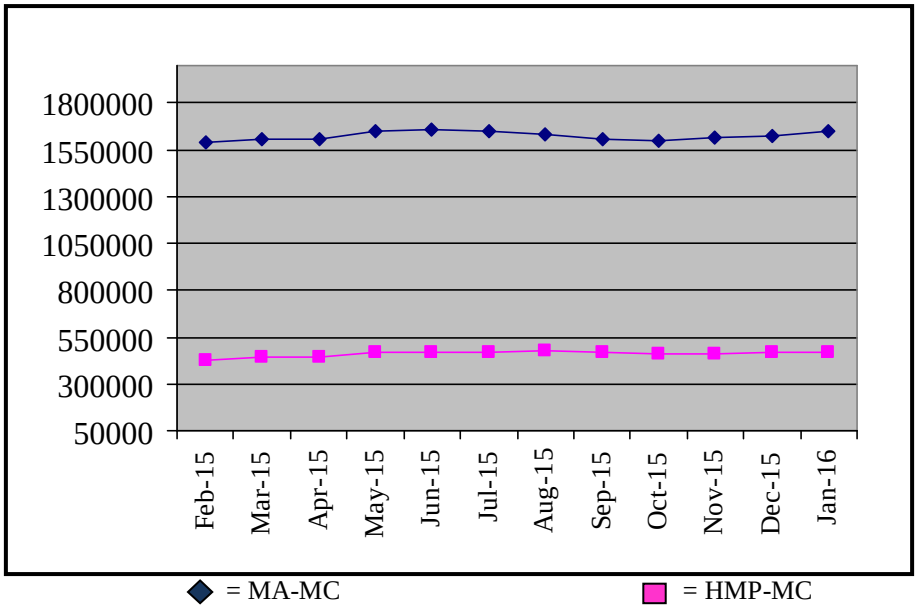
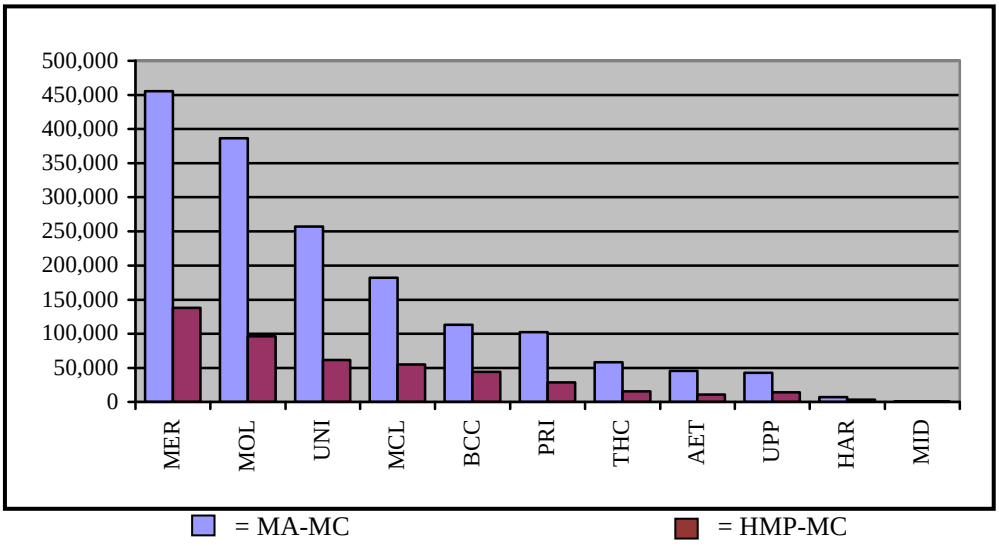


Figure 2: MA-MC and HMP-MC Enrollment, by Health Plan, January 2016



Medicaid Health Plan News

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

As of September 1, 2015 HealthPlus Partners, Inc. (HPP) is no longer an active Medicaid Health Plan. However, their information will continue to appear in the quarterly PMR until such data is no longer available.

As of January 1, 2016 Sparrow PHP (PHP) is no longer an active Medicaid Health Plan. However, their information will continue to appear in the quarterly PMR until such data is no longer available.

Cross-Plan Performance Monitoring Analyses

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

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.

Minimum Standard
N/A – This measure is informational only

Measurement Period
July 2014 – June 2015

Data Source
MDHHS 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.

Minimum Standard
N/A – This measure is informational only.

Measurement Period
July 2014 – June 2015

Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

Data for this measure will not be reported this quarter.

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.

Minimum Standard
At or above 70% (as shown on bar graph below)

Measurement Period
July 2014 – June 2015

Data Source
MDHHS Data Warehouse

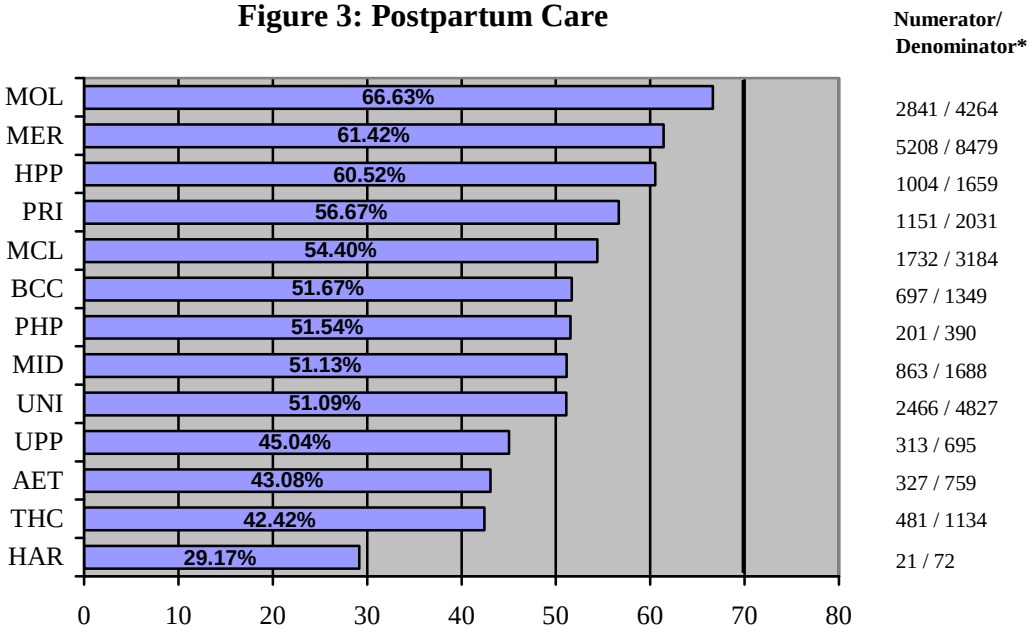
Measurement Frequency
Quarterly

Summary:
None of the plans met or exceeded the standard. Results ranged from 29.17% to 66.63%.

Table 2: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	22101	41409	53.37%
Fee For Service (FFS) only	692	2216	31.23%
Managed Care only	17581	31048	56.63%
MA-MC	16103	28456	56.59%
HMP-MC	603	1147	52.57%

Figure 3: 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.

Minimum Standard
At or above 81% for continuously enrolled children

Measurement Period
October 2015 – December 2015

Data Source
MDHHS Data Warehouse

Measurement Frequency
Monthly

Summary
Three plans met or exceeded the standard in October, November, and December, while nine plans (AET, BCC, HAR, MER, MID, MOL, PHP, THC, and UNI) did not.

Table 3: Blood Lead Testing for Two Year Olds

MHP	Standard	Cont. Enrolled Result			Standard Achieved		
		Oct	Nov	Dec	Oct	Nov	Dec
AET	81%	**74%**	**73%**	**71%**	**No**	**No**	**No**
BCC	81%	**67%**	**69%**	**69%**	**No**	**No**	**No**
HAR	81%	**64%**	**66%**	**66%**	**No**	**No**	**No**
MCL	81%	82%	82%	81%	Yes	Yes	Yes
MER	81%	**80%**	**79%**	**79%**	**No**	**No**	**No**
MID	81%	**70%**	**70%**	**71%**	**No**	**No**	**No**
MOL	81%	**73%**	**73%**	**73%**	**No**	**No**	**No**
PHP	81%	**80%**	**80%**	**79%**	**No**	**No**	**No**
PRI	81%	81%	82%	82%	Yes	Yes	Yes
THC	81%	**70%**	**70%**	**70%**	**No**	**No**	**No**
UNI	81%	**75%**	**75%**	**75%**	**No**	**No**	**No**
UPP	81%	89%	88%	89%	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.

Minimum Standard
At or above 19% - First year of Life
At or above 23% - Second Year of Life
At or above 17% - Third Year of Life

Measurement Period
October 2015 – December 2015

Data Source
MDHHS Data Warehouse

Measurement Frequency
Monthly

Summary:
Eleven plans met or exceeded the standard for the *first year of life* for October, November and December, while two plans (HAR and UPP) did not;
Ten plans met or exceeded the standard for the *second year of life* for October, November and December, while three plans (AET, HAR, and UPP) did not;
Eight plans met or exceeded the standard for the *third year of life* for October and November, while five plans (AET, HAR, PHP, THC, and UPP) did not. In December, Nine plans met or exceeded the standard, while four plans (AET, HAR, THC, and UPP) did not.

Table 4: Developmental Screening First Year of Life

MHP	Standard	Plan Result			Standard Achieved		
		Oct	Nov	Dec	Oct	Nov	Dec
AET	19%	19.67%	19.16%	20.40%	Yes	Yes	Yes
BCC	19%	37.98%	37.48%	38.01%	Yes	Yes	Yes
HAR	19%	**14.81%**	**14.81%**	**17.86%**	**No**	**No**	**No**
HPP	19%	33.73%	33.56%	34.14%	Yes	Yes	Yes
MCL	19%	22.72%	23.54%	23.67%	Yes	Yes	Yes
MER	19%	23.35%	23.65%	23.68%	Yes	Yes	Yes
MID	19%	30.57%	31.24%	31.65%	Yes	Yes	Yes
MOL	19%	23.61%	23.92%	24.08%	Yes	Yes	Yes
PHP	19%	20.92%	20.70%	22.75%	Yes	Yes	Yes
PRI	19%	25.44%	25.01%	24.81%	Yes	Yes	Yes
THC	19%	19.69%	19.06%	20.20%	Yes	Yes	Yes
UNI	19%	22.18%	22.88%	23.29%	Yes	Yes	Yes
UPP	19%	**14.68%**	**14.42%**	**14.30%**	**No**	**No**	**No**

Table 5: Developmental Screening Second Year of Life

MHP	Standard	Plan Result			Standard Achieved		
		Oct	Nov	Dec	Oct	Nov	Dec
AET	23%	**21.50%**	**21.47%**	**21.38%**	**No**	**No**	**No**
BCC	23%	44.90%	45.34%	45.85%	Yes	Yes	Yes
HAR	23%	**20.75%**	**20.37%**	**17.24%**	**No**	**No**	**No**
HPP	23%	37.15%	36.66%	36.72%	Yes	Yes	Yes
MCL	23%	26.23%	26.58%	27.03%	Yes	Yes	Yes
MER	23%	26.64%	26.94%	27.16%	Yes	Yes	Yes
MID	23%	34.09%	33.38%	34.01%	Yes	Yes	Yes
MOL	23%	25.56%	26.24%	26.58%	Yes	Yes	Yes
PHP	23%	26.54%	28.53%	29.04%	Yes	Yes	Yes
PRI	23%	36.89%	38.30%	38.50%	Yes	Yes	Yes
THC	23%	23.19%	23.75%	24.78%	Yes	Yes	Yes
UNI	23%	29.59%	29.89%	29.74%	Yes	Yes	Yes
UPP	23%	**17.89%**	**17.04%**	**16.07%**	**No**	**No**	**No**

Table 6: Developmental Screening Third Year of Life

MHP	Standard	Plan Result			Standard Achieved		
		Oct	Nov	Dec	Oct	Nov	Dec
AET	17%	**15.74%**	**15.72%**	**14.96%**	**No**	**No**	**No**
BCC	17%	34.46%	34.79%	35.49%	Yes	Yes	Yes
HAR	17%	**12.82%**	**11.11%**	**10.77%**	**No**	**No**	**No**
HPP	17%	30.13%	31.69%	32.17%	Yes	Yes	Yes
MCL	17%	21.12%	21.66%	21.26%	Yes	Yes	Yes
MER	17%	21.93%	22.00%	22.33%	Yes	Yes	Yes
MID	17%	25.88%	26.62%	27.22%	Yes	Yes	Yes
MOL	17%	18.21%	18.32%	18.73%	Yes	Yes	Yes
PHP	17%	**15.28%**	**16.27%**	17.45%	**No**	**No**	Yes
PRI	17%	30.97%	31.55%	31.76%	Yes	Yes	Yes
THC	17%	**14.26%**	**15.07%**	**14.95%**	**No**	**No**	**No**
UNI	17%	22.63%	22.56%	22.69%	Yes	Yes	Yes
UPP	17%	**13.72%**	**14.26%**	**14.31%**	**No**	**No**	**No**

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.

Minimum Standard
At or above 71% (as shown on bar graph below)

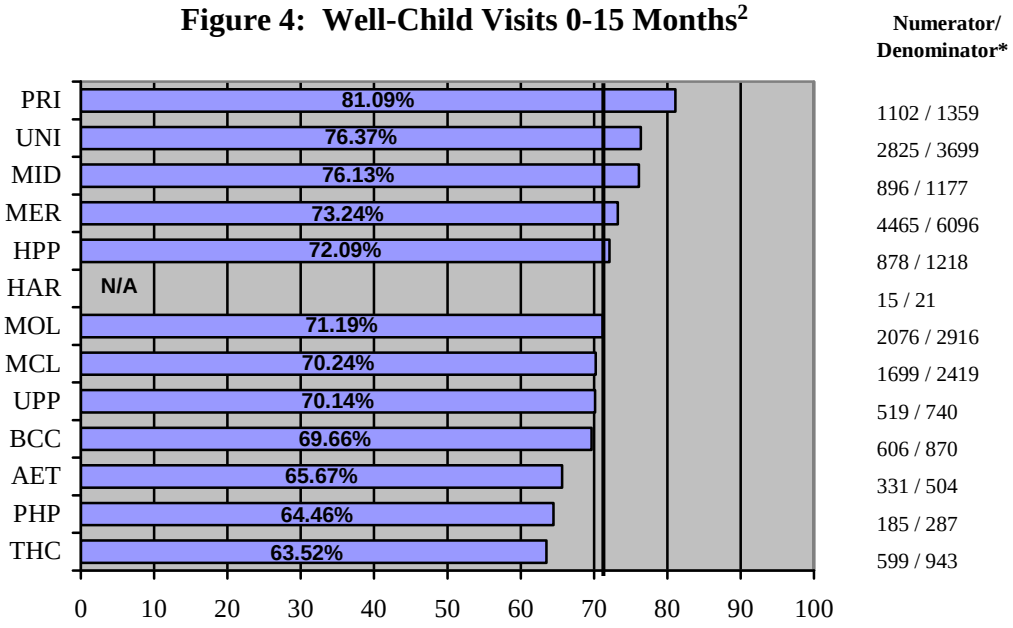
Measurement Period
July 2014 – June 2015

Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

Summary:
Six plans met or exceeded the standard, while six plans (AET, BCC, MCL, PHP, THC, and UPP) did not. Results ranged from 63.52% to 81.09%

Figure 4: Well-Child Visits 0-15 Months[2]



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

[2] 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.

Minimum Standard
At or above 79% (as shown on bar graph below)

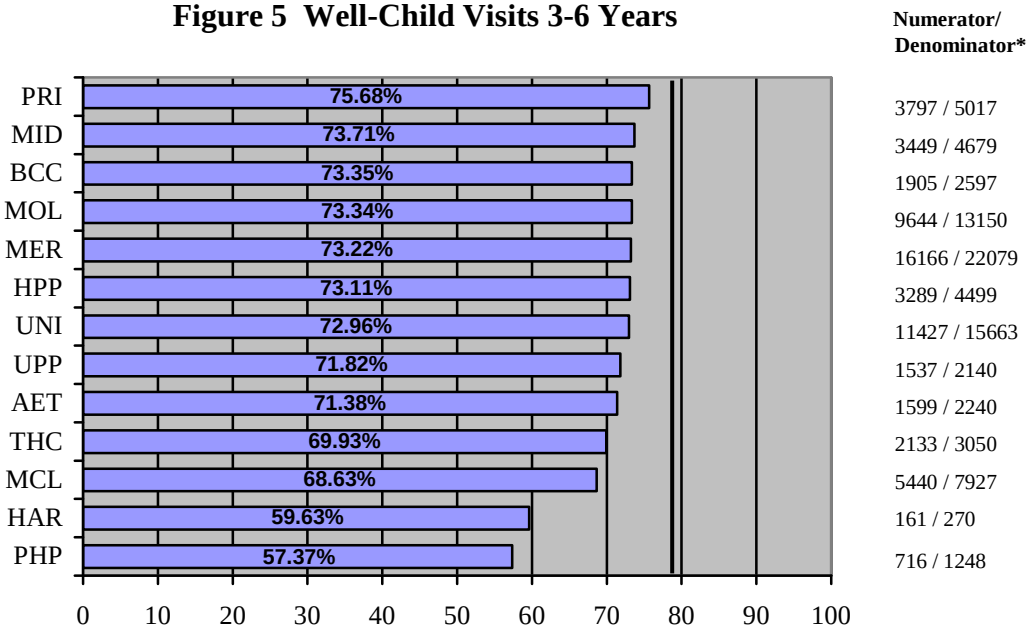
Measurement Period
July 2014 – June 2015

Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

Summary:
None of the plans met or exceeded the standard. Results ranged from 57.37% to 75.68%.

