STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

March 15, 2018

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 2018. 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 (8)

Michigan Adult Coverage Demonstration
Section 1115 Quarterly Report

Demonstration Year: 8 (01/01/2017 – 12/31/2017)
Federal Fiscal Quarter: 1 (10/01/2017 – 12/31/2017)

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 enrollment and disenrollment by month:

Table 1: Healthy Michigan Plan New Enrollments by Month			
October 2017	November 2017	December 2017	Total
32,204	38,675	33,505	104,384

Table 2: Healthy Michigan Plan Disenrollments by Month			
October 2017	November 2017	December 2017	Total
30,229	33,961	30,418	94,608

Most Healthy Michigan Plan beneficiaries choose a health plan as opposed to automatic assignment to a health plan. As of December 18, 2017, 382,042 or, 71 percent, of the State's 536,963 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, 4,359 of all Healthy Michigan Plan health plan enrollees changed health plans. This quarter, 2,371 or approximately 54 percent, of beneficiaries that changed plans were previously automatically assigned to a health plan. The remaining beneficiaries were those that changed plans after selecting a health plan.

Healthy Michigan Plan members have the opportunity to reduce cost-sharing requirements through the completion of Health Risk Assessments and engaging in healthy behaviors. MDHHS has developed a standard Health Risk Assessment form to be completed annually. Health Risk Assessment forms and reports are located on the MDHHS website. 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 91 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 2017 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 2017	3,720	91%	380	9%	4,100
November 2017	4,183	91%	389	9%	4,572
December 2017	5,003	91%	500	9%	5,503
Total	12,906	91%	1,269	9%	14,175

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 2017	November 2017	December 2017	Total
Health Risk Assessments Submitted	2,801	3,219	4,440	10,460
Gift Cards Earned	2,221	2,520	3,360	8,101
Reductions Earned	573	682	1,073	2,328
Reductions Applied	934	674	746	2,354

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 typical 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 2017 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 – 12/2017	Current Enrollees (year to date)	Disenrolled in Current Quarter
ABW Childless Adults	N/A	N/A	N/A
Healthy Michigan Adults	755,924	971,464	94,608

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. This quarter, MDHHS has conducted significant outreach to providers, beneficiaries, and stakeholders regarding the implementation of the Healthy Michigan Plan second waiver. MDHHS began the formal beneficiary notification process for those expected to be transitioned to the MI Marketplace Option. An MDHHS webpage with information specific to the MI Marketplace Option is available to the public. Additionally, MDHHS conducted a live provider webinar on November 7, 2017. The presentation has been included as an attachment to this report.

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 December 2017 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 and Letters with Healthy Michigan Plan Impact

Issue Date	Subject	Link
10/04/2017	Healthy Michigan Plan §1115 Demonstration Waiver Extension	L 17-46
10/23/2017	MI Marketplace Option Provider Information and Webinar	L 17-49
11/15/2017	Elimination of the Paper Version of the Facility Admission Notice	MSA 17-33
11/27/2017	Update to Physician Primary Care Rate Eligibility	MSA 17-43
11/27/2017	Inpatient and Outpatient Short Hospital Stay Rate of Reimbursement	MSA 17-47
11/27/2017	Managed Care Network Provider Enrollment in the Community Health Automated Medicaid Processing System (CHAMPS)	MSA 17-48
12/1/2017	Updates to the Early and Periodic Screening, Diagnosis and Treatment Chapter of the Medicaid Provider Manual and 2017 American Academy of Pediatrics Periodicity Schedule	MSA 17-34
12/1/2017	Michigan Department of Health and Human Services (MDHHS) File Transfer Application	MSA 17-36
12/1/2017	Rate Update for Neonatal and Pediatric Critical Care and Intensive Care Services	MSA 17-37
12/1/2017	Modernizing Continuum of Care (MCC) – Changes to Eligibility Inquiry/Response Transactions and CHAMPS Unique Health Plan ID	MSA 17-40
12/1/2017	Maternal Infant Health Program (MIHP) Consultant Authorization for Program Exceptions	MSA 17-41
12/1/2017	Updates to the Medicaid Provider Manual; Clarification to Bulletin MSA 17-10	MSA 17-44
12/1/2017	Peer Recovery Coach Certification	MSA 17-45
12/1/2017	Modernizing Continuum of Care (MCC) Project	MSA 17-46

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

	Approved HMP PMPM	Actual HMP PMPM (YTD)	Total Expenditures (YTD)	Total Member Months (YTD)
DY 5 - PMPM	$667.36	$477.45	$1,782,967,705	3,734,355
DY 6 - PMPM	$602.21	$481.57	$3,499,679,191	7,267,214
DY 7 - PMPM	$569.80	$495.43	$3,844,235,135	7,759,419
DY 8 - PMPM	$598.86	$449.31	$3,727,176,401	8,295,275
DY 9 - PMPM	$629.40	-	-	-

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, 2017.

Table 8: Healthy Michigan Plan Beneficiary Month Reporting

Eligibility Group	October 2017	November 2017	December 2017	Total for Quarter Ending 12/17
Healthy Michigan Adults	685,877	690,591	693,678	2,070,146

Consumer Issues

This quarter, the total number of Healthy Michigan Plan complaints reported to MDHHS was 54. Complaints reported to MDHHS are detailed by category in the table below. Overall, with over 2 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 2017 – December 2017

	Obtaining Prescriptions	Other Covered Services	Transportation	Total
Count	31	19	4	54
Percent	57%	35%	8%	

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, 2018 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 included in the attached November 2017 MI Health Account Executive Summary Report.

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 2017 to December 2017, there were 258 total appeals among all the Medicaid Health Plans. Medicaid Health Plan decisions were upheld in 53 percent of the appeals. From October 2017 to December 2017 there were a total of 1,069 grievances. The greatest number of grievances came from the Transportation 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 10: Managed Care Organization Appeals				
October 2017 – December 2017				
	Decision Upheld	Overturned	Undetermined/ Withdrawn	Total
Count	136	96	26	258
Percent	53%	37%	10%	

Table 11: Managed Care Organization Grievances		
October 2017 – December 2017		
Category	Count	Percent
Access	159	15%
Billing	147	14%
Administrative/Service	310	29%
Transportation	352	33%
Quality of Care	101	9%
Total	1,069	

Lessons Learned

MDHHS continues to learn from the experience of launching a program the size and scope of the Healthy Michigan Plan. This quarter, Michigan State University's (MSU) Institute for Health Policy (IHP) provided MDHHS with results of its all Medicaid program Non-Emergency Transportation (NEMT) Survey. Members have historically reported difficulty utilizing this benefit not only in the Healthy Michigan Plan but across the State's Medicaid programs. This can be especially pervasive in areas with driver shortages or rural locations. MSU-IHP, in coordination with MSU Office of Survey Research (OSR), surveyed Michigan Medicaid members to gain insight into this population's experiences with NEMT. This survey was not specific to the Healthy Michigan population but to members of all Medicaid programs. Both users and non-users were contacted via a mailed survey. Out of 4,000 surveys, response rates of users was 23% and 11% for non-users. Users reported a greater need and use of NEMT services than the non-user respondents. Less than 40% of non-users demonstrated an awareness of NEMT service availability. While half of users reported issues utilizing NEMT, 80% responded that their needs were met "usually" or "always." The problems most frequently mentioned were tardiness, missed appointments, driver cell phone use, and lack of choice in ride service. Some improvements highlighted by MSU-IHP included: educating members on the NEMT complaint process, improving and guaranteeing timeliness, expanding service provider choice, creating a process for driver confirmation calls/notifications, and greater ability to schedule services on short notice. MDHHS will utilize this information in addition to continuing to monitor complaints and grievances specific to transportation to maximize utilization and satisfaction with the NEMT

benefit. Additionally, MDHHS expects to incorporate an informational transportation measure in 2018 in its Health Plan Performance Monitoring reports.

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. 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:

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

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

Below is a summary of the key activities for the Fiscal Year (FY) 2018 first quarterly report:

Domain I
Domain I examines the impact of reducing the number of uninsured individuals on uncompensated care costs to hospitals in Michigan through Medicaid expansion. IHPI has engaged in activities to find and compare baseline uncompensated care results from hospital cost reports and the Internal Revenue Service (IRS) filings to understand the distribution of uncompensated care in Michigan. This quarter, IHPI constructed a data extract from the most up-to-date Medicare Cost Report data available and began analyzing this data. A similar extract was constructed from Medicaid Cost Report data, as well. After which, an analysis was conducted of changes in uncompensated care for all of Michigan hospitals. For the majority of hospitals, this analysis covers the period from FY 2013 to FY 2016. For the remainder of the remainder of the hospitals, the analysis covers the period from FY 2013 to FY 2015. Additionally, IHPI completed a report on changes in uncompensated care for the period 2013 to 2016 which is based on the Medicaid Cost Report data. IHPI has started examining the patient-level discharge data from the Michigan Hospital Association to complement the analysis utilizing the Cost Report data.

Domain II
Domain II evaluates the insured/uninsured rates, in general and more specifically by select population groups (e.g., income levels, geographic areas, age, gender, and race/ethnicity). This quarter, IHPI analyzed data from Michigan and other states from two U.S. Census Bureau

Surveys (American Community and the Current Population Surveys) to compare trends in uninsurance rates across time, within state and across states. IHPI completed analyzing the data and begun drafting the report for submission to MDHHS. IHPI staff initiated training on mapping software (ArcGIS), in order to present results graphically by Michigan geographic areas.

Domain III
Domain III assesses healthy behaviors, utilization and health outcomes for individuals enrolled in the Healthy Michigan Plan. This quarter, IHPI continued to calculate measures on emergency department utilization, healthy behaviors/preventive health services, and hospital admissions. IHPI analyzed trends over time and summarized for final evaluation report. A draft of the Initial Report was submitted to MDHHS for review.

Domain IV
Domain IV examines beneficiary and provider viewpoints of the Healthy Michigan Plan through survey data. IHPI continued to analyze the 2016 Healthy Michigan Voices (HMV) Beneficiary Survey of current enrollees. IHPI completed additional analyses of the 2016 HMV current enrollees data which included the incorporation of data from the MDHHS Data Warehouse and the findings were summarized and submitted to MDHHS. Further, IHPI conducted analyses of the Eligible But Unenrolled (EBU) interviews. It also conducted analyses on the 2017 HMV Beneficiary Survey data and longitudinal analyses of 2016 and 2017 HMV survey data for the HMV survey reports. IHPI continued the initial coding of the 2017 EBU interviews in Debose. Further, IHPI analyzed data from the 2016-2017 HMV survey of individuals no longer enrolled in Healthy Michigan Plan and summarized the findings which were submitted in a report to MDHHS for review. Data collection was completed for the survey of beneficiaries newly enrolled in Healthy Michigan Plan. IHPI is almost complete with the data collection for the one-year follow-up survey of current enrollees who completed their initial HMV survey in 2016. IHPI finalized the 2018 HMV survey instruments. Finally, based on the initial coding of the 2017 EBU interviews, IHPI began to outline proposed changes to the 2018 EBU interview guide.

Domains V/VI
Domains V and VI entail analyzing data to assess the impacts of contribution requirements and the MI Health Account statements on beneficiary utilization of health care services, respectively. This quarter, IHPI completed data acquisition and cleaning for relevant claims and HMV survey data needed to prepare the interim report. Those data were analyzed with respect to all four hypotheses that were to be tested. Draft results were discussed with MDHSS during a meeting on December 19, 2017. The findings are to be summarized in a report that will be submitted to MDHHS for review in mid-January 2018. IHPI began to conduct any remaining analyses on the impact of contribution requirements and impact of the MI Health Account.

Domain VII
Domain VII will evaluate the cost effectiveness of the HMP Marketplace Option (Marketplace Option). The Marketplace Option will not be implemented until April 2018. IHPI began log of Marketplace Option features that may impact subsequent analyses. Additionally, IHPI explored potential sources of beneficiary-level claims/encounter data for Marketplace option enrollees. IHPI also verified that the Marketplace Option enrollment will be housed in the MDHHS Data Warehouse.

