STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

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March 30, 2017

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 2017. 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 by phone at (517) 284-1190, or by e-mail at colemanj@michigan.gov.

Sincerely,

Penny L. Rutledge

Penny Rutledge, Director
Actuarial Division

cc: Ruth Hughes
Angela Garner

Enclosure (5)

Michigan Adult Coverage Demonstration
Section 1115 Quarterly Report

Demonstration Year: 7 (01/01/2016 – 12/31/2016)
Federal Fiscal Quarter: 1 (10/01/2016 – 12/31/2016)

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

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Introduction

On April 1, 2014, Michigan expanded its Medicaid program to include adults with income up to 133 percent of the Federal Poverty Level (FPL). To accompany this expansion, the Michigan Adult Benefits Waiver (ABW) was amended and transformed to establish the Healthy Michigan Plan, through which the Michigan Department of Health & Human Services (MDHHS) will test innovative approaches to beneficiary cost sharing and financial responsibility for health care for the new adult eligibility group. Organized service delivery systems will be utilized to improve coherence and overall program efficiency. The overarching themes used in the benefit design are 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. The 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. The new adult population with incomes above 100 percent of the FPL are required to make contributions toward the cost of their health care. In addition, all newly eligible adults from 0 to 133 percent of the FPL are subject to copayments consistent with federal regulations.

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.

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

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

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

MDHHS's goals in the demonstration are to:

- Improve access to healthcare for uninsured or underinsured low-income Michigan citizens;
- Improve the quality of healthcare services delivered;
- Reduce uncompensated care;
- Encourage individuals to seek preventive care and encourage the adoption of healthy behaviors;
- Help uninsured or underinsured individuals manage their health care issues;
- Encourage quality, continuity, and appropriate medical care; and

- Study the effects of a demonstration model that infuses market-driven principles into a public healthcare insurance program by examining:
    - The extent to which the increased availability of health insurance reduces the costs of uncompensated care borne by hospitals;
    - The extent to which availability of affordable health insurance results in a reduction in the number of uninsured/underinsured individuals who reside in Michigan;
    - Whether the availability of affordable health insurance, which provides coverage for preventive and health and wellness activities, will increase healthy behaviors and improve health outcomes; and
    - The extent to which beneficiaries feel that the Healthy Michigan Plan has a positive impact on personal health outcomes and financial well-being.

Enrollment and Benefits Information

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

Table 1: Healthy Michigan Plan New Enrollments by Month			
October 2016	November 2016	December 2016	Total
31,350	35,709	35,890	102,949

Table 2: Healthy Michigan Plan Disenrollments by Month			
October 2016	November 2016	December 2016	Total
25,507	28,301	30,210	84,018

Most Healthy Michigan Plan beneficiaries elect to choose a health plan as opposed to automatic assignment to a health plan. As of December 19, 2016, 361,749 or, 71 percent, of the State's 505,770 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, 4,606 of all Healthy Michigan Plan health plan enrollees changed health plans. This quarter, 2,680 or approximately 58 percent, of beneficiaries that changed plans were previously automatically assigned to a health plan. The remaining beneficiaries were those that changed plans after selecting a health plan.

Healthy Michigan Plan members have the opportunity to reduce cost-sharing requirements through the completion of Health Risk Assessments and engaging in healthy behaviors. MDHHS has developed a standard Health Risk Assessment form to be completed annually. Health Risk Assessment forms and reports are located on the MDHHS website. The Health Risk Assessment document is completed in two parts. The member typically completes the first

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

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

- Reduction in copayments: A 50 percent reduction in copayments is available to members that have agreed to address or maintain healthy behaviors and have paid 2 percent of their income in copayments.
- Reduction in contributions: A 50 percent reduction in contributions can be earned by members that have agreed to address or maintain healthy behaviors and have completed a Health Risk Assessment with a Primary Care Practitioner attestation.
- Gift card incentives: A $50.00 gift card is available to beneficiaries at or below 100 percent FPL that have agreed to address or maintain healthy behaviors and have completed a Health Risk Assessment with a Primary Care Practitioner attestation.

The initial assessment questions section of the Health Risk Assessments completed through the MDHHS enrollment broker had a completion rate of 93 percent this quarter. MDHHS is encouraged by the high level of participation by beneficiaries at the initial point of contact. The details of Health Risk Assessment completion can be found in the enclosed December 2016 Health Risk Assessment Report. 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 2016	2,649	95%	127	5%	2,649
November 2016	2,753	91%	261	9%	2,753
December 2016	3,482	92%	304	8%	3,482
Total	8,884	93%	692	7%	9,576

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 2016	November 2016	December 2016	Total
Health Risk Assessments Submitted	2,634	2,965	2,486	8,085
Gift Cards Earned	2,116	2,394	2,013	6,523
Reductions Earned	510	566	468	1,544
Reductions Applied	655	704	708	2,067

Enrollment Counts for Quarter and Year to Date

Healthy Michigan Plan enrollment in this quarter has remained consistent with previous quarters. In addition to stable Healthy Michigan Plan enrollment, MDHHS saw the standard 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. 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. Enrollment counts in the table below are for unique members for identified time periods. The unique enrollee count will differ from the December 2016 count from the Beneficiary Month Reporting section as a result of disenrollment that occurred during the quarter.

Table 5: Enrollment Counts for Quarter and Year to Date

Demonstration Population	Total Number of Demonstration Beneficiaries Quarter Ending – 12/2016	Current Enrollees (year to date)	Disenrolled in Current Quarter
ABW Childless Adults	N/A	N/A	N/A
Healthy Michigan Adults	713,563	952,774	84,018

Outreach/Innovation Activities to Assure Access

MDHHS utilizes the Healthy Michigan Program website to provide information to both beneficiaries and providers. The Healthy Michigan Plan website contains 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 continues to work closely with provider groups through meetings, Medicaid provider policy bulletins, and various interactions with community partners and provider trade associations. Progress reports are provided by MDHHS 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 2016 MCAC meeting occurred during the quarter covered by this report. The minutes for this meeting have been attached as an enclosure. MCAC meeting agendas and minutes are also available on the MDHHS website.

Collection and Verification of Encounter Data and Enrollment Data

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

Health Plans work collaboratively to correct any issues discovered as part of the review process.

Operational/Policy/Systems/Fiscal Developmental Issues

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

Table 6: Medicaid Policy Bulletins with Healthy Michigan Plan Impact

Issue Date	Subject	Link
11/01/2016	Changes in Benefit Administration of Maternal Infant Health Program Services for Individuals Enrolled in a Medicaid Health Plan	MSA 16-33
11/30/2016	Timely Filing Billing Limitation	MSA 16-37
11/30/2016	Interim Caries Arresting Medicament Application	MSA 16-38
11/30/2016	Peer Mentor Training	MSA 16-39
11/30/2016	Benefits Monitoring Program (BMP)	MSA 16-40
11/30/2016	Updates to the Medicaid Provider Manual; Blood Lead Nursing Assessment Visits	MSA 16-42
12/01/2016	Policy Clarification for Long-Term Acute Care Hospitals (LTACHs)	MSA 16-43
12/29/2016	Standards of Coverage and Documentation for Pull-on Briefs	MSA 16-45
12/29/2016	Coverage of Trauma Services for Children Under 21 Years of Age	MSA 16-46

Financial/Budget Neutrality Development Issues

Healthy Michigan Plan expenditures for all plan eligible groups are included in the budget neutrality monitoring table below as reported in the CMS Medicaid and Children's Health Insurance Program Budget and Expenditure System. 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. The State will continue to update data for each demonstration quarter as it becomes available.

Table 7: Healthy Michigan Plan Budget Neutrality Monitoring Table

	DY 5 - PMPM	DY 6 - PMPM	DY 7 - PMPM	DY 8 - PMPM	DY 9 - PMPM
Approved HMP PMPM	$667.36	$602.21	$569.80	$598.86	$629.40
Actual HMP PMPM (YTD)	$474.66	$482.06	$477.38	-	-
Total Expenditures (YTD)	$1,772,960,230.00	$3,503,856,050.00	$3,693,496,061.00	-	-
Total Member Months (YTD)	3,735,189	7,268,580	7,737,068	-	-

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, 2016.

Table 8: Healthy Michigan Plan Beneficiary Month Reporting				
Eligibility Group	October 2016	November 2016	December 2016	Total for Quarter Ending 12/16
Healthy Michigan Adults	642,885	650,293	655,973	1,949,151

Consumer Issues

This quarter, the total number of Healthy Michigan Plan complaints reported to MDHHS was 47. Complaints reported to MDHHS are detailed by category in the table below. Overall, with over 1.9 million member months during the quarter, MDHHS is encouraged by its low rate of contacts related to Healthy Michigan Plan complaints. MDHHS will continue to monitor calls to the Beneficiary Helpline to identify issues and improve member experiences.

Table 9: Healthy Michigan Plan Complaints Reported to MDHHS October 2016 – December 2016					
	Obtaining Prescriptions	Other Covered Services	Transportation	Other	Total
Count	32	7	6	2	47
Percent	67%	15%	13%	5%	

Quality Assurance/Monitoring Activity

MDHHS completes Performance Monitoring Reports (PMR) specific to the Medicaid Health Plans that are licensed and approved to provide coverage to Michigan's Medicaid beneficiaries. These reports are based on data submitted by the health plans. Information specific to the Healthy Michigan Plan are included in these reports. The measures for the Healthy Michigan Plan population mirrors those used for the traditional Medicaid population. MDHHS continues to collect data and assist health plans with deliverables for the purpose of PMR completion. The most recently published Bureau of Medicaid Program Operations & Quality Assurance quarterly PMR with Healthy Michigan Plan specific measures was published in January 2017 and is included as an enclosure.

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 PMRs described in the Quality Assurance/Monitoring Activity section of this report. MDHHS and the Medicaid Health Plans continue to monitor MI Health Account call center and payment activity.

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 by callers contacting the MI Health Account Call Center relate to general MI Health Account information and payment amounts. Members calling

regarding the quarterly statements have asked about amounts owed, requested clarification on the contents of the statement, and reported an inability to pay amounts owed.

During this quarter, Healthy Michigan Plan members continued making payments for contributions and copays to the MI Health Account. Detailed MI Health Account activity is documented in the following tables. Activity from the previous quarter that was not available in the previous quarterly report, due to report revisions and data lag, has also been included. The January 2017 MI Health Account Executive Summary Report has been included as an attachment with this report. The quarterly report document mirrors the information provided in the attached MI Health Account Executive Summary report but is formatted to reflect information specific to the quarter and information not available in previous quarterly reports.

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

Table 10: MI Health Account Statement Mailing

Month Statement Mailed	Statements Mailed	Statements Requiring a Copay Only	Statements Requiring a Contribution Only	Statements Requiring a Copay and Contribution	Percentage of Statements Requiring Payment
August 2016	75,685	16,025	7,566	9,395	43.58%
September 2016	86,801	18,082	7,615	10,633	41.85%
October 2016	101,250	22,430	9,608	12,427	43.92%
November 2016	-	-	-	-	-
December 2016	-	-	-	-	-
Calendar YTD	840,703	165,668	83,549	88,522	40.17%
Program Total	2,130,191	396,422	158,528	179,687	34.49%

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

Table 11: MI Health Account Collection Summary

Statement Month	Amount of copays owed	Amount of copays paid	Percentage of copays paid	Number of beneficiaries who owed copays	Number of beneficiaries who paid copays
Copays					
August 2016	$189,785.53	$63,260.35	33%	25,420	9,110
September 2016	$224,566.12	$78,224.99	35%	28,715	10,655
October 2016	$265,806.58	$69,965.61	26%	34,857	10,113
November 2016	-	-	-	-	-
December 2016	-	-	-	-	-
Calendar YTD	$1,991,873.91	$696,115.18	35%	253,793	95,066
Program Total	$4,193,929.02	$1,531,713.72	37%	574,634	215,045

Table 11: MI Health Account Collection Summary Continued					
Contributions					
Statement Month	Amount of contributions owed	Amount of contributions paid	Percentage of contributions paid	Number of beneficiaries who owed contributions	Number of beneficiaries who paid contributions
August 2016	$977,330.48	$278,457.57	28%	16,961	6,011
September 2016	$1,099,741.10	$322,540.79	29%	18,248	6,679
October 2016	$1,328,806.10	$277,932.77	21%	22,035	6,508
November 2016	-	-	-	-	-
December 2016	-	-	-	-	-
Calendar YTD	$9,733,043.14	$2,904,979.98	30%	172,050	64,350
Program Total	$18,862,765.36	$5,751,392.74	30%	338,193	127,067

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

Table 12: MI Health Account Quarterly Collection				
Enrollment Month	Quarterly Pay Cycles	Amount Owed	Amount Collected	Percentage Collected
April 2014	Oct 2014 - Dec 2014	$23,678.03	$15,094.16	63.75%
	Jan 2015 - Mar 2015	$194,071.16	$131,747.04	67.89%
	Apr 2015 - Jun 2015	$166,894.45	$102,178.71	61.22%
	Jul 2015 - Sep 2015	$163,655.43	$88,036.18	53.79%
	Oct 2015 - Dec 2015	$155,099.01	$77,812.60	50.17%
	Jan 2016 - Mar 2016	$143,618.04	$68,657.30	47.81%
	Apr 2016 - Jun 2016	$193,780.57	$83,640.37	43.16%
	Jul 2016 - Sep 2016	$147,826.43	$47,791.88	32.33%
	Oct 2016 - Dec 2016	$188,077.54	$60,036.18	31.92%
May 2014	Nov 2014 - Jan 2015	$35,769.76	$25,404.12	71.02%
	Feb 2015 - Apr 2015	$56,661.54	$38,402.76	67.78%
	May 2015 - Jul 2015	$45,969.47	$29,318.14	63.78%
	Aug 2015 - Oct 2015	$41,375.52	$24,684.92	59.66%
	Nov 2015 - Jan 2016	$39,658.82	$23,186.24	58.46%
	Feb 2016 - Apr 2016	$38,173.46	$20,724.70	54.29%
	May 2016 - Jul 2016	$46,732.90	$22,045.90	47.17%
	Aug 2016 - Oct 2016	$42,121.21	$17,676.50	41.97%
June 2014	Dec 2014 - Feb 2015	$457,077.32	$323,559.71	70.79%
	Mar 2015 - May 2015	$349,691.94	$245,822.23	70.30%
	Jun 2015 - Aug 2015	$348,734.58	$227,840.27	65.33%
	Sep 2015 - Nov 2015	$330,511.14	$201,875.24	61.08%
	Dec 2015 - Feb 2016	$240,812.88	$140,477.18	58.33%
	Mar 2016 - May 2016	$275,901.98	$156,449.23	56.70%
	Jun 2016 - Aug 2016	$234,906.55	$109,272.03	46.52%
	Sep 2016 - Nov 2016	$331,788.72	$157,305.18	47.41%

Table 12: MI Health Account Quarterly Collection				
Enrollment Month	Quarterly Pay Cycles	Amount Owed	Amount Collected	Percentage Collected
July 2014	Jan 2015 - Mar 2015	$340,336.16	$224,585.98	65.99%
	Apr 2015 - Jun 2015	$252,019.77	$157,638.50	62.55%
	Jul 2015 - Sep 2015	$242,586.21	$135,861.05	56.01%
	Oct 2015 - Dec 2015	$222,223.07	$117,558.62	52.90%
	Jan 2016 - Mar 2016	$198,122.85	$100,436.20	50.69%
	Apr 2016 - Jun 2016	$218,491.91	$98,315.37	45.00%
	Jul 2016 - Sep 2016	$175,393.24	$61,307.35	34.95%
	Oct 2016 - Dec 2016	$208,306.31	$67,217.85	32.27%
August 2014	Feb 2015 - Apr 2015	$169,952.88	$112,656.85	66.29%
	May 2015 - Jul 2015	$121,946.27	$71,555.75	58.68%
	Aug 2015 - Oct 2015	$111,305.54	$65,772.05	59.09%
	Nov 2015 - Jan 2016	$103,758.41	$58,578.82	56.46%
	Feb 2016 - Apr 2016	$98,753.04	$51,857.62	52.51%
	May 2016 - Jul 2016	$109,661.14	$44,830.08	40.88%
	Aug 2016 - Oct 2016	$93,178.22	$31,665.96	33.98%
September 2014	Mar 2015 - May 2015	$212,502.42	$116,732.42	54.93%
	Jun 2015 - Aug 2015	$147,593.40	$78,749.80	53.36%
	Sep 2015 - Nov 2015	$150,249.62	$78,749.69	52.41%
	Dec 2015 - Feb 2016	$121,102.64	$61,276.25	50.60%
	Mar 2016 - May 2016	$138,698.21	$62,580.39	45.12%
	Jun 2016 - Aug 2016	$103,820.98	$33,875.62	32.63%
	Sep 2016 - Nov 2016	$123,197.02	$41,800.38	33.93%
October 2014	Apr 2015 - Jun 2015	$173,628.90	$93,050.57	53.59%
	Jul 2015 - Sep 2015	$125,396.82	$66,853.49	53.31%
	Oct 2015 - Dec 2015	$124,321.49	$64,456.14	51.85%
	Jan 2016 - Mar 2016	$118,837.59	$57,740.07	48.59%
	Apr 2016 - Jun 2016	$137,597.80	$57,480.12	41.77%
	Jul 2016 - Sep 2016	$105,817.66	$32,758.27	30.96%
	Oct 2016 - Dec 2016	$123,818.43	$38,273.30	30.91%
November 2014	May 2015 - Jul 2015	$194,938.88	$102,293.00	52.47%
	Aug 2015 - Oct 2015	$126,130.16	$63,789.10	50.57%
	Nov 2015 - Jan 2016	$133,137.68	$68,436.51	51.40%
	Feb 2016 - Apr 2016	$134,326.41	$64,920.30	48.33%
	May 2016 - Jul 2016	$157,699.94	$57,803.10	36.65%
	Aug 2016 - Oct 2016	$124,681.58	$35,204.57	28.24%
December 2014	Jun 2015 - Aug 2015	$104,840.39	$58,490.27	55.79%
	Sep 2015 - Nov 2015	$81,531.22	$44,394.22	54.45%
	Dec 2015 - Feb 2016	$67,214.28	$35,730.49	53.16%
	Mar 2016 - May 2016	$80,357.48	$39,985.53	49.76%
	Jun 2016 - Aug 2016	$69,513.65	$22,647.77	32.58%
	Sep 2016 - Nov 2016	$75,910.69	$22,446.86	29.57%
January 2015	Jul 2015 - Sep 2015	$210,890.77	$125,380.54	59.45%
	Oct 2015 - Dec 2015	$169,826.10	$91,640.81	53.96%
	Jan 2016 - Mar 2016	$166,240.38	$90,754.71	54.59%
	Apr 2016 - Jun 2016	$192,186.52	$92,167.75	47.96%