Figure 5 Well-Child Visits 3-6 Years



*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 MDHHS during the measurement period.

Standard
At or below 0.15 complaints per 1,000 member months (as shown on bar graph below)

Measurement Period
July 2015 – September 2015

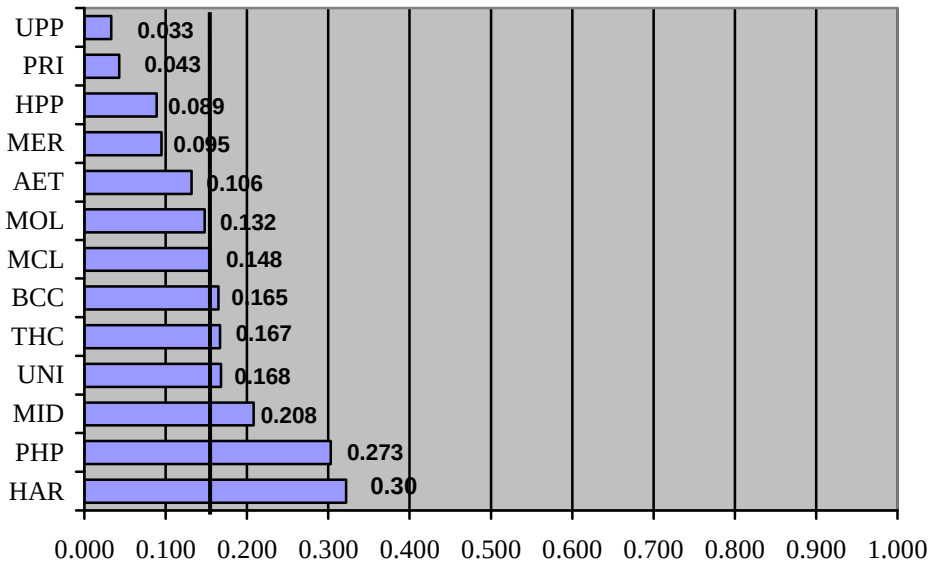
Data Source
Customer Relations System (CRM)

Measurement Frequency
Quarterly

Summary
Seven plans met or exceeded the standard, while six plans (BCC, HAR, MID, PHP, THC, and UNI) did not. The results ranged from 0.033 to 0.303 complaints per 1,000 member months.

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

Figure 6: 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 2015 – October 2015

Data Source
Claims report submitted by health plan

Measurement Frequency
Monthly

Summary
Twelve plans met or exceeded 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 in August, September, and October, while one plan (HAR) did not.

Table 7: Claims Processing August 2015

MHP	Timely	Accurate	≥95%	≤12%	≤1%	Standard Achieved
AET	Yes	Yes	100%	3%	0.00%	Yes
BCC	Yes	Yes	99%	4%	0.01%	Yes
HAR	Yes	**No**	**64%**	0%	**2.40%**	**No**
HPP	Yes	Yes	100%	2%	0.00%	Yes
MCL	Yes	Yes	99%	4%	0.09%	Yes
MER	Yes	Yes	99%	9%	0.00%	Yes
MID	Yes	Yes	99%	0%	0.00%	Yes
MOL	Yes	Yes	100%	3%	0.05%	Yes
PHP	Yes	Yes	99%	0%	0.00%	Yes
PRI	Yes	Yes	100%	5%	0.16%	Yes
THC	Yes	Yes	100%	3%	0.00%	Yes
UNI	Yes	Yes	100%	7%	0.07%	Yes
UPP	Yes	Yes	98%	9%	0.00%	Yes

Table 8: Claims Processing September 2015

MHP	Timely	Accurate	≥95%	≤12%	≤1%	Standard Achieved
AET	Yes	Yes	100%	3%	0.00%	Yes
BCC	Yes	Yes	100%	4%	0.00%	Yes
HAR	Yes	**No**	**50%**	0%	**7.06%**	**No**
HPP	Yes	Yes	100%	4%	0.05%	Yes
MCL	Yes	Yes	100%	4%	0.06%	Yes
MER	Yes	Yes	99%	8%	0.00%	Yes
MID	Yes	Yes	99%	1%	0.00%	Yes
MOL	Yes	Yes	100%	2%	0.19%	Yes
PHP	Yes	Yes	99%	0%	0.06%	Yes
PRI	Yes	Yes	100%	6%	0.02%	Yes
THC	Yes	Yes	100%	2%	0.00%	Yes
UNI	Yes	Yes	100%	6%	0.42%	Yes
UPP	Yes	Yes	98%	9%	0.00%	Yes

Table 9: Claims Processing October 2015

MHP	Timely	Accurate	≥95%	≤12%	≤1%	Standard Achieved
AET	Yes	Yes	98%	2%	0.07%	Yes
BCC	Yes	Yes	100%	5%	0.10%	Yes
HAR	Yes	**No**	**50%**	0%	**5.24%**	**No**
HPP	Yes	Yes	99%	6%	0.03%	Yes
MCL	Yes	Yes	99%	3%	0.15%	Yes
MER	Yes	Yes	100%	9%	0.00%	Yes
MID	Yes	Yes	98%	1%	0.00%	Yes
MOL	Yes	Yes	100%	2%	0.33%	Yes
PHP	Yes	Yes	100%	0%	0.28%	Yes
PRI	Yes	Yes	100%	6%	0.04%	Yes
THC	Yes	Yes	100%	3%	0.00%	Yes
UNI	Yes	Yes	100%	7%	0.21%	Yes
UPP	Yes	Yes	99%	8%	0.00%	Yes

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 MDHHS calculated minimum volume records accepted into the MDHHS data warehouse

Measurement Period
October 2015 – December 2015

Data Source
MDHHS Data Exchange Gateway, MDHHS Data Warehouse

Measurement Frequency
Monthly

Summary
All plans met the standard of submitting a minimum volume of professional and institutional September 2015 adjudicated claims by the 15th of October.
Twelve plans met the standard of submitting a minimum volume of professional and institutional October 2015 adjudicated claims by the 15th of November, while one (AET) did not.
Twelve plans met the standard of submitting a minimum volume of professional and institutional November 2015 adjudicated claims by the 15th of December, while one (MID) did not.

Table 10: Encounter Data Reporting October 2015

MHP	Standard	Timely	Complete		Standard Achieved
		15th of Month	Prof & Inst.	Min. Volume	
AET	Timely, Complete	Yes	Yes	Yes	Yes
BCC	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 November 2015

MHP	Standard	Timely	Complete		Standard Achieved
		15th of Month	Prof & Inst.	Min. Volume	
AET	Timely, Complete	Yes	**No**	**No**	**No**
BCC	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 12: Encounter Data Reporting December 2015

MHP	Standard	Timely	Complete		Standard Achieved
		15th of Month	Prof & Inst.	Min. Volume	
AET	Timely, Complete	Yes	Yes	Yes	Yes
BCC	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	**No**	**No**	**No**
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 2015 – December 2015

Data Source
MDHHS Data Exchange Gateway, Encounter Data

Measurement Frequency
Monthly

Summary[3]
All plans met the standard of submitting a minimum volume of pharmacy September 2015 adjudicated claims by the 15th of October.
All plans met the standard of submitting a minimum volume of pharmacy October 2015 adjudicated claims by the 15th of November.
All plans met the standard of submitting a minimum volume of pharmacy November 2015 adjudicated claims by the 15th of December.

Table 13: Pharmacy Encounter Data Reporting October 2015

MHP	Standard	Timely	Complete	Standard Achieved
		15th of Month	Min. Volume	
AET	Timely, Complete	Yes	Yes	Yes*
BCC	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*

[3] ***All plans will receive a pass for the pharmacy encounter measure for this quarter due to technical issues related to the transition to a new format.***

Table 14: Pharmacy Encounter Data Reporting November 2015

MHP	Standard	Timely	Complete	Standard Achieved
		15th of Month	Min. Volume	
AET	Timely, Complete	Yes	Yes	Yes*
BCC	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*

All plans will receive a pass for the pharmacy encounter measure for this quarter due to technical issues related to the transition to a new format.

Table 15: Pharmacy Encounter Data Reporting December 2015

MHP	Standard	Timely	Complete	Standard Achieved
		15th of Month	Min. Volume	
AET	Timely, Complete	Yes	Yes	Yes*
BCC	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*

All plans will receive a pass for the pharmacy encounter measure for this quarter due to technical issues related to the transition to a new format.

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 2015 – December 2015

Data Source
MDHHS Data Exchange Gateway, Encounter Data

Measurement Frequency
Monthly

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

Table 16: Provider File Reporting

MHP	Standard	Timely			Accurate			Standard Achieved		
		Oct	Nov	Dec	Oct	Nov	Dec	Oct	Nov	Dec
AET	Timely, Complete	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
BCC	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
At or above 80% (as shown on bar graph below)

Measurement Period
April 2015 – June 2015

Data Source
MDHHS Data Warehouse

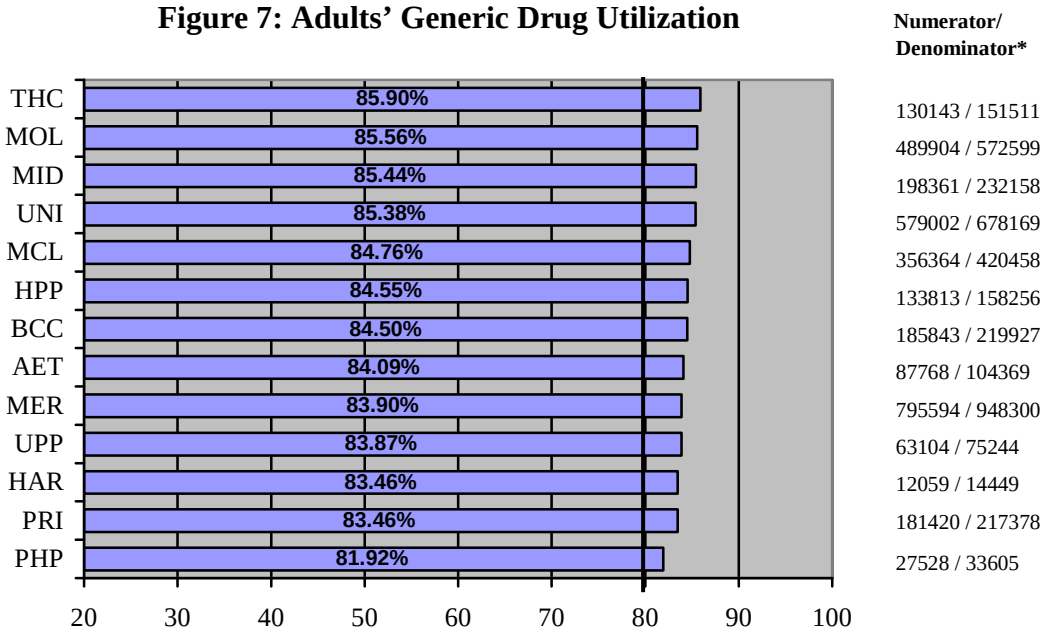
Measurement Frequency
Quarterly

Summary:
All plans met or exceeded the standard. Results ranged from 81.92% to 85.90%.

Table 17: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	3380254	4020176	84.08%
Fee For Service (FFS) only	36164	64575	56.00%
Managed Care only	3264214	3853889	84.70%
MA-MC	1861275	2205899	84.38%
HMP-MC	1385595	1627581	85.13%

Figure 7: 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
At or above 20% (as shown on bar graph below)

Enrollment Dates
January 2015 – March 2015

Data Source
MDHHS Data Warehouse

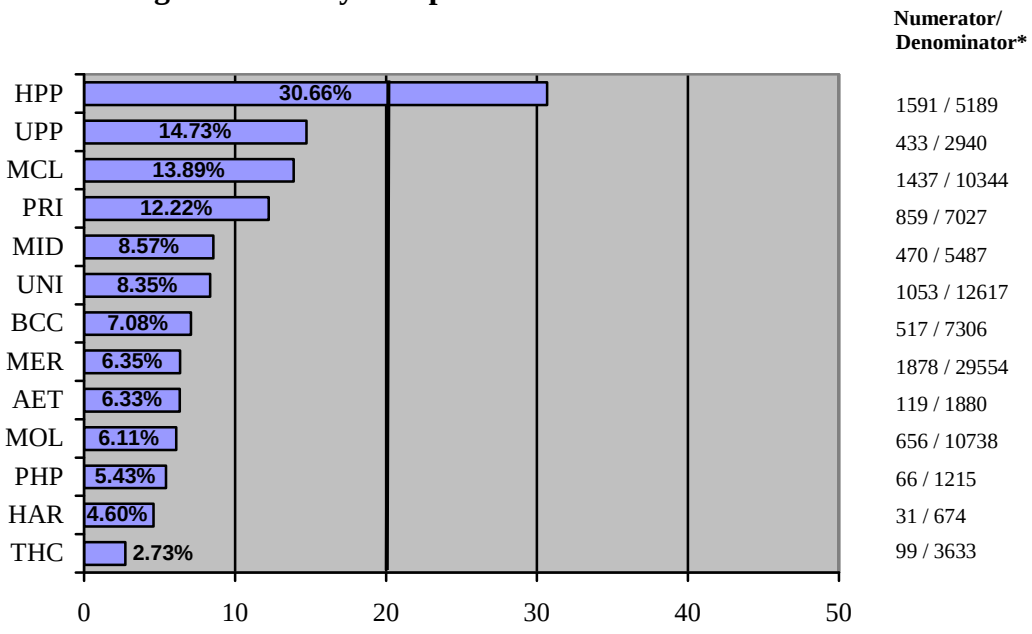
Measurement Frequency
Quarterly

Summary:
One plan met or exceeded the standard, while twelve plans (AET, BCC, HAR, MCL, MER, MID, MOL, PHP, PRI, THC, UNI, and UPP) did not. Results ranged from 2.73% to 30.66%.

Table 18: Program Total[4]

Medicaid Program	Numerator	Denominator	Percentage
HMP-MC	9209	98604	9.34%

Figure 8: Timely Completion of Initial HRA



Timely Completion of Initial HRA Percentages

*Numerator depicts the number of eligible beneficiaries who completed an HRA within 150 days of enrollment in a health plan. Denominator depicts the total number of eligible beneficiaries.

[4] This includes HRAs completed during the HMP FFS period prior to enrollment in a Medicaid health plan.

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
At or above 66% (as shown on bar graph below)

Enrollment Dates
January 2015 – March 2015

Data Source
MDHHS Data Warehouse

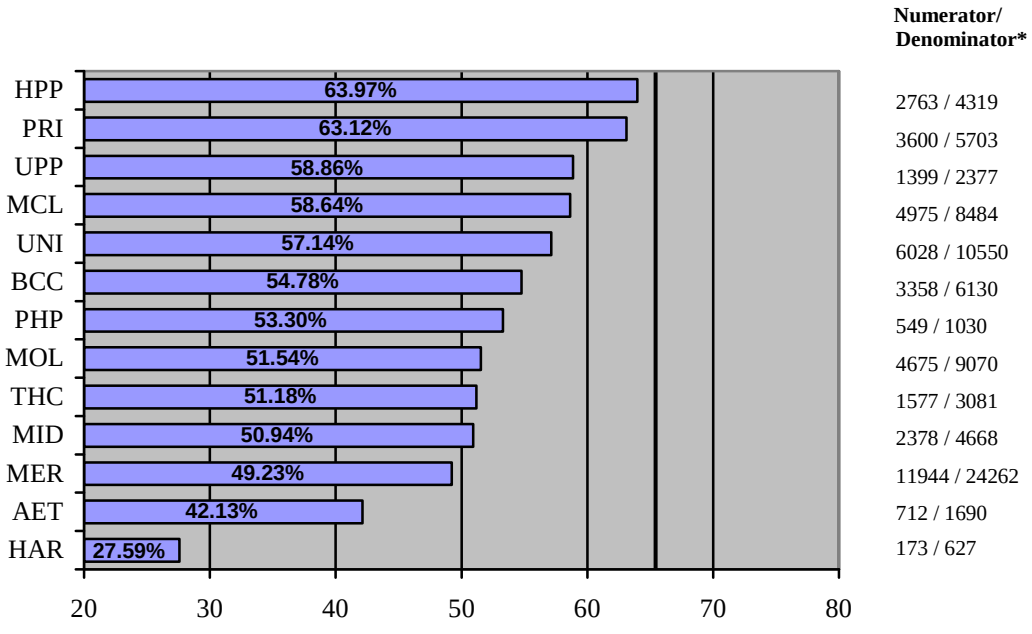
Measurement Frequency
Quarterly

Summary:
None of the plans met or exceeded the standard. Results ranged from 27.59% to 63.97%.