Enclosures/Attachments

1. December 2017 Health Risk Assessment Report
2. November 2017 Healthy Michigan Plan Provider Webinar Presentation
3. December 2017 MCAC Minutes
4. January 2018 Performance Monitoring Report
5. January 2018 Performance Monitoring Report: Dental
6. November 2017 MI Health Account Executive Summary
7. Medicaid Non-Emergency Transportation (NEMT) Survey Results

State Contacts

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

Jacqueline Coleman, Waiver Specialist

Phone: (517) 284-1190

Carly Todd, Analyst

Phone: (517) 284-1196

Andrew Schalk, Federal Regulation & Hospital Reimbursement Section Manager

Phone: (517) 284-1195

Penny Rutledge, Actuarial Division Director

Phone: (517) 284-1191

Actuarial Division

Bureau of Medicaid Operations and Actuarial Services

MSA, MDHHS, P.O. Box 30479

Lansing, MI 48909-7979

Fax: (517) 241-5112

Date Submitted to CMS

March 15, 2018

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 2017

Produced by:

Quality Improvement and Program Development - Managed Care Plan Divison

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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 355,769 Health Risk Assessments were completed through Michigan ENROLLS as of December 2017. This represents a completion rate of 94.97%. 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 2017	304,748	14,138 (4.43%)
February 2017	309,044	14,473 (4.47%)
March 2017	314,291	14,935 (4.54%)
April 2017	319,192	15,340 (4.59%)
May 2017	324,295	15,755 (4.63%)
June 2017	329,843	16,298 (4.71%)
July 2017	334,094	16,698 (4.76%)
August 2017	338,377	17,141 (4.82%)
September 2017	342,863	17,568 (4.87%)
October 2017	346,583	17,948 (4.92%)
November 2017	350,766	18,337 (4.97%)
December 2017	355,769	18,837 (5.03%)

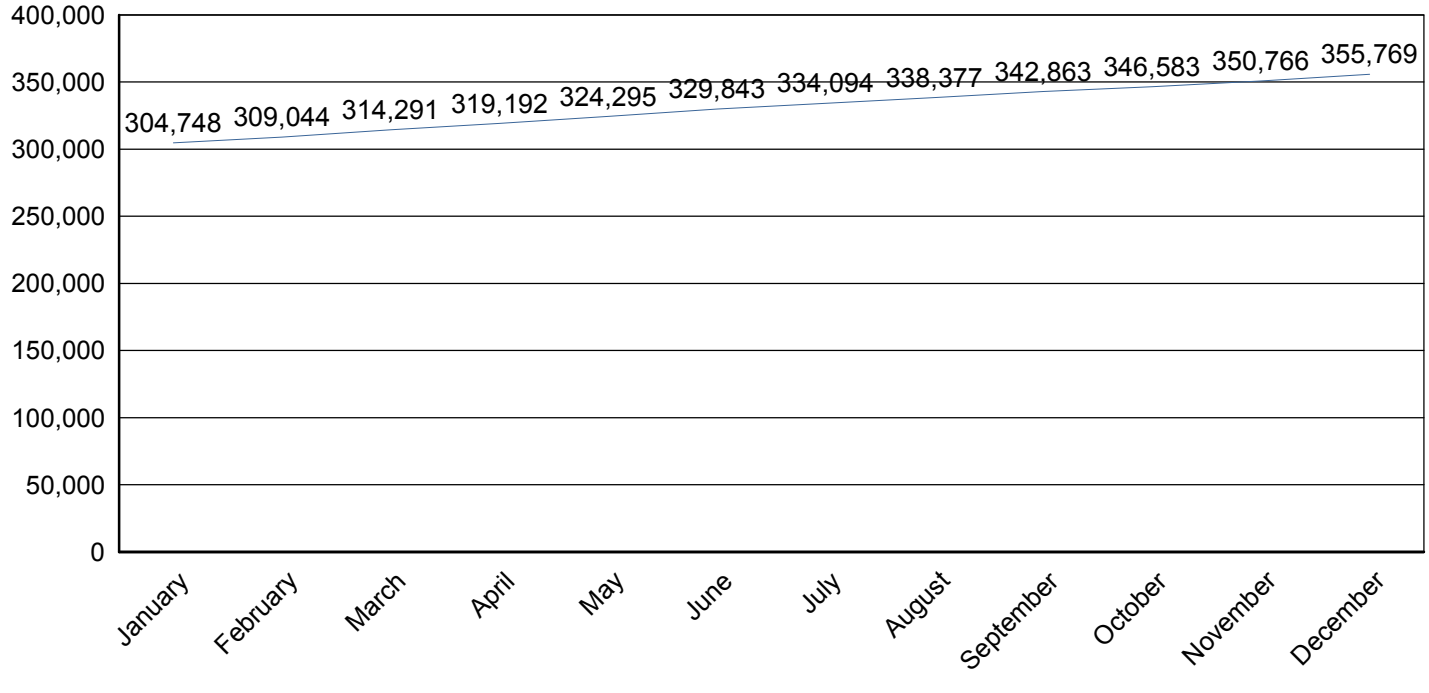
Table 11. Demographics of Population that Completed HRA Questions 1-9 with MI ENROLLS

January 2014 - December 2017

AGE GROUP	COMPLETED HRA	
19 - 29	79,593	22.37%
30 - 39	78,171	21.97%
40 - 49	70,472	19.81%
50 - 59	85,169	23.94%
60 +	42,364	11.91%
GENDER		
F	191,114	53.72%
M	164,655	46.28%
FPL		
< 100% FPL	298,047	83.78%
100 - 133% FPL	57,722	16.23%
TOTAL	**355,769**	**100.00%**

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

December 2017



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 2017. Among enrollees who completed the survey, this question had a 0.16% refusal rate.

Table 1. Health Rating for Total Population

December 2017

HEALTH RATING	TOTAL	PERCENT
Excellent	40,841	11.48%
Very Good	93,025	26.15%
Good	127,089	35.72%
Fair	71,426	20.08%
Poor	22,816	6.41%
Refused	572	0.16%
TOTAL	**355,769**	**100.00%**

Figure 1-1. Health Rating for Total Population

December 2017

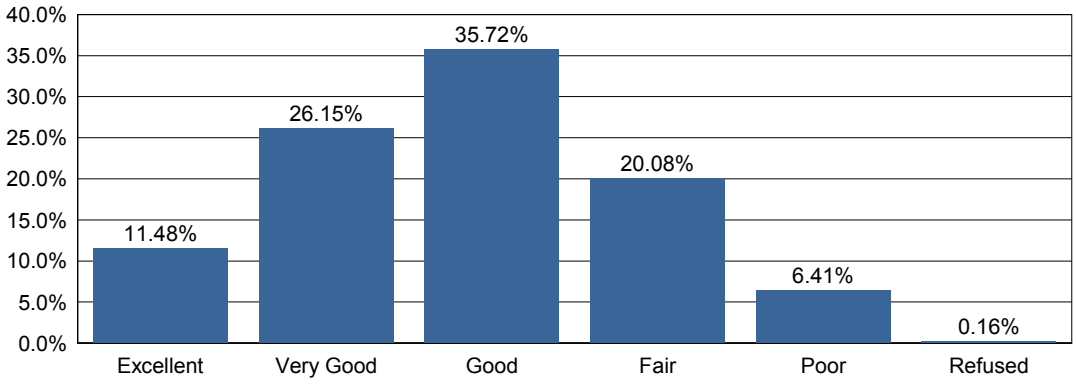


Figure 1-2. Health Rating by Age

December 2017

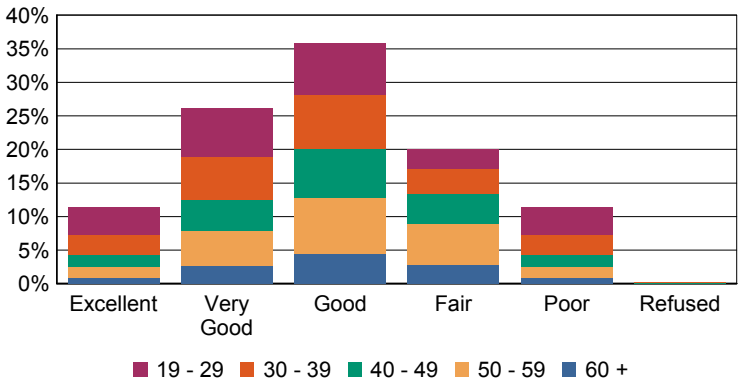
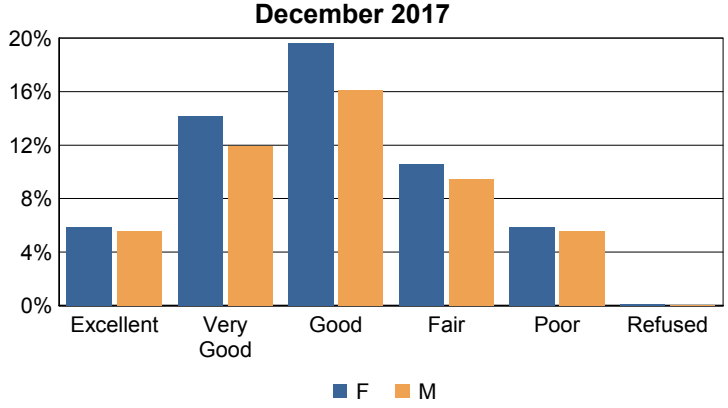


Figure 1-3. Health Rating by Gender

December 2017



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 2017. Among enrollees who participated in the survey, there was a 1.50% 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 2017

EXERCISE	TOTAL	PERCENT
Every Day	82,033	23.06%
3-6 Days	104,610	29.40%
1-2 Days	87,807	24.68%
No Days	75,984	21.36%
Refused	5,335	1.50%
TOTAL	**355,769**	**100.00%**

Figure 2-1. Exercise Reported for Total Population

December 2017

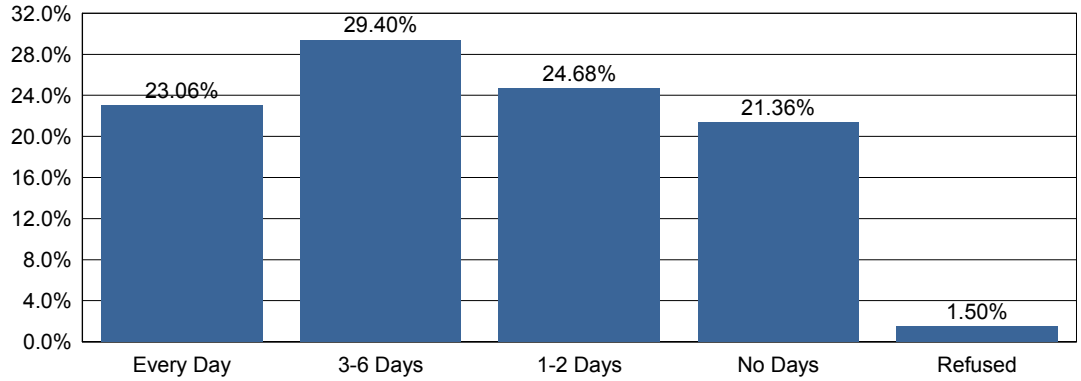


Figure 2-2. Exercise Reported by Age

December 2017

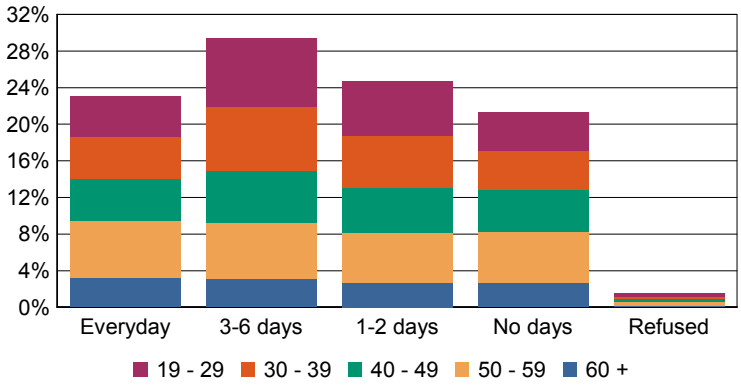
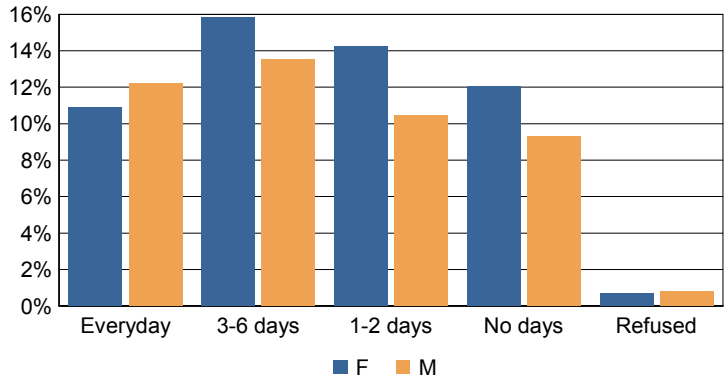


Figure 2-3. Exercise by Gender

December 2017



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 2017. Among enrollees who participated in the survey, there was a 1.85% 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 2017

NUTRITION	TOTAL	PERCENT
Every Day	120,790	33.95%
3-6 Days	123,689	34.77%
1-2 Days	80,827	22.72%
No Days	23,898	6.72%
Refused	6,565	1.85%
TOTAL	**355,769**	**100.00%**

Figure 3-1. Nutrition Reported for Total Population
December 2017

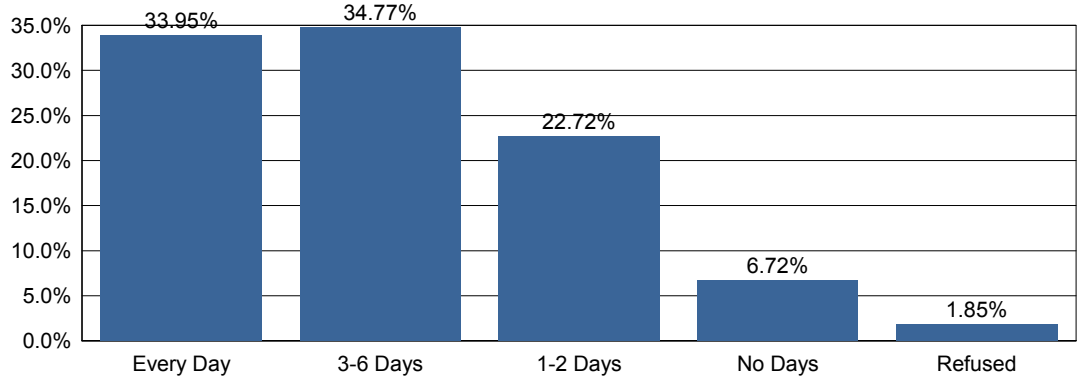


Figure 3-2. Nutrition Reported by Age
December 2017

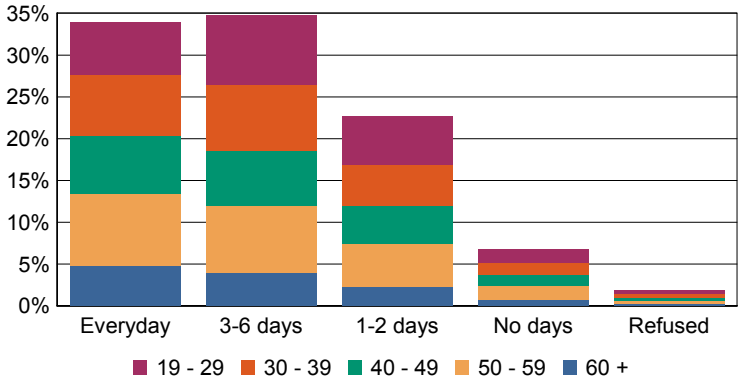
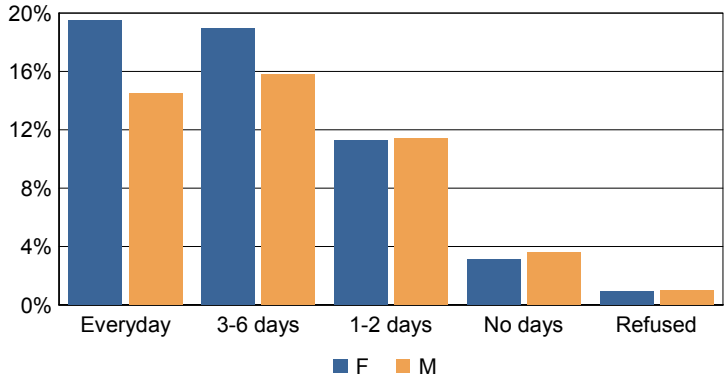