Table 12: MI Health Account Quarterly Collection Continued				
Enrollment Month	Quarterly Pay Cycles	Amount Owed	Amount Collected	Percentage Collected
January 2015	Jul 2016 - Sep 2016	$160,802.23	$55,588.98	34.57%
	Oct 2016 - Dec 2016	$172,905.93	$55,659.67	32.19%
February 2015	Aug 2015 - Oct 2015	$205,912.77	$116,459.38	56.56%
	Nov 2015 - Jan 2016	$132,552.90	$75,295.20	56.80%
	Feb 2016 - Apr 2016	$147,771.38	$86,169.47	58.31%
	May 2016 - Jul 2016	$192,083.28	$85,748.21	44.64%
	Aug 2016 - Oct 2016	$156,760.07	$55,097.64	35.15%
March 2015	Sep 2015 - Nov 2015	$220,919.11	$114,329.67	51.75%
	Dec 2015 - Feb 2016	$100,161.87	$52,619.61	52.53%
	Mar 2016 - May 2016	$109,529.52	$60,821.49	55.53%
	Jun 2016 - Aug 2016	$125,551.80	$53,184.50	42.36%
	Sep 2016 - Nov 2016	$133,357.35	$48,617.90	36.46%
April 2015	Oct 2015 - Dec 2015	$274,309.84	$139,686.63	50.92%
	Jan 2016 - Mar 2016	$136,837.80	$74,921.49	54.75%
	Apr 2016 - Jun 2016	$171,658.22	$92,381.92	53.82%
	Jul 2016 - Sep 2016	$149,720.98	$64,455.82	43.05%
	Oct 2016 - Dec 2016	$159,813.11	$56,856.42	35.58%
May 2015	Nov 2015 - Jan 2016	$185,291.91	$99,532.27	53.72%
	Feb 2016 - Apr 2016	$122,155.32	$73,156.79	59.89%
	May 2016 - Jul 2016	$163,639.15	$84,315.30	51.53%
	Aug 2016 - Oct 2016	$141,809.82	$60,357.77	42.56%
June 2015	Dec 2015 - Feb 2016	$150,852.37	$71,185.67	47.19%
	Mar 2016 - May 2016	$100,599.94	$51,547.08	51.24%
	Jun 2016 - Aug 2016	$93,341.94	$40,951.77	43.87%
	Sep 2016 - Nov 2016	$104,846.75	$38,747.65	36.96%
July 2015	Jan 2016 - Mar 2016	$138,741.20	$69,789.05	50.30%
	Apr 2016 - Jun 2016	$102,151.61	$48,419.96	47.40%
	Jul 2016 - Sep 2016	$86,500.84	$34,357.05	39.72%
	Oct 2016 - Dec 2016	$90,025.63	$29,827.01	33.13%
August 2015	Feb 2016 - Apr 2016	$137,300.38	$60,225.47	43.86%
	May 2016 - Jul 2016	$97,317.90	$37,685.50	38.72%
	Aug 2016 - Oct 2016	$82,090.11	$29,589.31	36.04%
September 2015	Mar 2016 - May 2016	$108,668.12	$48,096.32	44.26%
	Jun 2016 - Aug 2016	$69,903.19	$24,798.06	35.47%
	Sep 2016 - Nov 2016	$63,940.41	$23,278.46	36.41%
October 2015	Apr 2016 - Jun 2016	$121,181.79	$40,828.37	33.69%
	Jul 2016 - Sep 2016	$74,255.26	$24,246.24	32.65%
	Oct 2016 - Dec 2016	$79,804.04	$23,830.07	29.86%
November 2015	Jul 2016 - Sep 2016	$141,848.05	$45,696.37	32.22%
	Aug 2016 - Oct 2016	$96,538.34	$28,081.78	29.09%
December 2015	Jun 2016 - Aug 2016	$130,210.52	$44,858.62	34.45%
	Sep 2016 - Nov 2016	$104,381.33	$29,684.56	28.44%
January 2016	Jul 2016 - Sep 2016	$168,970.84	$65,725.72	38.90%
	Oct 2016 - Dec 2016	$132,268.43	$42,010.77	31.76%
February 2016	Aug 2016 - Oct 2016	$237,197.81	$98,971.85	41.73%

Table 12: MI Health Account Quarterly Collection Continued				
Enrollment Month	Enrollment Month	Enrollment Month	Enrollment Month	Enrollment Month
March 2016	Sep 2016 - Nov 2016	$197,021.75	$70,832.27	35.95%
April 2016	Oct 2016 - Dec 2016	$181,384.06	$54,382.48	29.98%

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 13: MI Health Account Methods of Payment					
	August 2016	September 2016	October 2016	November 2016	December 2016
Percent Paid Online	31.12%	28.64%	27.52%	-	-
Percent Paid by Mail	68.88%	71.36%	72.48%	-	-

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

Table 14: MI Health Account Adjustment Activities						
	August 2016		September 2016		October 2016	
	Number of Beneficiaries	Total Amount	Number of Beneficiaries	Total Amount	Number of Beneficiaries	Total Amount
Beneficiary is Under Age 21	783	$50,732.50	706	$46,129.00	763	$50,327.00
Pregnancy	376	$12,335.02	221	$6,301.96	203	$6,069.94
Hospice	0	$0.00	0	$0.00	0	$0.00
Native American	81	$2,248.33	97	26,$1,968.00	77	$1,253.00
Five Percent Cost Share Limit Met	29,623	$420,484.47	28,618	$377,155.20	31,234	$291,668.54
FPL No Longer >100% - Contribution	0	$0.00	0	$0.00	0	$0.00
Total	30,863	$485,800.32	29,642	$431,554.16	32,277	$349,318.48

Table 14: MI Health Account Adjustment Activities Continued						
	August 2016 to October 2016		Calendar YTD		Program YTD	
	Number of Beneficiaries	Total Amount	Number of Beneficiaries	Total Amount	Number of Beneficiaries	Total Amount
Beneficiary is Under Age 21	2,252	$147,188.50	6,609	$407,063.74	11,418	$671,319.24
Pregnancy	800	$24,706.92	2,876	$93,798.19	7,153	$216,449.76
Hospice	0	$0.00	0	$0.00	0	$0.00
Native American	255	$5,469.33	660	$13,502.66	1,154	$37,730.66
Five Percent Cost Share Limit Met	89,475	$1,089,308.21	288,825	$4,143,239.18	623,236	$8,997,246.32
FPL No longer >100% - Contribution	0	$0.00	0	$0.00	20	$1,152.50
Total	92,782	$1,266,672.96	298,970	$4,657,603.77	642,981	$9,923,898.48

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

Table 15: MI Health Account Healthy Behaviors Incentive Activity						
	August 2016		September 2016		October 2016	
	Number of Beneficiaries	Total Amount	Number of Beneficiaries	Total Amount	Number of Beneficiaries	Total Amount
Copay	2,374	$19,665.07	859	$4,060.58	966	$4,421.60
Contribution	3,484	$157,044.58	1,548	$62,472.11	1,624	$65,795.00
Gift Cards	3,408	n/a	1,613	n/a	2,531	n/a
Total	9,266	$176,709.65	4,020	$66,532.69	5,121	$70,216.60
	August 2016 to October 2016		Calendar YTD		Program YTD	
	Number of Beneficiaries	Total Amount	Number of Beneficiaries	Total Amount	Number of Beneficiaries	Total Amount
Copay	4,199	$28,147.25	25,722	$175,457.45	26,969	$180,499.97
Contribution	6,656	$285,311.69	22,750	$1,159,985.64	45,800	$1,913,147.33
Gift Cards	7,552	n/a	28,758	n/a	93,523	n/a
Total	18,407	$313,458.94	77,230	$1,335,443.09	166,292	$2,093,647.30

Table 17 shows the number of members with co-pays waived and the amount waived for services associated with chronic conditions.

Table 16: MI Health Account Waived Copays for High Value Services		
Month	Number of Beneficiaries with Copays Waived	Total Dollar Amount Waived
August 2016	26,114	$219,156
September 2016	32,490	$284,575
October 2016	39,421	$353,535
November 2016	-	-
December 2016	-	-
Calendar YTD	194,924	$1,708,435
Program Total	194,924	$1,708,435

Healthy Michigan Plan members that do not meet payment obligations for three consecutive months are deemed "consistently failing to pay." Consequences associated with consistently failing to pay include healthy behavior reduction and garnishment of tax refunds and lottery winnings. Table 18 provides cumulative past due collection amounts and the number of members that have past due balances that are eligible for collection through the Michigan Department of Treasury for this reporting quarter.

Table 17: MI Health Account Past Due Collection Amounts		
Month	Number of Beneficiaries with Past Due Co-Pays/Contributions	Number of Beneficiaries with Past Due Co-Pays/Contributions that are Collectible Debt
August 2016	118,480	47,218
September 2016	126,874	50,034
October 2016	128,105	52,073
November 2016	-	-
December 2016	-	-

Table 19 includes the total amount of past due balances by the length of time the account has been delinquent. The information below is cumulative and not limited to the current quarter.

Table 18: MI Health Account Delinquent Co-pay and Contribution Amounts by Aging Category						
Days	0-30 Days	31-60 Days	61-90 Days	91-120 Days	>120 Days	Total
Amount Due	$1,005,409.98	$937,070.06	$821,444.97	$721,709.71	$7,628,581.96	$11,114,216.68
Number of Beneficiaries That Owe	77,939	70,807	63,656	58,713	141,565	187,664

MDHHS staff effectively collaborate with the MI Health Account vendor to continue the garnishment process. Staff continue to work with the MI Health Account vendor and the Michigan Department of Treasury to ensure data quality and accuracy. Applicable beneficiaries are mailed a notice informing them of amounts that could be garnished by the Michigan Department of Treasury. The pre-garnishment notice process occurs annually in July. Table 20 shows the beneficiary payment activity associated with pre-garnishment notices.

Table 19: MI Health Account Pre-Garnishment Notices				
Month/Year	Number of Beneficiaries that Received a Pre-Garnishment Notice	Total Amount Owed	Number of Beneficiaries that Paid Following Pre-Garnishment Notice	Total Amount Collected
July 2015	5,893	$589,770.20	2,981	$78,670.02
July 2016	41,460	$5,108,153.13	3,832	$404,921.47
Calendar YTD	41,460	$5,108,153.13	3,832	$404,921.47
Program Total	47,353	$5,697,923.33	6,813	$483,591.49

Healthy Michigan Plan members that still owe at least $50 in the November after the pre-garnishment notice are referred to the Michigan Department of Treasury for garnishment. Table 21 shows the number of beneficiaries that have been referred.

Table 20: MI Health Account Garnishments Sent to Treasury		
Month	Number of Beneficiaries Sent to Treasury for Garnishment	Total Amount Sent to Treasury for Garnishment
November 2015	4,635	$460,231.19
November 2016	31,932	$3,946,091.28

The Michigan Department of Treasury garnishes tax refunds and lottery winnings to collect the MDHHS referred MI Health Account balance. Table 22 displays the MI Health Account garnishment activities performed by the Michigan Department of Treasury.

Table 21: MI Health Account Garnishments Collected by Treasury						
Tax Year	Collected by Taxes		Collected by Lottery		Total Garnishments Collected	
	Number	Total Amount	Number	Total Amount	Number	Total Amount
2015	2,151	$207,873.10	7	$485.67	2,158	$208,358.77
2016	7,491	$908,366.12	29	$3,136.01	7,520	$911,502.13
Calendar YTD	7,491	$908,366.12	29	$3,136.01	7,520	$911,502.13
Program Total	9,642	$1,116,239.22	36	$3,621.68	9,678	$1,119,860.90

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.

From October to December 2016, there were 169 total appeals among all the Medicaid Health Plans. Medicaid Health Plan decisions were upheld in 46 percent of the appeals. From October to December 2016 there were a total of 1,191 grievances. The greatest number of grievances came from the Access category. Access grievances can include a primary care physician not accepting new patients, limited specialist availability, the refusal of a primary care physician to complete a referral or write a prescription, a lack of services provided by the primary care physician, long wait times for appointments and denied services. Transportation grievances relate to issues with the transportation benefit and often mirror the complaints members directly reported to MDHHS. 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. MDHHS has included grievance and appeals data reported by the Medicaid Health Plans from this quarter in the following tables:

Table 22: Managed Care Organization Appeals
October 2016 – December 2016

	Decision Upheld	Overturned	Undetermined/ Withdrawn	Total
Count	78	83	8	169
Percent	46%	49%	5%	

Table 23: Managed Care Organization Grievances
October 2016 – December 2016

	Access	Quality of Care	Administrative/Service	Billing	Transportation	Total
Count	673	55	94	100	269	1,191
Percent	57%	5%	8%	8%	23%	

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 continued crafting proposals to improve the Health Risk Assessment form, submission process, and program participation. Based on feedback collected by the demonstration evaluator, providers are interested in a streamlined approach to document submission. MDHHS is working toward the goal of a single submission portal for providers to securely submit Health Risk Assessments. Additional questions and goals are also being considered for a future improved Health Risk Assessment form to inform service delivery and improve Healthy Behavior program participation. MDHHS continues to identify and embrace measures to improve Healthy Michigan member experiences and outcomes.

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 seven domains over the course of the five year evaluation period:

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

Below is a summary of the key activities for the Fiscal Year (FY) 2017 first quarterly report:

Domain I

Domain I will examine the impact of reducing the number of uninsured individuals on uncompensated care costs of Michigan hospitals. 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 began preliminary analysis of the Medicare cost data. Further, IHPI utilized Medicaid cost data to examine changes in uncompensated care for fiscal years 2013 to 2015. IHPI obtained the most recent IRS Form 990 data and extracted data from the Healthcare Cost and Utilization Project (HCUP) Fast Stats Program. The analyses of this data will complement those conducted with the Cost Report Data. IHPI began its preliminary analysis of studying how uncompensated care has changed among states that implemented Medicaid Expansion.

Domain II

Domain II will examine the hypothesis that, when affordable health insurance is available and the applicable for insurance is simplified, the uninsured population will decrease significantly. This quarter, IHPI completed a data update with the most recent American Community Survey (ACS) data which became available during this quarter to investigate and understand the differences in the estimated insurance coverage rates between US Census Bureau data sources. An extract was constructed, in order to analyze this data. Also, IHPI has been tracking academic literature to determine how it can inform their analysis of the Heathy Michigan Plan.

Domain III
Domain III will assess health behaviors, utilization and health outcomes for individuals enrolled in the Healthy Michigan Plan. This quarter, IHPI conducted data completeness tests for outpatient visits, Emergency Room visits and inpatient admissions to ensure adequate run-out for claims analysis. They also investigated potential problems with ICD-9 to ICD-10 comparability for classification of chronic disease groups. Lastly, IHPI studied data issues with cost fields.

Domain IV
Domain IV will examine beneficiary and provider viewpoints of the Healthy Michigan Plan through surveys. In November 2016, data collection for the 2016 Healthy Michigan Voices Survey of current enrollees was completed with 4,108 participants. IHPI completed the descriptive analyses and the analyses of relationships among subgroups is underway. An Initial Selected Findings Reports was submitted to MDHHS for review in December 2016. Additionally, the 2016 Healthy Michigan Voices Survey of those who have been disenrolled is in the field and data collection is expected to be completed by March 2017. IHPI prepared a report of other health practitioners (Specialists, Mental Providers, Emergency Room Physicians, Community Health Workers, Dentists, Rural Hospital Leaders and Practice Care Managers) perspectives on the impact of the Healthy Michigan Plan to be submitted to MDHHS for review.

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. This quarter, IHPI updated its analytic plan and further specified cost variables and issues requiring linkages between claims and other data (e.g. enrollment, demographics, survey). They obtained claims data and tested the completeness of information on charges, approved costs and patient out-of-pocket costs. Based on the tests that were conducted to assess the validity of the data, IHPI developed further questions for MDHHS regarding the data structure and definitions.

Domain VII
Domain VII will evaluate the cost effectiveness of the Healthy Michigan Marketplace Option. The Marketplace Option will not be implemented until April 2018. IHPI worked on the modifications to the evaluation plan based on CMS feedback. Additionally, IHPI began preparations for the Secret Shopper Study and analyses of quality measures by examining trends in data. IHPI has been meeting with MDHHS staff regarding the implementation of the Marketplace Option and cost data that can be utilized for the purposes of this analysis.