Table 19: Program Total[5]

Medicaid Program	Numerator	Denominator	Percentage
HMP-MC	60769	98629	61.61%

Figure 9: Outreach & Engagement to Facilitate Entry to Primary Care



Outreach & Engagement to Facilitate Entry to Primary Care Percentages

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

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

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
At or below 16% (as shown on bar graph below)

Enrollment Dates
July 2014 – June 2015

Data Source
MDHHS Data Warehouse

Measurement Frequency
Annually

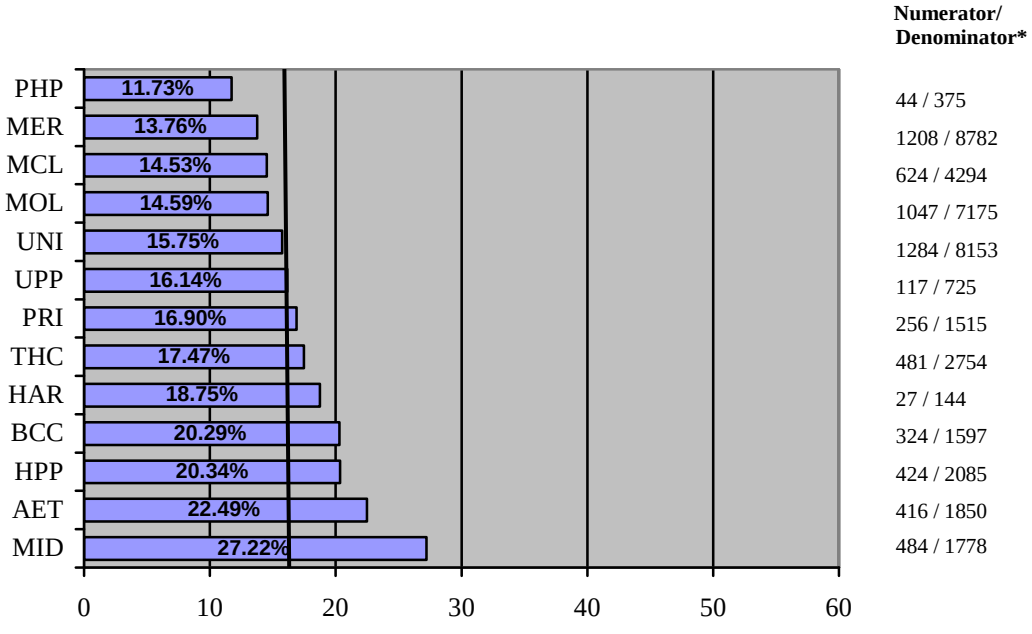
Summary:
Five plans met or exceeded the standard, while eight plans (AET, BCC, HAR, HPP, MID, PRI, THC, and UPP) did not. Results ranged from 11.73% to 27.22%.

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

Table 20: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	10205	63564	16.05%
Fee For Service (FFS) only	550	2805	19.61%
Managed Care only	7228	44209	16.35%
MA-MC	6633	38794	17.10%
HMP-MC	301	2962	10.16%

Figure 10: Plan All-Cause Acute 30-Day Readmissions



Plan All-Cause Acute 30-Day Readmissions Percentages

*Numerator depicts the number of acute readmissions for any diagnosis within 30 days of an Index Discharge Date. Denominator depicts the total number of Index Discharge dates during the measurement year, not enrollees.

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
At or above 87% (as shown on bar graph below)

Measurement Period
July 2014 – June 2015

Data Source
MDHHS Data Warehouse

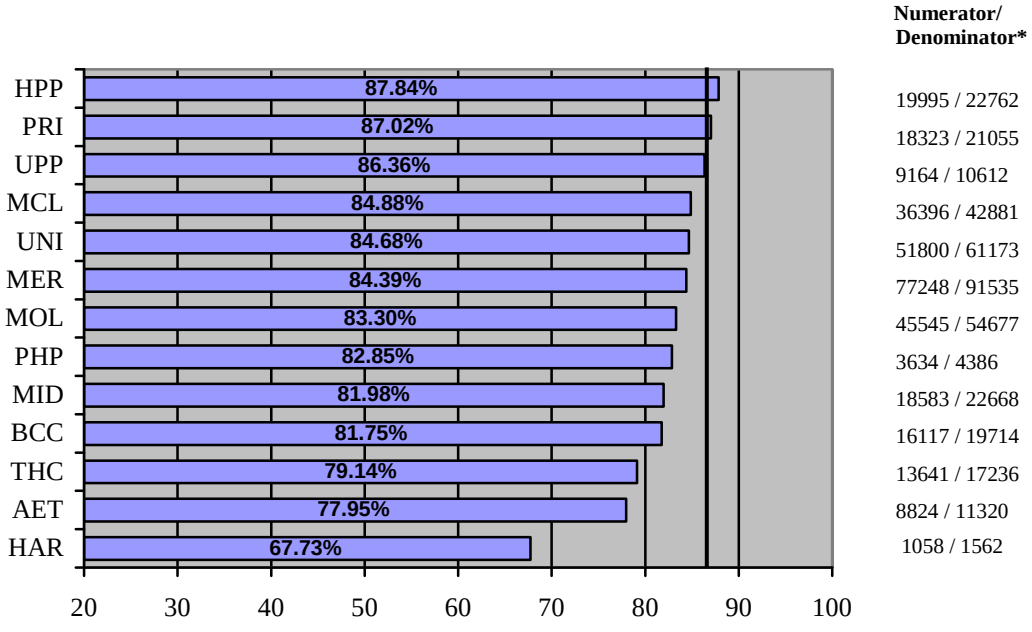
Measurement Frequency
Quarterly

Summary:
Two plans met or exceeded the standard, while eleven plans (AET, BCC, HAR, MCL, MER, MID, MOL, PHP, THC, UNI, UPP) did not. Results ranged from 67.73% to 87.84%.

Table 21: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	500702	615446	81.36%
Fee For Service (FFS) only	9085	16908	53.73%
Managed Care only	332517	395188	84.14%
MA-MC	191632	227686	84.17%
HMP-MC	102154	120823	84.55%

Figure 11: 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
At or above 79% (as shown on bar graph below)

Measurement Period
July 2014 – June 2015

Data Source
MDHHS Data Warehouse

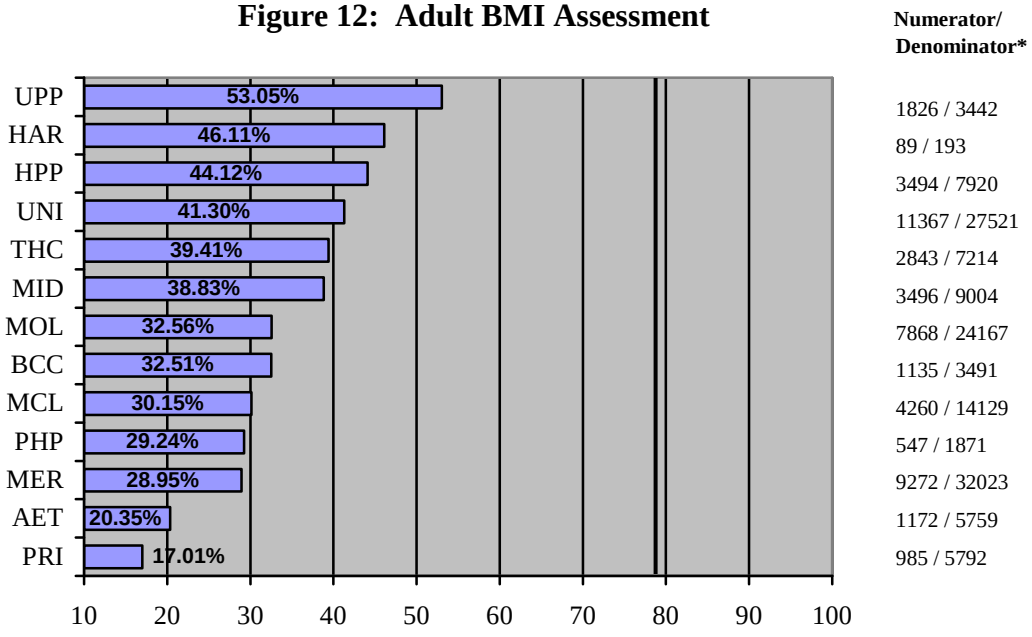
Measurement Frequency
Quarterly

Summary:
None of the plans met or exceeded the standard. Results ranged from 17.01% to 53.05%.

Table 22: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	71818	214601	33.47%
Fee For Service (FFS) only	873	2924	29.86%
Managed Care only	51990	151921	34.22%
MA-MC	45767	131408	34.83%
HMP-MC	N/A	N/A	N/A

Figure 12: Adult BMI Assessment



Adult BMI Assessment Percentages

*Numerator depicts the number of eligible beneficiaries whose BMI was documented during the measurement period or the year prior to the measurement period. 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
At or above 58% (as shown on bar graph below)

Measurement Period
July 2014 – June 2015

Data Source
MDHHS Data Warehouse

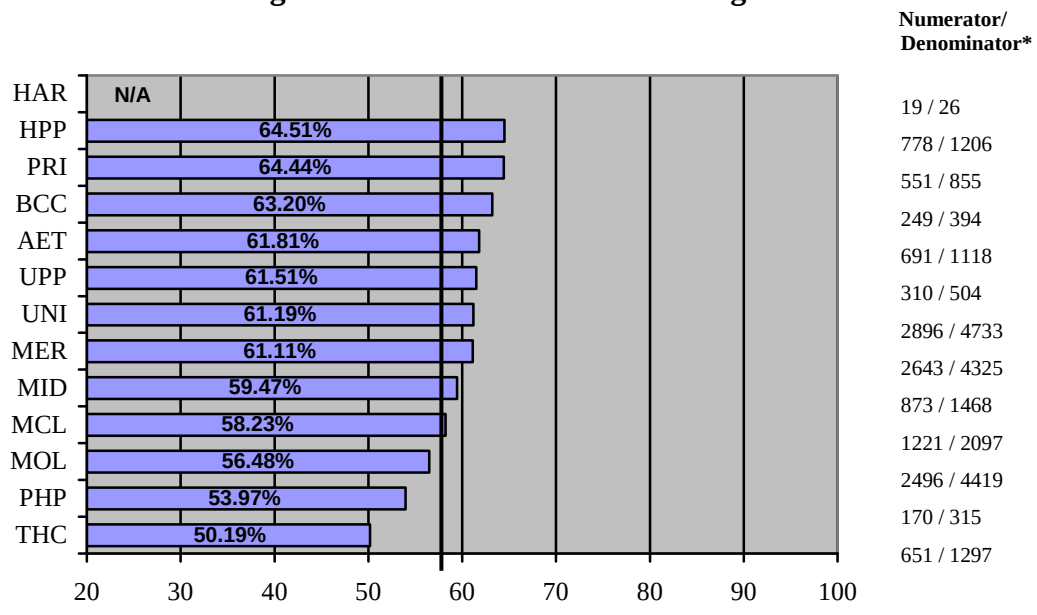
Measurement Frequency
Quarterly

Summary:
Nine plans met or exceeded the standard, while three plans (MOL, PHP, and THC) did not. Results ranged from 50.19% to 64.51%.

Table 23: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	17300	29736	58.18%
Fee For Service (FFS) only	495	972	50.93%
Managed Care only	14471	24337	59.46%
MA-MC	13885	23387	59.37%
HMP-MC	N/A	N/A	N/A

Figure 13: Breast Cancer Screening[6]



Breast Cancer Screening Percentages

*Numerator depicts the number of eligible beneficiaries who had one (1) or more mammograms during the measurement period or the two (2) years prior to the measurement period. 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.

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
At or above 72% (as shown on bar graph below)

Measurement Period
July 2014 – June 2015

Data Source
MDHHS Data Warehouse

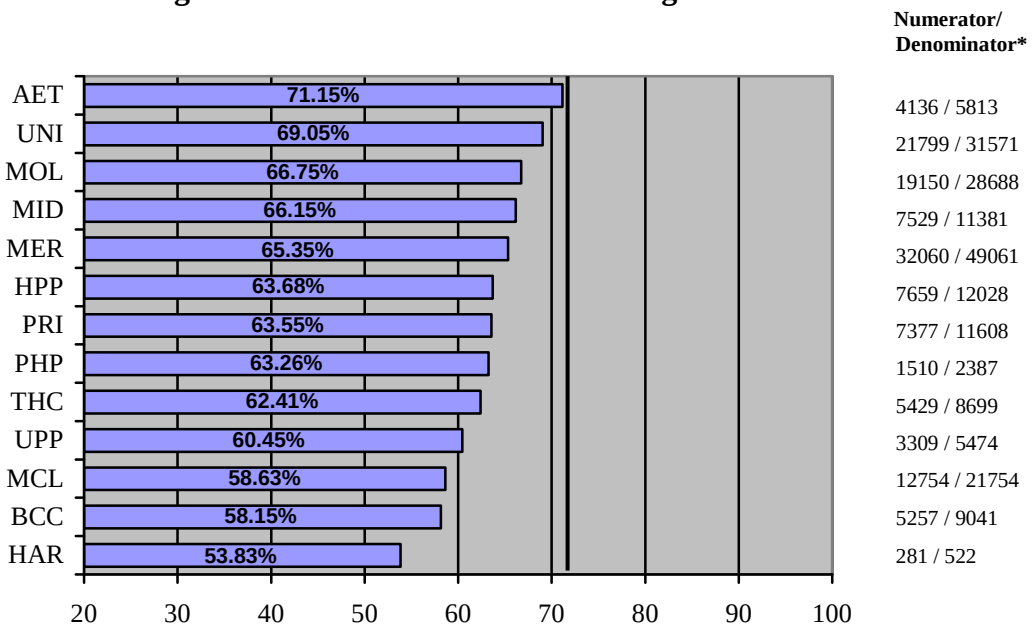
Measurement Frequency
Quarterly

Summary:
None of the plans met or exceeded the standard. Results ranged from 53.83% to 71.15%.

Table 24: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	194357	315859	61.53%
Fee For Service (FFS) only	3610	8799	41.03%
Managed Care only	133515	205801	64.88%
MA-MC	87677	125546	69.84%
HMP-MC	28499	56082	50.82%

Figure 14: 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 2014 – June 2015

Data Source
MDHHS Data Warehouse

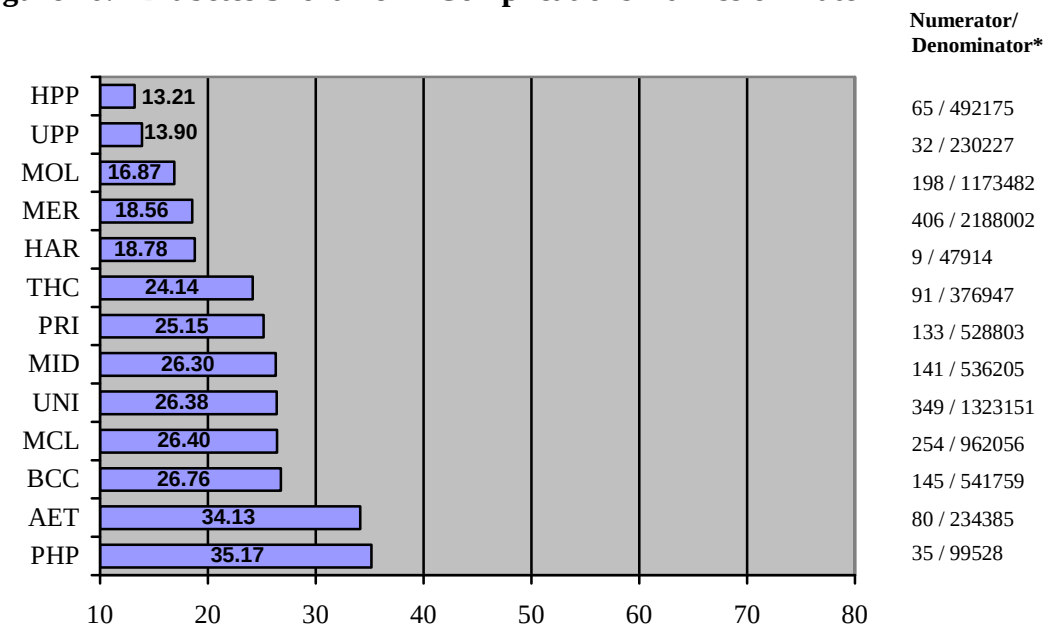
Measurement Frequency
Quarterly

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

Table 25: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Rate
Michigan Medicaid All	2614	10884371	24.02
Fee For Service (FFS) only	675	2146955	31.44
Managed Care only	1939	8737416	22.19
MA-MC	1247	4594409	27.14
HMP-MC	692	4143007	16.70

Figure 16: Diabetes Short-Term Complications Admission Rate



Diabetes Short-Term Complications Admission Rate

*Numerator depicts the total number of eligible beneficiaries who were discharged for diabetes short-term complications of diabetes. Denominator depicts the total number of months of health plan enrollment for eligible beneficiaries during the measurement period.