Figure 3-3. Nutrition by Gender
December 2017



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 2017. Among enrollees who participated in the survey, there was a 0.81% 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 2017

ALCOHOL	TOTAL	PERCENT
Never	295,035	82.93%
Once a Week	39,253	11.03%
2-3 times a Week	15,073	4.24%
More than 3	3,515	0.99%
Refused	2,893	0.81%
TOTAL	**355,769**	**100.00%**

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

December 2017

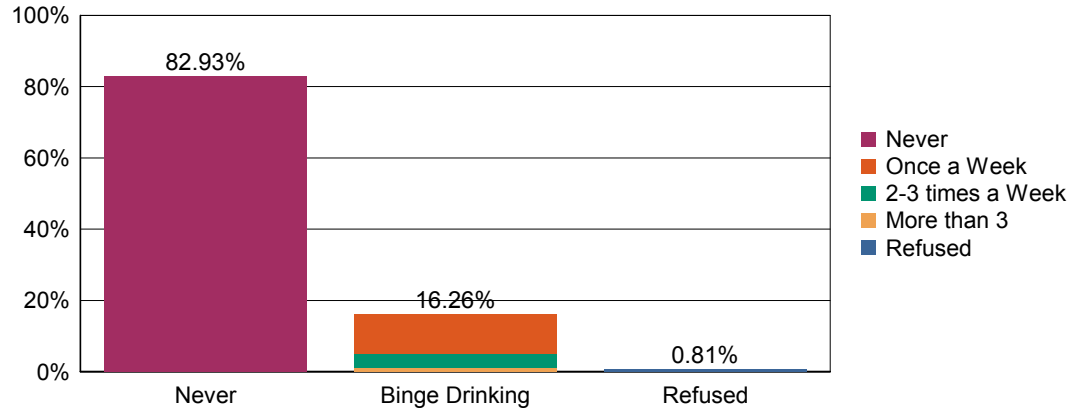


Figure 4-2. Binge Alcohol Use Reported by Age

December 2017

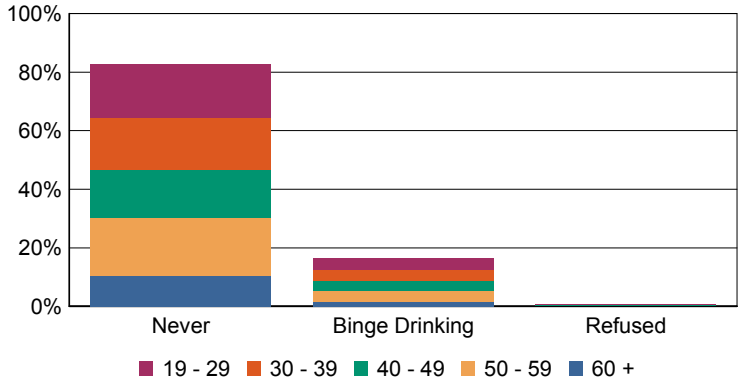
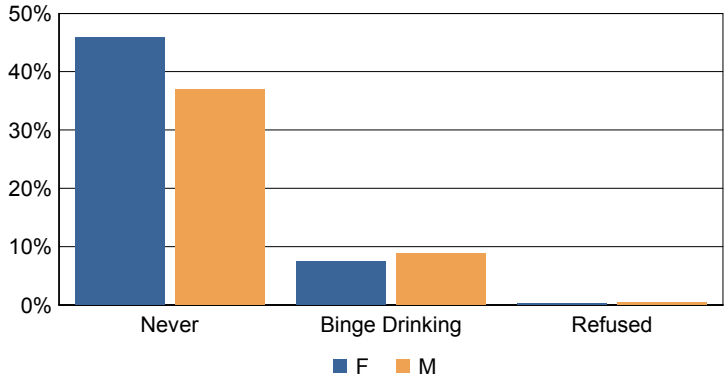


Figure 4-3. Binge Alcohol Use by Gender

December 2017



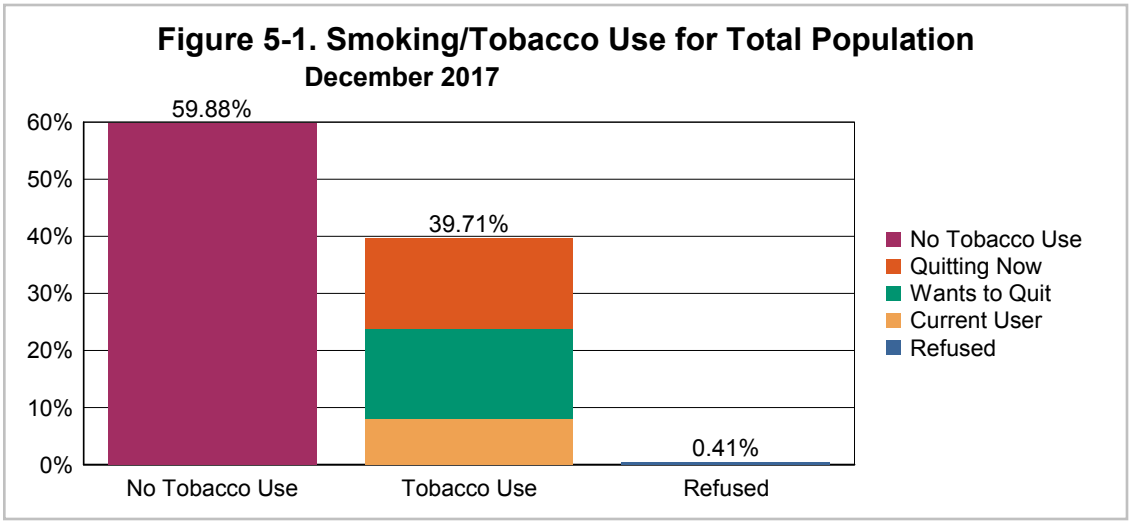
Question 5. Smoking/Tobacco Use

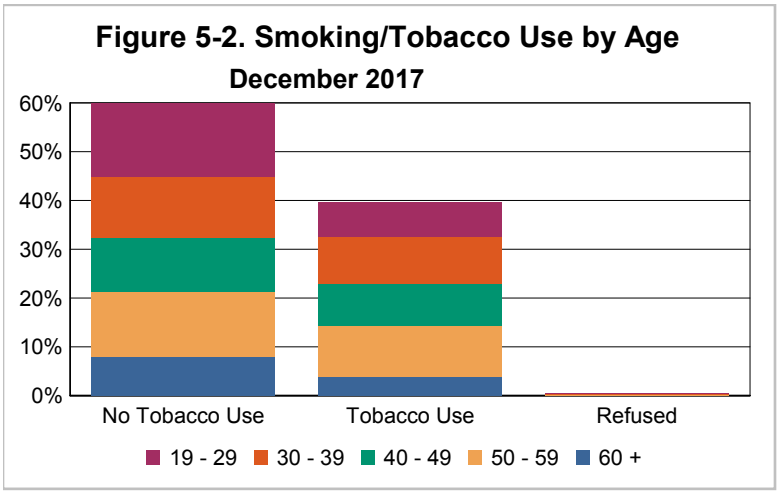
Question 5. In the last 30 days, have you smoked or used tobacco? This question is used to assess self-reported smoking/tobacco use. Healthy Michigan Plan enrollees were given the answer options of yes or no. Enrollees who answered yes, were asked a follow-up question: If YES, do you want to quit smoking 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 2017. Question 5 had a 0.41% refusal rate. Figures 5-1 through 5-3 show smoking/tobacco use reported for the total population, and by age and gender.

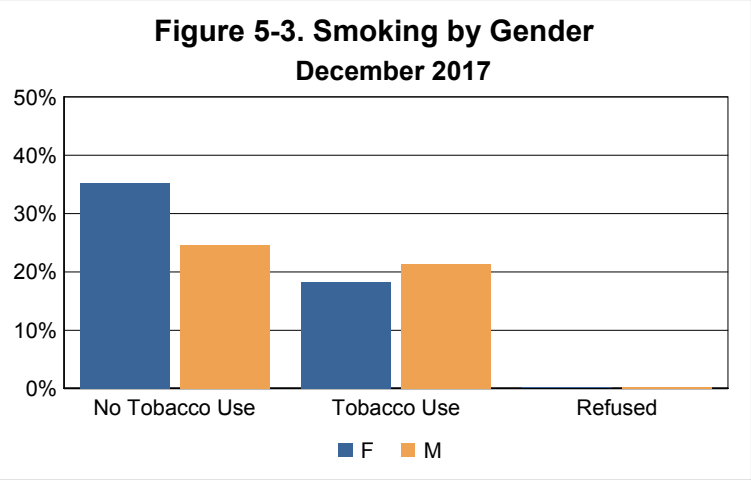
Table 5. Smoking/Tobacco Use Reported for Total Population

December 2017

TOBACCO USE	TOTAL	PERCENT
No Tobacco Use	213,039	59.88%
Quitting Now	56,483	15.88%
Wants to Quit	56,181	15.79%
Current User	28,598	8.04%
Refused	1,468	0.41%
TOTAL	**355,769**	**100.00%**







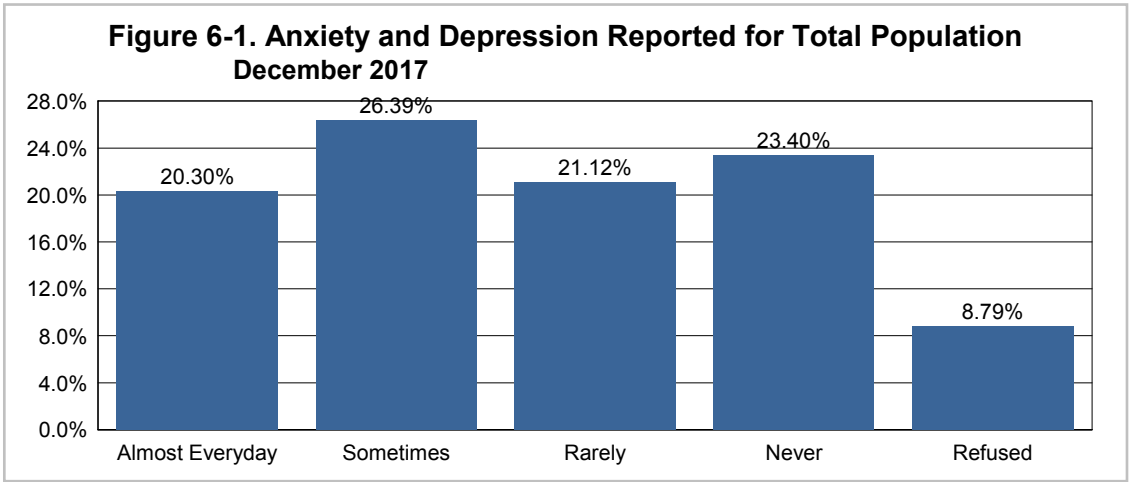
Question 6. Anxiety and Depression

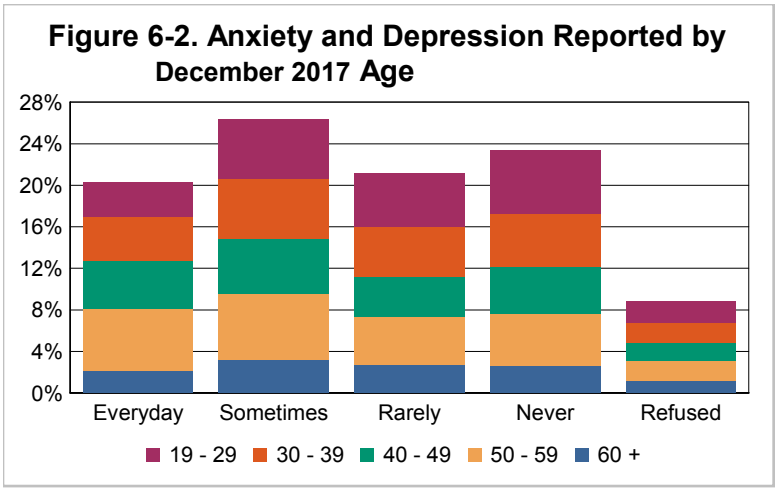
Question 6. In the last 30 days, how often have you felt tense, anxious or depressed? This question is used to assess selfreported mental health status. Healthy Michigan Plan enrollees were given the answer options of almost every day, sometimes, rarely and never. Table 6 shows the overall answers to this question for December 2017. Among enrollees who participated in the survey, there was a 8.79% 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.