Enclosures/Attachments

1. December 2016 Health Risk Assessment Report
2. November 2016 MCAC Minutes
3. January 2017 Performance Monitoring Report
4. January 2017 MI Health Account Executive Summary

State Contacts

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Michigan Department of Health and Human Services

Medical Services Administration

Bureau of Medicaid Care Management and Quality Assurance

Healthy Michigan Plan - Health Risk Assessment Report

December 2016

Produced by:

Quality Improvement and Program Development - Managed Care Plan Divison

Table of Contents

Health Risk Assessment Part 1

Health Risk Assessment Part 2

Introduction

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

Health Risk Assessment Part 1

Health Risk Assessments completion through Michigan ENROLLS

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

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

The data displayed in Part 1 of this report reflect the responses to questions 1-9 of Section 1 of the Health Risk Assessment completed through Michigan ENROLLS. As shown in Table I, a total of 301,746 Health Risk Assessments were completed through Michigan ENROLLS as of December 2016. This represents a completion rate of 95.60%. 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 2016	261,417	11,585 (4.24%)
February 2016	269,644	11,983 (4.26%)
March 2016	275,839	12,239 (4.25%)
April 2016	279,562	12,476 (4.27%)
May 2016	282,318	12,620 (4.28%)
June 2016	284,785	12,745 (4.28%)
July 2016	287,641	12,896 (4.29%)
August 2016	289,929	13,019 (4.30%)
September 2016	292,862	13,187 (4.31%)
October 2016	295,511	13,314 (4.31%)
November 2016	298,264	13,575 (4.35%)
December 2016	301,746	13,879 (4.40%)

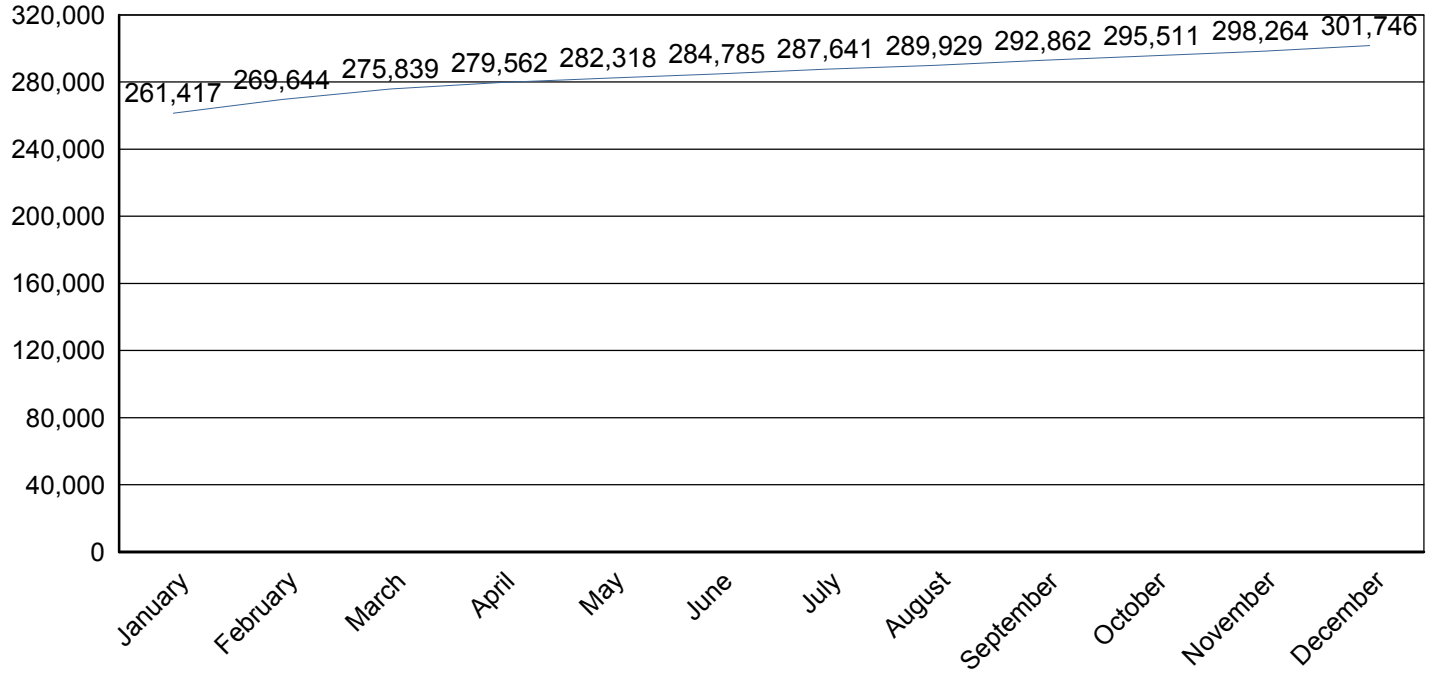
Table 11. Demographics of Population that Completed HRA Questions 1-9 with MI ENROLLS

January 2014 - December 2016

AGE GROUP	COMPLETED HRA	
19 - 29	71,978	23.85%
30 - 39	64,270	21.30%
40 - 49	61,735	20.46%
50 - 59	72,955	24.18%
60 +	30,808	10.21%
GENDER		
F	162,579	53.88%
M	139,167	46.12%
FPL		
< 100% FPL	249,074	82.54%
100 - 133% FPL	52,672	17.46%
TOTAL	**301,746**	**100.00%**

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

December 2016



Question 1. General Health Rating

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

Table 1. Health Rating for Total Population

December 2016

HEALTH RATING	TOTAL	PERCENT
Excellent	34,087	11.30%
Very Good	78,094	25.88%
Good	107,842	35.74%
Fair	61,265	20.30%
Poor	19,960	6.62%
Refused	498	0.17%
TOTAL	**301,746**	**100.00%**

Figure 1-1. Health Rating for Total Population

December 2016

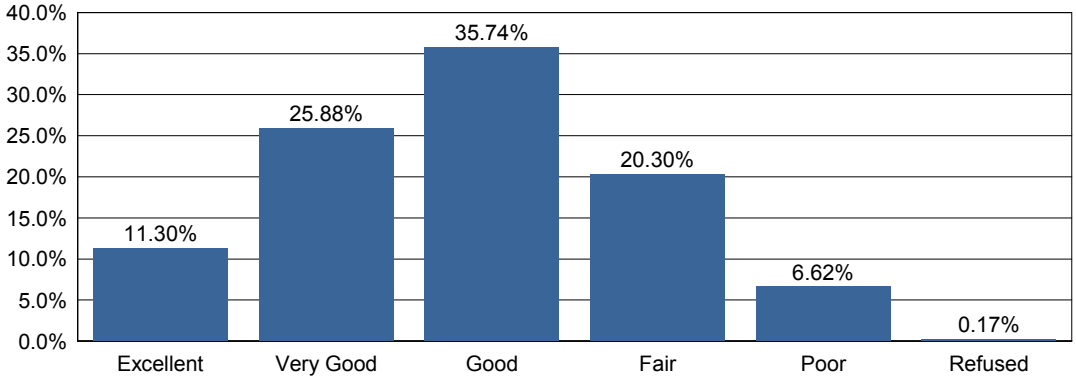


Figure 1-2. Health Rating by Age

December 2016

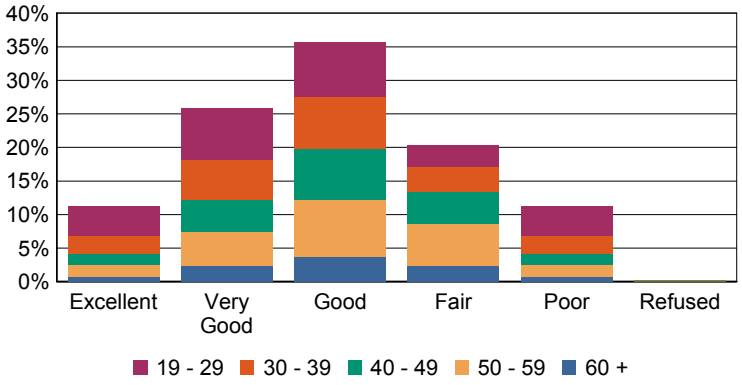
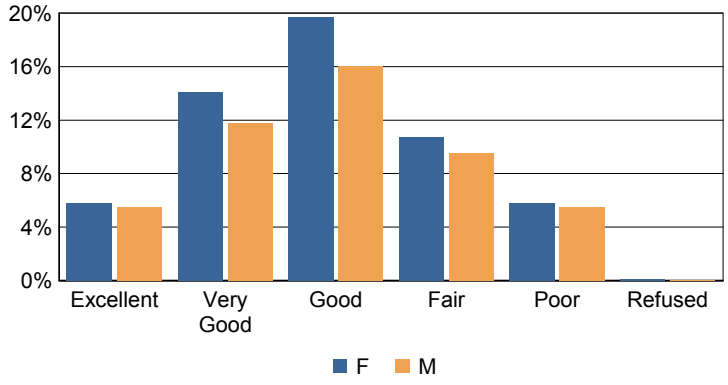


Figure 1-3. Health Rating by Gender

December 2016



Question 2. Exercise

Question 2. In the last 7 days, how often did you exercise for at least 20 minutes a day? This question is used to assess selfreported exercise frequency as an important component of maintaining a healthy weight. Healthy Michigan Plan enrollees were given the answer options of every day, 3-6 days, 1-2 days or 0 days. Table 2 shows the overall answers to this question for December 2016. Among enrollees who participated in the survey, there was a 1.51% 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 2016

EXERCISE	TOTAL	PERCENT
Every Day	69,176	22.93%
3-6 Days	88,048	29.18%
1-2 Days	74,484	24.68%
No Days	65,475	21.70%
Refused	4,563	1.51%
TOTAL	**301,746**	**100.00%**

Figure 2-1. Exercise Reported for Total Population

December 2016

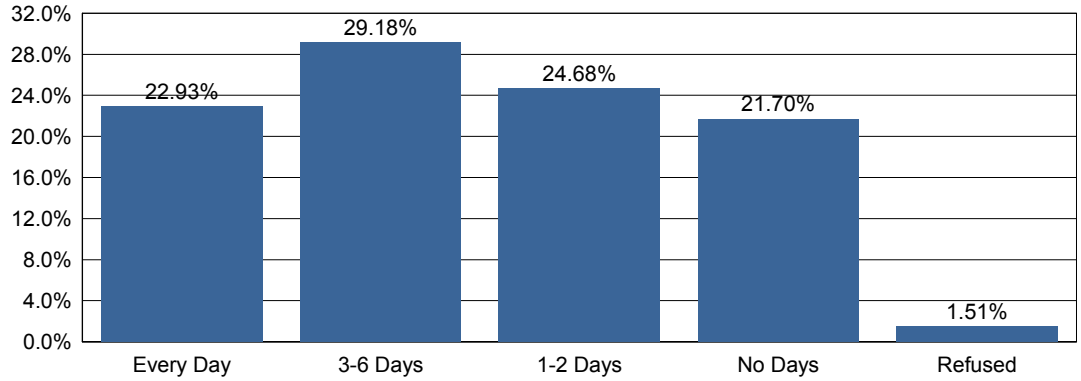


Figure 2-2. Exercise Reported by Age

December 2016

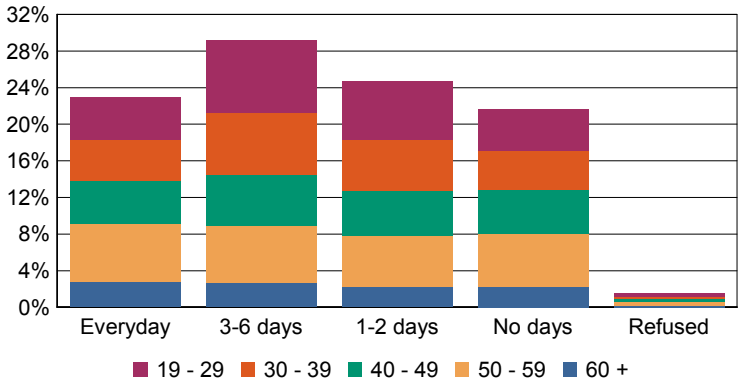
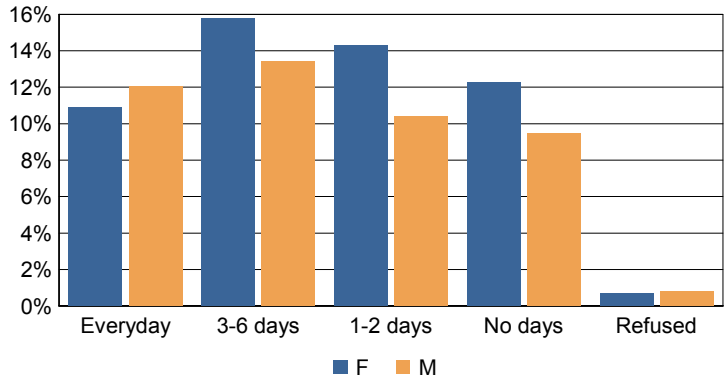


Figure 2-3. Exercise by Gender

December 2016



Question 3. Nutrition (Fruits and Vegetables)

Question 3. In the last 7 days, how often did you eat 3 or more servings of fruits or vegetables in a day? This question is used to assess self-reported nutrition as an important component of maintaining a healthy weight. Healthy Michigan Plan enrollees were given the answer options of every day, 3-6 days, 1-2 days or 0 days. Table 3 shows the overall answers to this question for December 2016. Among enrollees who participated in the survey, there was a 1.87% 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 2016

NUTRITION	TOTAL	PERCENT
Every Day	101,923	33.78%
3-6 Days	104,654	34.68%
1-2 Days	68,866	22.82%
No Days	20,662	6.85%
Refused	5,641	1.87%
TOTAL	**301,746**	**100.00%**

Figure 3-1. Nutrition Reported for Total Population
December 2016

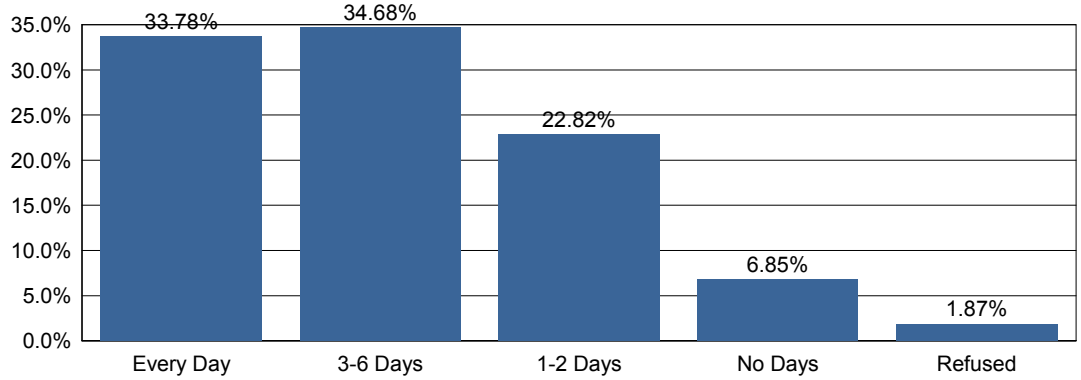


Figure 3-2. Nutrition Reported by Age
December 2016

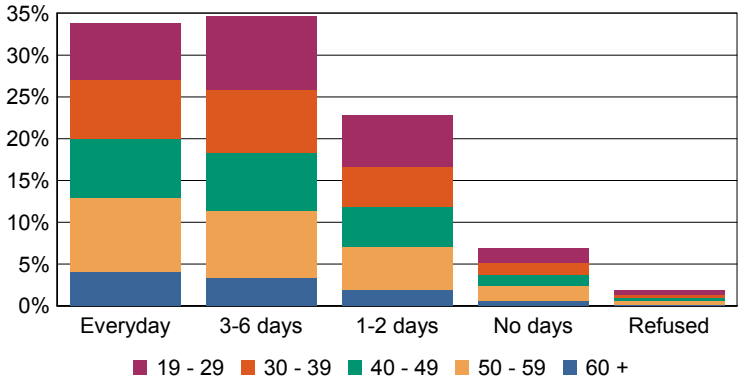
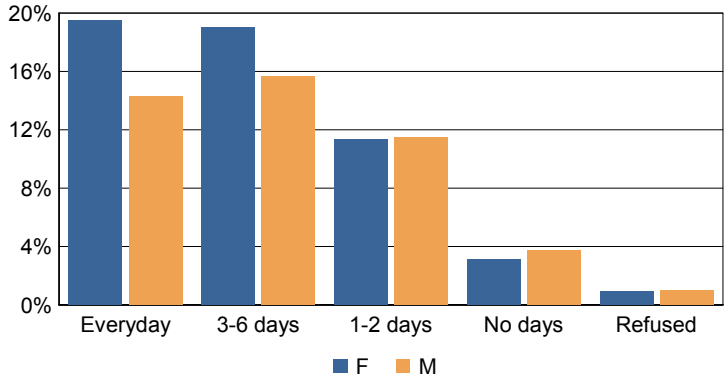


Figure 3-3. Nutrition by Gender
December 2016



Question 4. Binge Alcohol Use

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

Table 4. Binge Alcohol Use Reported for Total Population

December 2016

ALCOHOL	TOTAL	PERCENT
Never	249,684	82.75%
Once a Week	33,489	11.10%
2-3 times a Week	13,023	4.32%
More than 3	3,066	1.02%
Refused	2,484	0.82%
TOTAL	**301,746**	**100.00%**

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

December 2016

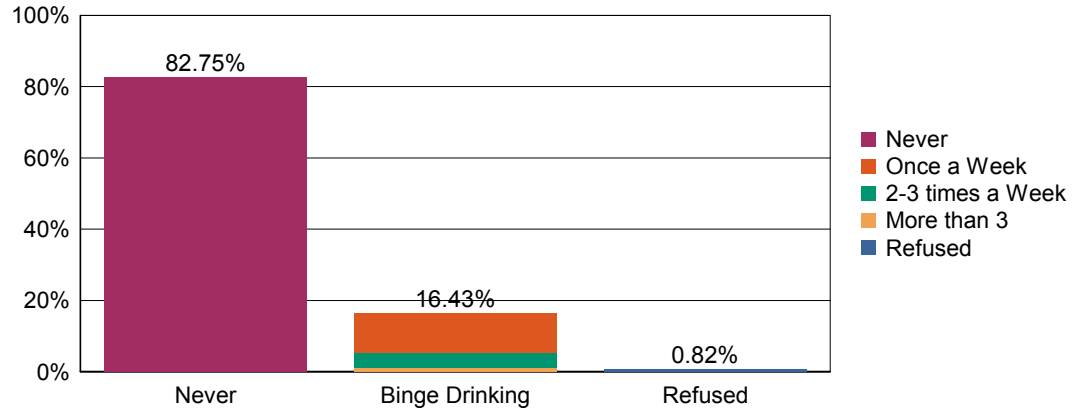


Figure 4-2. Binge Alcohol Use Reported by Age

December 2016

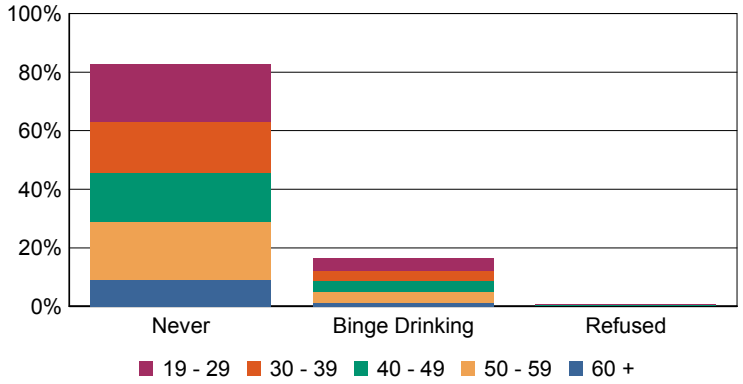
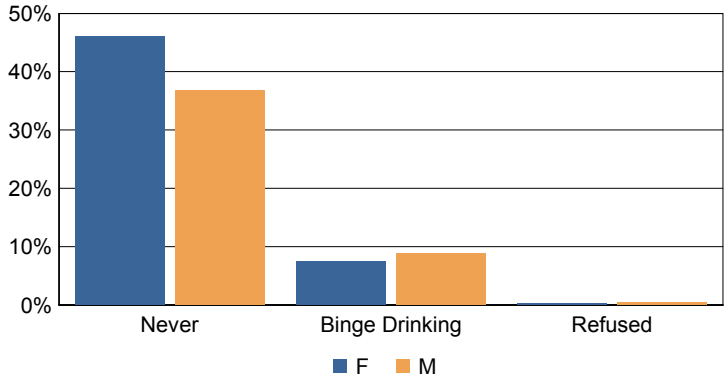