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 2014 – June 2015

Data Source
MDHHS Data Warehouse

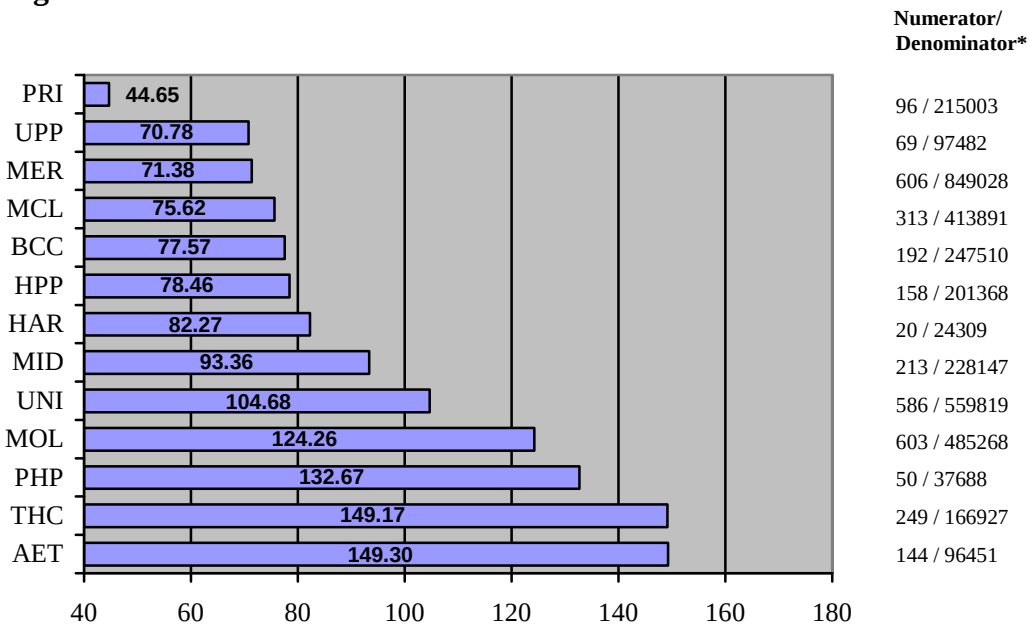
Measurement Frequency
Quarterly

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

Table 26: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Rate
Michigan Medicaid All	3878	4407891	87.98
Fee For Service (FFS) only	578	784071	73.72
Managed Care only	3300	3623820	91.06
MA-MC	2605	1709503	152.38
HMP-MC	695	1914317	36.31

Figure 16: COPD or Asthma in Older Adults Admission Rate



*Numerator depicts the number of discharges for COPD, asthma, or a primary diagnosis of acute bronchitis accompanied by any secondary diagnosis of COPD. Denominator depicts the total number of member months of health plan enrollment for eligible beneficiaries during the measurement period.

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 2014 – June 2015

Data Source
MDHHS Data Warehouse

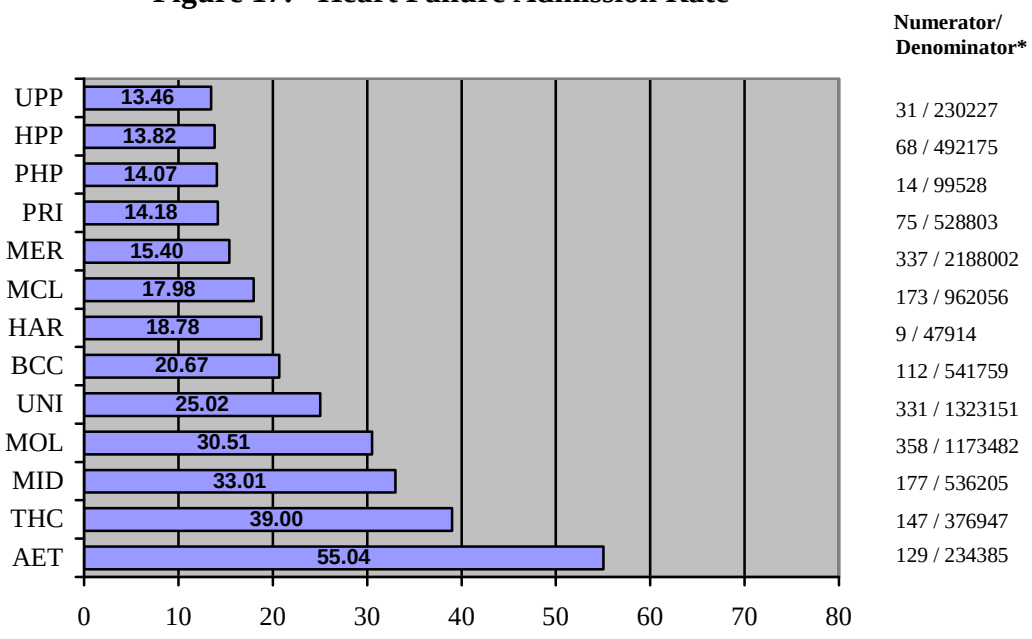
Measurement Frequency
Quarterly

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

Table 27: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Rate
Michigan Medicaid All	2514	10884371	23.10
Fee For Service (FFS) only	551	2146955	25.66
Managed Care only	1963	8737416	22.47
MA-MC	1555	4594409	33.85
HMP-MC	408	4143007	9.85

Figure 17: Heart Failure Admission Rate



Heart Failure Admission Rate

*Numerator depicts the number of eligible beneficiaries who were discharged for heart failure. Denominator depicts the total number of months of health plan enrollment for eligible beneficiaries during the measurement period.

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 2014 – June 2015

Data Source
MDHHS Data Warehouse

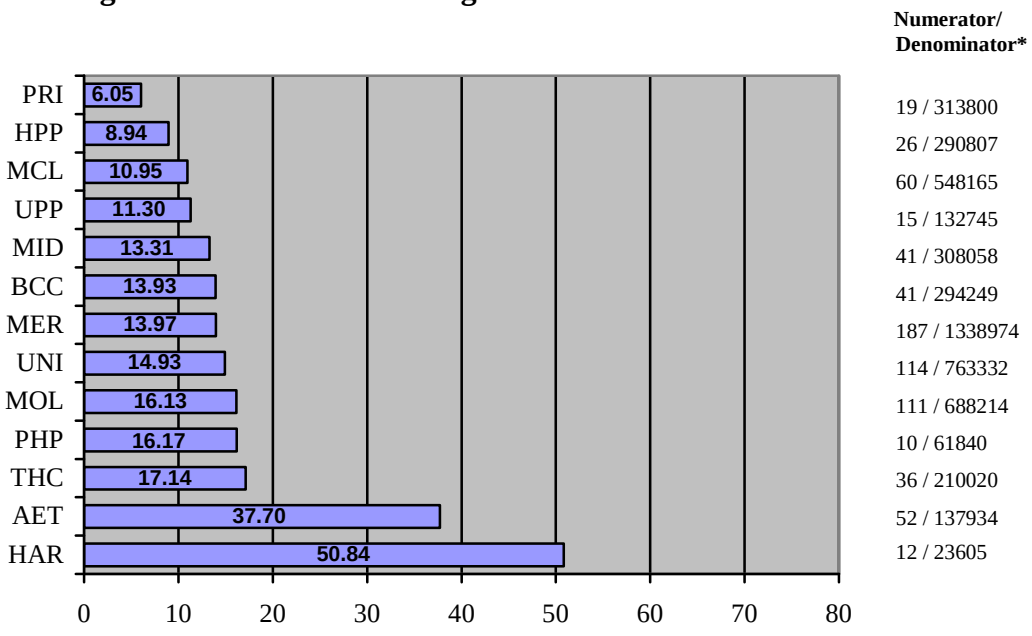
Measurement Frequency
Quarterly

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

Table 28: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Rate
Michigan Medicaid All	933	6476480	14.41
Fee For Service (FFS) only	209	1362884	15.34
Managed Care only	724	5113596	14.16
MA-MC	515	2884906	17.85
HMP-MC	209	2228690	9.38

Figure 18: Asthma in Younger Adults Admission Rate



Asthma in Younger Adults Admission Rate

*Numerator depicts the number of eligible beneficiaries who were discharged for asthma. Denominator depicts the total number of member months of health plan enrollment for eligible beneficiaries during the measurement period.

Chlamydia Screening in Woman

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
At or above 71% (as shown on bar graph below)

Measurement Period
July 2014 – June 2015

Data Source
MDHHS Data Warehouse

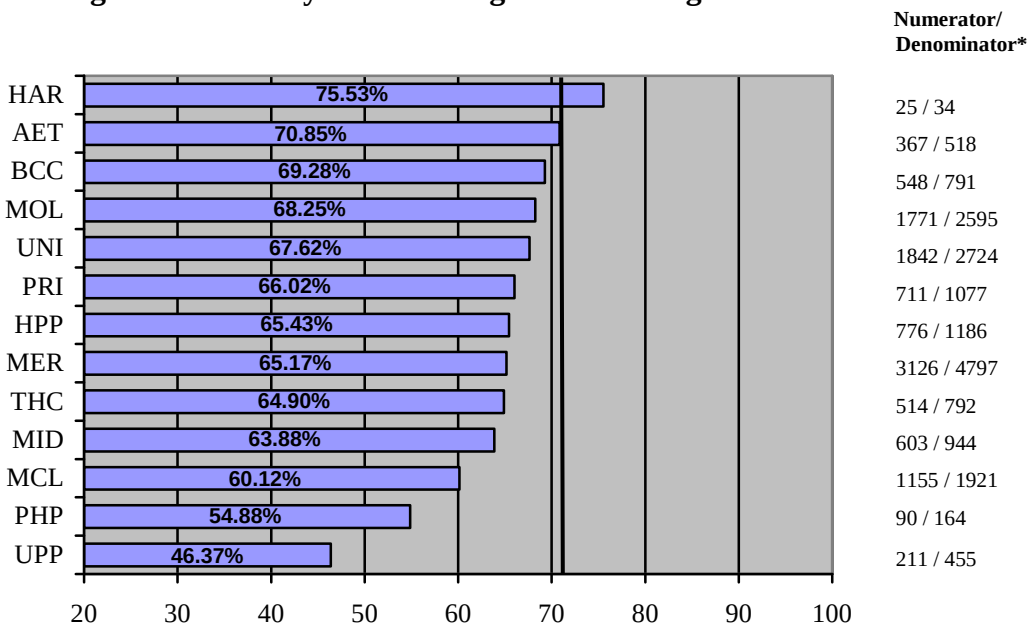
Measurement Frequency
Quarterly

Summary:
One plan met or exceeded the standard, while twelve plans (AET, BCC, HPP, MCL, MER, MID, MOL, PHP, PRI, THC, UNI, and UPP) did not. Results ranged from 46.37% to 75.53%.

Table 29: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	22750	34943	65.11%
Fee For Service (FFS) only	358	736	48.64%
Managed Care only	12309	18805	65.46%
MA-MC	7811	11661	66.98%
HMP-MC	2730	4460	61.21%

Figure 19: Chlamydia Screening in Women Ages 21 to 24[7]



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.

[7] 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
At or above 87% (as shown on bar graph below)

Measurement Period
July 2014 – June 2015

Data Source
MDHHS Data Warehouse

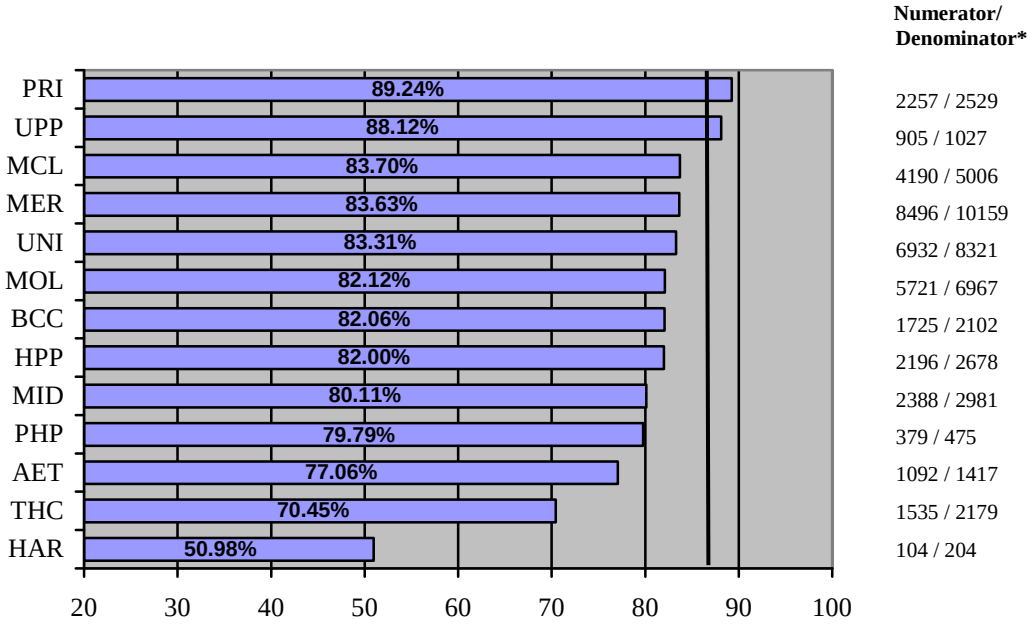
Measurement Frequency
Quarterly

Summary:
Two plans met or exceeded the standard, while eleven plans (AET, BCC, HAR, HPP, MCL, MER, MID, MOL, PHP, THC, UNI) did not. Results ranged from 50.98% to 89.24%.

Table 30: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	52507	64581	81.30%
Fee For Service (FFS) only	1462	1998	73.17%
Managed Care only	39366	47805	82.35%
MA-MC	25631	31572	81.18%
HMP-MC	11176	13084	85.42%

Figure 20: 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 during the measurement period. 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 for this quarter.

Measurement Period
April 2014 – March 2015

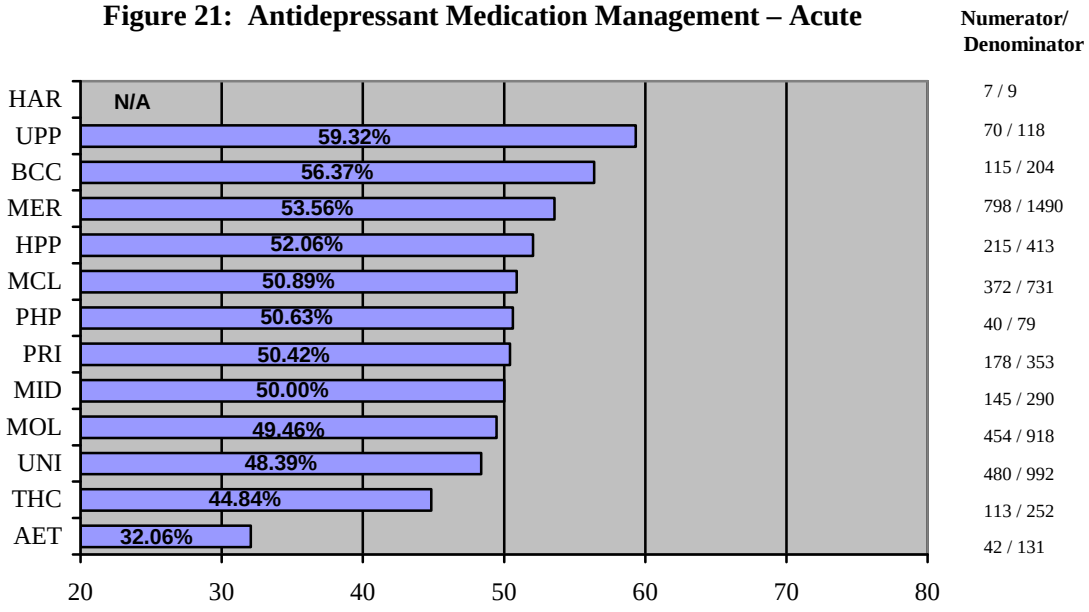
Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

Table 31: Comparison across Medicaid Programs – Acute

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	5667	10558	53.67%
Fee For Service (FFS) only	174	304	57.24%
Managed Care only	3049	6020	50.65%
MA-MC	2336	4797	48.70%
HMP-MC	409	665	61.50%

Figure 21: Antidepressant Medication Management – Acute

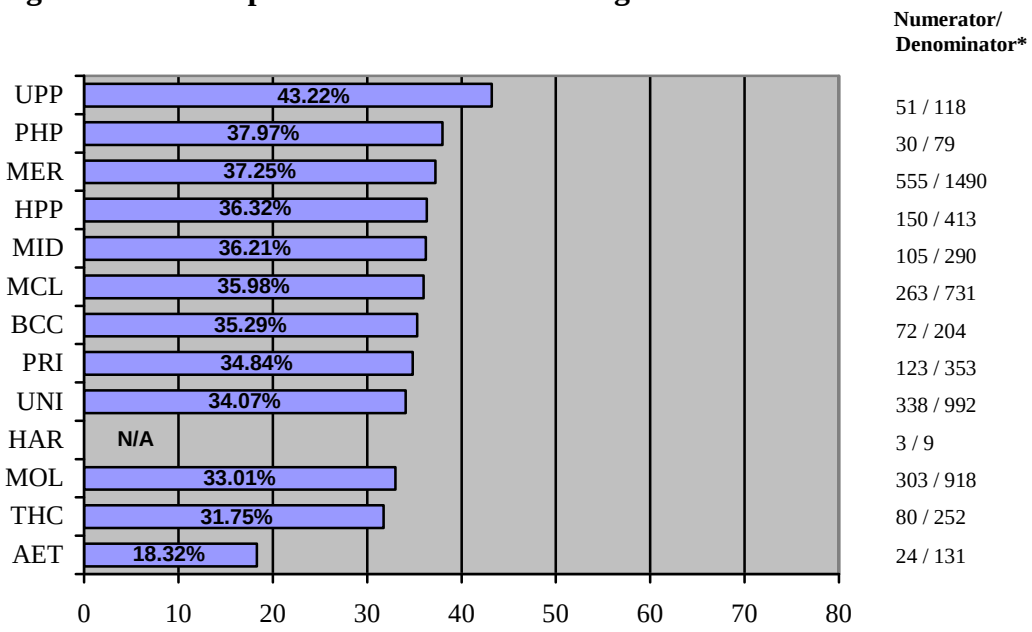


Antidepressant Medication Management – Acute Percentages
*Numerator depicts the number of eligible beneficiaries who remained on an antidepressant medication for at least 84 days (12 weeks). Denominator depicts the total number of eligible beneficiaries.