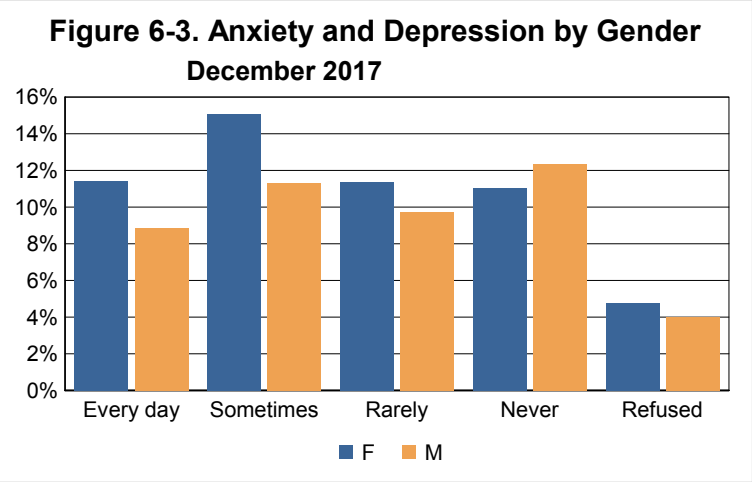
Table 6. Anxiety and Depression Reported for Total Population

December 2017

DEPRESSION	TOTAL	PERCENT
Almost Every day	72,220	20.30%
Sometimes	93,889	26.39%
Rarely	75,138	21.12%
Never	83,235	23.40%
Refused	31,287	8.79%
TOTAL	**355,769**	**100.00%**







Question 7. Drugs and Substance Use

Question 7. Do you use drugs or medications (other than exactly as prescribed for you) which affect your mood or help you to relax? This question is used to assess self-reported substance use. Healthy Michigan Plan enrollees were given the answer options of almost every day, sometimes, rarely and never. Table 7 shows the overall answers to this question for December 2017. Among enrollees who participated in the survey, there was a 0.77% 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 2017

SUBSTANCE USE	TOTAL	PERCENT
Almost Every Day	6,910	1.94%
Sometimes	9,229	2.59%
Rarely	8,612	2.42%
Never	328,265	92.27%
Refused	2,753	0.77%
TOTAL	**355,769**	**100.00%**

Figure 7-1. Substance Use Reported for Total Population

December 2017

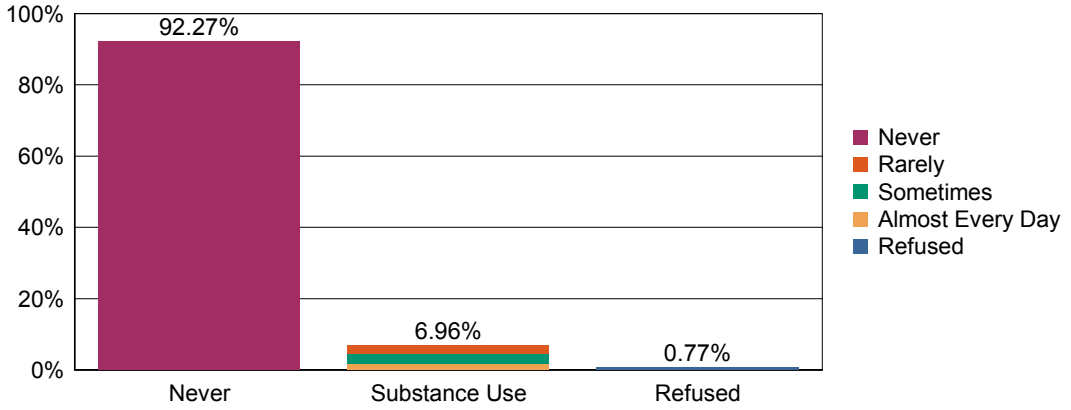


Figure 7-2. Substance Use Reported by Age

December 2017

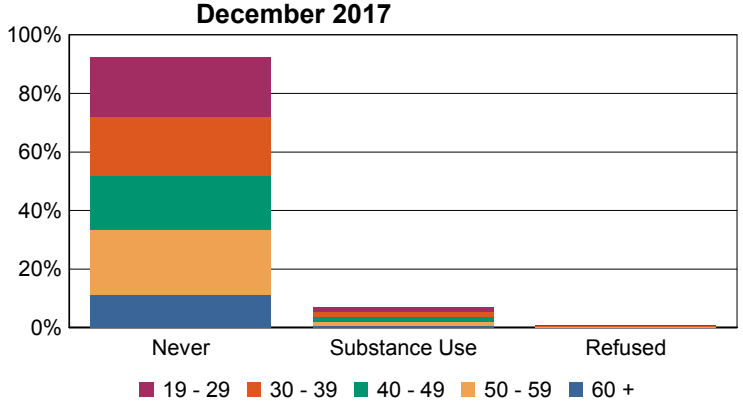
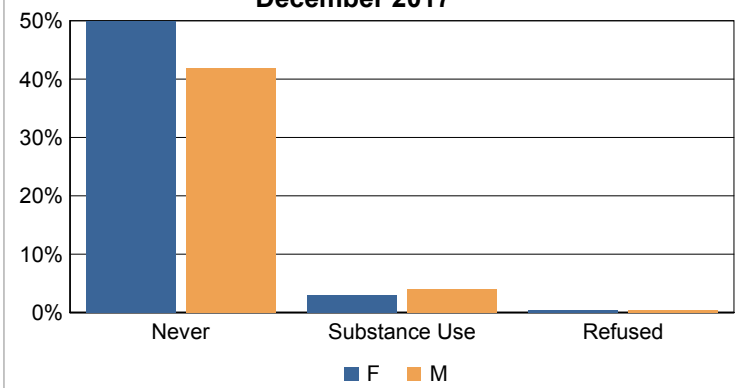


Figure 7-3. Substance Use by Gender

December 2017



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 2017. Among enrollees who participated in the survey, there was a 1.91% 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 2017

IMMUNIZATION	TOTAL	PERCENT
Yes	80,319	22.58%
No	268,642	75.51%
Refused	6,808	1.91%
TOTAL	**355,769**	**100.00%**

Figure 8-1. Immunization Status Reported for Total Population

December 2017

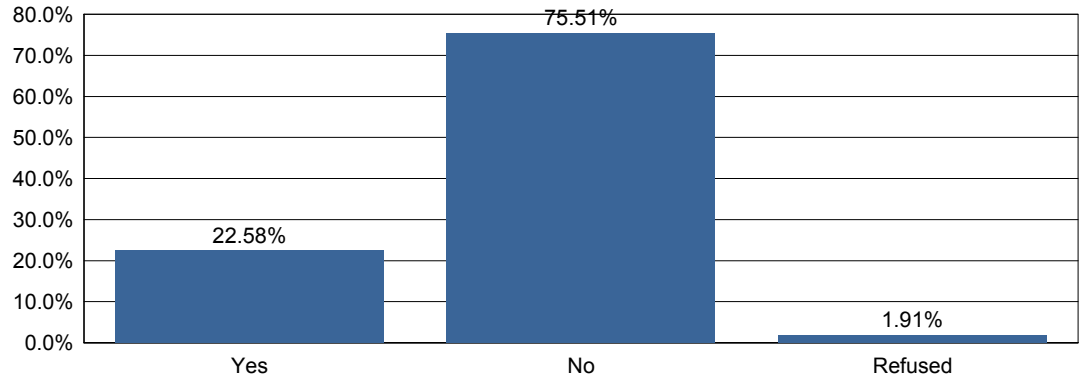


Figure 8-2. Immunization Status Reported by Age

December 2017

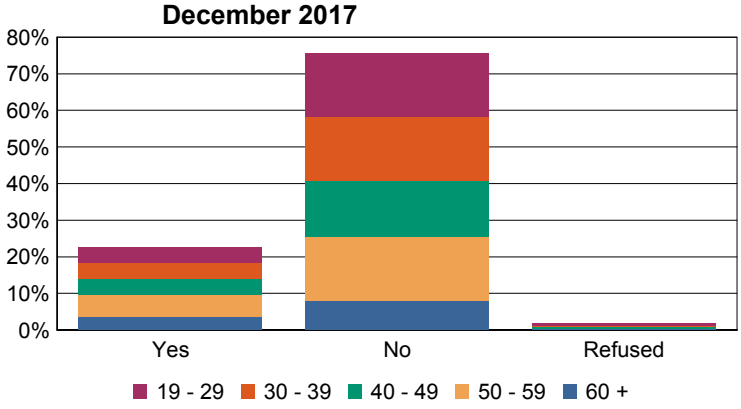
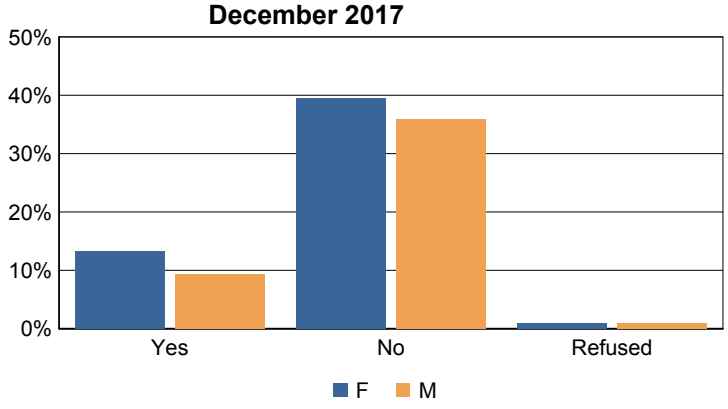


Figure 8-3. Immunization Status by Gender

December 2017



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 2017. Among enrollees who participated in the survey, there was a 3.06% 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 2017

CHECK-UP	TOTAL	PERCENT
Within the last year	186,818	52.51%
Between 1 & 3 years	88,360	24.84%
More than 3 years	69,691	19.59%
Refused	10,900	3.06%
TOTAL	**355,769**	**100.00%**

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

December 2017

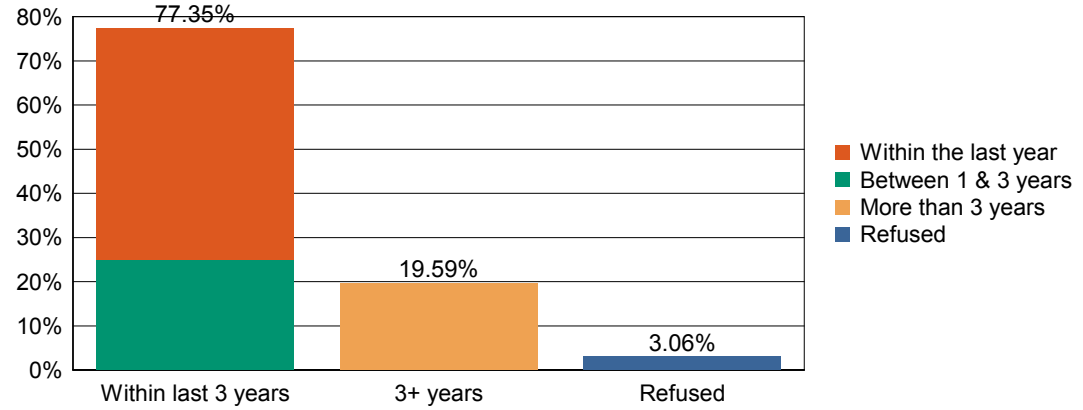


Figure 9-2. Well Check Visit Reported by Age

December 2017

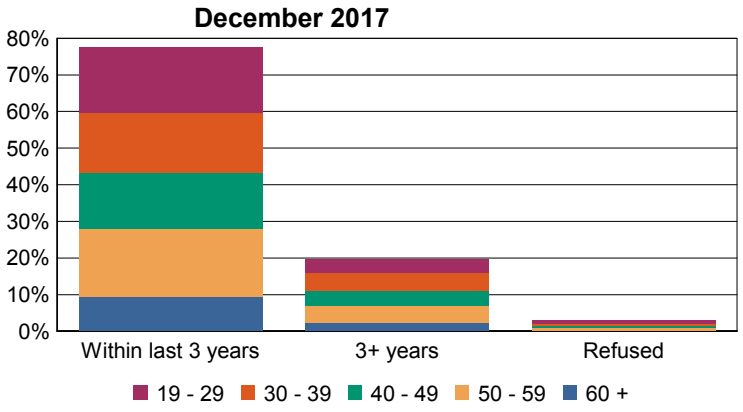
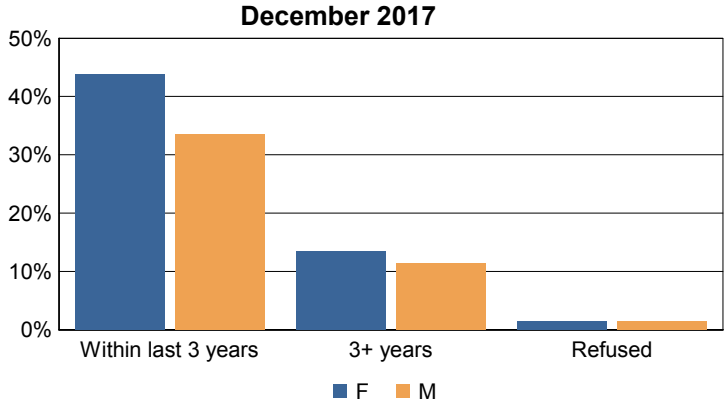


Figure 9-3. Well Check Visit by Gender

December 2017



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 938,077 beneficiaries who have been enrolled in a health plan for at least six months, 178,106 or 19.0% have completed the Health Risk Assessment with their primary care provider as of December 2017.

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 227,143 Health Risk Assessments were completed with primary care providers as of December 2017. Health Risk Assessment completion is reported by age, gender and Federal Poverty Level in Table 11.