Figure 4-3. Binge Alcohol Use by Gender

December 2016



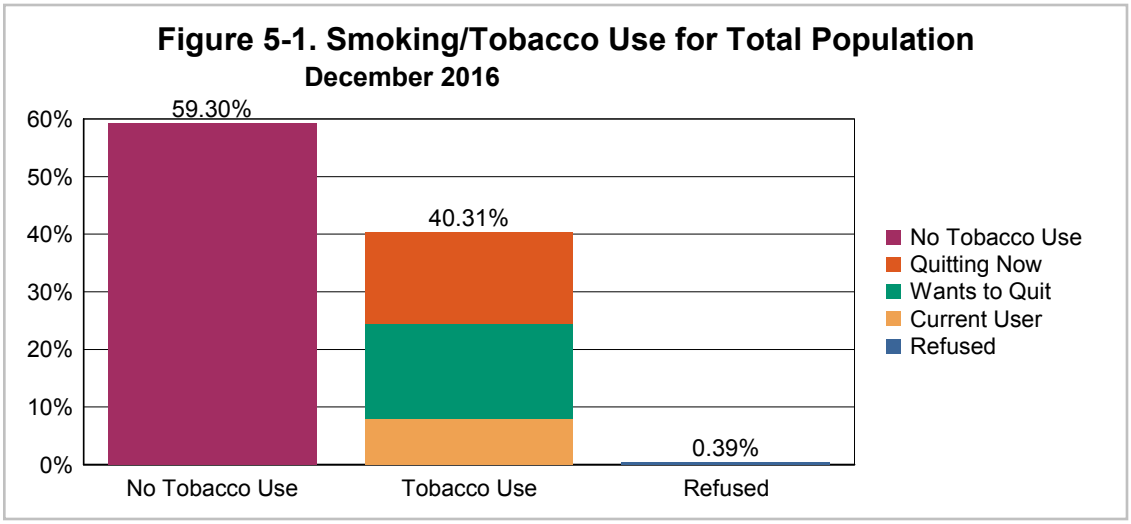
Question 5. Smoking/Tobacco Use

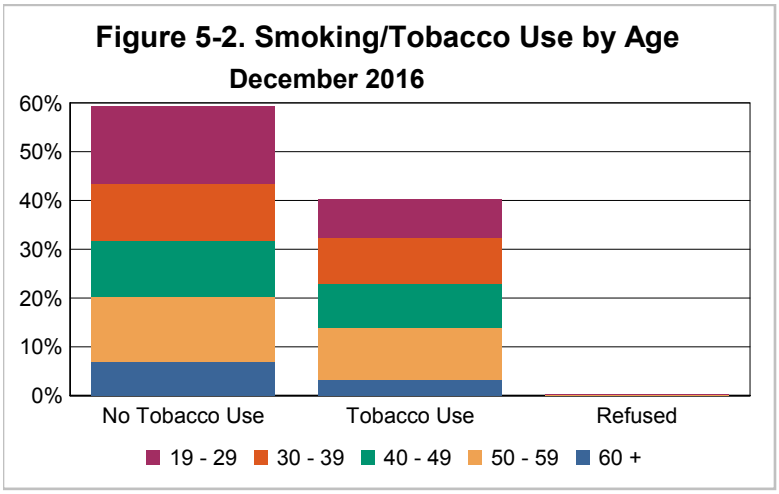
Question 5. In the last 30 days, have you smoked or used tobacco? This question is used to assess self-reported smoking/tobacco use. Healthy Michigan Plan enrollees were given the answer options of yes or no. Enrollees who answered yes, were asked a follow-up question: If YES, do you want to quit smoking or using tobacco? For this follow-up question, enrollees were given the answer options of yes, I am working on quitting or cutting back right now and no. Table 5 shows the combined overall answers to these questions for December 2016. Question 5 had a 0.39% refusal rate. Figures 5-1 through 5-3 show smoking/tobacco use reported for the total population, and by age and gender.

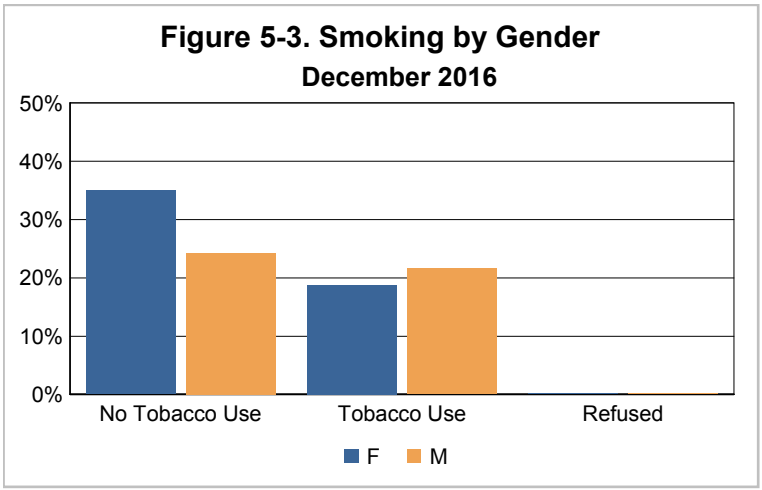
Table 5. Smoking/Tobacco Use Reported for Total Population

December 2016

TOBACCO USE	TOTAL	PERCENT
No Tobacco Use	178,926	59.30%
Quitting Now	47,991	15.90%
Wants to Quit	49,263	16.33%
Current User	24,381	8.08%
Refused	1,185	0.39%
TOTAL	**301,746**	**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 2016. Among enrollees who participated in the survey, there was a 10.07% 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 2016

DEPRESSION	TOTAL	PERCENT
Almost Every day	62,500	20.71%
Sometimes	79,281	26.27%
Rarely	63,839	21.16%
Never	65,753	21.79%
Refused	30,373	10.07%
TOTAL	**301,746**	**100.00%**

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

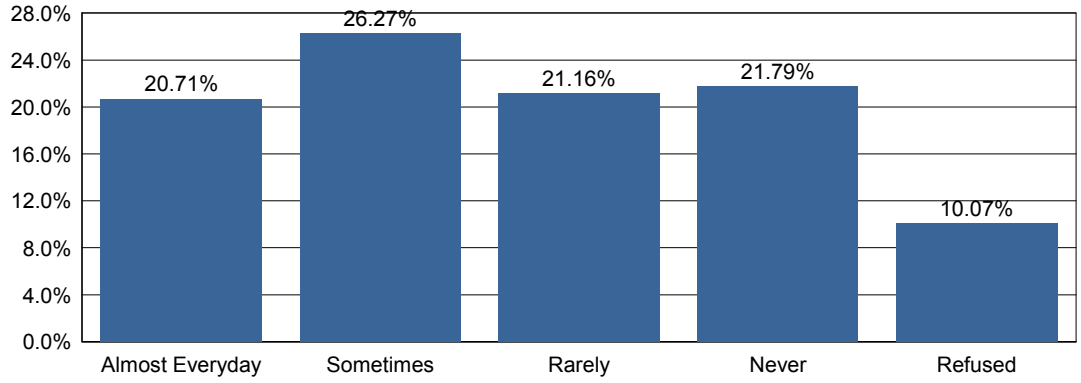


Figure 6-2. Anxiety and Depression Reported by December 2016 Age

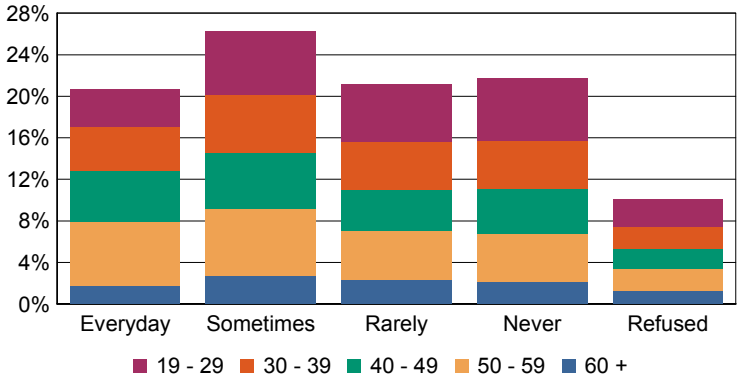
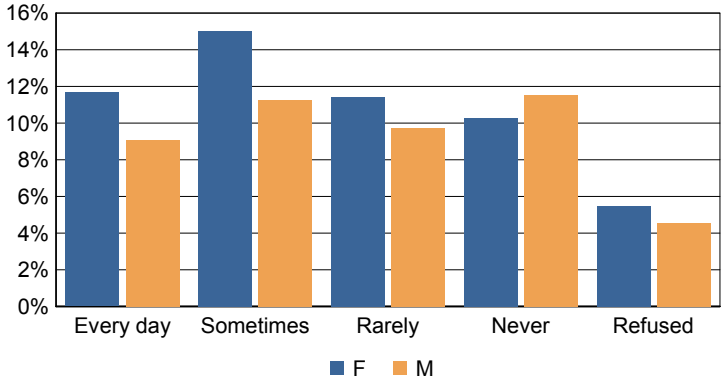


Figure 6-3. Anxiety and Depression by Gender
December 2016



Question 7. Drugs and Substance Use

Question 7. Do you use drugs or medications (other than exactly as prescribed for you) which affect your mood or help you to relax? This question is used to assess self-reported substance use. Healthy Michigan Plan enrollees were given the answer options of almost every day, sometimes, rarely and never. Table 7 shows the overall answers to this question for December 2016. Among enrollees who participated in the survey, there was a 0.74% refusal rate for this question. Figures 7-1 through 7-3 show substance use reported for the total population, and by age and gender.

Table 7. Substance Use Reported for Total Population

December 2016

SUBSTANCE USE	TOTAL	PERCENT
Almost Every Day	5,831	1.93%
Sometimes	7,771	2.58%
Rarely	7,085	2.35%
Never	278,816	92.40%
Refused	2,243	0.74%
TOTAL	**301,746**	**100.00%**

Figure 7-1. Substance Use Reported for Total Population

December 2016

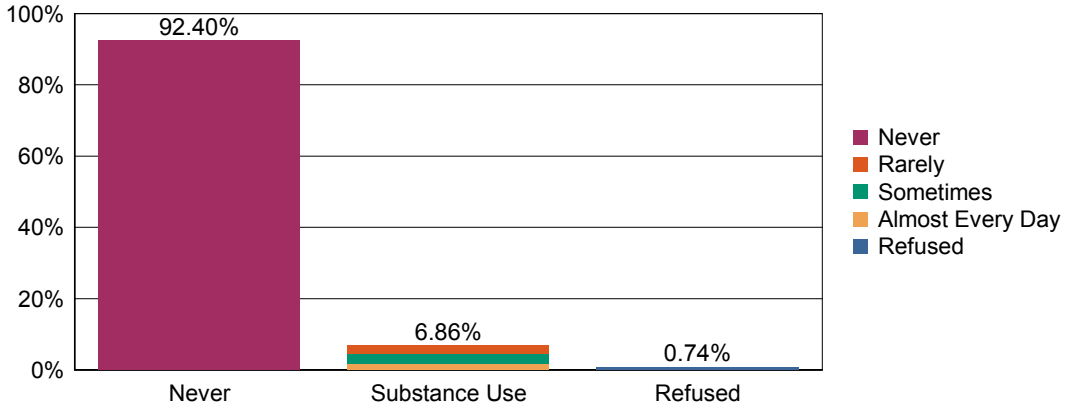


Figure 7-2. Substance Use Reported by Age

December 2016

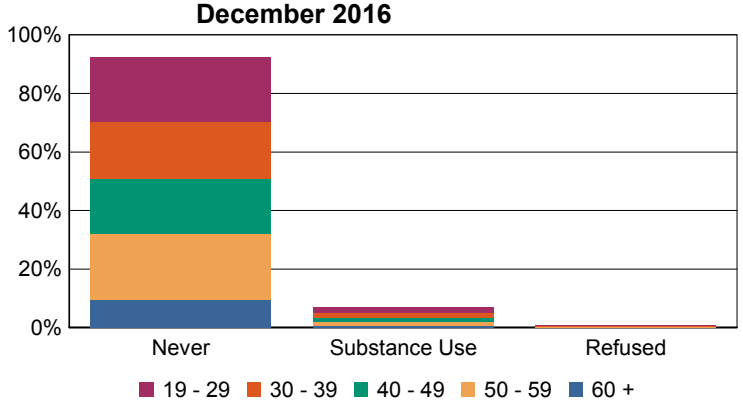
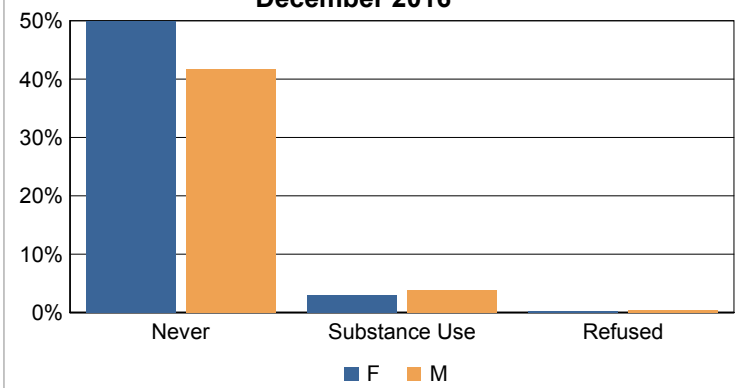


Figure 7-3. Substance Use by Gender

December 2016



Question 8. Immunization Status (Annual Flu Vaccine)

Question 8. The flu vaccine can be a shot in the arm or a spray in the nose. Have you had a flu shot or flu spray in the last year?
This question is used to assess self-reported annual flu vaccine as an indicator of immunization status. Healthy Michigan Plan enrollees were given the answer options of yes or no. Table 8 shows the overall answers to this question for December 2016. Among enrollees who participated in the survey, there was a 1.83% 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 2016

IMMUNIZATION	TOTAL	PERCENT
Yes	67,166	22.26%
No	229,066	75.91%
Refused	5,514	1.83%
TOTAL	**301,746**	**100.00%**

Figure 8-1. Immunization Status Reported for Total Population

December 2016

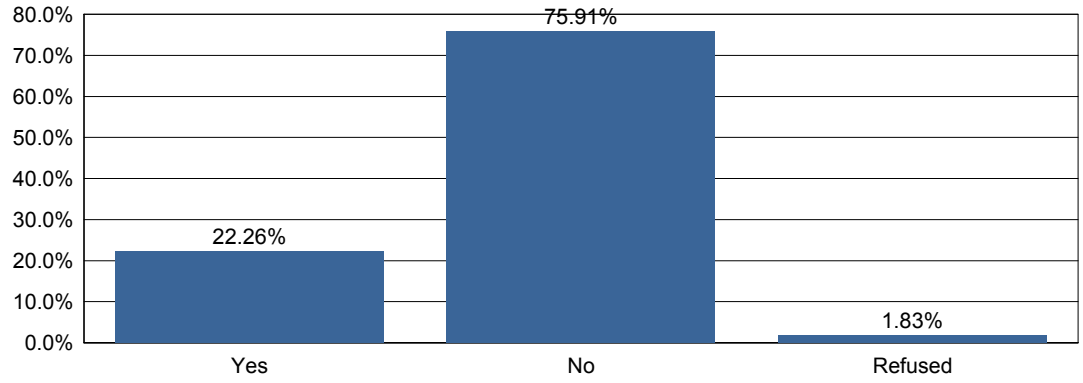


Figure 8-2. Immunization Status Reported by Age

December 2016

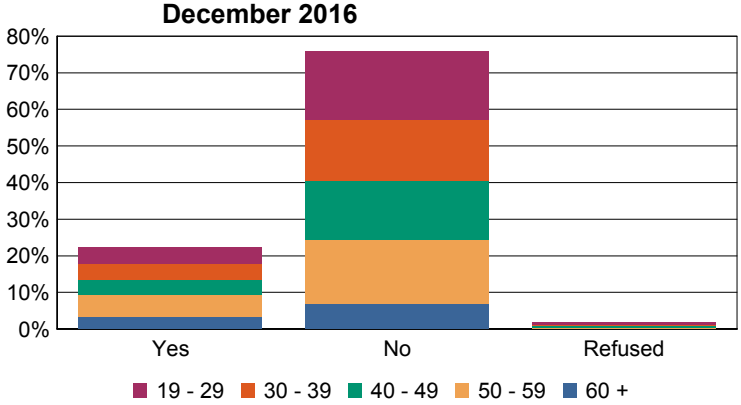
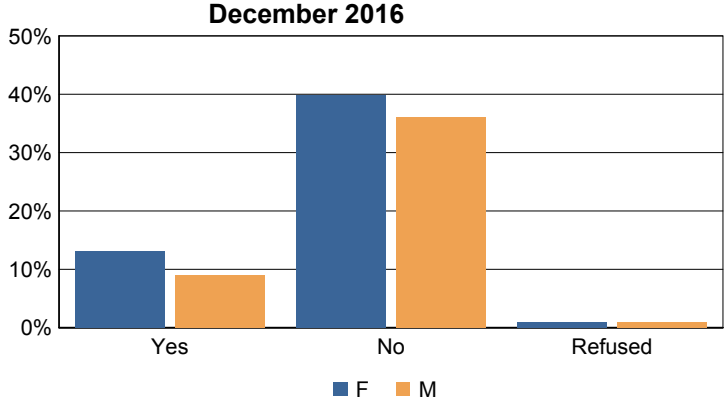


Figure 8-3. Immunization Status by Gender

December 2016



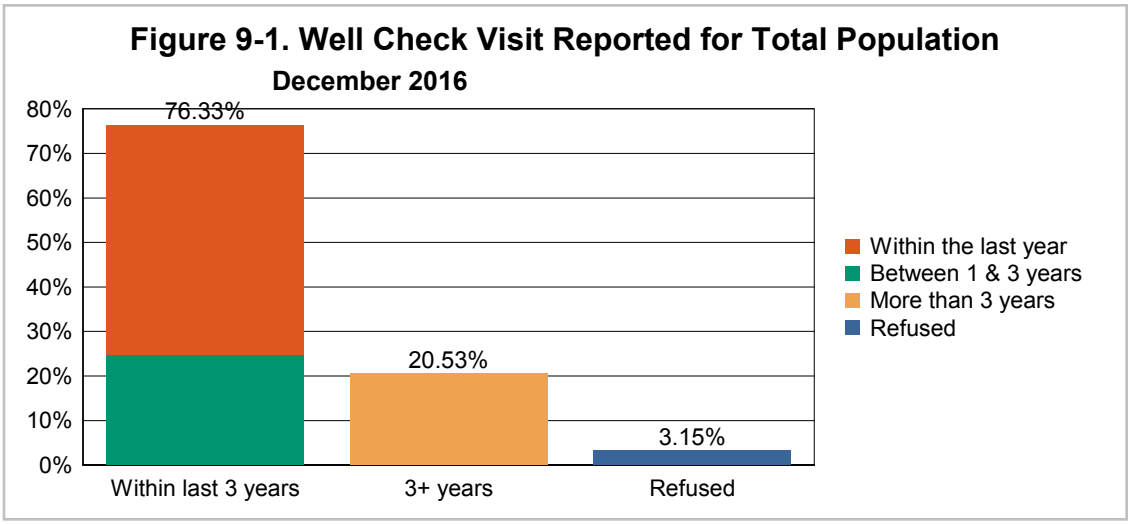
Question 9. Well Check Visit

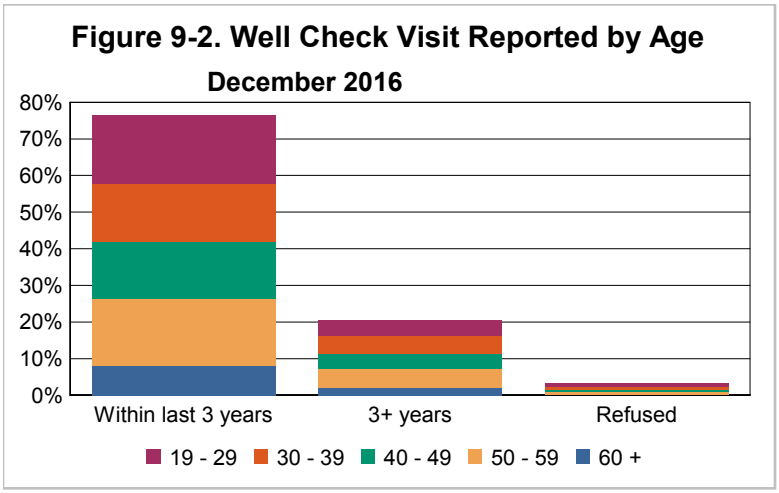
Question 9. A checkup is a visit to a doctor's office that is NOT for a specific problem. How long has it been since your last check-up? This question is used to assess self-reported well check visit. Healthy Michigan Plan enrollees were given the answer options of within the last year, between 1-3 years and more than 3 years. Table 9 shows the overall answers to this question for December 2016. Among enrollees who participated in the survey, there was a 3.15% 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.