Table 32: Comparison across Medicaid Programs - Continuous

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	4076	10558	38.61%
Fee For Service (FFS) only	143	304	47.04%
Managed Care only	2109	6020	35.03%
MA-MC	1563	4797	32.58%
HMP-MC	336	665	50.53%

Figure 22: 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
- Total rate for annual monitoring for enrollees on persistent medications

Standard
At or above 87% - for the ***Total Rate***

Measurement Period
April 2014 – March 2015

Data Source
MDHHS Data Exchange Gateway, Encounter Data

Measurement Frequency
Quarterly

Summary:
None of the plans met or exceeded the standard. Results ranged from 72.56% to 85.45%.

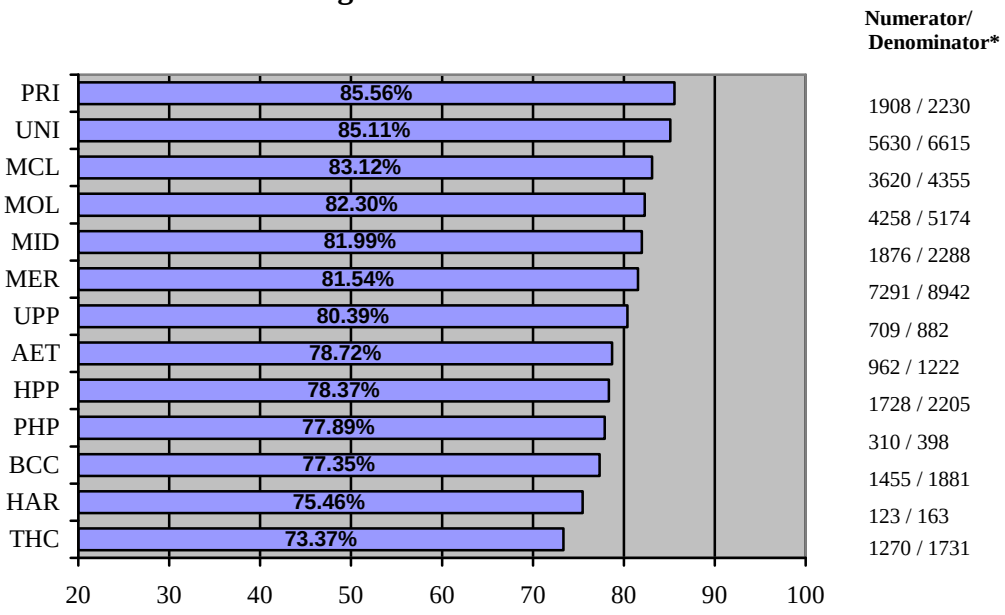
See next page for tables and figures

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

Table 33: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	40696	49795	81.73%
Fee For Service (FFS) only	553	674	82.05%
Managed Care only	32179	39326	81.83%
MA-MC	18785	22679	82.83%
HMP-MC	11282	14064	80.22%

Figure 23: Annual monitoring for enrollees on ACE inhibitors or ARB



Annual monitoring for enrollees on ACE inhibitors or ARB Percentages

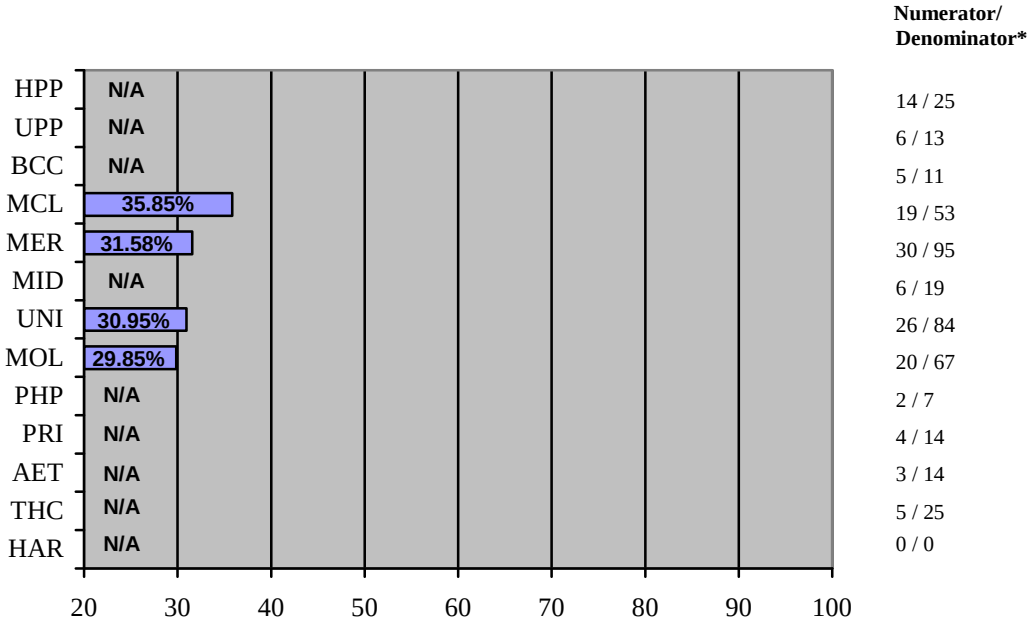
*Numerator depicts the number of eligible beneficiaries who received annual monitoring while on ACE inhibitors or ARB. Denominator depicts the total number of eligible beneficiaries.

Annual monitoring for enrollees on digoxin:

Table 34: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	169	490	34.49%
Fee For Service (FFS) only	1	5	N/A
Managed Care only	146	436	33.49%
MA-MC	117	346	33.82%
HMP-MC	22	73	30.14%

Figure 24: Annual monitoring for enrollees on Digoxin[8]



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.

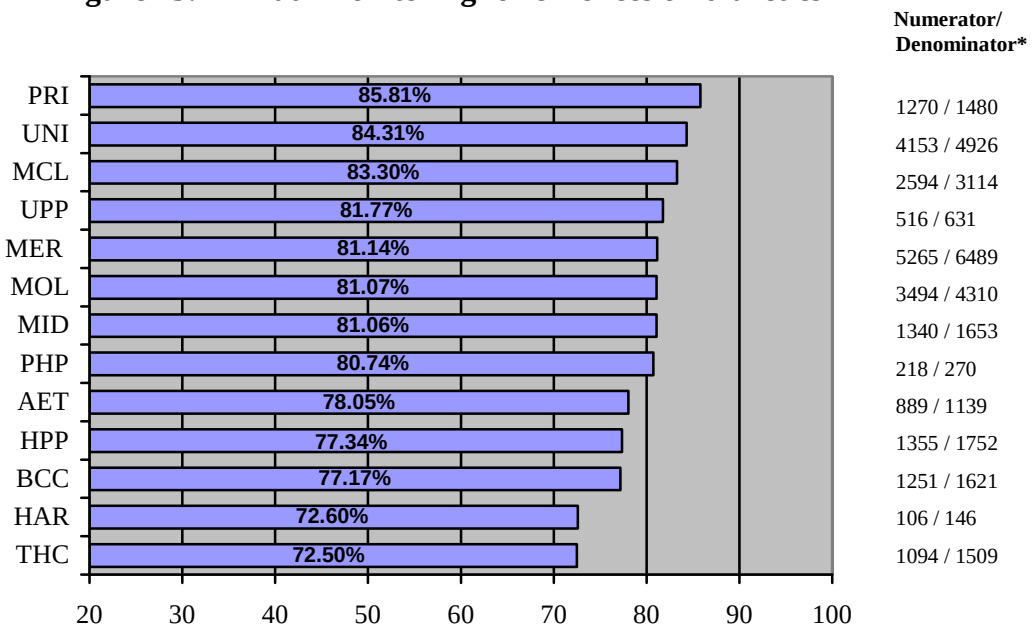
[8] A rate was not calculated for plans with a numerator under 5 or a denominator under 30.

Annual monitoring for enrollees on diuretic:

Table 35: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	30538	37691	81.02%
Fee For Service (FFS) only	376	462	81.39%
Managed Care only	24334	29999	81.12%
MA-MC	14439	17602	82.03%
HMP-MC	8335	10463	79.66%

Figure 25: Annual monitoring for enrollees on diuretics



Annual monitoring for enrollees on diuretics Percentages

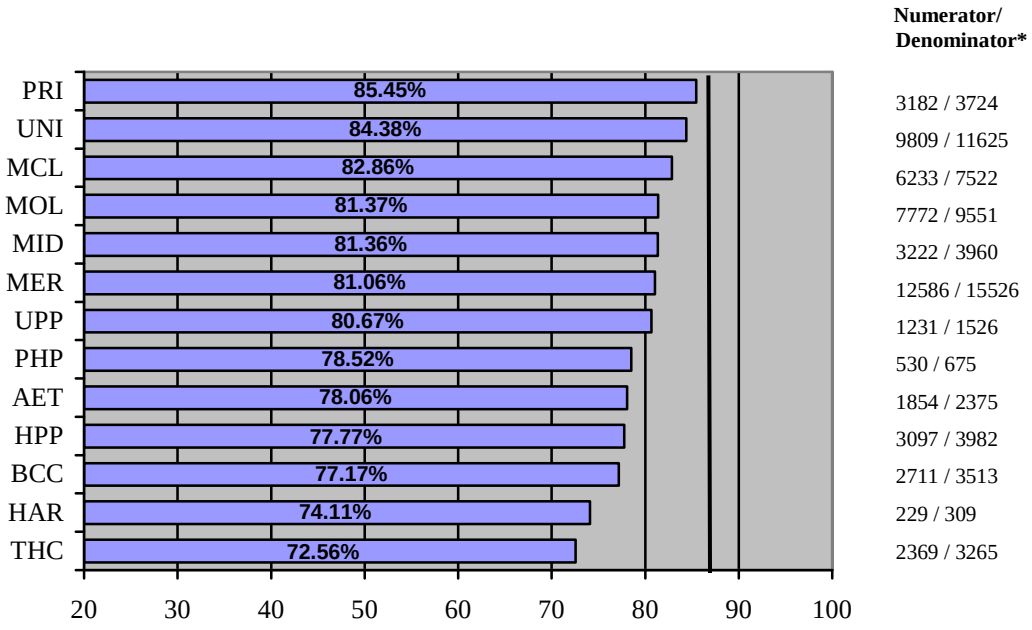
*Numerator depicts the number of eligible beneficiaries who received annual monitoring while on diuretics. Denominator depicts the total number of eligible beneficiaries.

A total rate will also be calculated:

Table 36: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	71403	87976	81.16%
Fee For Service (FFS) only	930	1141	81.51%
Managed Care only	56659	69761	81.22%
MA-MC	33341	40627	82.07%
HMP-MC	19639	24600	79.83%

Figure 26: Annual monitoring for enrollees on persistent medications – Total Rate



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 MDHHS identifying each Medicaid Health Plan.

AET	Aetna Better Health of Michigan
BCC	Blue Cross Complete of Michigan, Inc.
HAR	Harbor Health Plan, Inc.
MCL	McLaren Health Plan
MER	Meridian Health Plan
MID	HAP Midwest Health Plan, Inc.
MOL	Molina Healthcare of Michigan
PRI	Priority Health Choice
THC	Total Health Care
UNI	UnitedHealthcare Community Plan
UPP	Upper Peninsula Health Plan

Appendix B: One Year Plan-Specific Analysis

Aetna Better Health of Michigan – AET

MEDICAID MANAGED CARE:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Childhood Immunizations	Jul 14 – Jun 15	N/A	N/A	N/A
Elective Delivery	Jul 14 – Jun 15	N/A	N/A	N/A
Postpartum Care	Jul 14 – Jun 15	70%	43.08%	No
Blood Lead Testing	Oct 15	81%	74%	No
	Nov 15	81%	73%	No
	Dec 15	81%	71%	No

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 15	19%	19.67%	Yes	23%	21.50%	No	17%	15.74%	No
	Nov 15	19%	19.16%	Yes	23%	21.47%	No	17%	15.72%	No
	Dec 15	19%	20.40%	Yes	23%	21.38%	No	17%	14.96%	No

Well-Child 0-15 Months	Jul 14 – Jun 15	71%	65.67%	No
Well-Child 3-6 Years	Jul 14 – Jun 15	79%	71.38%	No
Complaints	Jul 15 – Sep 15	<.15/1000 MM	0.106	Yes

MM = Member Months ***This is a reverse measure. A lower rate indicates better performance.***

Claims Processing	Aug 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 3%, 0.00%	Yes
	Sep 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 3%, 0.00%	Yes
	Oct 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 98%, 2%, 0.07%	Yes

T = Timely; A = Accurate; NT = Not Timely; NA = Not Accurate

Encounter Data	Oct 15	Timely, Complete	T, C	Yes
	Nov 15	Timely, Complete	T, NC	No
	Dec 15	Timely, Complete	T, C	Yes

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

Performance Monitoring Report

Aetna Better Health of Michigan – AET

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Pharmacy Encounter Data	**Oct 15**	**Timely, Complete**	**T, C**	**Yes***
	Nov 15	**Timely, Complete**	**T, C**	**Yes***
	Dec 15	**Timely, Complete**	**T, C**	**Yes***

All Plans received a pass for the Pharmacy Encounter measure this quarter due to technical issues related to the transition to a new format.

Provider File Reporting	**Oct 15**	**Timely, Accurate**	**T, A**	**Yes**
	Nov 15	**Timely, Accurate**	**T, A**	**Yes**
	Dec 15	**Timely, Accurate**	**T, A**	**Yes**

T = Timely; A = Accurate; NT = Not Timely; NA = Not Accurate

HEALTHY MICHIGAN PLAN:

Adults' Generic Drug Utilization	**Apr 15 – Jun 15**	**80%**	**84.09%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**20%**	**6.33%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**66%**	**42.13%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**22.49%**	**No**

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

Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**87%**	**77.95%**	**No**

ADULT CORE SET MEASURES:

Adult BMI Assessment	**Jul 14 – Jun 15**	**79%**	**20.35%**	**No**
Breast Cancer Screening	**Jul 14 – Jun 15**	**58%**	**61.81%**	**Yes**
Cervical Cancer Screening	**Jul 14 – Jun 15**	**72%**	**71.15%**	**No**
Diabetes Short-Term Complications Admission Rate	**Jul 14 – Jun 15**	**N/A**	**34.13**	**N/A**

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

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

Performance Monitoring Report

Aetna Better Health of Michigan – AET

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
COPD/Asthma in Older Adults Admission Rate	**Jul 14 – Jun 15**	**N/A**	**149.30**	**N/A**
This is a reverse measure. A lower rate indicates better performance.				
Heart Failure Admission Rate	**Jul 14 – Jun 15**	**N/A**	**55.04**	**N/A**
This is a reverse measure. A lower rate indicates better performance.				
Asthma in Younger Adults Admission Rate	**Jul 14 – Jun 15**	**N/A**	**37.70**	**N/A**
This is a reverse measure. A lower rate indicates better performance.				
Chlamydia Screening	**Jul 14 – Jun 15**	**71%**	**70.85%**	**No**
Diabetes Care: Hemoglobin A1c Testing	**Jul 14 – Jun 15**	**87%**	**77.06%**	**No**
Antidepressant Medication Management (Acute)	**Jul 14 – Jun 15**	**N/A**	**32.06%**	**N/A**
Antidepressant Medication Management (Continuous)	**Jul 14 – Jun 15**	**N/A**	**18.32%**	**N/A**
Annual Monitoring for Patients on Persistent Medications (Total)	**Jul 14 – Jun 15**	**87%**	**78.06%**	**No**

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

Appendix B: One Year Plan-Specific Analysis

Blue Cross Complete of Michigan, Inc. – BCC

MEDICAID MANAGED CARE:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Childhood Immunizations	Jul 14 – Jun 15	N/A	N/A	N/A
Elective Delivery	Jul 14 – Jun 15	N/A	N/A	N/A
Postpartum Care	Jul 14 – Jun 15	70%	51.67%	No
Blood Lead Testing	Oct 15	81%	67%	No
	Nov 15	81%	69%	No
	Dec 15	81%	69%	No

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 15	19%	37.98%	Yes	23%	44.90%	Yes	17%	34.46%	Yes
	Nov 15	19%	37.48%	Yes	23%	45.34%	Yes	17%	34.79%	Yes
	Dec 15	19%	38.01%	Yes	23%	45.85%	Yes	17%	35.49%	Yes

Well-Child 0-15 Months	Jul 14 – Jun 15	71%	69.66%	No
Well-Child 3-6 Years	Jul 14 – Jun 15	79%	73.35%	No
Complaints	Jul 15 – Sep 15	<.15/1000 MM	0.165	No

MM = Member Months ***This is a reverse measure. A lower rate indicates better performance.***

Claims Processing	Aug 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 99%, 4%, 0.01%	Yes
	Sep 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 4%, 0.00%	Yes
	Oct 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 5%, 0.10%	Yes

T = Timely; A = Accurate; NT = Not Timely; NA = Not Accurate

Encounter Data	Oct 15	Timely, Complete	T, C	Yes
	Nov 15	Timely, Complete	T, C	Yes
	Dec 15	Timely, Complete	T, C	Yes

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

Performance Monitoring Report

Blue Cross Complete of Michigan, Inc. – BCC

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Pharmacy Encounter Data	**Oct 15**	**Timely, Complete**	**T, C**	**Yes***
	Nov 15	**Timely, Complete**	**T, C**	**Yes***
	Dec 15	**Timely, Complete**	**T, C**	**Yes***

All Plans received a pass for the Pharmacy Encounter measure this quarter due to technical issues related to the transition to a new format.