Among beneficiaries who completed the Health Risk Assessment, 194,675 or 85.7% of beneficiaries agreed to address health risk behaviors. In addition, 30,527 or 13.4% 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 194,675 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 2017	4,614	174,037
February 2017	5,299	179,443
March 2017	6,024	185,526
April 2017	5,717	191,298
May 2017	5,895	197,272
June 2017	4,896	202,244
July 2017	4,631	206,925
August 2017	5,763	212,750
September 2017	4,549	217,349
October 2017	4,829	222,215
November 2017*	3,626	225,862
December 2017*	1,276	227,143

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

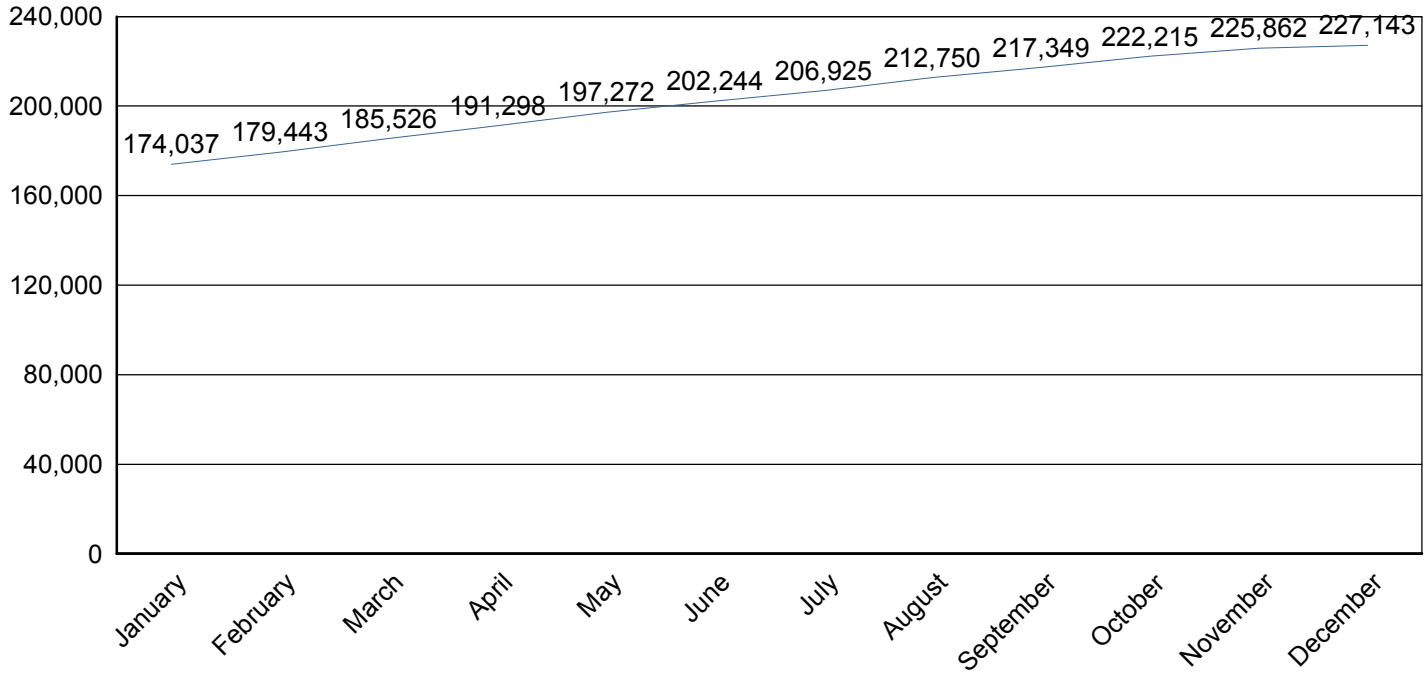
Table 11. Demographics of Population that Completed HRA with Primary Care Provider

September 2014 - December 2017

AGE GROUP	COMPLETED HRA	
19 - 29	44,462	19.57%
30 - 39	40,872	17.99%
40 - 49	42,602	18.76%
50 - 59	63,730	28.06%
60 +	35,477	15.62%
GENDER		
F	130,338	57.38%
M	96,805	42.62%
FPL		
< 100% FPL	188,042	82.79%
100 - 133% FPL	39,101	17.21%
TOTAL	**227,143**	**100.00%**

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

December 2017



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

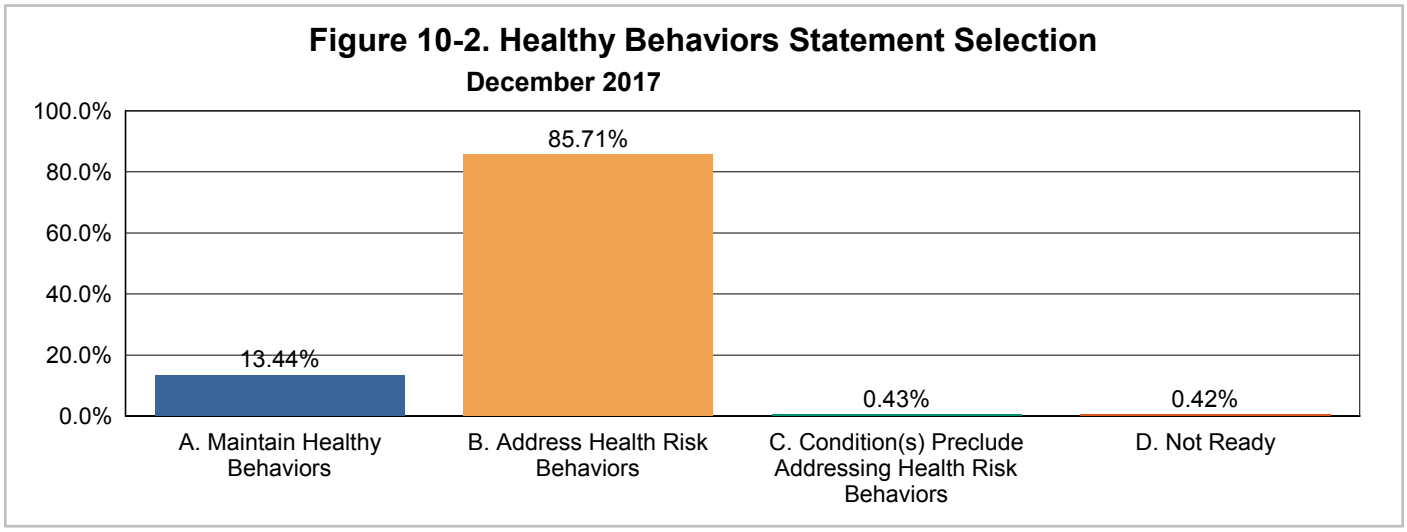
C. Patient has a serious medical, behavioral or social condition or conditions which precludes addressing unhealthy behaviors at this time.

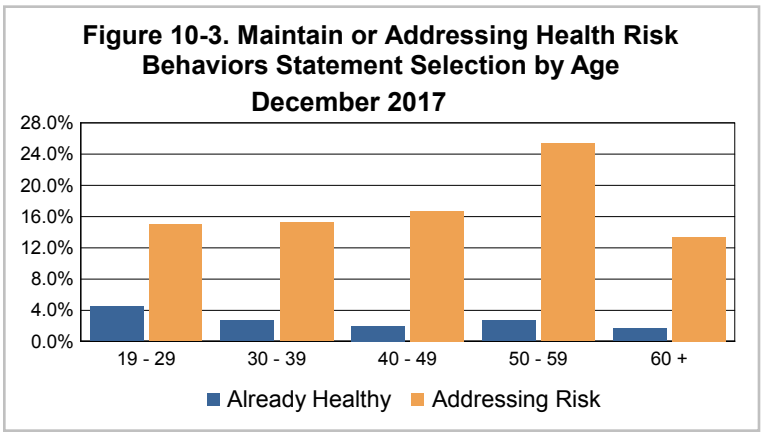
D. Unhealthy behaviors have been identified, patient's readiness to change has been assessed, and patient is not ready to make changes at this time.

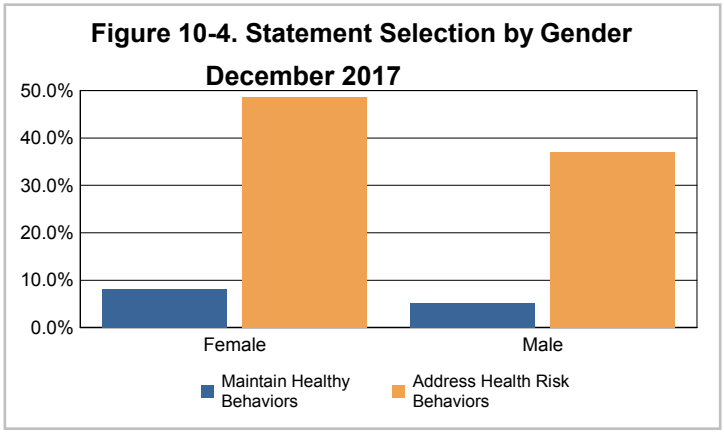
Figures 10-2 through 10-4 show Healthy Behaviors Statement Selections for the total population, and by age and gender.

Table 12. Healthy Behaviors Statement Selection
December 2017

CHECK-UP	TOTAL	PERCENT
A. Maintain Healthy Behaviors	30,527	13.44%
B. Address Health Risk Behaviors	194,675	85.71%
C. Condition(s) Precluding Addressing Health Risk Behaviors	989	0.44%
D. Not Ready	952	0.42%
TOTAL	**227,143**	**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 194,675 HRAs submitted through December 2017 where the beneficiary chose to address health risk behaviors, 60.32% 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

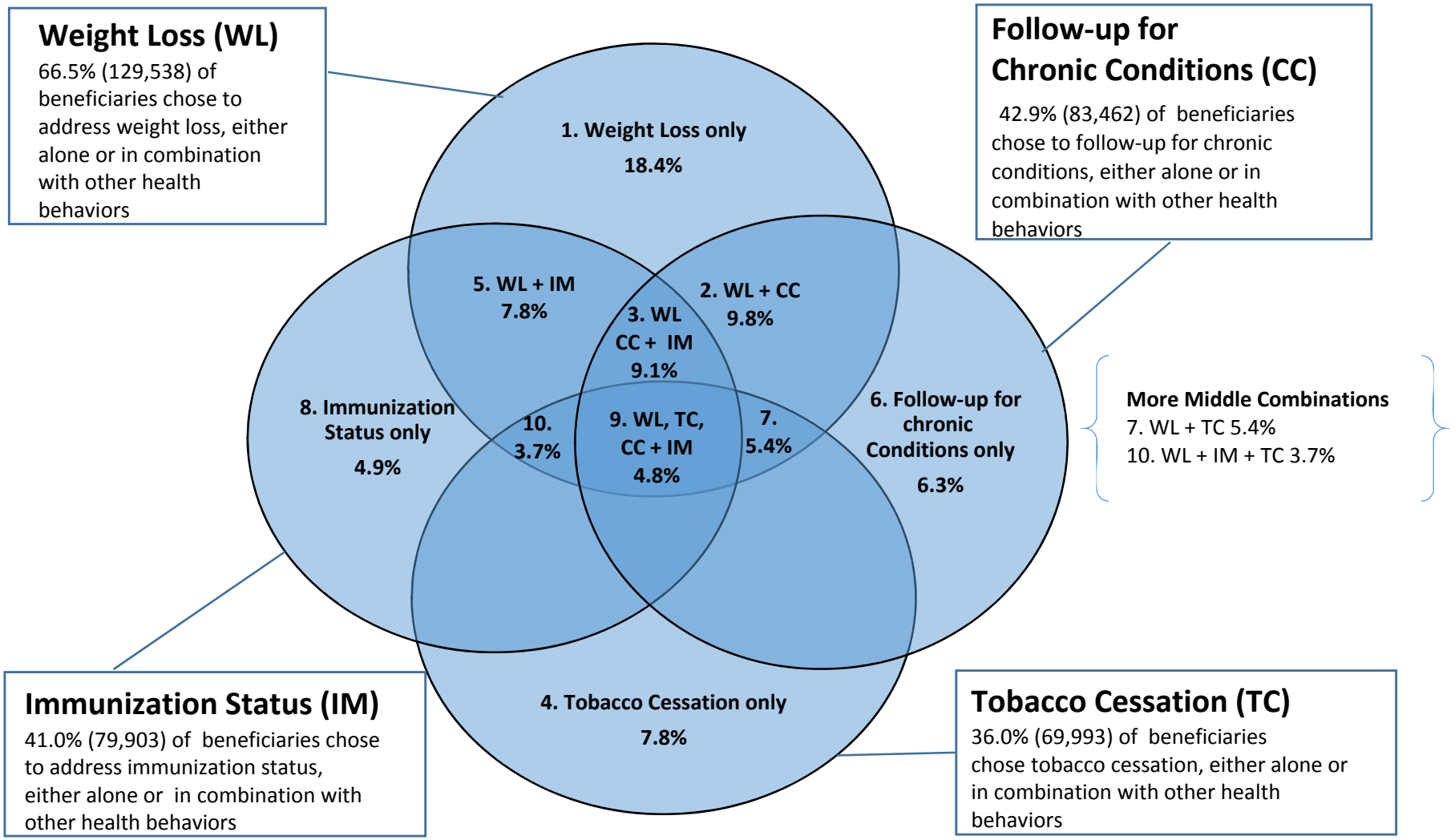
Health Risk Behavior Combination	Count	Percent
1. Weight Loss ONLY	35,759	18.37%
2. Weight Loss, Follow-up for Chronic Conditions	19,003	9.76%
3. Weight Loss, Immunization Status, Follow-up for Chronic Conditions	17,804	9.15%
4. Tobacco Cessation ONLY	15,266	7.84%
5. Weight Loss, Immunization Status	15,153	7.78%
6. Follow-up for Chronic Conditions	12,341	6.34%
7. Weight Loss, Tobacco Cessation	10,516	5.40%
Total for Top 7	125,842	64.64%
Total for All Other Combinations	68,833	35.36%
Total	**194,675**	**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	66.54%	18.37%
Tobacco Cessation	35.96%	7.84%
Immunization Status (Annual Flu Vaccine)	41.05%	4.91%
Follow-up for Chronic Conditions	42.88%	6.34%
Addressing Alcohol Abuse	4.26%	0.34%
Addressing Substance Abuse	1.15%	0.11%
Other	4.36%	1.77%

Health Risk Assessment Completion with Primary Care Provider

Representation of the overlapping nature of top 10 health risk behavior selections December 2017



Healthy Michigan Plan
Second Waiver Implementation
November 7, 2017

Jackie Prokop, RN, MHA
Director
Program Policy Division,
Medical Services Administration
Michigan Department of Health and Human Services

Meta Kreiner, MSc
Population Health Specialist
Managed Care Plan Division,
Medical Services Administration
Michigan Department of Health and Human Services

Presentation Overview

- Healthy Michigan Plan information is posted on the MDHHS website:
  - http://www.michigan.gov/healthymichiganplan
- First Waiver
  - Unique cost-sharing feature
  - MI Health Account
  - Healthy Behaviors
- Second Waiver for HMP
  - Healthy Behaviors
  - Marketplace Option
  - Timeframe

HEALTHY MICHIGAN PLAN

The Healthy Michigan Plan

- The Healthy Michigan Plan celebrated its three-year anniversary April 1, 2017

- <u>Over 665,000</u> Michigan residents are covered by the Healthy Michigan Plan

HEALTHY MICHIGAN PLAN

Federal and State Laws

- Affordable Care Act (ACA) authorization
  - New eligibility category
- Funding must be appropriated by State
  - Public Act 107 of 2013 was signed into law by Governor Snyder on September 16, 2013.
  - State law requires certain cost-sharing responsibility and health promotion activity
- Requirement of federal waivers (Section 1115)
  - First Waiver approved December 30, 2013
  - Second Waiver approved December 17, 2015
  - The Healthy Michigan Plan Waiver ends December 30, 2018
    - Will be submitting renewal request by December 30, 2017.