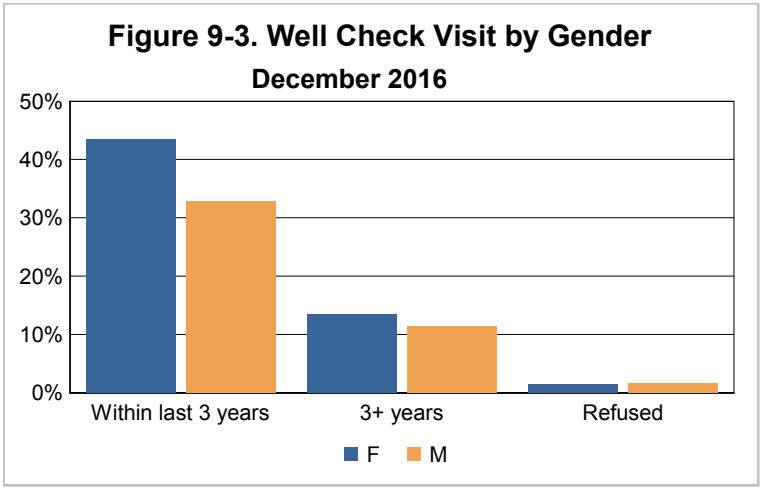
Table 9. Well Check Visit Reported for Total Population

December 2016

CHECK-UP	TOTAL	PERCENT
Within the last year	155,406	51.50%
Between 1 & 3 years	74,904	24.82%
More than 3 years	61,946	20.53%
Refused	9,490	3.15%
TOTAL	**301,746**	**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 763,066 beneficiaries who have been enrolled in a health plan for at least six months, 132,749 or 17.4% have completed the Health Risk Assessment with their primary care provider as of December 2016.

The data displayed in Part 2 of this report reflect the healthy behavior goals selected jointly by Healthy Michigan Plan beneficiaries and their primary care provider in the final section of the Health Risk Assessment. As shown in Table 10, a total of 162,167 Health Risk Assessments were completed with primary care providers as of December 2016. Health Risk Assessment completion is reported by age, gender and Federal Poverty Level in Table 11.

Among beneficiaries who completed the Health Risk Assessment, 139,124 or 85.8% of beneficiaries agreed to address health risk behaviors. In addition, 21,631 or 13.3% of beneficiaries who completed the Health Risk Assessment chose to maintain current healthy behaviors, meaning that 99.1% 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 139,124 beneficiaries who agreed to address health risk behaviors, 60.3% 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 2016	5,139	109,833
February 2016	6,205	116,044
March 2016	6,546	122,605
April 2016	5,667	128,284
May 2016	5,381	133,682
June 2016	5,018	138,727
July 2016	4,274	143,066
August 2016	5,249	148,368
September 2016	4,449	152,843
October 2016	4,487	157,356
November 2016*	3,977	161,355
December 2016*	812	162,167

*Many HRAs completed during this month have not yet been submitted.

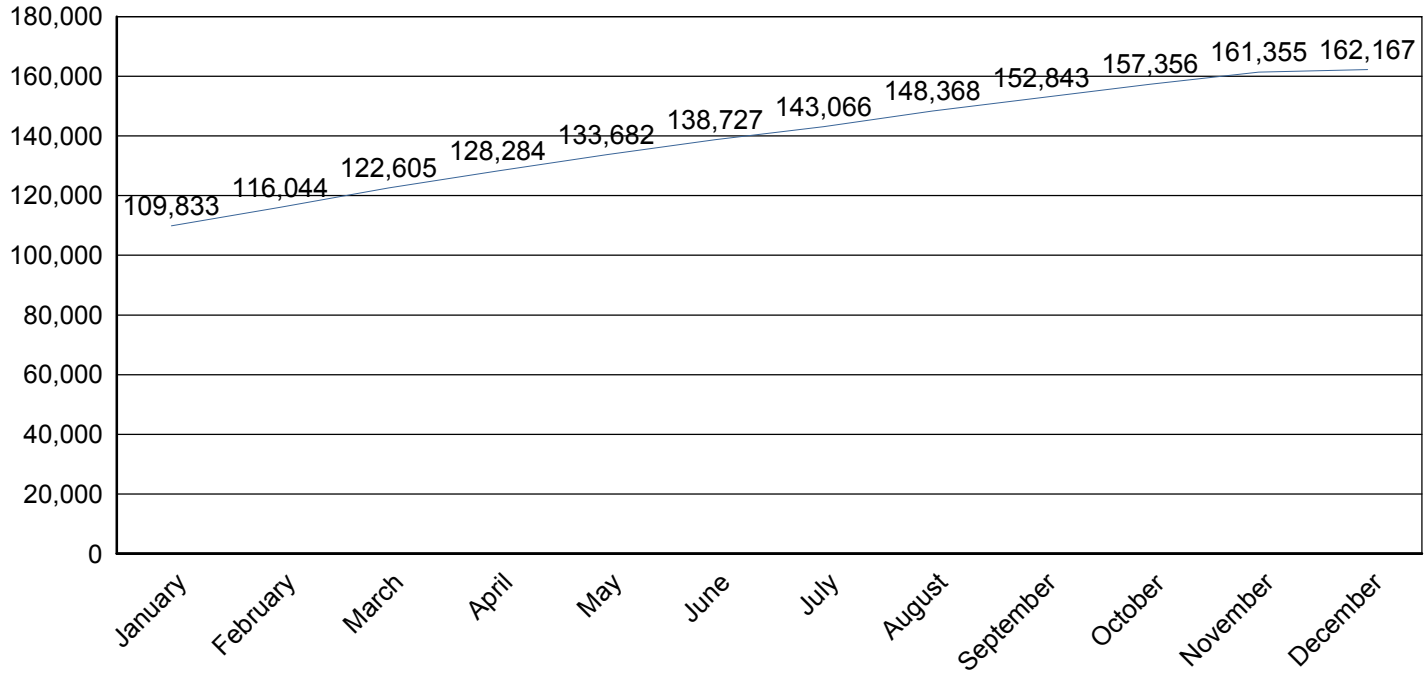
Table 11. Demographics of Population that Completed HRA with Primary Care Provider

September 2014 - December 2016

AGE GROUP	COMPLETED HRA	
19 - 29	32,719	20.18%
30 - 39	28,441	17.54%
40 - 49	31,400	19.36%
50 - 59	46,745	28.83%
60 +	22,862	14.10%
GENDER		
F	93,305	57.54%
M	68,862	42.46%
FPL		
< 100% FPL	131,189	80.90%
100 - 133% FPL	30,978	19.10%
TOTAL	**162,167**	**100.00%**

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

December 2016



Healthy Behaviors Statement Selection

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

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

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

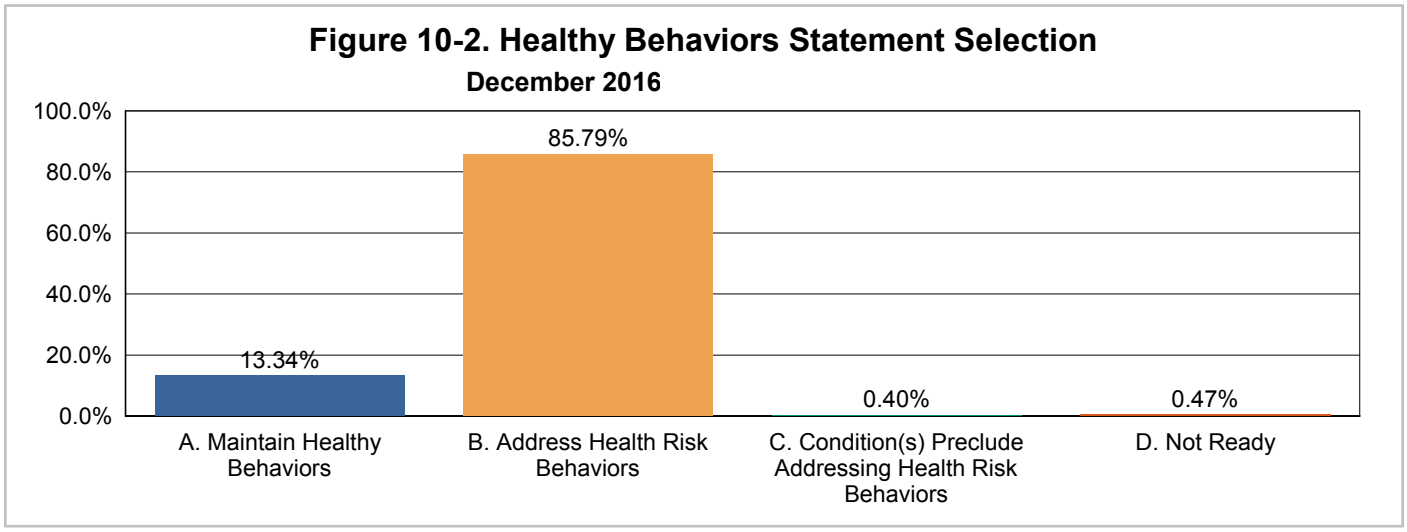
C. Patient has a serious medical, behavioral or social condition or conditions which precludes addressing unhealthy behaviors at this time.

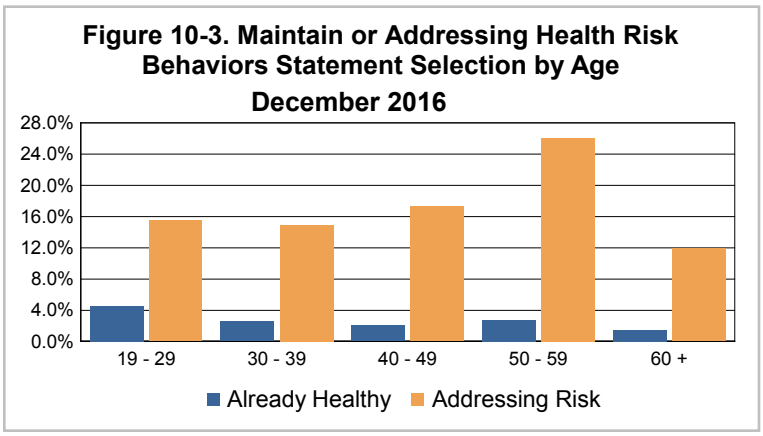
D. Unhealthy behaviors have been identified, patient's readiness to change has been assessed, and patient is not ready to make changes at this time.

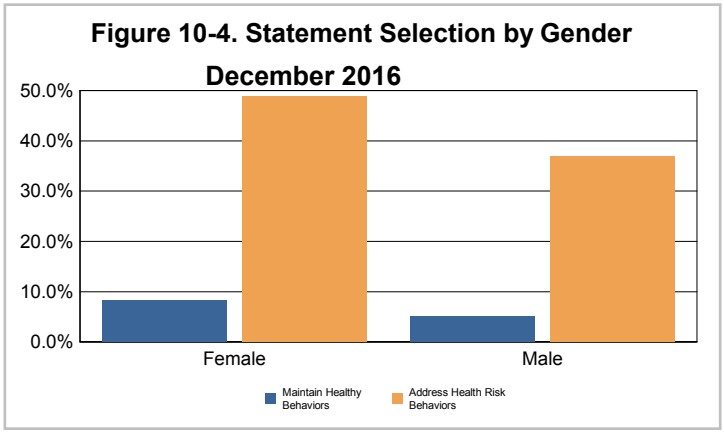
Figures 10-2 through 10-4 show Healthy Behaviors Statement Selections for the total population, and by age and gender.

Table 12. Healthy Behaviors Statement Selection
December 2016

CHECK-UP	TOTAL	PERCENT
A. Maintain Healthy Behaviors	21,631	13.34%
B. Address Health Risk Behaviors	139,124	85.79%
C. Condition(s) Preclude Addressing Health Risk Behaviors	655	0.40%
D. Not Ready	757	0.47%
TOTAL	**162,167**	**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 139,124 HRAs submitted through December 2016 where the beneficiary chose to address health risk behaviors, 60.29% 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

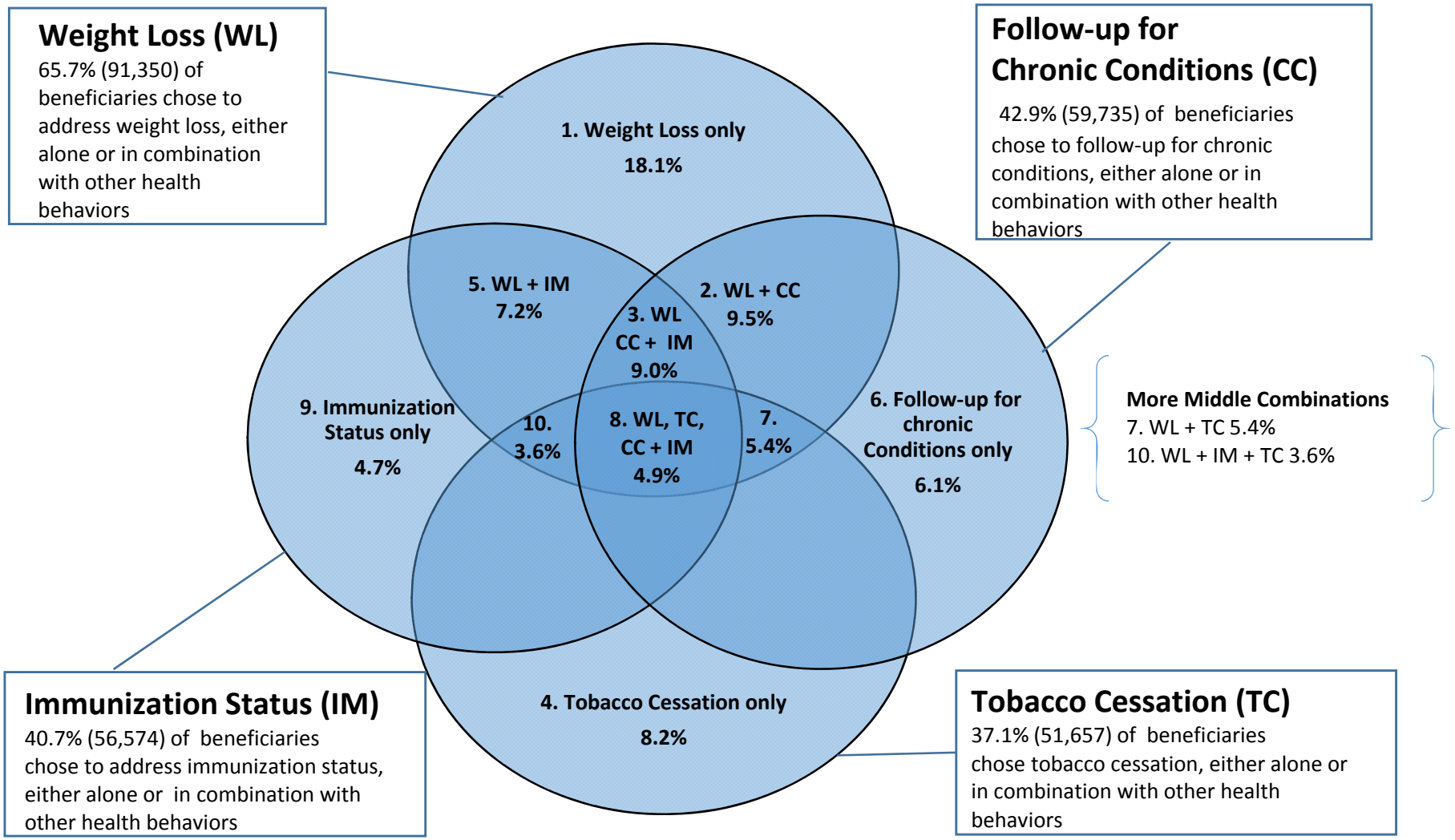
Health Risk Behavior Combination	Count	Percent
1. Weight Loss ONLY	25,117	18.05%
2. Weight Loss, Follow-up for Chronic Conditions	13,203	9.49%
3. Weight Loss, Immunization Status, Follow-up for Chronic Conditions	12,499	8.98%
4. Tobacco Cessation ONLY	11,463	8.24%
5. Weight Loss, Immunization Status	10,062	7.23%
6. Follow-up for Chronic Conditions	8,529	6.13%
7. Weight Loss, Tobacco Cessation	7,611	5.47%
Total for Top 7	88,484	63.60%
Total for All Other Combinations	50,640	36.40%
Total	**139,124**	**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	65.66%	18.05%
Tobacco Cessation	37.13%	8.24%
Immunization Status (Annual Flu Vaccine)	40.66%	4.75%
Follow-up for Chronic Conditions	42.94%	6.13%
Addressing Alcohol Abuse	4.48%	0.36%
Addressing Substance Abuse	1.20%	0.11%
Other	4.88%	2.07%

Health Risk Assessment Completion with Primary Care Provider

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



Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Meeting Minutes

Date: Wednesday, November 16, 2016

Time: 1:00 pm – 4:30 pm

Where: Michigan Public Health Institute (MPHI)
2436 Woodlake Circle
Okemos, MI 48864

Attendees: **Council Members:** Robin Reynolds, Dianne Haas, Marilyn Litka-Klein, Veronica Perera, Mark Swan (for Jeff Towns), Alison Hirschel, Pam Lupo, Pat Anderson (for Dave LaLumia), Marion Owen, Warren White, Karlene Ketola, Barry Cargill, Dominick Pallone, Kim Singh, Eric Roath, April Stopczynski, Dave Herbel

Staff: Chris Priest, Lynda Zeller, Kathy Stiffler, Brian Keisling, Dick Miles, Jackie Prokop, Erin Emerson, Cindy Linn, Craig Boyce, Michelle Best

Other Attendees: Tiffany Stone

Welcome, Introductions

Robin Reynolds opened the meeting and introductions were made. Chris Priest addressed the results of the November 8, 2016 Presidential election, and reported that the Michigan Department of Health and Human Services (MDHHS) is continuing to work with its federal partners to implement the Department's programs as planned.