Provider File Reporting	**Oct 15**	**Timely, Accurate**	**T, A**	**Yes**
	Nov 15	**Timely, Accurate**	**T, A**	**Yes**
	Dec 15	**Timely, Accurate**	**T, A**	**Yes**

T = Timely; A = Accurate; NT = Not Timely; NA = Not Accurate

HEALTHY MICHIGAN PLAN:

Adults' Generic Drug Utilization	**Apr 15 – Jun 15**	**80%**	**84.50%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**20%**	**7.08%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**66%**	**54.78%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**20.29%**	**No**

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

Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**87%**	**81.75%**	**No**

ADULT CORE SET MEASURES:

Adult BMI Assessment	**Jul 14 – Jun 15**	**79%**	**32.51%**	**No**
Breast Cancer Screening	**Jul 14 – Jun 15**	**58%**	**63.20%**	**Yes**
Cervical Cancer Screening	**Jul 14 – Jun 15**	**72%**	**58.15%**	**No**
Diabetes Short-Term Complications Admission Rate	**Jul 14 – Jun 15**	**N/A**	**26.76**	**N/A**

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

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

Performance Monitoring Report

Blue Cross Complete of Michigan, Inc. – BCC

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
COPD/Asthma in Older Adults Admission Rate	**Jul 14 – Jun 15**	**N/A**	**77.57**	**N/A**
***This is a reverse measure. A lower rate indicates better performance.**				
Heart Failure Admission Rate	**Jul 14 – Jun 15**	**N/A**	**20.67**	**N/A**
***This is a reverse measure. A lower rate indicates better performance.**				
Asthma in Younger Adults Admission Rate	**Jul 14 – Jun 15**	**N/A**	**13.93**	**N/A**
***This is a reverse measure. A lower rate indicates better performance.**				
Chlamydia Screening	**Jul 14 – Jun 15**	**71%**	**69.28%**	**No**
Diabetes Care: Hemoglobin A1c Testing	**Jul 14 – Jun 15**	**87%**	**82.06%**	**No**
Antidepressant Medication Management (Acute)	**Jul 14 – Jun 15**	**N/A**	**56.37%**	**N/A**
Antidepressant Medication Management (Continuous)	**Jul 14 – Jun 15**	**N/A**	**35.29%**	**N/A**
Annual Monitoring for Patients on Persistent Medications (Total)	**Jul 14 – Jun 15**	**87%**	**77.17%**	**No**

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

Appendix B: One Year Plan-Specific Analysis

Harbor Health Plan, Inc. – HAR

MEDICAID MANAGED CARE:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Childhood Immunizations	Jul 14 – Jun 15	N/A	N/A	N/A
Elective Delivery	Jul 14 – Jun 15	N/A	N/A	N/A
Postpartum Care	Jul 14 – Jun 15	70%	29.17%	No
Blood Lead Testing	Oct 15	81%	64%	No
	Nov 15	81%	66%	No
	Dec 15	81%	66%	No

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 15	19%	14.81%	No	23%	20.75%	No	17%	12.82%	No
	Nov 15	19%	14.81%	No	23%	20.37%	No	17%	11.11%	No
	Dec 15	19%	17.86%	No	23%	17.24%	No	17%	10.77%	No

Well-Child 0-15 Months	Jul 14 – Jun 15	71%	N/A	N/A

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

Well-Child 3-6 Years	Jul 14 – Jun 15	79%	59.63%	No

Complaints	Jul 15 – Sep 15	<.15/1000 MM	0.303	No

MM = Member Months ***This is a reverse measure. A lower rate indicates better performance.***

Claims Processing	Aug 15	T/A, ≥95%, ≤12%, ≤1.0%	T/NA, 64%, 0%, 2.40%	No
	Sep 15	T/A, ≥95%, ≤12%, ≤1.0%	T/NA, 50%, 0%, 7.06%	No
	Oct 15	T/A, ≥95%, ≤12%, ≤1.0%	T/NA, 50%, 0%, 5.24%	No

T = Timely; A = Accurate; NT = Not Timely; NA = Not Accurate

Encounter Data	Oct 15	Timely, Complete	T, C	Yes
	Nov 15	Timely, Complete	T, C	Yes
	Dec 15	Timely, Complete	T, C	Yes

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

Performance Monitoring Report

Harbor Health Plan, Inc. – HAR

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Pharmacy Encounter Data	**Oct 15**	**Timely, Complete**	**T, C**	**Yes***
	Nov 15	**Timely, Complete**	**T, C**	**Yes***
	Dec 15	**Timely, Complete**	**T, C**	**Yes***

All Plans received a pass for the Pharmacy Encounter measure this quarter due to technical issues related to the transition to a new format.

Provider File Reporting	**Oct 15**	**Timely, Accurate**	**T, A**	**Yes**
	Nov 15	**Timely, Accurate**	**T, A**	**Yes**
	Dec 15	**Timely, Accurate**	**T, A**	**Yes**

T = Timely; A = Accurate; NT = Not Timely; NA = Not Accurate

HEALTHY MICHIGAN PLAN:

Adults' Generic Drug Utilization	**Apr 15 – Jun 15**	**80%**	**83.46%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**20%**	**4.60%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**66%**	**27.59%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**18.75%**	**No**

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

Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**87%**	**67.73%**	**No**

ADULT CORE SET MEASURES:

Adult BMI Assessment	**Jul 14 – Jun 15**	**79%**	**46.11%**	**No**
Breast Cancer Screening	**Jul 14 – Jun 15**	**58%**	**N/A**	**N/A**

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

Cervical Cancer Screening	**Jul 14 – Jun 15**	**72%**	**53.83%**	**No**
Diabetes Short-Term Complications Admission Rate	**Jul 14 – Jun 15**	**N/A**	**18.78**	**N/A**

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

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

Performance Monitoring Report

Harbor Health Plan, Inc. – HAR

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
COPD/Asthma in Older Adults Admission Rate	**Jul 14 – Jun 15**	**N/A**	**82.27**	**N/A**

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

Heart Failure Admission Rate	**Jul 14 – Jun 15**	**N/A**	**18.78**	**N/A**

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

Asthma in Younger Adults Admission Rate	**Jul 14 – Jun 15**	**N/A**	**50.84**	**N/A**

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

Chlamydia Screening	**Jul 14 – Jun 15**	**71%**	**75.53%**	**Yes**

Diabetes Care: Hemoglobin A1c Testing	**Jul 14 – Jun 15**	**87%**	**50.98%**	**No**

Antidepressant Medication Management (Acute)	**Jul 14 – Jun 15**	**N/A**	**N/A**	**N/A**

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

Antidepressant Medication Management (Continuous)	**Jul 14 – Jun 15**	**N/A**	**N/A**	**N/A**

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

Annual Monitoring for Patients on Persistent Medications (Total)	**Jul 14 – Jun 15**	**87%**	**74.11%**	**No**

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

Appendix B: One Year Plan-Specific Analysis

McLaren Health Plan – MCL

MEDICAID MANAGED CARE:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Childhood Immunizations	Jul 14 – Jun 15	N/A	N/A	N/A
Elective Delivery	Jul 14 – Jun 15	N/A	N/A	N/A
Postpartum Care	Jul 14 – Jun 15	70%	54.40%	No
Blood Lead Testing	Oct 15	81%	82%	Yes
	Nov 15	81%	82%	Yes
	Dec 15	81%	81%	Yes

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 15	19%	22.72%	Yes	23%	26.23%	Yes	17%	21.12%	Yes
	Nov 15	19%	23.54%	Yes	23%	26.58%	Yes	17%	21.66%	Yes
	Dec 15	19%	23.67%	Yes	23%	27.03%	Yes	17%	21.26%	Yes

Well-Child 0-15 Months	Jul 14 – Jun 15	71%	70.24%	No
Well-Child 3-6 Years	Jul 14 – Jun 15	79%	68.63%	No
Complaints	Jul 15 – Sep 15	<.15/1000 MM	0.148	Yes

MM = Member Months ***This is a reverse measure. A lower rate indicates better performance.***

Claims Processing	Aug 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 99%, 4%, 0.09%	Yes
	Sep 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 4%, 0.06%	Yes
	Oct 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 99%, 3%, 0.15%	Yes

T = Timely; A = Accurate; NT = Not Timely; NA = Not Accurate

Encounter Data	Oct 15	Timely, Complete	T, C	Yes
	Nov 15	Timely, Complete	T, C	Yes
	Dec 15	Timely, Complete	T, C	Yes

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

Performance Monitoring Report

McLaren Health Plan – MCL

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Pharmacy Encounter Data	**Oct 15**	**Timely, Complete**	**T, C**	**Yes***
	Nov 15	**Timely, Complete**	**T, C**	**Yes***
	Dec 15	**Timely, Complete**	**T, C**	**Yes***

All Plans received a pass for the Pharmacy Encounter measure this quarter due to technical issues related to the transition to a new format.

Provider File Reporting	**Oct 15**	**Timely, Accurate**	**T, A**	**Yes**
	Nov 15	**Timely, Accurate**	**T, A**	**Yes**
	Dec 15	**Timely, Accurate**	**T, A**	**Yes**

T = Timely; A = Accurate; NT = Not Timely; NA = Not Accurate

HEALTHY MICHIGAN PLAN:

Adults' Generic Drug Utilization	**Apr 15 – Jun 15**	**80%**	**84.76%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**20%**	**13.89%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**66%**	**58.64%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**14.53%**	**Yes**

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

Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**87%**	**84.88%**	**No**

ADULT CORE SET MEASURES:

Adult BMI Assessment	**Jul 14 – Jun 15**	**79%**	**30.15%**	**No**
Breast Cancer Screening	**Jul 14 – Jun 15**	**58%**	**58.23%**	**Yes**
Cervical Cancer Screening	**Jul 14 – Jun 15**	**72%**	**58.63%**	**No**
Diabetes Short-Term Complications Admission Rate	**Jul 14 – Jun 15**	**N/A**	**26.40**	**N/A**

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

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

Performance Monitoring Report

McLaren Health Plan – MCL

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
COPD/Asthma in Older Adults Admission Rate	**Jul 14 – Jun 15**	**N/A**	**75.62**	**N/A**
This is a reverse measure. A lower rate indicates better performance.				
Heart Failure Admission Rate	**Jul 14 – Jun 15**	**N/A**	**17.98**	**N/A**
This is a reverse measure. A lower rate indicates better performance.				
Asthma in Younger Adults Admission Rate	**Jul 14 – Jun 15**	**N/A**	**10.95**	**N/A**
This is a reverse measure. A lower rate indicates better performance.				
Chlamydia Screening	**Jul 14 – Jun 15**	**71%**	**60.12%**	**No**
Diabetes Care: Hemoglobin A1c Testing	**Jul 14 – Jun 15**	**87%**	**83.70%**	**No**
Antidepressant Medication Management (Acute)	**Jul 14 – Jun 15**	**N/A**	**50.89%**	**N/A**
Antidepressant Medication Management (Continuous)	**Jul 14 – Jun 15**	**N/A**	**35.98%**	**N/A**
Annual Monitoring for Patients on Persistent Medications (Total)	**Jul 14 – Jun 15**	**87%**	**82.86%**	**No**

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

Appendix B: One Year Plan-Specific Analysis

Meridian Health Plan – MER

MEDICAID MANAGED CARE:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Childhood Immunizations	Jul 14 – Jun 15	N/A	N/A	N/A
Elective Delivery	Jul 14 – Jun 15	N/A	N/A	N/A
Postpartum Care	Jul 14 – Jun 15	70%	61.42%	No
Blood Lead Testing	Oct 15	81%	80%	No
	Nov 15	81%	79%	No
	Dec 15	81%	79%	No

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 15	19%	23.35%	Yes	23%	26.64%	Yes	17%	21.93%	Yes
	Nov 15	19%	23.65%	Yes	23%	26.94%	Yes	17%	22.00%	Yes
	Dec 15	19%	23.68%	Yes	23%	27.16%	Yes	17%	22.33%	Yes

Well-Child 0-15 Months	Jul 14 – Jun 15	71%	73.24%	Yes
Well-Child 3-6 Years	Jul 14 – Jun 15	79%	73.22%	No
Complaints	Jul 15 – Sep 15	<.15/1000 MM	0.095	Yes

MM = Member Months ***This is a reverse measure. A lower rate indicates better performance.***

Claims Processing	Aug 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 99%, 9%, 0.00%	Yes
	Sep 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 99%, 8%, 0.00%	Yes
	Oct 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 9%, 0.00%	Yes

T = Timely; A = Accurate; NT = Not Timely; NA = Not Accurate

Encounter Data	Oct 15	Timely, Complete	T, C	Yes
	Nov 15	Timely, Complete	T, C	Yes
	Dec 15	Timely, Complete	T, C	Yes

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

Performance Monitoring Report

Meridian Health Plan – MER

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Pharmacy Encounter Data	**Oct 15**	**Timely, Complete**	**T, C**	**Yes***
	Nov 15	**Timely, Complete**	**T, C**	**Yes***
	Dec 15	**Timely, Complete**	**T, C**	**Yes***

All Plans received a pass for the Pharmacy Encounter measure this quarter due to technical issues related to the transition to a new format.

Provider File Reporting	**Oct 15**	**Timely, Accurate**	**T, A**	**Yes**
	Nov 15	**Timely, Accurate**	**T, A**	**Yes**
	Dec 15	**Timely, Accurate**	**T, A**	**Yes**

T = Timely; A = Accurate; NT = Not Timely; NA = Not Accurate

HEALTHY MICHIGAN PLAN:

Adults' Generic Drug Utilization	**Apr 15 – Jun 15**	**80%**	**83.90%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**20%**	**6.35%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**66%**	**49.23%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**13.76%**	**Yes**

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

Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**87%**	**84.39%**	**No**

ADULT CORE SET MEASURES:

Adult BMI Assessment	**Jul 14 – Jun 15**	**79%**	**28.95%**	**No**
Breast Cancer Screening	**Jul 14 – Jun 15**	**58%**	**61.11%**	**Yes**
Cervical Cancer Screening	**Jul 14 – Jun 15**	**72%**	**65.35%**	**No**
Diabetes Short-Term Complications Admission Rate	**Jul 14 – Jun 15**	**N/A**	**18.56**	**N/A**

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

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

Performance Monitoring Report

Meridian Health Plan – MER

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
COPD/Asthma in Older Adults Admission Rate	**Jul 14 – Jun 15**	**N/A**	**71.38**	**N/A**
This is a reverse measure. A lower rate indicates better performance.				
Heart Failure Admission Rate	**Jul 14 – Jun 15**	**N/A**	**15.40**	**N/A**
This is a reverse measure. A lower rate indicates better performance.				
Asthma in Younger Adults Admission Rate	**Jul 14 – Jun 15**	**N/A**	**13.97**	**N/A**
This is a reverse measure. A lower rate indicates better performance.				
Chlamydia Screening	**Jul 14 – Jun 15**	**71%**	**65.17%**	**No**
Diabetes Care: Hemoglobin A1c Testing	**Jul 14 – Jun 15**	**87%**	**83.63%**	**No**
Antidepressant Medication Management (Acute)	**Jul 14 – Jun 15**	**N/A**	**53.56%**	**N/A**
Antidepressant Medication Management (Continuous)	**Jul 14 – Jun 15**	**N/A**	**37.25%**	**N/A**
Annual Monitoring for Patients on Persistent Medications (Total)	**Jul 14 – Jun 15**	**87%**	**81.06%**	**No**

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

Appendix B: One Year Plan-Specific Analysis

HAP Midwest Health Plan, Inc. – MID

MEDICAID MANAGED CARE:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Childhood Immunizations	Jul 14 – Jun 15	N/A	N/A	N/A
Elective Delivery	Jul 14 – Jun 15	N/A	N/A	N/A
Postpartum Care	Jul 14 – Jun 15	70%	51.13%	No
Blood Lead Testing	Oct 15	81%	70%	No
	Nov 15	81%	70%	No
	Dec 15	81%	71%	No

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 15	19%	30.57%	Yes	23%	34.09%	Yes	17%	25.88%	Yes
	Nov 15	19%	31.24%	Yes	23%	33.38%	Yes	17%	26.62%	Yes
	Dec 15	19%	31.65%	Yes	23%	34.01%	Yes	17%	27.22%	Yes

Well-Child 0-15 Months	Jul 14 – Jun 15	71%	76.13%	Yes
Well-Child 3-6 Years	Jul 14 – Jun 15	79%	73.71%	No
Complaints	Jul 15 – Sep 15	<.15/1000 MM	0.208	No

MM = Member Months **This is a reverse measure. A lower rate indicates better performance.**

Claims Processing	Aug 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 99%, 0%, 0.00%	Yes
	Sep 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 99%, 1%, 0.00%	Yes
	Oct 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 98%, 1%, 0.00%	Yes

T = Timely; A = Accurate; NT = Not Timely; NA = Not Accurate

Encounter Data	Oct 15	Timely, Complete	T, C	Yes
	Nov 15	Timely, Complete	T, C	Yes
	Dec 15	Timely, Complete	T, NC	No

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

Performance Monitoring Report

HAP Midwest Health Plan, Inc. –MID

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Pharmacy Encounter Data	**Oct 15**	**Timely, Complete**	**T, C**	**Yes***
	Nov 15	**Timely, Complete**	**T, C**	**Yes***
	Dec 15	**Timely, Complete**	**T, C**	**Yes***

All Plans received a pass for the Pharmacy Encounter measure this quarter due to technical issues related to the transition to a new format.