HEALTHY MICHIGAN PLAN

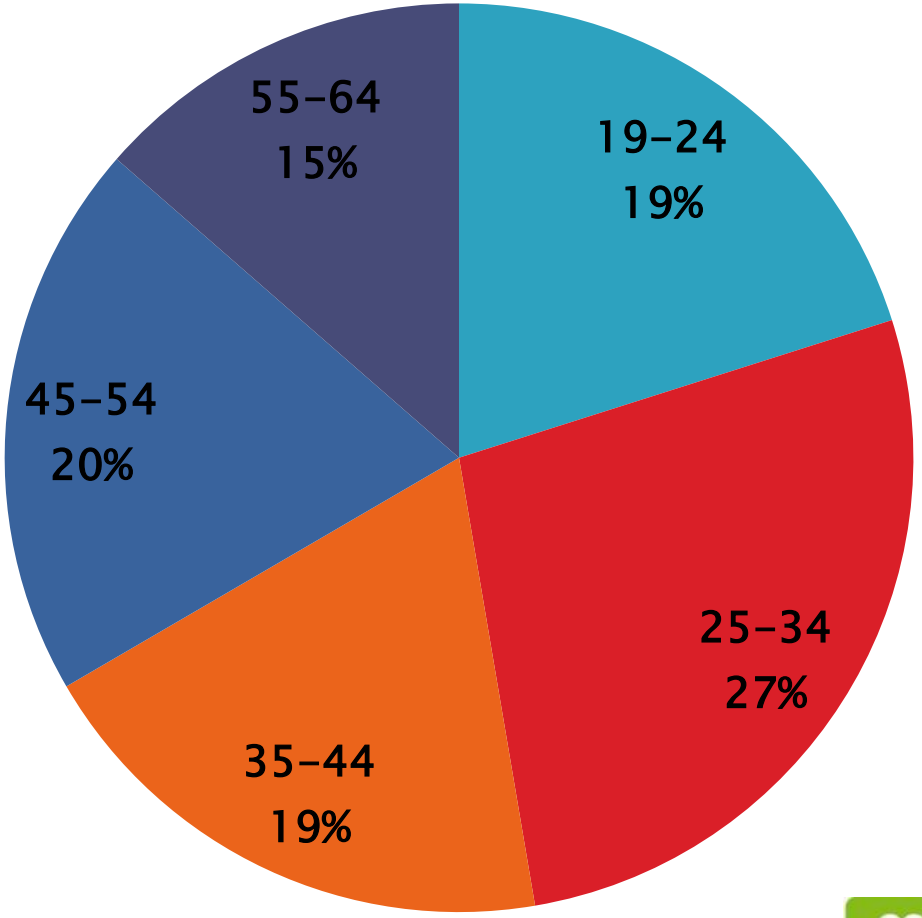
Eligibility Requirements

Michigan residents who:

- Are ages 19–64
- Are not receiving or eligible for Medicare benefits
- Are not eligible for other Medicaid programs
- Are not pregnant at the time of application
- Have income at or below 133% of the Federal Poverty Level (FPL)
  - Note – 5% disregard = 138%
- Must meet other federal requirements

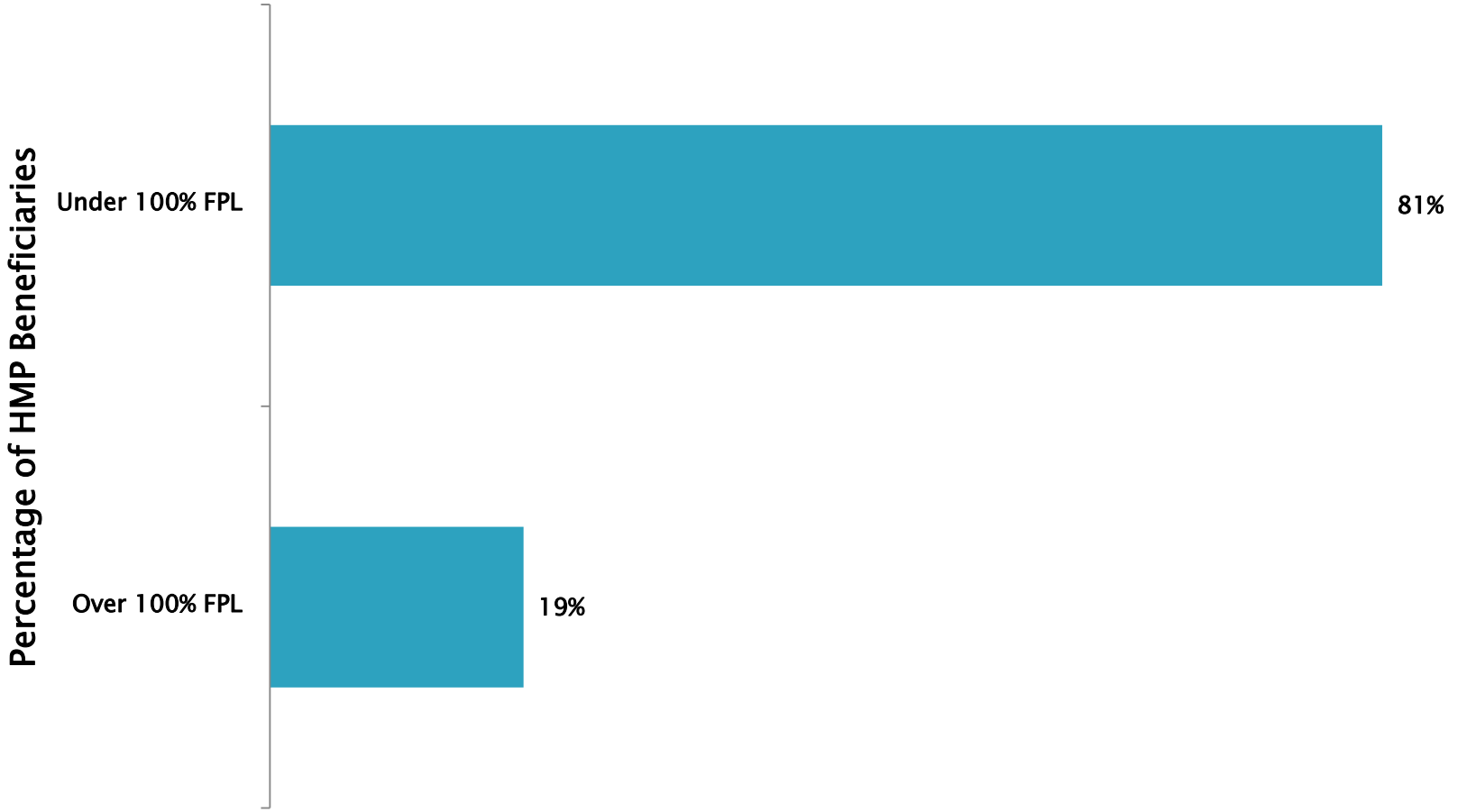
HEALTHY MICHIGAN PLAN

Enrollment by Age



HEALTHY MICHIGAN PLAN

Enrollment by Federal Poverty Level



HEALTHY MICHIGAN PLAN

MI Health Account

- Mechanism to facilitate beneficiary education and responsibility of health care service utilization
  - Required by Public Act 107 of 2013
- Begins six months after individual enrolls in a Medicaid Health Plan
- MI Health Account Quarterly Statement
  - Itemization of health services received
  - Cost of services for the beneficiary and the Medicaid Health Plan
  - Co-pays and/or contributions owed by the beneficiary
  - Reductions in cost-sharing
  - Payment coupons

HEALTHY MICHIGAN PLAN

Cost-Sharing Requirements

- Two types of cost-sharing to be paid on a monthly basis
  - Average monthly co-pays
    - Based on past beneficiary service utilization
  - Contributions
    - Limited to beneficiaries above 100% of the FPL
    - Total annual amounts may be up to 2% of income
- Efforts to align cost-sharing requirements with high-value services
- Many factors determine cost-sharing responsibilities

HEALTHY MICHIGAN PLAN

Cost-Sharing Requirements – Co-pays

Covered Services	Co-Pay	
	Income less than or equal to 100% FPL	Income more than 100% FPL
Physician Office Visits (including Free-Standing Urgent Care Centers)	$ 2	$ 4
Outpatient Hospital Clinic Visit	$ 1	$ 4
Emergency Room Visit for Non-Emergency Services • Co-payment ONLY applies to non-emergency services • There is no co-payment for true emergency services	$ 3	$ 8
Inpatient Hospital Stay (with the exception of emergent admissions)	$ 50	$ 100
Pharmacy	$ 1 preferred $ 3 non-preferred	$ 4 preferred $ 8 non-preferred
Chiropractic Visits	$ 1	$ 3
Dental Visits	$ 3	$ 4
Hearing Aids	$ 3 per aid	$ 3 per aid
Podiatric Visits	$ 2	$ 4
Vision Visits	$ 2	$ 2

Co-pay Exemptions

Groups Exempt from Co-Pay Requirements	Services Exempt from Co-Pay Requirements
• Beneficiaries under age 21 • Individuals residing in a nursing facility • Individuals receiving hospice care • Native American Indians and Alaskan Natives consistent with Federal regulations at 42 CFR 447.56(a)(1)(x) • Beneficiaries dually eligible for Healthy Michigan Plan and Children's Special Health Care Services	• Emergency services • Family planning services • Pregnancy-related services • Preventive services • Federally Qualified Health Center, Rural Health Clinics, or Tribal Health Center services • Mental health specialty services and supports provided/paid through the Prepaid Inpatient Health Plan / Community Mental Health Services Program • Mental health services provided through state psychiatric hospitals, the state Developmental Disabilities Center, and the Center for Forensic Psychiatry • Services related to program-specific chronic conditions *

** A list of program-specific chronic conditions can be found online at www.michigan.gov/healthymichiganplan >> Healthy Michigan Plan Provider Information*

HEALTHY MICHIGAN PLAN

Chronic Conditions Exempt from Cost-Sharing

- Anemia
- Alcohol Use Disorder
- Alzheimer's
- Asthma
- Atrial Fibrillation
- Bipolar Disorder
- Cancer Diagnoses
- Cataract
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease and Bronchiectasis
- Cystic Fibrosis
- DVT (while on anticoagulation)/PE (chronic anticoagulation)
- Depression
- Diabetes
- Glaucoma
- Heart Failure
- Hemophilia
- HIV
- Hyperlipidemia
- Hypertension
- Ischemic Heart Disease
- Lead Exposure
- Liver Disease
- Obesity
- Osteoporosis
- Rheumatoid Arthritis Osteoarthritis
- Schizophrenia
- Stroke/Transient Ischemic Attack
- Substance Use Disorder
- Tobacco Use Disorder
- Viral Hepatitis
- Other

HEALTHY MICHIGAN PLAN

Tax Offsets

- Owe greater than $50.
- People who consistently fail to pay.
- Complete a tax offset process
- Lottery winnings

HEALTHY MICHIGAN PLAN

Health Risk Assessment

- Health Risk Assessment form
  - Phone survey at time of health plan enrollment
  - Primary Care Provider's office

- HRA covers the following health domains:
  - General health status rating
  - Exercise frequency
  - Nutrition
  - Alcohol use
  - Anxiety and depression
  - Smoking/tobacco/drug and substance use
  - Flu vaccinations
  - Chronic conditions

HEALTHY MICHIGAN PLAN

Health Risk Assessment

- Beneficiaries who complete a Health Risk Assessment and agree to address or maintain a healthy behavior may be eligible to receive financial incentives:
  - A 50% reduction in their required monthly co-pay amounts (after 2% of income has already been paid in co-pays), **AND**
  - A 50% reduction in required contributions or a comparably valued gift card from their health plan if they are not required to pay contributions.
- Primary care provider attestation is required.

HEALTHY MICHIGAN PLAN

Healthy Behavior Initiatives

- All health plans have an incentive for primary care providers who complete and return the Health Risk Assessment form for their Healthy Michigan Plan patients.

- Each health plan designed their own provider incentives, which thus far vary by plan.

HMP Second Waiver

- Healthy Behaviors
  Marketplace Option
  Timeline

Healthy Michigan Plan
Second Waiver – Affected Population

- Beginning **April 1, 2018**, targets all beneficiaries who have incomes above 100% of the FPL level.
  - Does not apply to people who are below 100% of the FPL.
- Medically Frail (medical exemption), Native Americans, pregnant women and under 21 years are exempt.
- Will need to obtain coverage from a Marketplace issuer.