Update on Flint

MDHHS received approval from the Centers for Medicare and Medicaid Services (CMS) on May 9, 2016 for a waiver to provide coverage for children and pregnant women with incomes up to 400% of the Federal Poverty Level (FPL) impacted by Flint water. To date, 24,171 eligible individuals have enrolled in health coverage under the Flint Waiver. MDHHS has also received CMS approval to use Children's Health Insurance Program (CHIP) funding for the purpose of lead abatement in Flint and targeted communities around the State of Michigan. A residence located in Flint or other targeted areas of the state, which will be identified by MDHHS, may be eligible for lead abatement services if a Medicaid or CHIP-eligible child or pregnant woman lives in the home. In response to an inquiry, MDHHS staff discussed some of the non-Medicaid resources available to assist individuals impacted by Flint water who are not eligible for Medicaid or CHIP.

Budget/Boilerplate Update

Medicaid Health Plan (MHP)/Prepaid Inpatient Health Plan (PIHP) Allocation Adjustments for Fiscal Year (FY) 2017

MDHHS staff provided an update on MHP and PIHP rate allocation adjustments for FY 2017, and reported that MHP rates have been reduced by 6% for the Healthy Michigan Plan population, while PIHP rates have been reduced by 3%. MDHHS examined data for FY 2015 for the purpose of setting MHP and PIHP rates for FY 2017, and the allocation reduction is a reflection of reduced utilization during the review period. However, MDHHS staff noted that the MHPs have reported increased utilization, particularly for pharmacy claims, during plan years following FY 2015. For the general Medicaid population, MHP claim costs have decreased by 0.2% for FY 2017, while the actuarial sound rate for PIHPs has increased by 1%. MDHHS staff and meeting attendees discussed the implications of the recently reported increase in utilization at length. MDHHS and the MHPs continue to hold meetings to discuss the rates.

Health Insurance Claim Adjustment (HICA) Tax Update

Chris Priest reported that a bill to reconfigure the way in which the current 6% use tax on Medicaid Health Maintenance Organizations (HMOs) is utilized recently passed the legislature but was vetoed by the governor. CMS has disallowed the use tax, and as a result, it will sunset on December 31, 2016. MDHHS is currently working with the Michigan House and Senate on subsequent legislation to place a moratorium on the use tax in order to implement the CMS requirement. Dominick Pallone indicated that the Michigan Association of Health Plans supports an amendment to the legislation to specify that the use tax will be suspended on December 31, 2016 and not require CMS to provide a written declaration indicating their decision to disallow its use in Michigan. Robin Reynolds will share the proposed amendment with the Medical Care Advisory Council (MCAC) for review, and called for a motion to support sending a letter on behalf of the MCAC in support of the legislation. A motion was made in support of sending a letter on behalf of the MCAC by Barry Cargill, with a second by Dianne Haas. The motion carried. The use tax currently accounts for $460 million in revenue.

Federal Regulatory Guidance Update

Chris Priest provided an overview of new federal regulatory guidance that is anticipated in the final months of the Obama administration, including:

- A State Medicaid Director letter on Community First Choice;
- Additional regulation on pass-through payments;
- A final Payment Error Rate Measurement (PERM) regulation; and

- A potential new rule regarding Disproportionate Share Hospital (DSH) and supplemental payments.

MDHHS has retained Health Management Associates to assist the Department in working through the new federal requirements related to Medicaid managed care.

Medicaid Managed Care

Provider Surveys

MDHHS and the Michigan State University Institute for Health Policy developed a draft survey for providers to give input on their experience working with the Medicaid Health Plans, which has been distributed to the MCAC for review. Once the survey is finalized, the Department will randomly select Primary Care Providers (PCPs) contracted with a Medicaid Health Plan and ask them to provide feedback on a particular plan. When the PCP completes their assigned survey, they may complete additional surveys to provide feedback on their experience working with other Medicaid Health Plans. MDHHS staff and meeting attendees also discussed the possibility of developing future provider surveys for specialist providers to give input on their experience working with the Medicaid Health Plans pending the results of the PCP survey. Meeting attendees were asked to submit comments on the draft survey to Kathy Stiffler by November 28, 2016.

Healthy Kids Dental Bid

Kathy Stiffler announced that MDHHS is planning to bid for a new ***Healthy Kids Dental*** contract, and reported that a Request for Information (RFI) was posted to www.buy4michigan.com on November 7, 2016. Comments from potential bidders were due on November 14, 2016, and MDHHS must respond to the questions by November 23, 2016. Final RFI submissions are due November 30, 2016, though Kathy noted that RFI submissions are not binding, and that potential vendors who did not respond to the RFI may still submit proposals when the bid is issued. MDHHS plans to implement the new contract effective October 1, 2017, and would like to issue contracts to more than one statewide vendor. In response to a meeting participant's concern regarding the proposed timeline for implementation, Kathy noted that the safe transition of members can extend at least 90 days beyond the start date of the new contract.

Medicaid/Other

MDHHS staff announced that Gretchen Backer has been hired as the director of the Program Review Division following the retirement of Sheila Embry, and that Dr. Debra Eggleston will retire as the director of the Office of Medical Affairs effective December 31, 2016.

2016 Access Monitoring Review Plan

MDHHS staff provided an overview of the 2016 Access Monitoring Review Plan, which was developed at the request of CMS to demonstrate that the Department is using data-driven decisions to set Medicaid Fee-for-Service rates and that rate changes do not negatively impact beneficiaries' access to care. The Plan was posted for a 30-day public comment period, which concluded on October 16, 2016, and has been submitted to CMS.

Healthy Michigan Plan

Second Waiver Update

Under the terms of the second waiver, beginning April 1, 2018, Healthy Michigan Plan beneficiaries above 100% of the Federal Poverty Level (FPL) who do not meet the criteria for "Medically Frail" and who have not completed a Health Risk Assessment (HRA) must leave the Healthy Michigan Plan and receive coverage from the Federally Facilitated Marketplace (FFM). MDHHS is continuing to work with the Department of Insurance and Financial Services (DIFS) to develop guidelines for health plans on the FFM that will serve this population.

Eligibility Redetermination Update

MDHHS staff reported that the Department began the process of implementing a system of passive redetermination of eligibility for Medicaid beneficiaries in June 2016. As of September 2016, MDHHS has the ability to conduct passive redetermination of eligibility for approximately 80-82% of beneficiaries enrolled in Modified Adjusted Gross Income (MAGI) categories. In order to conduct passive redetermination on the remaining MAGI beneficiaries, the Department must receive their income information from the Internal Revenue Service (IRS). However, MDHHS has experienced systems problems when attempting to retrieve data from the IRS, and is working to resolve the issue. The Department also plans to implement passive redetermination for non-MAGI groups in the future. In order to participate in the passive redetermination process, beneficiaries must provide their consent at the time of application.

Behavioral Health Updates

Integration of Behavioral Health and Physical Health

MDHHS staff provided an update on the Stakeholder 298 work group, which was convened to develop recommendations around the coordination of physical and behavioral health services. The work group is working to complete a report, which is due to the legislature by January 15, 2017. The FY 2017 budget requires a report with policy recommendations; financial model recommendations; and benchmarks for measuring progress toward better coordination, both in terms of delivery and outcome. MDHHS hopes to release a draft report containing policy recommendations, summaries of the affinity groups and consensus recommendations from the

affinity group meetings along with background on the process by November 28, 2016. The draft report will then be posted for public comment for a period of at least 30 days, and MDHHS plans to host at least one public forum to accept comments as well.

Certified Community Behavioral Health Clinics (CCBHCs)

In October 2015, the State of Michigan received a planning grant for CCBHCs, which provide intensive person-centered multi-disciplinary evidence-based screening, assessment, and diagnostic treatment and prevention services for individuals with mental health concerns. MDHHS submitted an application to be one of eight states chosen for a CCBHC demonstration grant, and has selected 14 sites that would serve as CCBHCs in Michigan under the demonstration. No public announcement has been made to identify the sites, as the states have not yet been selected for participation in the demonstration grant; however, MDHHS staff offered to share the names of the proposed CCBHC sites with the MCAC. CMS is expected to announce the eight states chosen to participate in the CCBHC demonstration grant by the end of December 2016, with implementation to begin as early as January 1, 2017. States that are chosen to participate have until June 30, 2017 to establish operational CCBHCs. MDHHS staff indicated that the intent of the CCBHC demonstration is to expand access to care for behavioral health services and maximize the existing health plan provider network, and noted that the program's impact on the budget is currently unknown.

State Innovation Model (SIM)

Leadership Changes

Chris Priest announced that Elizabeth Hertel has left MDHHS and that Matt Lori is now overseeing the SIM project.

Medicare Patient-Centered Medical Home (PCMH) Model

The PCMH model currently operates within the Michigan Primary Care Transformation (MiPCT) project, which will end on December 31, 2016. Beginning January 1, 2017, the PCMH model will move to the SIM, as required by the new contract between MDHHS and the Medicaid Health Plans. Eligible PCMH sites that currently participate in MiPCT and those located within a SIM region may take part in the SIM. For additional information on the PCMH SIM initiative, providers may visit the MDHHS website at www.michigan.gov/mdhhs >> Doing Business with MDHHS >> Health Care Providers >> State Innovation Model or email SIM@mail.mihealth.org.

Long Term Care Services and Supports Updates

MI Health Link

Dick Miles reported that MDHHS hosted a provider summit on November 9, 2016 to discuss MI Health Link, and provided meeting attendees with an update on the implementation of the Demonstration. Enrollment in MI Health Link has remained stable at approximately 37,500 beneficiaries following the implementation of a process known as deeming, in which MI Health Link beneficiaries who lose their Medicaid eligibility may remain enrolled in MI Health Link for up to 90 days while their eligibility status is resolved. MDHHS has also renegotiated its contract with the Integrated Care Organizations (ICOs) to provide services to MI Health Link beneficiaries, which took effect on November 1, 2016. One change noted in the new contract is that beneficiaries who elect hospice services may now remain enrolled in MI Health Link.

Other

Dick Miles also provided meeting attendees with additional updates related to long term care, including:

- A new section has been established within the Medical Services Administration (MSA) to serve as a single point of accountability for the Home Help Program. Michelle Martin has been hired as the manager of the Home Help Section, and MSA is working to provide additional staff for the section, as well.
- Effective October 1, 2016, providers of Home Help services must submit an Electronic Services Verification (ESV) or Paper Services Verification (PSV) form in order to receive payment for services provided under the program. This process requires Home Help Providers to register in the Community Health Automated Medicaid Processing System (CHAMPS).
- The Department is working to implement the new federal managed care rule as it relates to MI Choice Waiver Agencies, which are classified as Prepaid Ambulatory Health Plans (PAHPs). The MI Choice Waiver will need to be renewed in October 2018, and MDHHS will need to make changes to the way the program operates as a result of the new managed care rule.
- MDHHS is in the process of submitting a section 1115 Brain Injury Waiver (BIW) to provide necessary services and supports to persons suffering qualifying brain injuries who, but for the provision of these services, would otherwise be served in an institutional setting. The BIW has completed the consultation process, and the Department is targeting an implementation date of April 1, 2017.
- State law requires MDHHS to set up a workgroup related to the Program of All Inclusive Care for the Elderly (PACE), which will begin the week of November 21, 2016. The workgroup will discuss issues such as timely eligibility processing, barriers to new enrollment, and future expansion criteria.
- MDHHS is working to finalize rates MI Choice Waiver Agency rates for FY 2017.

Policy Updates

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

The meeting was adjourned at 4:00 p.m.

Next Meeting: Thursday, February 16, 2017

Medical Services Administration
Bureau of Medicaid Care Management and Quality Assurance

PERFORMANCE MONITORING REPORT

HEALTHY MICHIGAN PLAN

Composite – All Plans

January 2017

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

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Healthy Michigan Plan

Appendixes

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Executive Summary

This Performance Monitoring Report (PMR) 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.

The Michigan Department of Health and Human Services (MDHHS) monitors the performance of the State's Medicaid Health Plans (MHPs) through twenty-six (26) key performance measures aimed at improving the quality and efficiency of health care services provided to the Michigan residents enrolled in a Medicaid program. These measures include Medicaid Managed Care specific measures, Healthy Michigan Plan (HMP) measures, and HEDIS measures. **This report focuses only on the Healthy Michigan Plan (HMP) measures.** The following HMP measures will be included in this report:

Healthy Michigan Plan				
Adults' Generic Drug Utilization	*Timely Completion of HRA*	*Outreach & Engagement to Facilitate Entry to PCP*	*Plan All-Cause Acute 30-Day Readmissions*	*Adults' Access to Ambulatory Health Services*

Data for these five measures are represented on a quarterly basis. The body of the report contains a cross-plan analysis of the most current data available for each of these measures. A composite summary of plan performance for all standards is displayed in Appendix A. Appendix B contains specific three letter codes identifying each of the MHPs. Appendix C contains the one-year plan specific analysis for each measure.

Measurement Frequency

The data for each performance measure in this report will be run and represented on a quarterly basis. Measurement Periods may vary and are based on the specifications for that individual measure. In addition to this, Figures 3 through 7 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 table displays 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 quarter for fiscal year 2017 unless otherwise noted.

Table 1: Fiscal Year 2017

Quarterly Reported Measures	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Adults' Generic Drug Utilization	11/11			
Timely Completion of Initial HRA	2/11			
Outreach & Engagement to Facilitate Entry to PCP	0/11			
Plan All-Cause Acute 30-Day Readmissions	3/10			
Adults' Access to Ambulatory Health Services	5/11			

Managed Care Enrollment

The Healthy Michigan Plan (HMP-MC) enrollment has also remained steady over the past year. In January 2017, enrollment was 514,497, down 5,979 enrollees (1.3%) from February 2016. An increase 8,727 enrollees (1.7%) was realized between December 2016 and January 2017.

Figure 1: HMP-MC Enrollment, February 2016 – January 2017[1]

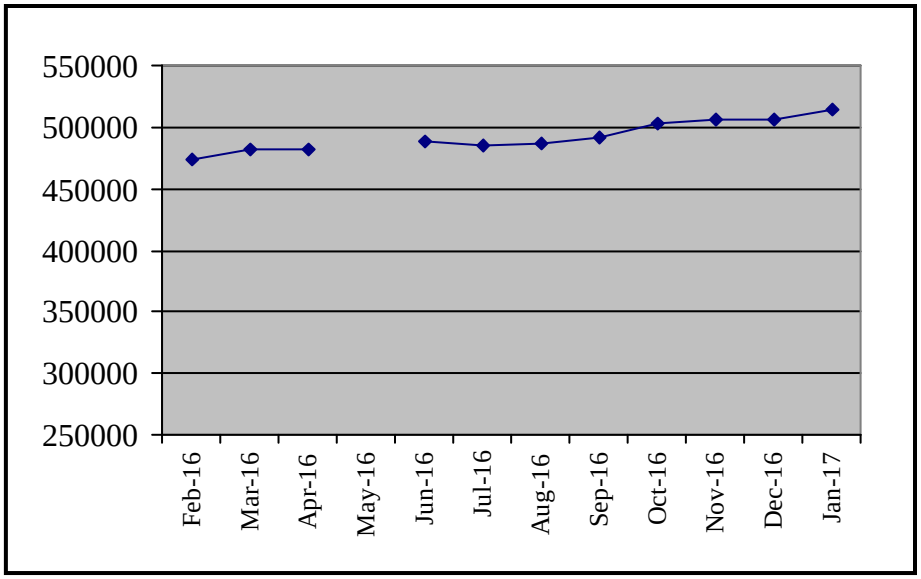
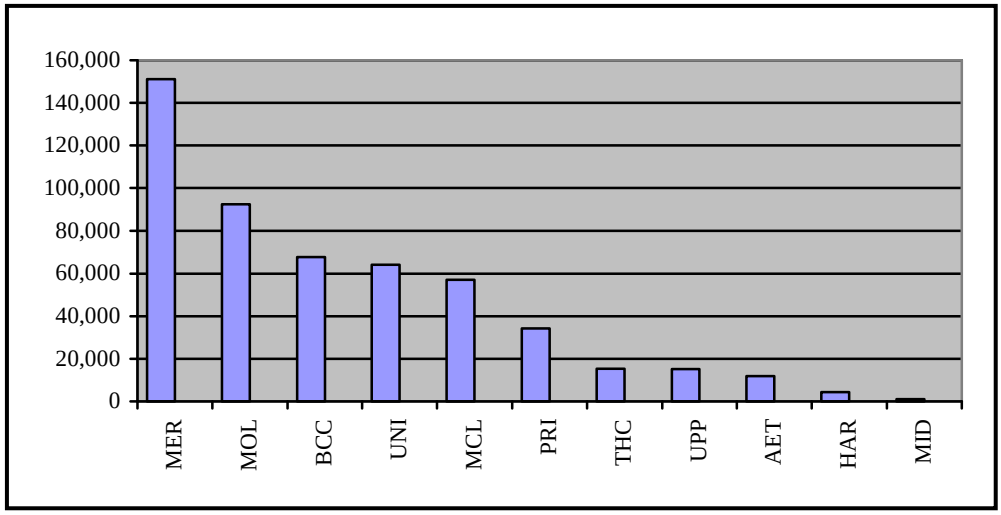


Figure 2: HMP-MC Enrollment by Medicaid Health Plan, January 2017



[1] Enrollment data was not available for HMP-MC Enrollment for May 2016 at the time of publication.

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.

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.