Provider File Reporting	**Oct 15**	**Timely, Accurate**	**T, A**	**Yes**
	Nov 15	**Timely, Accurate**	**T, A**	**Yes**
	Dec 15	**Timely, Accurate**	**T, A**	**Yes**

T = Timely; A = Accurate; NT = Not Timely; NA = Not Accurate

HEALTHY MICHIGAN PLAN:

Adults' Generic Drug Utilization	**Apr 15 – Jun 15**	**80%**	**85.44%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**20%**	**8.57%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**66%**	**50.94%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**27.22%**	**No**

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

Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**87%**	**81.98%**	**No**

ADULT CORE SET MEASURES:

Adult BMI Assessment	**Jul 14 – Jun 15**	**79%**	**38.83%**	**No**
Breast Cancer Screening	**Jul 14 – Jun 15**	**58%**	**59.47%**	**Yes**
Cervical Cancer Screening	**Jul 14 – Jun 15**	**72%**	**66.15%**	**No**
Diabetes Short-Term Complications Admission Rate	**Jul 14 – Jun 15**	**N/A**	**26.30**	**N/A**

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

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

Performance Monitoring Report

HAP Midwest Health Plan, Inc. – MID

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
COPD/Asthma in Older Adults Admission Rate	**Jul 14 – Jun 15**	**N/A**	**93.36**	**N/A**
This is a reverse measure. A lower rate indicates better performance.				
Heart Failure Admission Rate	**Jul 14 – Jun 15**	**N/A**	**33.01**	**N/A**
This is a reverse measure. A lower rate indicates better performance.				
Asthma in Younger Adults Admission Rate	**Jul 14 – Jun 15**	**N/A**	**13.31**	**N/A**
This is a reverse measure. A lower rate indicates better performance.				
Chlamydia Screening	**Jul 14 – Jun 15**	**71%**	**63.88%**	**No**
Diabetes Care: Hemoglobin A1c Testing	**Jul 14 – Jun 15**	**87%**	**80.11%**	**No**
Antidepressant Medication Management (Acute)	**Jul 14 – Jun 15**	**N/A**	**50.00%**	**N/A**
Antidepressant Medication Management (Continuous)	**Jul 14 – Jun 15**	**N/A**	**36.21%**	**N/A**
Annual Monitoring for Patients on Persistent Medications (Total)	**Jul 14 – Jun 15**	**87%**	**81.36%**	**No**

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

Appendix B: One Year Plan-Specific Analysis

Molina Healthcare of Michigan – MOL

MEDICAID MANAGED CARE:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Childhood Immunizations	Jul 14 – Jun 15	N/A	N/A	N/A
Elective Delivery	Jul 14 – Jun 15	N/A	N/A	N/A
Postpartum Care	Jul 14 – Jun 15	70%	66.63%	No
Blood Lead Testing	Oct 15	81%	73%	No
	Nov 15	81%	73%	No
	Dec 15	81%	73%	No

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 15	19%	23.61%	Yes	23%	25.56%	Yes	17%	18.21%	Yes
	Nov 15	19%	23.92%	Yes	23%	26.24%	Yes	17%	18.32%	Yes
	Dec 15	19%	24.08%	Yes	23%	26.58%	Yes	17%	18.73%	Yes

Well-Child 0-15 Months	Jul 14 – Jun 15	71%	71.19%	Yes
Well-Child 3-6 Years	Jul 14 – Jun 15	79%	73.34%	No
Complaints	Jul 15 – Sep 15	<.15/1000 MM	0.132	Yes

MM = Member Months ***This is a reverse measure. A lower rate indicates better performance.***

Claims Processing	Aug 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 3%, 0.05%	Yes
	Sep 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 2%, 0.19%	Yes
	Oct 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 2%, 0.33%	Yes

T = Timely; A = Accurate; NT = Not Timely; NA = Not Accurate

Encounter Data	Oct 15	Timely, Complete	T, C	Yes
	Nov 15	Timely, Complete	T, C	Yes
	Dec 15	Timely, Complete	T, C	Yes

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

Performance Monitoring Report

Molina Healthcare of Michigan – MOL

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Pharmacy Encounter Data	**Oct 15**	**Timely, Complete**	**T, C**	**Yes***
	Nov 15	**Timely, Complete**	**T, C**	**Yes***
	Dec 15	**Timely, Complete**	**T, C**	**Yes***

All Plans received a pass for the Pharmacy Encounter measure this quarter due to technical issues related to the transition to a new format.

Provider File Reporting	**Oct 15**	**Timely, Accurate**	**T, A**	**Yes**
	Nov 15	**Timely, Accurate**	**T, A**	**Yes**
	Dec 15	**Timely, Accurate**	**T, A**	**Yes**

T = Timely; A = Accurate; NT = Not Timely; NA = Not Accurate

HEALTHY MICHIGAN PLAN:

Adults' Generic Drug Utilization	**Apr 15 – Jun 15**	**80%**	**85.56%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**20%**	**6.11%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**66%**	**51.54%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**14.59%**	**Yes**

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

Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**87%**	**83.30%**	**No**

ADULT CORE SET MEASURES:

Adult BMI Assessment	**Jul 14 – Jun 15**	**79%**	**32.56%**	**No**
Breast Cancer Screening	**Jul 14 – Jun 15**	**58%**	**56.48%**	**No**
Cervical Cancer Screening	**Jul 14 – Jun 15**	**72%**	**66.75%**	**No**
Diabetes Short-Term Complications Admission Rate	**Jul 14 – Jun 15**	**N/A**	**16.87**	**N/A**

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

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

Performance Monitoring Report

Molina Healthcare of Michigan – MOL

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
COPD/Asthma in Older Adults Admission Rate	**Jul 14 – Jun 15**	**N/A**	**124.26**	**N/A**
This is a reverse measure. A lower rate indicates better performance.				
Heart Failure Admission Rate	**Jul 14 – Jun 15**	**N/A**	**30.51**	**N/A**
This is a reverse measure. A lower rate indicates better performance.				
Asthma in Younger Adults Admission Rate	**Jul 14 – Jun 15**	**N/A**	**16.13**	**N/A**
This is a reverse measure. A lower rate indicates better performance.				
Chlamydia Screening	**Jul 14 – Jun 15**	**71%**	**68.25%**	**No**
Diabetes Care: Hemoglobin A1c Testing	**Jul 14 – Jun 15**	**87%**	**82.12%**	**No**
Antidepressant Medication Management (Acute)	**Jul 14 – Jun 15**	**N/A**	**49.46%**	**N/A**
Antidepressant Medication Management (Continuous)	**Jul 14 – Jun 15**	**N/A**	**33.01%**	**N/A**
Annual Monitoring for Patients on Persistent Medications (Total)	**Jul 14 – Jun 15**	**87%**	**81.37%**	**No**

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

Appendix B: One Year Plan-Specific Analysis

Priority Health Choice – PRI

MEDICAID MANAGED CARE:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Childhood Immunizations	Jul 14 – Jun 15	N/A	N/A	N/A
Elective Delivery	Jul 14 – Jun 15	N/A	N/A	N/A
Postpartum Care	Jul 14 – Jun 15	70%	56.67%	No
Blood Lead Testing	Oct 15	81%	81%	Yes
	Nov 15	81%	82%	Yes
	Dec 15	81%	82%	Yes

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 15	19%	25.44%	Yes	23%	36.89%	Yes	17%	30.97%	Yes
	Nov 15	19%	25.01%	Yes	23%	38.30%	Yes	17%	31.55%	Yes
	Dec 15	19%	24.81%	Yes	23%	38.50%	Yes	17%	31.76%	Yes

Well-Child 0-15 Months	Jul 14 – Jun 15	71%	81.09%	Yes
Well-Child 3-6 Years	Jul 14 – Jun 15	79%	75.68%	No
Complaints	Jul 15 – Sep 15	<.15/1000 MM	0.043	Yes

MM = Member Months ***This is a reverse measure. A lower rate indicates better performance.***

Claims Processing	Aug 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 5%, 0.16%	Yes
	Sep 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 6%, 0.02%	Yes
	Oct 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 6%, 0.04%	Yes

T = Timely; A = Accurate; NT = Not Timely; NA = Not Accurate

Encounter Data	Oct 15	Timely, Complete	T, C	Yes
	Nov 15	Timely, Complete	T, C	Yes
	Dec 15	Timely, Complete	T, C	Yes

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

Performance Monitoring Report

Priority Health Choice – PRI

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Pharmacy Encounter Data	**Oct 15**	**Timely, Complete**	**T, C**	**Yes***
	Nov 15	**Timely, Complete**	**T, C**	**Yes***
	Dec 15	**Timely, Complete**	**T, C**	**Yes***

All Plans received a pass for the Pharmacy Encounter measure this quarter due to technical issues related to the transition to a new format.

Provider File Reporting	**Oct 15**	**Timely, Accurate**	**T, A**	**Yes**
	Nov 15	**Timely, Accurate**	**T, A**	**Yes**
	Dec 15	**Timely, Accurate**	**T, A**	**Yes**

T = Timely; A = Accurate; NT = Not Timely; NA = Not Accurate

HEALTHY MICHIGAN PLAN:

Adults' Generic Drug Utilization	**Apr 15 – Jun 15**	**80%**	**83.46%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**20%**	**12.22%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**66%**	**63.12%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**16.90%**	**No**

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

Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**87%**	**87.02%**	**Yes**

ADULT CORE SET MEASURES:

Adult BMI Assessment	**Jul 14 – Jun 15**	**79%**	**17.01%**	**No**
Breast Cancer Screening	**Jul 14 – Jun 15**	**58%**	**64.44%**	**Yes**
Cervical Cancer Screening	**Jul 14 – Jun 15**	**72%**	**63.55%**	**No**
Diabetes Short-Term Complications Admission Rate	**Jul 14 – Jun 15**	**N/A**	**25.15**	**N/A**

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

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

Performance Monitoring Report

Priority Health Choice – PRI

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
COPD/Asthma in Older Adults Admission Rate	**Jul 14 – Jun 15**	**N/A**	**44.65**	**N/A**
This is a reverse measure. A lower rate indicates better performance.				
Heart Failure Admission Rate	**Jul 14 – Jun 15**	**N/A**	**14.18**	**N/A**
This is a reverse measure. A lower rate indicates better performance.				
Asthma in Younger Adults Admission Rate	**Jul 14 – Jun 15**	**N/A**	**6.05**	**N/A**
This is a reverse measure. A lower rate indicates better performance.				
Chlamydia Screening	**Jul 14 – Jun 15**	**71%**	**66.02%**	**No**
Diabetes Care: Hemoglobin A1c Testing	**Jul 14 – Jun 15**	**87%**	**89.24%**	**Yes**
Antidepressant Medication Management (Acute)	**Jul 14 – Jun 15**	**N/A**	**50.42%**	**N/A**
Antidepressant Medication Management (Continuous)	**Jul 14 – Jun 15**	**N/A**	**34.84%**	**N/A**
Annual Monitoring for Patients on Persistent Medications (Total)	**Jul 14 – Jun 15**	**87%**	**85.45%**	**No**

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

Appendix B: One Year Plan-Specific Analysis

Total Health Care – THC

MEDICAID MANAGED CARE:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Childhood Immunizations	Jul 14 – Jun 15	N/A	N/A	N/A
Elective Delivery	Jul 14 – Jun 15	N/A	N/A	N/A
Postpartum Care	Jul 14 – Jun 15	70%	42.42%	No
Blood Lead Testing	Oct 15	81%	70%	No
	Nov 15	81%	70%	No
	Dec 15	81%	70%	No

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 15	19%	19.69%	Yes	23%	23.19%	Yes	17%	14.26%	No
	Nov 15	19%	19.06%	Yes	23%	23.75%	Yes	17%	15.07%	No
	Dec 15	19%	20.20%	Yes	23%	24.78%	Yes	17%	14.95%	No

Well-Child 0-15 Months	Jul 14 – Jun 15	71%	63.52%	No
Well-Child 3-6 Years	Jul 14 – Jun 15	79%	69.93%	No
Complaints	Jul 15 – Sep 15	<.15/1000 MM	0.167	No

MM = Member Months ***This is a reverse measure. A lower rate indicates better performance.***

Claims Processing	Aug 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 3%, 0.00%	Yes
	Sep 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 2%, 0.00%	Yes
	Oct 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 3%, 0.00%	Yes

T = Timely; A = Accurate; NT = Not Timely; NA = Not Accurate

Encounter Data	Oct 15	Timely, Complete	T, C	Yes
	Nov 15	Timely, Complete	T, C	Yes
	Dec 15	Timely, Complete	T, C	Yes

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

Performance Monitoring Report

Total Health Care – THC

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Pharmacy Encounter Data	**Oct 15**	**Timely, Complete**	**T, C**	**Yes***
	Nov 15	**Timely, Complete**	**T, C**	**Yes***
	Dec 15	**Timely, Complete**	**T, C**	**Yes***

All Plans received a pass for the Pharmacy Encounter measure this quarter due to technical issues related to the transition to a new format.

Provider File Reporting	**Oct 15**	**Timely, Accurate**	**T, A**	**Yes**
	Nov 15	**Timely, Accurate**	**T, A**	**Yes**
	Dec 15	**Timely, Accurate**	**T, A**	**Yes**

T = Timely; A = Accurate; NT = Not Timely; NA = Not Accurate

HEALTHY MICHIGAN PLAN:

Adults' Generic Drug Utilization	**Apr 15 – Jun 15**	**80%**	**85.90%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**20%**	**2.73%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**66%**	**51.18%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**17.47%**	**No**

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

Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**87%**	**79.14%**	**No**

ADULT CORE SET MEASURES:

Adult BMI Assessment	**Jul 14 – Jun 15**	**79%**	**39.41%**	**No**
Breast Cancer Screening	**Jul 14 – Jun 15**	**58%**	**50.19%**	**No**
Cervical Cancer Screening	**Jul 14 – Jun 15**	**72%**	**62.41%**	**No**
Diabetes Short-Term Complications Admission Rate	**Jul 14 – Jun 15**	**N/A**	**24.14**	**N/A**

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

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

Performance Monitoring Report

Total Health Care – THC

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
COPD/Asthma in Older Adults Admission Rate	**Jul 14 – Jun 15**	**N/A**	**149.17**	**N/A**
This is a reverse measure. A lower rate indicates better performance.				
Heart Failure Admission Rate	**Jul 14 – Jun 15**	**N/A**	**39.00**	**N/A**
This is a reverse measure. A lower rate indicates better performance.				
Asthma in Younger Adults Admission Rate	**Jul 14 – Jun 15**	**N/A**	**17.14**	**N/A**
This is a reverse measure. A lower rate indicates better performance.				
Chlamydia Screening	**Jul 14 – Jun 15**	**71%**	**64.90%**	**No**
Diabetes Care: Hemoglobin A1c Testing	**Jul 14 – Jun 15**	**87%**	**70.45%**	**No**
Antidepressant Medication Management (Acute)	**Jul 14 – Jun 15**	**N/A**	**44.84%**	**N/A**
Antidepressant Medication Management (Continuous)	**Jul 14 – Jun 15**	**N/A**	**31.75%**	**N/A**
Annual Monitoring for Patients on Persistent Medications (Total)	**Jul 14 – Jun 15**	**87%**	**72.56%**	**No**

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

Appendix B: One Year Plan-Specific Analysis

UnitedHealthcare Community Plan – UNI

MEDICAID MANAGED CARE:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Childhood Immunizations	Jul 14 – Jun 15	N/A	N/A	N/A
Elective Delivery	Jul 14 – Jun 15	N/A	N/A	N/A
Postpartum Care	Jul 14 – Jun 15	70%	51.09%	No
Blood Lead Testing	Oct 15	81%	75%	No
	Nov 15	81%	75%	No
	Dec 15	81%	75%	No

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 15	19%	22.18%	Yes	23%	29.59%	Yes	17%	22.63%	Yes
	Nov 15	19%	22.88%	Yes	23%	29.89%	Yes	17%	22.56%	Yes
	Dec 15	19%	23.29%	Yes	23%	29.74%	Yes	17%	22.69%	Yes

Well-Child 0-15 Months	Jul 14 – Jun 15	71%	76.37%	Yes
Well-Child 3-6 Years	Jul 14 – Jun 15	79%	72.96%	No
Complaints	Jul 15 – Sep 15	<.15/1000 MM	0.168	No

MM = Member Months ***This is a reverse measure. A lower rate indicates better performance.***

Claims Processing	Aug 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 7%, 0.07%	Yes
	Sep 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 6%, 0.42%	Yes
	Oct 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 100%, 7%, 0.21%	Yes

T = Timely; A = Accurate; NT = Not Timely; NA = Not Accurate

Encounter Data	Oct 15	Timely, Complete	T, C	Yes
	Nov 15	Timely, Complete	T, C	Yes
	Dec 15	Timely, Complete	T, C	Yes

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

Performance Monitoring Report

UnitedHealthcare Community Plan – UNI

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Pharmacy Encounter Data	**Oct 15**	**Timely, Complete**	**T, C**	**Yes***
	Nov 15	**Timely, Complete**	**T, C**	**Yes***
	Dec 15	**Timely, Complete**	**T, C**	**Yes***

All Plans received a pass for the Pharmacy Encounter measure this quarter due to technical issues related to the transition to a new format.