Healthy Michigan Plan Second Waiver Details

- Affected beneficiaries will choose between two delivery system options:
  - The "traditional" Healthy Michigan Plan, available with the completion of a healthy behavior, **OR**
  - The Marketplace Option, whereby beneficiaries receive coverage through a Marketplace issuer.
    - Will receive essential health benefits

- NOTE: Beneficiaries newly enrolled after April 1, 2018, may have one year enrollment in the traditional HMP to allow for completion of healthy behaviors.

HEALTHY MICHIGAN PLAN

Protocol Updates – Related to the Second Waiver

1. New Protocol – Marketplace Option Protocol
2. MI Health Account Operational Protocol – updated
3. Healthy Behaviors Operational Protocol – updated
4. The protocols were posted for public comment for 30 days.
   - Public comment period ended September 15, 2017.
5. Revised protocols are posted – subject to CMS approval.

HEALTHY MICHIGAN PLAN

Diagrams

Healthy Behaviors Update
Healthy Michigan Plan

Three ways to document healthy behaviors:

1. Health Risk Assessment
   - Agree to address or maintain a healthy behavior
   - Removing biometrics
   - Adding attestation on previous goals achieved
   - Creating a single state-wide fax line for submission

2. Completion of approved wellness programs

3. Claims for specific wellness services
   - Annual preventive visit
   - Preventive dental services
   - Appropriate cancer screening
   - Tobacco cessation
   - ACIP recommended vaccination(s)
   - Other preventive screening

HEALTHY MICHIGAN PLAN

Healthy Behaviors Update
Healthy Michigan Plan

Healthy Behaviors Incentives

- Health Risk Assessment
  - A 50% reduction in their required monthly co-pay amounts (after 2%/3% of income is paid in co-pays), **AND**
  - Reduction in required contributions or a gift card
    - 1 annual HRA: Pay 1% of income in monthly contributions
    - 2+ annual HRAs: monthly contributions waived in its entirety

- Completion of approved wellness programs and Claims for specific wellness services
  - Same contribution and copay reduction incentives only.
  - Individuals at or below 100 percent of the Federal Poverty Level can still earn the gift card incentive through completion of a Health Risk Assessment.

HEALTHY MICHIGAN PLAN

Healthy Behaviors Update Marketplace Option

- Health Risk Assessment
  - Same HRA form
  - Can be completed telephonically including Healthy Behaviors goal selection and attestation

- Incentives
  - 50% premium reduction
  - Transition back to the Healthy Michigan Plan at the end of their Marketplace Option Plan enrollment period

HEALTHY MICHIGAN PLAN

Healthy Michigan Plan–Second Waiver Next Steps

Month	Activities
September-Ongoing	• Monthly Operations Meetings with Marketplace issuers • System design and implementation
September	• Operational protocols submitted to CMS for approval
October	• Medicaid Health Plans approved to begin targeted outreach for individuals who have not completed the Healthy Behaviors protocol
November	• Educational webinar hosted by MDHHS • Formal MDHHS notice sent to all Healthy Michigan Plan enrollees (except medically frail)
February	• Transition letter sent from MDHHS to those who will be sent to MI Marketplace Option
April	• Transition process begins

MI Marketplace Option

The marketplace option will be known as the MI Marketplace Option.

HEALTHY MICHIGAN PLAN

Questions?

HEALTHY MICHIGAN PLAN

Michigan Department of Health and Human Services
Medical Services Administration

Medical Care Advisory Council

Meeting Minutes

Date: Wednesday, December 6, 2017

Time: 1:00 p.m. – 4:30 p.m.

Where: Michigan Public Health Institute (MPHI)
2436 Woodlake Circle, Suite 380
Okemos, MI 48864

Attendees: **Council Members:** Robin Reynolds, Eric Liu, Dan Thompson (for Loretta Bush), Kim Singh, Alison Hirschel, Emily Schwarzkopf, Michelle Best (for Amy Hundley), David LaLumia, Dianne Haas, Pam Lupo, Deb Brinson, Rod Auton, Barry Cargill, David Herbel, Warren White, Karlene Ketola, Amy Zaagman, Jeff Towns, April Stopczynski

Staff: Kathy Stiffler, Lynda Zeller, Erin Emerson, Brian Keisling, Dick Miles, Jackie Prokop, Pam Diebolt, Marie LaPres, Philip Bergquist, Phil Kurdunowicz

Other Attendees: Jeff Holm, Jane Pilditch

Welcome, Introductions, Announcements

Robin Reynolds opened the meeting and introductions were made. Kathy Stiffler announced that Chris Priest has stepped down from the role of State Medicaid Director, and that she has agreed to serve as acting director until a replacement is named.

Federal Update

Children's Health Insurance Program (CHIP) Reauthorization

Kathy Stiffler reported that CHIP expired on September 30, 2017, and has not yet been re-authorized by congress. While MDHHS staff are optimistic that the program will be renewed, Michigan currently has the resources to fund CHIP at the current Federal Matching Assistance Percentage (FMAP) rate through April or May 2018 if no action is taken. Robin Reynolds offered to draft a letter in support of renewing CHIP on behalf of the Medical Care Advisory Council (MCAC) to send to congress.

Cost Sharing Reductions

MDHHS staff discussed recent changes to cost sharing requirements for beneficiaries, noting that beginning in October 2017, cost sharing reduction (CSR) payments made by the federal government to qualified health plans on behalf of individuals with incomes between 100-250% of the federal poverty level (FPL) who receive health care coverage through the Marketplace were discontinued.

Budget/Boilerplate Update

2019 Budget Update

For details related to the FY 2019 budget, attendees were referred to the update provided by Farah Hanley at the August MCAC meeting, as documented in the meeting minutes. The minutes are available on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Numbered Letters >> click "Medical Care Advisory Council (MCAC)" under Provider Liaison Meetings. Overall, the budget is expected to include funding to wrap up several initiatives advocated by Governor Snyder, as this will be the last budget for the current administration.

2018 Supplemental

Erin Emerson reported that the legislature is expected to pass a FY2018 supplemental appropriations bill before the winter recess.

Provider Enrollment Requirements

MDHHS issued bulletin MSA 17-48 on December 1, 2017, which requires all providers with a National Provider Identifier (NPI) to enroll in the Community Health Automated Medicaid Processing System (CHAMPS) by March 1, 2018, per the requirements of the 21st Century Cures Act. The policy also requires prescribing providers to be enrolled in CHAMPS by May 1, 2018. Beginning May 1, 2018, all claims submitted for prescriptions ordered by non-enrolled providers will be denied. Enrollment of atypical providers (e.g., personal care services providers, volunteer Non-Emergency Medical Transportation [NEMT] providers, etc.) in CHAMPS is targeted for fall 2018.

In response to an inquiry, MDHHS staff and meeting attendees discussed implementing a system for pharmacies to request emergency overrides to fill prescriptions ordered by non-enrolled providers.

MDHHS has also issued proposed policy 1635-PE for public comment, which describes provider enrollment fitness criteria outlining federal and state felonies and misdemeanors that would prohibit a provider from participating in the State's Medicaid programs. The Department received many comments on the policy, and as a result, it will be revised and re-issued for public comment in early 2018.

Integrated Service Delivery (ISD)

MDHHS is in the process of implementing a new universal caseload system known as ISD to provide a single portal for beneficiaries who receive services from multiple MDHHS programs. Implementation of ISD will include the use of a new all programs application that will allow individuals to apply for multiple MDHHS programs in a single application, revisions to the

MI Bridges system to improve the user experience, and a new a central call center to assist applicants and beneficiaries. A pilot universal caseload system will be conducted in Gratiot and Shiawassee counties in late January 2018, with a phased rollout statewide to begin in summer 2018 that is projected to complete in mid-2019. While most beneficiaries who contact local MDHHS offices will be assisted through the new universal caseload system, MDHHS plans to exclude certain program enrollees from the system and allow those beneficiaries to maintain a relationship with a single caseworker in order to be better served. Local offices will also maintain the discretion to determine the best way to serve certain beneficiaries on an individual basis.

MDHHS staff and meeting attendees discussed at length the ways in which ISD is expected to improve efficiency in resolving customers' needs.

Medicaid Managed Care

Healthy Kids Dental Bid Update

MDHHS has completed the process for selecting new vendors to provide services under the ***Healthy Kids Dental*** program, and has awarded statewide contracts to Blue Cross Blue Shield of Michigan, which will work with DentaQuest to provide dental benefits, and Delta Dental. While MDHHS initially planned to begin the new contract on April 1, 2018, the start date was delayed until October 1, 2018 to allow additional time to implement systems changes. Beginning October 1, 2018, ***Healthy Kids Dental*** enrollees will have the opportunity to choose their dental plan, though MDHHS is working to implement a process for auto-assigning beneficiaries who do not make a choice.

Member Transportation Survey

MDHHS worked with the Michigan State University Institute for Health Policy to conduct a survey of both users and non-users of Medicaid transportation services. The survey process has been completed, and a final report was distributed to the MCAC via email prior to the meeting. Kathy Stiffler provided an overview of the report, and invited attendees to continue to examine the document and contact her with questions as necessary.

Dental Services for Pregnant Women

Ms. Stiffler reported that MDHHS has obtained funding to provide dental coverage through the health plans for pregnant women enrolled in Medicaid, and that the Department is working to develop a process for identifying Medicaid beneficiaries who are pregnant. MDHHS staff and meeting attendees discussed the issue at length.

Healthy Michigan Plan

Healthy MI Waiver Renewal Update

Since the previous MCAC meeting held on August 30, 2017, MDHHS released the Healthy Michigan Plan Section 1115 Demonstration Waiver extension application for public comment, and conducted a public hearing to discuss the application. Few comments were received during this process, and MDHHS is currently seeking final approval from Governor Snyder for the waiver renewal application. While the current waiver expires on December 31, 2018, the renewal application must be submitted to CMS by December 31, 2017.

Transition to Marketplace for Healthy Michigan Plan Members

Under the terms of the second waiver for the Healthy Michigan Plan beginning April 1, 2018, individuals who have been enrolled in the Healthy Michigan Plan for more than 12 months, have incomes above 100% of the federal poverty level, do not meet the criteria for "medically frail" and choose not to engage in a healthy behavior must leave the Healthy Michigan Plan and receive insurance coverage from the Marketplace. MDHHS has identified approximately 14,000 current Healthy Michigan Plan enrollees who meet the criteria to transition to the Marketplace, and will begin sending notices to these individuals in February 2018. The February notice will include a reminder that the beneficiary may still complete a Health Risk Assessment (HRA) or Medically Frail form and submit documentation to MDHHS by April 1, 2018 to remain enrolled in the Healthy Michigan Plan. The Department is also in the process of sending a letter to all Healthy Michigan Plan beneficiaries to inform them of this change, and has conducted a webinar to share information with providers about this process, as well. Additional information about the implementation of the Healthy Michigan Plan second waiver is available on the MDHHS website at www.michigan.gov/healthymichiganplan >> Healthy Michigan Plan Second Waiver Operational Protocols.

Behavioral Health Updates

Lynda Zeller provided an overview of the current priorities for the Behavioral Health and Developmental Disabilities Administration (BHDDA), which include:

- Improving access to inpatient psychiatric care close to home;
- Increasing diversion efforts to address the prevalence of individuals with mental health/substance use disorders who are among the jail and prison population in Michigan;
- Working to increase cultural and linguistic competencies within the BHDDA system, particularly concerning enabling greater access to services for tribal members and individuals who are deaf or blind; and
- Early intervention for childhood trauma victims.

Section 298 Update

The Michigan legislature directed MDHHS to develop up to three pilots and one demonstration model to test publicly integrated physical health and behavioral health services. The three pilots will test the financial integration for these services at the payer level, while the demonstration model (which will take place in Kent County) will test service integration. MDHHS has worked with MPHI since August 2017 to develop the structure of the pilots based on the legislative requirement and the recommendations of the Stakeholder 298 workgroup, in addition to holding meetings throughout the State of Michigan to gather stakeholder input on the pilot development process. As required by law, a report was submitted to the legislature on November 20, 2017 to show the timelines for implementation of the pilots, barriers to implementation and proposed solutions. The report, along with additional information related to the Section 298 Initiative, is available on the MDHHS website at www.michigan.gov/stakeholder298. MDHHS is now working to issue a Request for Information (RFI) to select the pilot sites, which is planned for release in mid-December 2017. If more than three responses are received, the Department may need to initiate a competitive bid process for those sites interested in participating in the pilot. MDHHS plans begin operating the pilot and demonstration sites by July 1, 2018.

The demonstration model for the Stakeholder 298 Initiative will maintain the current funding mechanism in which physical health services are funded through the Medicaid Health Plans and behavioral health services are funded through the Prepaid Inpatient Health Plans (PIHPs). The demonstration will be established in Kent County through Network180 (the Community Mental Health Services Program [CMHSP] in Kent County) in partnership with any willing MHPs. The partnership is working on a project plan, which must be approved by the Department, and targeting implementation on July 1, 2018. MDHHS has selected the University of Michigan to conduct an evaluation of up to three pilot sites and the demonstration sites, and up to four comparison sites. This will include a baseline survey for each site, as well as a final survey at the conclusion of the pilot and demonstration.

In addition, MDHHS is also working to implement the 76 policy recommendations proposed by the Stakeholder 298 workgroup and will report back to stakeholders in early 2018 with a plan for moving forward with the recommendations.

Section 1115 Waiver Update

Erin Emerson reported that the Section 1115 Waiver request to provide all behavioral health services under a single waiver authority is pending approval, and that CMS has requested to conduct weekly calls with the Department beginning in January 2018 to discuss the waiver.