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 2016 –June 2016

Data Source
MDHHS Data Warehouse

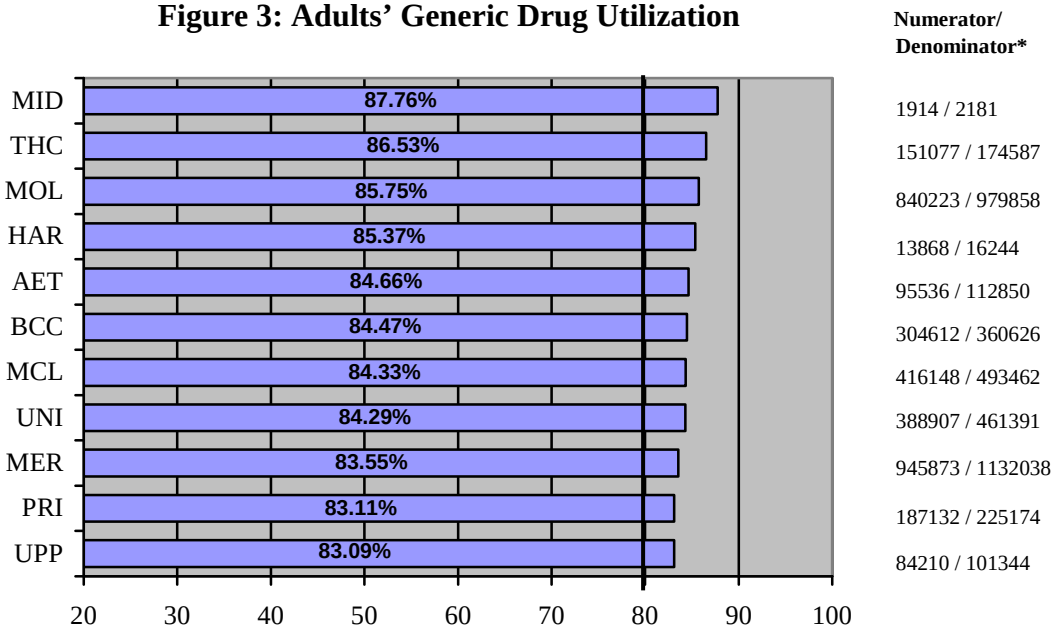
Measurement Frequency
Quarterly

Summary: All of the plans met or exceeded the standard. Results ranged from 83.09% to 87.76%.

Table 2: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	3528242	4206585	83.87%
Fee For Service (FFS) only	22798	50897	44.79%
Managed Care only	3445271	4078533	84.47%
MA-MC	1978833	2345081	84.38%
HMP-MC	1434010	1695233	84.59%

Figure 3: 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 15% (as shown on bar graph below)

Enrollment Dates
January 2016 – March 2016

Data Source
MDHHS Data Warehouse

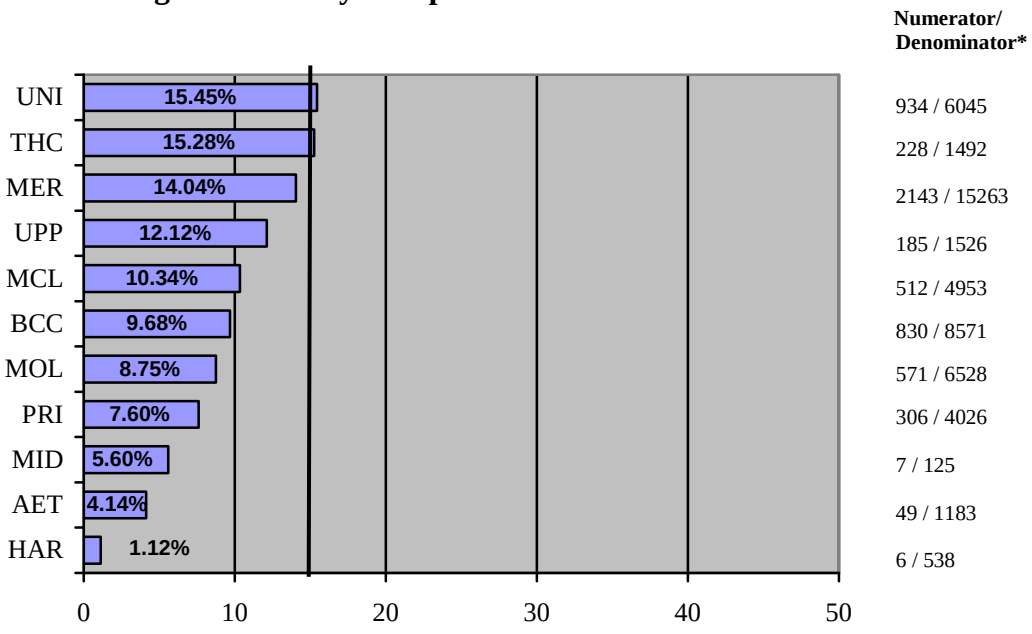
Measurement Frequency
Quarterly

Summary: Two of the plans met or exceeded the standard, while nine plans (AET, BCC, HAR, MCL, MER, MID, MOL, PRI, and UPP). Results ranged from 1.12% to 15.45%.

Table 3: Program Total[2]

Medicaid Program	Numerator	Denominator	Percentage
HMP-MC	5771	50250	11.48%

Figure 4: 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.

[2] 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 60% (as shown on bar graph below)

Enrollment Dates
January 2016 – March 2016

Data Source
MDHHS Data Warehouse

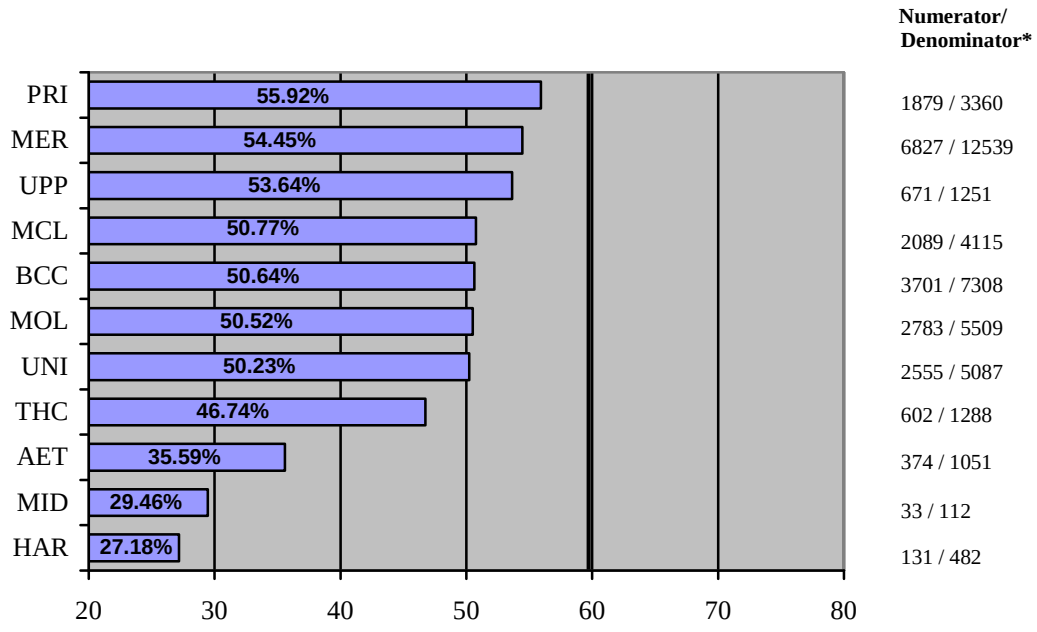
Measurement Frequency
Quarterly

Summary: None of the plans met or exceeded the standard. None of the plans met 10% improvement towards the standard for this quarter. Results ranged from 27.18% to 55.92%.

Table 4: Program Total[3]

Medicaid Program	Numerator	Denominator	Percentage
HMP-MC	29793	50250	59.29%

Figure 5: 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.

[3] 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 <u>below</u> 16% (as shown on bar graph below)

Enrollment Dates
July 2015 –June 2016

Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

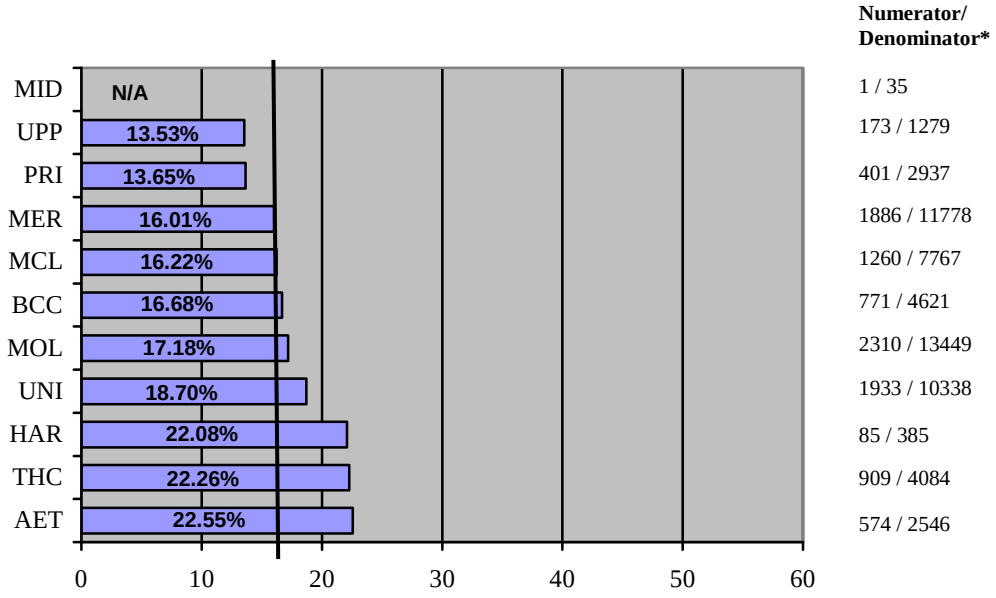
Summary: Two of the plans met or exceeded the standard, while eight plans (AET, BCC, HAR, MCL, MER, MOL, THC, and UNI) did not. Results ranged from 13.53% to 22.55%.

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

Table 5: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	12586	70565	17.84%
Fee For Service (FFS) only	1309	6028	21.72%
Managed Care only	10637	60936	17.46%
MA-MC	8022	40265	19.92%
HMP-MC	2551	20198	12.63%

Figure 6: Plan All-Cause Acute 30-Day Readmissions[4]



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.

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

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 83% (as shown on bar graph below)

Measurement Period
July 2015 –June 2016

Data Source
MDHHS Data Warehouse

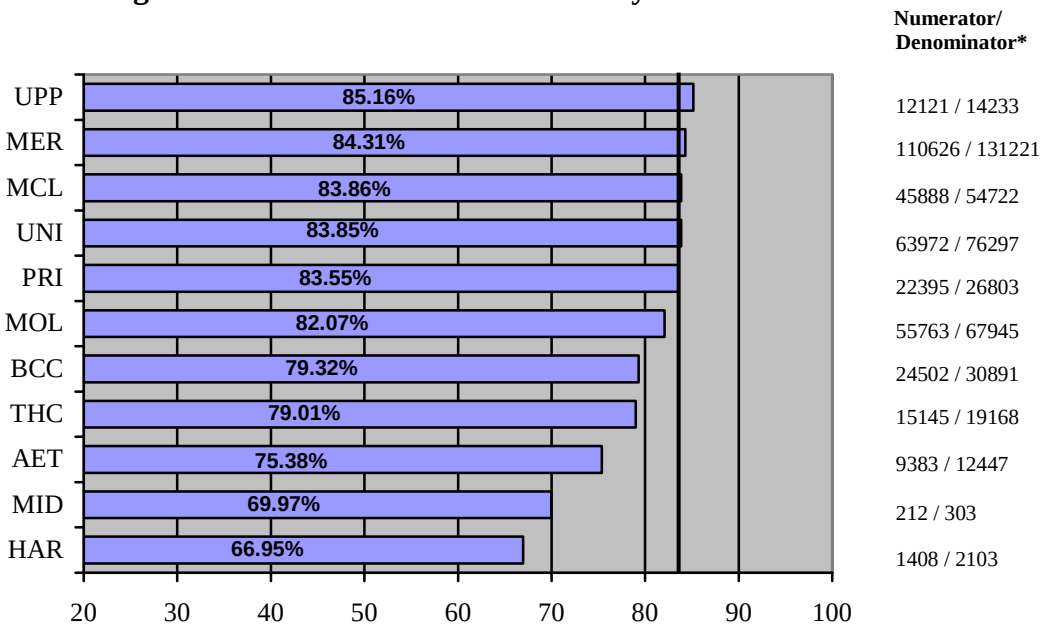
Measurement Frequency
Quarterly

Summary: Five of the plans met or exceeded the standard. While six plans (AET, BCC, HAR, MID, MOL, and THC) did not. Results ranged from 66.95% to 85.16%.

Table 6: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	568936	698992	81.39%
Fee For Service (FFS) only	9752	15408	63.29%
Managed Care only	432216	519700	83.17%
MA-MC	217492	260384	83.53%
HMP-MC	177762	215761	82.39%

Figure 7: 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.

Appendix A: Composite Performance Monitoring Summary[5]

January 2017

Plans	Adults Generic Drug Utilization	Timely Completion of Initial HRA	Outreach & Engagement to Facilitate Entry to PCP	Plan All-Cause Acute 30-Day Readmission	Adults' Access to Ambulatory Health Services	Total Standards Achieved
AET	Y	**N**	**N**	**N**	**N**	**1**
BCC	Y	**N**	**N**	**N**	**N**	**1**
HAR	Y	**N**	**N**	**N**	**N**	**1**
MCL	Y	**N**	**N**	**N**	Y	**2**
MER	Y	**N**	**N**	**N**	Y	**2**
MID	Y	**N**	**N**	N/A	**N**	**1**
MOL	Y	**N**	**N**	**N**	**N**	**1**
PRI	Y	**N**	**N**	Y	Y	**3**
THC	Y	Y	**N**	**N**	**N**	**2**
UNI	Y	Y	**N**	**N**	Y	**3**
UPP	Y	**N**	**N**	Y	Y	**3**
Total	**11/11**	**2/11**	**0/11**	**2/10**	**5/11**	

Appendix B: Three Letter Medicaid Health Plan 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

[5] "N/A" in the Plan All-Cause Acute 30-Day Readmission column represents plans who had a denominator under 5 and a numerator under 30.

Appendix C: One Year Plan-Specific Analysis

Aetna Better Health of Michigan – AET

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 16 – Jun 16**	**80%**	**84.66%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**15%**	**4.14%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**60%**	**35.59%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**22.55%**	**No**
Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**83%**	**75.38%**	**No**

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

Appendix C: One Year Plan-Specific Analysis

Blue Cross Complete of Michigan – BCC

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 16 – Jun 16**	**80%**	**84.47%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**15%**	**9.68%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**60%**	**50.64%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**16.68%**	**No**
Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**83%**	**79.32%**	**No**

****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

Appendix C: One Year Plan-Specific Analysis

Harbor Health Plan, Inc. – HAR

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 16 – Jun 16**	**80%**	**85.37%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**15%**	**1.12%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**60%**	**27.18%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**22.08%**	**No**
Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**83%**	**66.95%**	**No**

****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

Appendix C: One Year Plan-Specific Analysis

McLaren Health Plan – MCL

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 16 – Jun 16**	**80%**	**84.33%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**15%**	**10.34%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**60%**	**50.77%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**16.22%**	**No**
Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**83%**	**83.86%**	**Yes**

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

Appendix C: One Year Plan-Specific Analysis

Meridian Health Plan – MER

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 16 – Jun 16**	**80%**	**83.55%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**15%**	**14.04%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**60%**	**54.45%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**16.01%**	**No**
Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**83%**	**84.31%**	**Yes**

****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

Appendix C: One Year Plan-Specific Analysis

HAP Midwest Health Plan, Inc. – MID

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 16 – Jun 16**	**80%**	**87.76%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**15%**	**5.60%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**60%**	**29.46%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**N/A**	**N/A**

This is a reverse measure. A lower rate indicates better performance.
A rate was not calculated for plans with a numerator under 5 or a denominator under 30.

Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**83%**	**69.97%**	**No**

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

Appendix C: One Year Plan-Specific Analysis

Molina Healthcare of Michigan – MOL

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 16 – Jun 16**	**80%**	**85.75%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**15%**	**8.75%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**60%**	**50.52%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**17.18%**	**No**
Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**83%**	**82.07%**	**No**

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

Appendix C: One Year Plan-Specific Analysis

Priority Health Choice – PRI

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 16 – Jun 16**	**80%**	**83.11%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**15%**	**7.60%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**60%**	**55.92%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**13.65%**	**Yes**
Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**83%**	**83.55%**	**Yes**

****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

Appendix C: One Year Plan-Specific Analysis

Total Health Care – THC

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 16 – Jun 16**	**80%**	**86.53%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**15%**	**15.25%**	**Yes**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**60%**	**46.74%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**22.26%**	**No**
Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**83%**	**79.01%**	**No**

****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

Appendix C: One Year Plan-Specific Analysis

UnitedHealthcare Community Plan – UNI

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 16 – Jun 16**	**80%**	**84.29%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**15%**	**15.45%**	**Yes**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**60%**	**50.23%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**18.70%**	**No**
Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**83%**	**83.85%**	**Yes**

****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

Appendix C: One Year Plan-Specific Analysis

Upper Peninsula Health Plan – UPP

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 16 – Jun 16**	**80%**	**83.09%**	**Yes**
Timely Completion of HRA	**Jan 15 – Mar 15**	**15%**	**12.12%**	**No**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 15 – Mar 15**	**60%**	**53.64%**	**No**
Plan All-Cause Acute 30-Day Readmissions	**Jul 14 – Jun 15**	**16%**	**13.53%**	**Yes**
Adults' Access to Ambulatory Health Services	**Jul 14 – Jun 15**	**83%**	**85.16%**	**Yes**

****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

MI HEALTH ACCOUNT

EXECUTIVE SUMMARY REPORT

JANUARY 2017

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: JANUARY 2017

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

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

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

Quarterly Statement Mailing Guidelines

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

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

Chart 1: Account Statement Mailing

Month Statement Mailed	Statements Mailed	Statements Requiring a Copay Only	Statements Requiring a Contribution Only	Statements Requiring a Copay and Contribution	Percentage of Statements Requiring Payment
Aug-16	75,685	16,025	7,566	9,395	43.58%
Sep-16	86,801	18,082	7,615	10,633	41.85%
Oct-16	101,250	22,430	9,608	12,427	43.92%
Calendar YTD	**840,703**	**165,668**	**83,549**	**88,522**	**40.17%**
Program Total	**2,130,191**	**396,422**	**158,528**	**179,687**	**34.49%**