Provider File Reporting	**Oct 15**	**Timely, Accurate**	**T, A**	**Yes**
	Nov 15	**Timely, Accurate**	**T, A**	**Yes**
	Dec 15	**Timely, Accurate**	**T, A**	**Yes**

T = Timely; A = Accurate; NT = Not Timely; NA = Not Accurate

HEALTHY MICHIGAN PLAN:

Adults' Generic Drug Utilization	**Apr 15 – Jun 15**	**80%**	**85.38%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**20%**	**8.35%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**66%**	**57.14%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**15.75%**	**Yes**

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

Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**87%**	**84.68%**	**No**

ADULT CORE SET MEASURES:

Adult BMI Assessment	**Jul 14 – Jun 15**	**79%**	**41.30%**	**No**
Breast Cancer Screening	**Jul 14 – Jun 15**	**58%**	**61.19%**	**Yes**
Cervical Cancer Screening	**Jul 14 – Jun 15**	**72%**	**69.05%**	**No**
Diabetes Short-Term Complications Admission Rate	**Jul 14 – Jun 15**	**N/A**	**26.38**	**N/A**

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

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

Performance Monitoring Report

UnitedHealthcare Community Plan – UNI

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
COPD/Asthma in Older Adults Admission Rate	**Jul 14 – Jun 15**	**N/A**	**104.68**	**N/A**
This is a reverse measure. A lower rate indicates better performance.				
Heart Failure Admission Rate	**Jul 14 – Jun 15**	**N/A**	**25.02**	**N/A**
This is a reverse measure. A lower rate indicates better performance.				
Asthma in Younger Adults Admission Rate	**Jul 14 – Jun 15**	**N/A**	**14.93**	**N/A**
This is a reverse measure. A lower rate indicates better performance.				
Chlamydia Screening	**Jul 14 – Jun 15**	**71%**	**67.62%**	**No**
Diabetes Care: Hemoglobin A1c Testing	**Jul 14 – Jun 15**	**87%**	**83.31%**	**No**
Antidepressant Medication Management (Acute)	**Jul 14 – Jun 15**	**N/A**	**48.39%**	**N/A**
Antidepressant Medication Management (Continuous)	**Jul 14 – Jun 15**	**N/A**	**34.07%**	**N/A**
Annual Monitoring for Patients on Persistent Medications (Total)	**Jul 14 – Jun 15**	**87%**	**84.38%**	**No**

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

Appendix B: One Year Plan-Specific Analysis

Upper Peninsula Health Plan – UPP

MEDICAID MANAGED CARE:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Childhood Immunizations	Jul 14 – Jun 15	N/A	N/A	N/A
Elective Delivery	Jul 14 – Jun 15	N/A	N/A	N/A
Postpartum Care	Jul 14 – Jun 15	70%	45.04%	N/A
Blood Lead Testing	Oct 15	81%	89%	Yes
	Nov 15	81%	88%	Yes
	Dec 15	81%	89%	Yes

		Year 1	Result	Standard Achieved	Year 2	Result	Standard Achieved	Year 3	Result	Standard Achieved
Developmental Screening	Oct 15	19%	14.68%	No	23%	17.89%	No	17%	13.72%	No
	Nov 15	19%	14.42%	No	23%	17.04%	No	17%	14.26%	No
	Dec 15	19%	14.30%	No	23%	16.07%	No	17%	14.31%	No

Well-Child 0-15 Months	Jul 14 – Jun 15	71%	70.14%	No
Well-Child 3-6 Years	Jul 14 – Jun 15	79%	71.82%	No
Complaints	Jul 15 – Sep 15	<.15/1000 MM	0.033	Yes

MM = Member Months ***This is a reverse measure. A lower rate indicates better performance.***

Claims Processing	Aug 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 98%, 9%, 0.00%	Yes
	Sep 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 98%, 9%, 0.00%	Yes
	Oct 15	T/A, ≥95%, ≤12%, ≤1.0%	T/A, 99%, 8%, 0.00%	Yes

T = Timely; A = Accurate; NT = Not Timely; NA = Not Accurate

Encounter Data	Oct 15	Timely, Complete	T, C	Yes
	Nov 15	Timely, Complete	T, C	Yes
	Dec 15	Timely, Complete	T, C	Yes

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

Performance Monitoring Report

Upper Peninsula Health Plan – UPP

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Pharmacy Encounter Data	**Oct 15**	**Timely, Complete**	**T, C**	**Yes***
	Nov 15	**Timely, Complete**	**T, C**	**Yes***
	Dec 15	**Timely, Complete**	**T, C**	**Yes***

All Plans received a pass for the Pharmacy Encounter measure this quarter due to technical issues related to the transition to a new format.

Provider File Reporting	**Oct 15**	**Timely, Accurate**	**T, A**	**Yes**
	Nov 15	**Timely, Accurate**	**T, A**	**Yes**
	Dec 15	**Timely, Accurate**	**T, A**	**Yes**

T = Timely; A = Accurate; NT = Not Timely; NA = Not Accurate

HEALTHY MICHIGAN PLAN:

Adults' Generic Drug Utilization	**Apr 15 – Jun 15**	**80%**	**83.87%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**20%**	**14.73%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**66%**	**58.86%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**16.14%**	**No**

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

Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**87%**	**86.36%**	**No**

ADULT CORE SET MEASURES:

Adult BMI Assessment	**Jul 14 – Jun 15**	**79%**	**53.05%**	**No**
Breast Cancer Screening	**Jul 14 – Jun 15**	**58%**	**61.51%**	**Yes**
Cervical Cancer Screening	**Jul 14 – Jun 15**	**72%**	**60.45%**	**No**
Diabetes Short-Term Complications Admission Rate	**Jul 14 – Jun 15**	**N/A**	**13.90**	**N/A**

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

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

Performance Monitoring Report

Upper Peninsula Health Plan – UPP

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
COPD/Asthma in Older Adults Admission Rate	**Jul 14 – Jun 15**	**N/A**	**70.78**	**N/A**
This is a reverse measure. A lower rate indicates better performance.				
Heart Failure Admission Rate	**Jul 14 – Jun 15**	**N/A**	**13.46**	**N/A**
This is a reverse measure. A lower rate indicates better performance.				
Asthma in Younger Adults Admission Rate	**Jul 14 – Jun 15**	**N/A**	**11.30**	**N/A**
This is a reverse measure. A lower rate indicates better performance.				
Chlamydia Screening	**Jul 14 – Jun 15**	**71%**	**46.37%**	**No**
Diabetes Care: Hemoglobin A1c Testing	**Jul 14 – Jun 15**	**87%**	**88.12%**	**Yes**
Antidepressant Medication Management (Acute)	**Jul 14 – Jun 15**	**N/A**	**59.32%**	**N/A**
Antidepressant Medication Management (Continuous)	**Jul 14 – Jun 15**	**N/A**	**43.22%**	**N/A**
Annual Monitoring for Patients on Persistent Medications (Total)	**Jul 14 – Jun 15**	**87%**	**80.67%**	**No**

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

MI Health Account Statements: Early Experiences of Beneficiaries Report Summary

September 14, 2015

University of Michigan
Institute for Healthcare Policy and Innovation

Evaluation team: Edith Kieffer, Susan Goold, Sarah Clark, John Ayanian, Aaron Scherer, Jeffrey Kullgren, Lisa Szymecko, Tolu Olorode, Erin Beathard, Mirella Villalpando Zamora

Overview

As required by PA 107 of 2013, Healthy Michigan Plan (HMP) beneficiaries receive a quarterly MI Health Account Statement and Payment Coupon, beginning six months after HMP enrollment. The statement provides beneficiaries with information on their health care spending and payment responsibilities. The Michigan Department of Health and Human Services (MDHHS) requested the University of Michigan Institute for Healthcare Policy and Innovation (IHPI) to conduct an early evaluation of beneficiary experiences with their MI Health Account Statement and Payment Coupon.

Objectives

1. Evaluate how beneficiaries perceive and comprehend the MI Health Account letter, statement and payment coupons;
2. Identify specific portions of the statement that are not well understood;
3. Evaluate beneficiaries' perceptions of cost-sharing;
4. Describe how beneficiaries' behaviors or intended behaviors related to payment, use of health services and other aspects of daily life have been influenced by the information from the statements;
5. Evaluate beneficiaries' experiences using checks, money orders or online payment;
6. Identify beneficiaries' suggestions for changes in the statement and payment mechanisms.

Participants

Between April and June 2015, we conducted 32 in-person, one-on-one cognitive interviews with HMP beneficiaries, after receipt of at least one statement. Nine resided in Detroit, eight in Kent County, seven in Saginaw/Midland/Bay Counties, three in Alcona/Oscoda/Alpena Counties, and five in Iron/Baraga/ Marquette Counties. Those interviewed included 13 beneficiaries with contributions, nine with copays only and 10 with services only. Of the 22 beneficiaries required to make payments, 16 reported they had paid; two reported they had not reached their payment due date; and 4 reported that they had not yet paid for various other reasons. Among participants, nine health plans were represented. Of the 32 beneficiaries, 21 were non-Hispanic white, nine were African American and two Latino; 18 were women and 14 were men; 15 were 50 years of age or older; eight were under 35 years old and eight were 35-49 years old.

Key Findings

I. Beneficiaries' Receipt and Understanding of their MI Health Account Statements and Payment Coupon

A. The MI Health Account introductory letter had little impact on beneficiaries. Many recalled receiving some kind of document, but its impersonal appearance diminished the attention of many to the letter. A third of beneficiaries did not recall receiving the letter, and many did not recall its content or realize they would be receiving statements.

Recommendations:

- Personalize the letter, including a salutation and personalized addressee information.
- Define MI Health Account, MI Health Account statement, co-pays and contributions, health risk assessment and healthy behavior reward in the letter, and use consistent terminology, definitions and explanations in the letter and statement.
- Continue to introduce the $25 per month payment maximum in the letter, and use it again in the statement instead of, or complementing, the more abstract 5% of income maximum.
- Include information about when the first MI Health Account statement should be expected.
- See sample statements for changes in sections of text that are similar to those in the letter.

B. Most beneficiaries had not read much of the statement. Most focused on what they owed. Most beneficiaries had little or incomplete knowledge and understanding of the MI Health Account and its concepts. The lengthy statement, lack of definitions of key terms (e.g. MI Health Account, vouchers) and varying usage of terms (e.g. reward, healthy behavior reward, healthy behavior reduction) hindered understanding. The $25 monthly payment maximum was introduced in the letter but only the 5% of income payment maximum was mentioned in the statement. Most beneficiaries understood that copays represented paying a small fee for services received; that contributions represented paying a share of their health care costs; and that coupons are meant to be sent with payments. Many did not understand how copays and contributions are calculated; how contributions are used; how, or if, the $25 monthly maximum related to the 5% of income payment maximum; and how and where the vouchers can be used for health care. Most beneficiaries were unfamiliar with, or did not understand, the terms "health risk assessment", "healthy behavior reward", "healthy behavior reduction." Most were unaware of how they are earned. Some beneficiaries did not understand why they were paying in advance.

C. Summary sections and cues pointing to key information were viewed as helpful but most beneficiaries had not read them prior to the interview. During the interview, beneficiaries found the short, bullet-pointed explanatory summaries to be helpful for understanding the statement.

Recommendations:

- Shorten, reorganize and simplify the statement to focus on key features. This includes removing repetition when possible, increasing use of bullet points versus paragraphs, and placing these explanatory points close to the related tables. Place additional bullet-pointed information in a Frequently Asked Questions section (see statement samples, pages 3-4).

- Define the MI Health Account and MI Health Account Statement and other key terms using clear and consistent definitions (see statement samples, page 1). Add a key words list at the end of the statement (see statement samples for definitions and words list, page 5).
- Consider using the $25 monthly payment maximum mentioned in the letter instead of, or complementing, the more abstract 5% of income maximum mentioned in the statement.
- Consider using videos, public service announcements and educational sessions for beneficiaries and navigators to introduce and review the statement and its key features.

D. The tables and graphic were confusing. Many beneficiaries did not understand how copays, contributions, or the total owed, were calculated. The two most problematic statement features were the Account History Table and the Contributions Graphic. Many beneficiaries confused the purpose of the Account History Table with the Health Services Table, especially when they had no previous payments. The visually complex Contributions Graphic confused almost all contributors, and did not help them understand how contributions were calculated or used. Contributors sometimes interpreted the 'arrow-like' figure as the temporal order of how their health care was paid (e.g. plan pays a certain amount first, followed by healthy behavior reward, then personal contributions). This led to confusion about why they were paying anything when the "contributions used to date" amount was lower than the contributions from their plan.

Recommendations: (See example statement).

- Create a renamed Account Activity and Payments Due table that combines what were previously called the "Payments" table and "Services & Co-Pays" table (see sample statements, page 2).
- Within the table: Add lines for "Previous statement balance", "Payments received since previous statement" and "Balance due from previous statement" at the top of the table; add the dates covered by the statement; add lines to show the application of each type of healthy behavior reward discount; indent monthly payment amounts and move them directly below the total amount owed for the next 3 months; add a "you could have saved X amount" message to make the benefit of the healthy behavior reward more concrete.
- Place explanatory information in bullet points directly after the table.
- Create a simplified and renamed Account Payment History table and place it after the new Account Activity and Payments Due table, with explanatory information directly below the table (see statement samples, page 3).
- Delete the contributions graphic table and related explanations.

E. Most beneficiaries did not ask for help, despite not understanding. Most beneficiaries said they had not contacted anyone for assistance, sometimes

because they felt they understood enough to pay, or did not want to call because of prior experiences with call attempts. Some called their health plan or DHS office; others the beneficiary helpline. A Spanish-speaking beneficiary was not able to read the English-only statement.

Recommendations:

- Add a "When to Call for More Information" table at the end of the statement.
- Translate the letter and statement into Spanish and Arabic.
- For key concepts and features, supplement statements with other communication methods that don't rely on reading and numeracy skills, e.g. videos, roadmap graphic.

II. Beneficiaries' Payment Experiences

A. Many beneficiaries thought that the payments were affordable and fair. Most beneficiaries were grateful to have health insurance and said that the payments seemed reasonable, particularly in relation to the benefits they had received in health care and improved health. Several commented on their sense of responsibility for paying a share of the cost, but were relieved that the amounts were small.

B. Most beneficiaries reported that they had already paid or stated their intention to pay what they owed. Many appreciated the payment coupons. Most of those with required payments reported that they had paid, regardless of payment type. Most had paid by mail. Some had not reached the due date but intended to pay. Beneficiaries appreciated having the payment coupons that helped them keep track of what they owed and when.

C. Some beneficiaries, regardless of payment type, described personal, financial and structural challenges to making payments. Lack of home internet access, problems navigating the website, lack of a bank account, and lack of trust in the security of online payments were reasons that mail was preferred. Limitations in accepted payment methods were noted. Fees associated with getting a money order, sometimes nearly equaling the amount owed, made payment seem costly for some. Lack of money or competing demands for money - including caring for their families, joblessness, disability and hospitalization - posed additional payment challenges.

Recommendations:

- Add clarifying language in the "How Do I Pay What I Owe" section regarding use of the coupons and excluded payment methods (see example statements, page 3).

- Expand payment mechanisms, including allowing payment/money cards or credit cards, and designating certain locations to accept in-person payments, e.g. MoneyGram locations are often used to pay other bills.

III. Beneficiaries' Perceptions and Experiences with the Health Risk Assessment and Healthy Behavior Rewards

A. Many beneficiaries appeared to have completed a health risk assessment, but didn't recognize the name and did not connect it to earning healthy behavior rewards. Beneficiaries mentioned new diagnoses (e.g., diabetes), immunizations, screenings, and healthy behavior counseling as benefits of the assessments. Most beneficiaries did not know about the connection between completion of the health risk assessment and the healthy behavior reward.

B. The interview helped beneficiaries understand the purpose of the healthy behavior rewards, what they are and how they are earned. Most beneficiaries indicated at some point during the interview that they had no idea what the healthy behavior rewards were. Very few could name even one form of healthy behavior reward. By the end of the facilitated review, most beneficiaries recognized the rationale for healthy behavior rewards and were interested in earning a reward if they had not done so already.

C. Most beneficiaries did not see any relationship between the statement and their health-related behaviors, including seeing the costs of their health services. The two main reasons beneficiaries reported no changes in behavior were that (1) they viewed the statement only as a bill or source of information about their health care coverage, and (2) they already viewed themselves as "healthy" or doing what they needed to do for their health. The interview process made some beneficiaries more aware of their health care service use and reminded them to schedule needed health services. The cost of care borne by their health plans in the statement was usually overlooked by most beneficiaries.

Recommendations:

- Use clear and consistent definitions of "health risk assessment" and "healthy behavior reward"; eliminate use of "reward" (by itself) or "healthy behavior reduction".
- Consider using the word "discount" to help explain how the "healthy behavior reward" reduces payments owed. Include the definition of these and other key words in a key word list at the end of the statement (see statement samples, pages 1 and 5, for definitions and word list).
- Consider using videos, public service announcements and educational sessions for beneficiaries and navigators to emphasize the role of healthy behaviors for Healthy Michigan Plan beneficiaries and the process for earning healthy behavior rewards.