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: JANUARY 2017

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

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

Copays					
Statement Month	Amount of copays owed	Amount of copays paid	Percentage of copays paid	Number of beneficiaries who owed copays	Number of beneficiaries who paid copays
Aug-16	$189,785.53	$63,260.35	33%	25,420	9,110
Sep-16	$224,566.12	$78,224.99	35%	28,715	10,655
Oct-16	$265,806.58	$69,965.61	26%	34,857	10,113
Calendar YTD	**$1,991,873.91**	**$696,115.18**	**35%**	**253,793**	**95,066**
Program Total	**$4,193,929.02**	**$1,531,713.72**	**37%**	**574,634**	**215,045**
Contributions					
Statement Month	Amount of contributions owed	Amount of contributions paid	Percentage of contributions paid	Number of beneficiaries who owed contributions	Number of beneficiaries who paid contributions
Aug-16	$977,330.48	$278,457.57	28%	16,961	6,011
Sep-16	$1,099,741.10	$322,540.79	29%	18,248	6,679
Oct-16	$1,328,806.10	$277,932.77	21%	22,035	6,508
Calendar YTD	**$9,733,043.14**	**$2,904,979.98**	**30%**	**172,050**	**64,350**
Program Total	**$18,862,765.36**	**$5,751,392.74**	**30%**	**338,193**	**127,067**

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: JANUARY 2017

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

Chart 3: Quarterly Collection

Enrollment Month	Quarterly Pay Cycles	Amount Owed	Amount Collected	Percentage Collected
Apr-14	Oct 2014 - Dec 2014	$23,678.03	$15,094.16	63.75
	Jan 2015 - Mar 2015	$194,071.16	$131,747.04	67.89
	Apr 2015 - Jun 2015	$166,894.45	$102,178.71	61.22
	Jul 2015 - Sep 2015	$163,655.43	$88,036.18	53.79
	Oct 2015 - Dec 2015	$155,099.01	$77,812.60	50.17
	Jan 2016 - Mar 2016	$143,618.04	$68,657.30	47.81
	Apr 2016 - Jun 2016	$193,780.57	$83,640.37	43.16
	Jul 2016 - Sep 2016	$147,826.43	$47,791.88	32.33
	Oct 2016 - Dec 2016	$188,077.54	$60,036.18	31.92
May-14	Nov 2014 - Jan 2015	$35,769.76	$25,404.12	71.02
	Feb 2015 - Apr 2015	$56,661.54	$38,402.76	67.78
	May 2015 - Jul 2015	$45,969.47	$29,318.14	63.78
	Aug 2015 - Oct 2015	$41,375.52	$24,684.92	59.66
	Nov 2015 - Jan 2016	$39,658.82	$23,186.24	58.46
	Feb 2016 - Apr 2016	$38,173.46	$20,724.70	54.29
	May 2016 - July 2016	$46,732.90	$22,045.90	47.17
	Aug 2016 - Oct 2016	$42,121.21	$17,676.50	41.97
Jun-14	Dec 2014 - Feb 2015	$457,077.32	$323,559.71	70.79
	Mar 2015 - May 2015	$349,691.94	$245,822.23	70.30
	Jun 2015 - Aug 2015	$348,734.58	$227,840.27	65.33
	Sep 2015 - Nov 2015	$330,511.14	$201,875.24	61.08
	Dec 2015 - Feb 2016	$240,812.88	$140,477.18	58.33
	Mar 2016 - May 2016	$275,901.98	$156,449.23	56.70
	Jun 2016 - Aug 2015	$234,906.55	$109,272.03	46.52
	Sep 2016 - Nov 2016	$331,788.72	$157,305.18	47.41

Chart 3 continued on page 5

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: JANUARY 2017

Chart 3 continued from page 4

Chart 3: Quarterly Collection				
Enrollment Month	**Quarterly Pay Cycles**	**Amount Owed**	**Amount Collected**	**Percentage Collected**
Jul-14	Jan 2015 - Mar 2015	$340,336.16	$224,585.98	65.99%
	Apr 2015 - Jun 2015	$252,019.77	$157,638.50	62.55%
	Jul 2015 - Sep 2015	$242,586.21	$135,861.05	56.01%
	Oct 2015 - Dec 2015	$222,223.07	$117,558.62	52.90%
	Jan 2016 - Mar 2016	$198,122.85	$100,436.20	50.69%
	Apr 2016 - Jun 2016	$218,491.91	$98,315.37	45.00%
	Jul 2016 - Sep 2016	$175,393.24	$61,307.35	34.95%
	Oct 2016 - Dec 2016	$208,306.31	$67,217.85	32.27%
Aug-14	Feb 2015 - Apr 2015	$169,952.88	$112,656.85	66.29%
	May 2015 - Jul 2015	$121,946.27	$71,555.75	58.68%
	Aug 2015 - Oct 2015	$111,305.54	$65,772.05	59.09%
	Nov 2015 - Jan 2016	$103,758.41	$58,578.82	56.46%
	Feb 2016 - Apr 2016	$98,753.04	$51,857.62	52.51%
	May 2016 - July 2016	$109,661.14	$44,830.08	40.88%
	Aug 2016 - Oct 2016	$93,178.22	$31,665.96	33.98%
Sep-14	Mar 2015 - May 2015	$212,502.42	$116,732.42	54.93%
	Jun 2015 - Aug 2015	$147,593.40	$78,749.80	53.36%
	Sep 2015 - Nov 2015	$150,249.62	$78,749.69	52.41%
	Dec 2015 - Feb 2016	$121,102.64	$61,276.25	50.60%
	Mar 2016 - May 2016	$138,698.21	$62,580.39	45.12%
	Jun 2016 - Aug 2016	$103,820.98	$33,875.62	32.63%
	Sep 2016 - Nov 2016	$123,197.02	$41,800.38	33.93%
Oct-14	Apr 2015 - Jun 2015	$173,628.90	$93,050.57	53.59%
	Jul 2015 - Sep 2015	$125,396.82	$66,853.49	53.31%
	Oct 2015 - Dec 2015	$124,321.49	$64,456.14	51.85%
	Jan 2016 - Mar 2016	$118,837.59	$57,740.07	48.59%
	Apr 2016 - Jun 2016	$137,597.80	$57,480.12	41.77%
	Jul 2016 - Sep 2016	$105,817.66	$32,758.27	30.96%
	Oct 2016 - Dec 2016	$123,818.43	$38,273.30	30.91%

Chart 3 continued on page 6

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: JANUARY 2017

Chart 3 continued from page 5

Chart 3: Quarterly Collection				
Enrollment Month	**Quarterly Pay Cycles**	**Amount Owed**	**Amount Collected**	**Percentage Collected**
Nov-14	May 2015 - Jul 2015	$194,938.88	$102,293.00	52.47%
	Aug 2015 - Oct 2015	$126,130.16	$63,789.10	50.57%
	Nov 2015 - Jan 2016	$133,137.68	$68,436.51	51.40%
	Feb 2016 - Apr 2016	$134,326.41	$64,920.30	48.33%
	May 2016 - July 2016	$157,699.94	$57,803.10	36.65%
	Aug 2016 - Oct 2016	$124,681.58	$35,204.57	28.24%
Dec-14	Jun 2015 - Aug 2015	$104,840.39	$58,490.27	55.79%
	Sep 2015 - Nov 2015	$81,531.22	$44,394.22	54.45%
	Dec 2015 - Feb 2016	$67,214.28	$35,730.49	53.16%
	Mar 2016 - May 2016	$80,357.48	$39,985.53	49.76%
	Jun 2016 - Aug 2016	$69,513.65	$22,647.77	32.58%
	Sep 2016 - Nov 2016	$75,910.69	$22,446.86	29.57%
Jan-15	Jul 2015 - Sep 2015	$210,890.77	$125,380.54	59.45%
	Oct 2015 - Dec 2015	$169,826.10	$91,640.81	53.96%
	Jan 2016 - Mar 2016	$166,240.38	$90,754.71	54.59%
	Apr 2016 - Jun 2016	$192,186.52	$92,167.75	47.96%
	Jul 2016 - Sep 2016	$160,802.23	$55,588.98	34.57%
	Oct 2016 - Dec 2016	$172,905.93	$55,659.67	32.19%
Feb-15	Aug 2015 - Oct 2015	$205,912.77	$116,459.38	56.56%
	Nov 2015 - Jan 2016	$132,552.90	$75,295.20	56.80%
	Feb 2016 - Apr 2016	$147,771.38	$86,169.47	58.31%
	May 2016 - July 2016	$192,083.28	$85,748.21	44.64%
	Aug 2016 - Oct 2016	$156,760.07	$55,097.64	35.15%
Mar-15	Sep 2015 - Nov 2015	$220,919.11	$114,329.67	51.75%
	Dec 2015 - Feb 2016	$100,161.87	$52,619.61	52.53%
	Mar 2016 - May 2016	$109,529.52	$60,821.49	55.53%
	Jun 2016 - Aug 2015	$125,551.80	$53,184.50	42.36%
	Sep 2016 - Nov 2016	$133,357.35	$48,617.90	36.46%
Apr-15	Oct 2015 - Dec 2015	$274,309.84	$139,686.63	50.92%
	Jan 2016 - Mar 2016	$136,837.80	$74,921.49	54.75%
	Apr 2016 - Jun 2016	$171,658.22	$92,381.92	53.82%
	Jul 2016 - Sep 2016	$149,720.98	$64,455.82	43.05%
	Oct 2016 - Dec 2016	$159,813.11	$56,856.42	35.58%

Chart 3 continued on page 7

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: JANUARY 2017

Chart 3 continued from page 6

Chart 3: Quarterly Collection				
Enrollment Month	**Quarterly Pay Cycles**	**Amount Owed**	**Amount Collected**	**Percentage Collected**
May-15	Nov 2015 - Jan 2016	$185,291.91	$99,532.27	53.72%
	Feb 2016 - Apr 2016	$122,155.32	$73,156.79	59.89%
	May 2016 - July 2016	$163,639.15	$84,315.30	51.53%
	Aug 2016 - Oct 2016	$141,809.82	$60,357.77	42.56%
Jun-15	Dec 2015 - Feb 2016	$150,852.37	$71,185.67	47.19%
	Mar 2016 - May 2016	$100,599.94	$51,547.08	51.24%
	Jun 2016 - Aug 2016	$93,341.94	$40,951.77	43.87%
	Sep 2016 - Nov 2016	$104,846.75	$38,747.65	36.96%
Jul-15	Jan 2016 - Mar 2016	$138,741.20	$69,789.05	50.30%
	Apr 2016 - Jun 2016	$102,151.61	$48,419.96	47.40%
	Jul 2016 - Sep 2016	$86,500.84	$34,357.05	39.72%
	Oct 2016 - Dec 2016	$90,025.63	$29,827.01	33.13%
Aug-15	Feb 2016 - Apr 2016	$137,300.38	$60,225.47	43.86%
	May 2016 - July 2016	$97,317.90	$37,685.50	38.72%
	Aug 2016 - Oct 2016	$82,090.11	$29,589.31	36.04%
Sep-15	Mar 2016 - May 2016	$108,668.12	$48,096.32	44.26%
	Jun 2016 - Aug 2016	$69,903.19	$24,798.06	35.47%
	Sep 2016 - Nov 2016	$63,940.41	$23,278.46	36.41%
Oct-15	Apr 2016 - Jun 2016	$121,181.79	$40,828.37	33.69%
	Jul 2016 - Sep 2016	$74,255.26	$24,246.24	32.65%
	Oct 2016 - Dec 2016	$79,804.04	$23,830.07	29.86%
Nov-15	May 2016 - Jul 2016	$141,848.05	$45,696.37	32.22%
	Aug 2016 - Oct 2016	$96,538.34	$28,081.78	29.09%
Dec-15	Jun 2016 - Aug 2016	$130,210.52	$44,858.62	34.45%
	Sep 2016 - Nov 2016	$104,381.33	$29,684.56	28.44%
Jan-16	Jul 2016 - Sep 2016	$168,970.84	$65,725.72	38.90%
	Oct 2016 - Dec 2016	$132,268.43	$42,010.77	31.76%
Feb-16	Aug 2016 - Oct 2016	$237,197.81	$98,971.85	41.73%
Mar-16	Sep 2016 - Nov 2016	$197,021.75	$70,832.27	35.95%
Apr-16	Oct 2016 - Dec 2016	$181,384.06	$54,382.48	29.98%

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: JANUARY 2017

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

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

Chart 4: Methods of Payment

	Aug-16	Sep-16	Oct-16
Percent Paid Online	31.12%	28.64%	27.52%
Percent Paid by Mail	68.88%	71.36%	72.48%

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: JANUARY 2017

Adjustment Activities

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

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

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

Chart 5A: Adjustment Activities

	Aug-16		Sep-16		Oct-16	
	#	Total $	#	Total $	#	Total $
Beneficiary is under age 21	783	$50,732.50	706	$46,129.00	763	$50,327.00
Pregnancy	376	$12,335.02	221	$6,301.96	203	$6,069.94
Hospice	0	$0.00	0	$0.00	0	$0.00
Native American	81	$2,248.33	97	$1,968.00	77	$1,253.00
Five Percent Cost Share Limit Met	29,623	$420,484.47	28,618	$377,155.20	31,234	$291,668.54
FPL No longer >100% - Contribution	0	$0.00	0	$0.00	0	$0.00
TOTAL	**30,863**	**$485,800.32**	**29,642**	**$431,554.16**	**32,277**	**$349,318.48**
	Aug-16 to Oct-16		**Calendar YTD**		**Program YTD**	
	#	Total $	#	Total $	#	Total $
Beneficiary is under age 21	2,252	$147,188.50	6,609	$407,063.74	11,418	$671,319.24
Pregnancy	800	$24,706.92	2,876	$93,798.19	7,153	$216,449.76
Hospice	0	$0.00	0	$0.00	0	$0.00
Native American	255	$5,469.33	660	$13,502.66	1,154	$37,730.66
Five Percent Cost Share Limit Met	89,475	$1,089,308.21	288,825	$4,143,239.18	623,236	$8,997,246.32
FPL No longer >100% - Contribution	0	$0.00	0	$0.00	20	$1,152.50
TOTAL	**92,782**	**$1,266,672.96**	**298,970**	**$4,657,603.77**	**642,981**	**$9,923,898.48**

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: JANUARY 2017

Healthy Behavior Incentives

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

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

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

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

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

Chart 5B: Healthy Behaviors

	Aug-16		Sep-16		Oct-16	
	#	Total $	#	Total $	#	Total $
Co-pay	2,374	$19,665.07	859	$4,060.58	966	$4,421.60
Contribution	3,484	$157,044.58	1,548	$62,472.11	1,624	$65,795.00
Gift Cards	3,408	n/a	1,613	n/a	2,531	n/a
TOTAL	**9,266**	**$176,709.65**	**4,020**	**$66,532.69**	**5,121**	**$70,216.60**
	Aug 16 to Oct-16		**Calendar YTD**		**Program YTD**	
	#	Total $	#	Total $	#	Total $
Co-pay	4,199	$28,147.25	25,722	$175,457.45	26,969	$180,499.97
Contribution	6,656	$285,311.69	22,750	$1,159,985.64	45,800	$1,913,147.33
Gift Cards	7,552	n/a	28,758	n/a	93,523	n/a
TOTAL	**18,407**	**$313,458.94**	**77,230**	**$1,335,443.09**	**166,292**	**$2,093,647.30**

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: JANUARY 2017

Typically, beneficiaries will pay a co-pay for the following services:

- Physician Office Visits (including free standing Urgent Care Centers)
- Outpatient Hospital Clinic Visit
- Outpatient Non-Emergent ER Visit (co-pay not required for emergency services)
- Inpatient Hospital Stay (co-pay not required for emergency admissions)
- Pharmacy (brand name and generic)
- Vision Services
- Dental Visits
- Chiropractic Visits
- Hearing Aids
- Podiatric Visits

If a beneficiary receives any of the above services for a chronic condition, the co-pay will be waived and the beneficiary will not be billed. This promotes greater access to high value services that prevent the progression of and complications related to chronic disease.

Chart 6 shows the number of beneficiaries whose co-pays were waived and the dollar amount waived due to receiving services for chronic conditions. Co-pay adjustments for high value services are processed quarterly based on the beneficiaries' individual enrollment and statement cycles.

Chart 6: Waived Copays for High Value Services

Month	# of Beneficiaries with Copays Waived	Total Dollar Amount Waived
Aug-16	26,114	$219,156
Sep-16	32,490	$284,575
Oct-16	39,421	$353,535
Calendar YTD	**194,924**	**$1,708,435**
Program Total	**194,924**	**$1,708,435**

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: JANUARY 2017

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

Chart 7 displays the past due collection history and the number of beneficiaries that have past due balances that can be collected through the Department of Treasury. These numbers are cumulative from quarter to quarter.

Chart 7: Past Due Collection Amounts

Month	# of Beneficiaries with Past Due Co-pays/Contributions	# of Beneficiaries with Past Due Co-pays/Contributions that Can be Sent to Treasury
Aug-16	118,480	47,218
Sep-16	126,874	50,034
Oct-16	128,105	52,073

Chart 8 displays the total amount of past due invoices according to the length of time the invoice has been outstanding. Each length of time displays the unique number of beneficiaries for that time period. The total number of delinquent beneficiaries is also listed along with the corresponding delinquent amount owed.

Chart 8: Delinquent Copay and Contribution Amounts by Aging Category

Days	0-30 Days	31-60 Days	61-90 Days	91-120 Days	>120 Days	TOTAL
Amount Due	$1,005,409.98	$937,070.06	$821,444.97	$721,709.71	$7,628,581.96	**$11,114,216.68**
Number of Beneficiaries That Owe	77,939	70,807	63,656	58,713	141,565	**187,664**

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: JANUARY 2017

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

Chart 9 displays the beneficiary payment activity as a result of the pre-garnishment notice.

Chart 9: Pre-Garnishment Notices

Month/Year	# of Beneficiaries that Received a Garnishment Notice	Total Amount Owed	# of Beneficiaries that Paid Following Pre-Garnishment Notice	Total Amount Collected
Jul-15	5,893	$589,770.20	2,981	$78,670.02
Jul-16	41,460	$5,108,153.13	3,832	$404,921.47
Calendar YTD	**41,460**	**$5,108,153.13**	**3,832**	**$404,921.47**
Program Total	**47,353**	**$5,697,923.33**	**6,813**	**$483,591.49**

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

Chart 10 displays the number of beneficiaries that were referred to Treasury.

Chart 10: Garnishments Sent to Treasury

Month	# of Beneficiaries Sent to Treasury for Garnishment	Total Amount Sent to Treasury for Garnishment
Nov-15	4,635	$460,231.19
Nov-16	31,932	$3,946,091.28

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: JANUARY 2017

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

Chart 11 displays collection activities by the Department of Treasury.

Chart 11: Garnishments Collected by Treasury

	Collected by Taxes		Collected by Lottery		Total Garnishments Collected	
Tax Year	**#**	**Total**	**#**	**Total**	**#**	**Total**
2015	2,151	$207,873.10	7	$485.67	**2,158**	**$208,358.77**
2016	7,491	$908,366.12	29	$3,136.01	**7,520**	**$911,502.13**
Calendar YTD	**7,491**	**$908,366.12**	**29**	**$3,136.01**	7,520	**$911,502.13**
Program Total	**9,642**	**$1,116,239.22**	**36**	**$3,621.68**	9,678	**$1,119,860.90**