Long Term Care Updates

Dick Miles provided several updates related to Long Term Care, which include:

- In July 2016, MDHHS submitted a Section 1115 Demonstration Waiver 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 Brain Injury Waiver (BIW) is still pending approval by CMS, as it contains language related to housing services and supports that is similar to the Behavioral Health Section 1115 Demonstration waiver, which is currently under consideration, as well.
- On October 23, 2017, MDHHS implemented the MiAIMS time and task system statewide for billing encounters by home help and adult protective services providers.
- Proposed Policy 1723-HH, which will allow travel time payment to home help providers for shopping and laundry services, has been issued for public comment. MDHHS is also working to issue a policy to clarify portions of bulletin MSA 15-13, regarding Home Help Agency Provider Standards.
- The MI Choice Waiver currently expires on September 30, 2018, and MDHHS is in the process of holding meetings to solicit stakeholder involvement in the waiver renewal process. Information about upcoming stakeholder meetings and the waiver renewal process is available on the MDHHS website at www.michigan.gov/medicaidproviders >> MI Choice.
- The Department is continuing to work toward resolving ongoing issues related to the Level of Care Determination (LOCD) process.
- Over 39,000 people are now enrolled in the MI Health Link demonstration program for individuals who are dually eligible for Medicare and Medicaid, and Mr. Miles reported that enrollment has stabilized. The demonstration is currently authorized through 2020.
- MDHHS issued bulletin MSA 17-42 on November 27, 2017, which discusses a new Medicaid Provider Manual Chapter for Home and Community Based Services. MSA 17-42 was issued concurrently for public comment review, and interested parties may submit comments until January 1, 2018.
- As required by the 21st Century Cures Act, MDHHS is currently in the process of developing an Electronic Visit Verification (EVV) system to track the services provided by personal care providers, as well as the location and time. The EVV system must be implemented by January 2019.

Managed Long Term Care Services and Supports

Public Act 107 of 2017 (the fiscal year 2018 Appropriations Act) directed the Department to "explore the implementation of a managed care long-term support service" by July 1, 2018. Since the previous MCAC meeting held on August 30, 2017, MDHHS has received funding from the Health Endowment Fund that will allow the Department to partner with contracted entities to continue to take the required steps to explore the many potential options for moving to a managed long term care system. Currently, two elements of Michigan's $2.6 billion long term care programs (State Plan Personal Care and many nursing facility beneficiaries) have no

system for managed care in place. MDHHS plans to begin the first phase of the stakeholder engagement process in December 2017, which will consist of conducting focus groups and interviews with stakeholders.

Policy Updates

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

MCAC Leadership

Robin Reynolds announced that she will be stepping down as chair of the MCAC at the end of 2017, and Emily Schwarzkopf was nominated and confirmed as the new chairperson.

4:30 – Adjourn

Medical Services Administration
Bureau of Medicaid Care Management and Quality Assurance

PERFORMANCE MONITORING REPORT

Composite – All Plans

January 2018

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

Table of Contents

Healthy Michigan Plan

Appendixes

Figures

Tables

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-eight (28) key performance measures aimed at improving the quality and efficiency of health care services provided to the Michigan residents enrolled in a Medicaid program. 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 Initial HRA*	*Completion of Annual HRA*
Outreach & Engagement to Facilitate Entry to PCP	*Adults' Access to Ambulatory Health Services*	*Transition into Consistently Fail to Pay (CFP) Status*
Transition out of Consistently Fail to Pay (CFP) Status		

Data for these 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. Measurement Periods may vary and are based on the specifications for that individual measure. Appendix A contains specific three letter codes identifying each of the MHPs. Appendix B contains the one-year plan specific analysis for each measure.

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 2018 unless otherwise noted.

Table 1: Fiscal Year 2018[1]

Quarterly Reported Measures	Reported in 1st Quarter	Reported in 2nd Quarter	Reported in 3rd Quarter	Reported in 4th Quarter
Adults' Generic Drug Utilization	10/11			
Timely Completion of Initial HRA	5/9			
Completion of Annual HRA	N/A			
Outreach & Engagement to Facilitate Entry to PCP	7/11			
Adults' Access to Ambulatory Health Services	0/11			
Transition into CFP Status	N/A			
Transition out of CFP Status	N/A			

[1] N/A will be shown for measures where the standard is Informational Only.

Healthy Michigan Plan Enrollment

The Healthy Michigan Plan (HMP-MC) enrollment has remained steady over the past year. Due to changes with the way the reports are pulled, current enrollment data is unavailable at this time.

Figure 1: HMP-MC Enrollment, February 2017 – January 2018

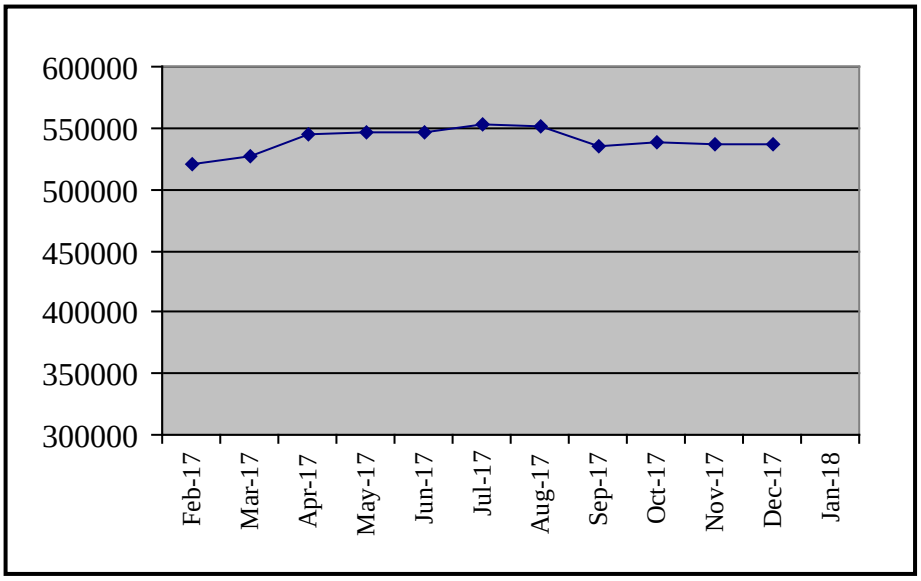
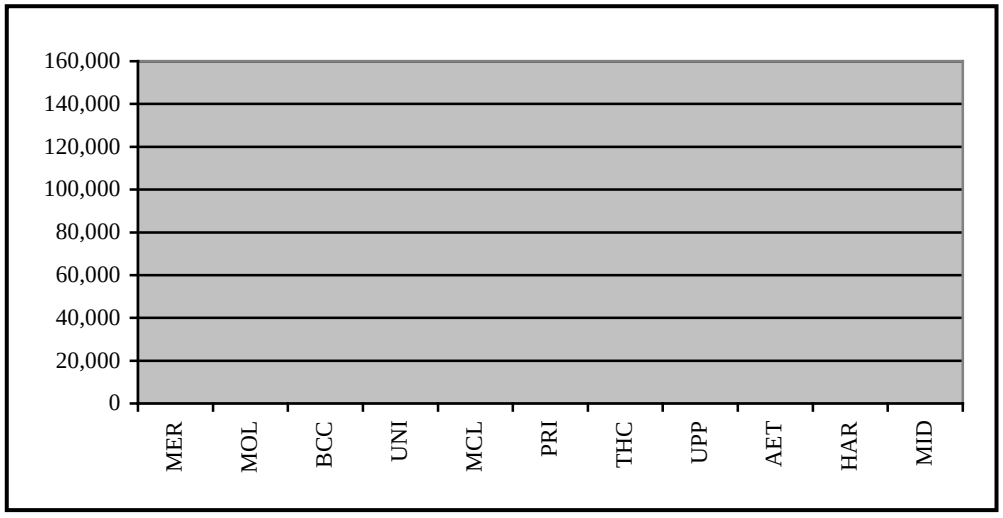


Figure 2: HMP-MC Enrollment by Medicaid Health Plan, January 2018



Medicaid Health Plan News

The Performance Monitoring Report contains data for all Healthy 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.

Results for the Transition into Consistently Fail to Pay Status, Transition out of Consistently Fail to Pay Status and the Completion of Annual Health Risk Assessment measures will be reported as "Informational Only" until a standard has been set.

Due to a change in methodology the Plan All-Cause Acute 30-Day Readmission measure has been taken out of this report and will be put into a separate PMR.

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
The percentage of generic prescriptions filled for adult members of health plans during the measurement period.

Standard
At or above 84% (as shown on bar graph below)

Measurement Period
April 2017 –June 2017

Data Source
MDHHS Data Warehouse

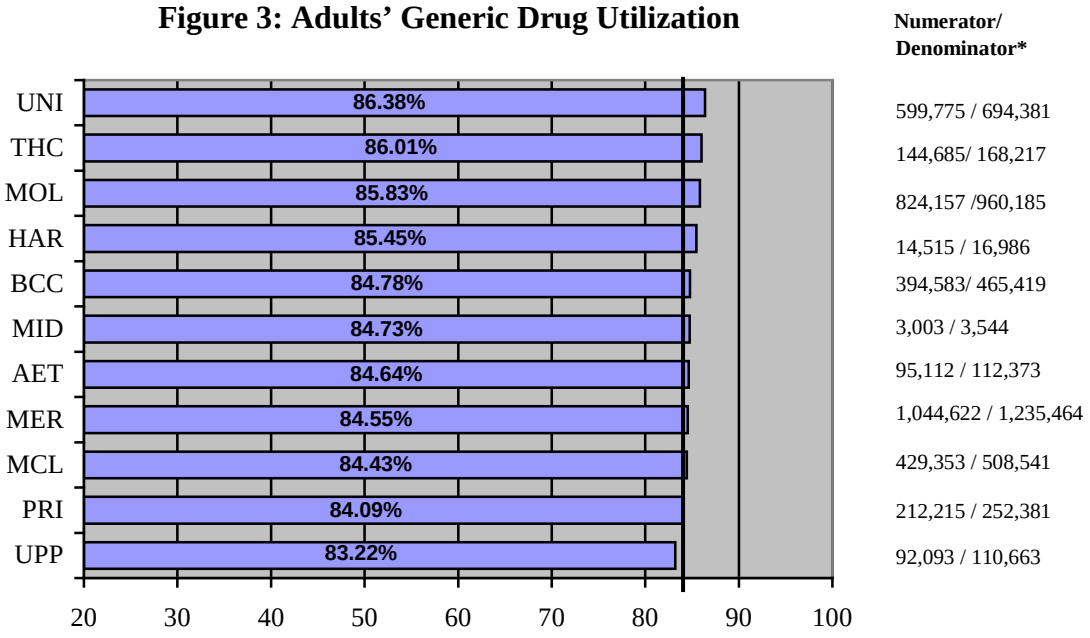
Measurement Frequency
Quarterly

Summary: Ten plans met or exceeded the standard, while one plan (UPP) did not. Results ranged from 83.22% to 86.38%.

Table 2: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	3,926,989	4,640,775	84.62%
Fee For Service (FFS) only	13,053	37,304	34.99%
Managed Care only	3,871,632	4,549,021	85.11%
MA-MC	1,964,327	2,316,504	84.80%
HMP-MC	1,869,654	2,188,425	85.43%

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 (HRA)

Measure
The 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 9% (as shown on bar graph below)

Enrollment Dates
January 2017 – March 2017

Data Source
MDHHS Data Warehouse

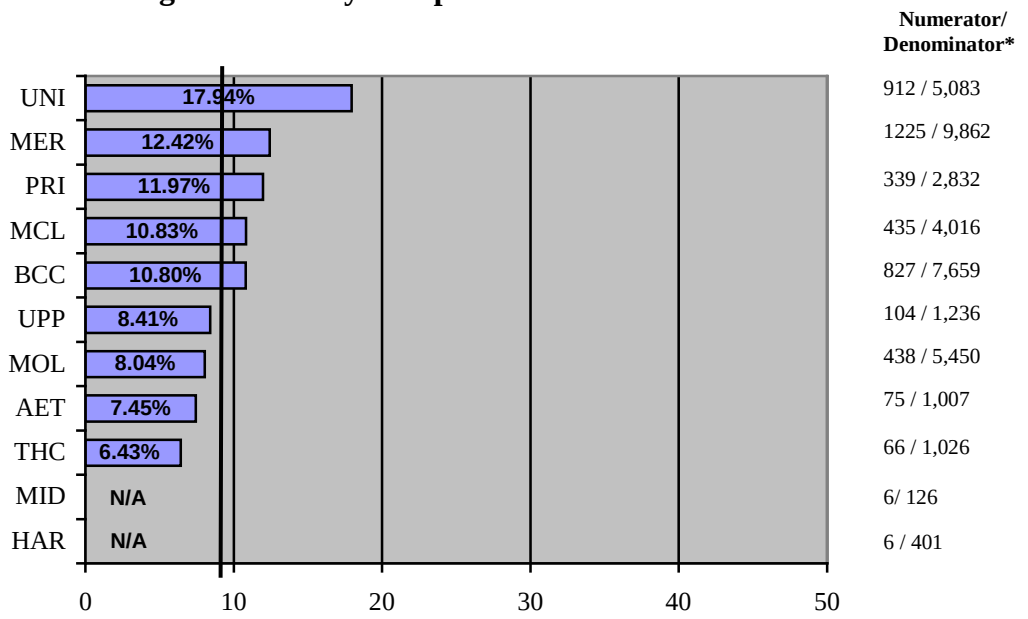
Measurement Frequency
Quarterly

Summary: Five plans met or exceeded the standard, while four plans (AET, MOL, THC, and UPP) did not. Results ranged from 1.50% to 17.94%.

Table 3: Program Total[2]

Medicaid Program	Numerator	Denominator	Percentage
HMP-MC	4,433	38,698	11.46%

Figure 4: Timely Completion of Initial HRA[3]



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.

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

Completion of Annual Health Risk Assessment (HRA)

Measure
The percentage of new Healthy Michigan Plan beneficiaries enrolled in a health plan who had a second Health Risk Assessment (HRA) completed within one year (defined as 11-15 months) of their first HRA.

Standard
N/A – Informational Only

First Attestation Dates
July 2015 – June 2016

Second Attestation Dates
June 2016 – September 2017

Data Source
MDHHS Data Warehouse

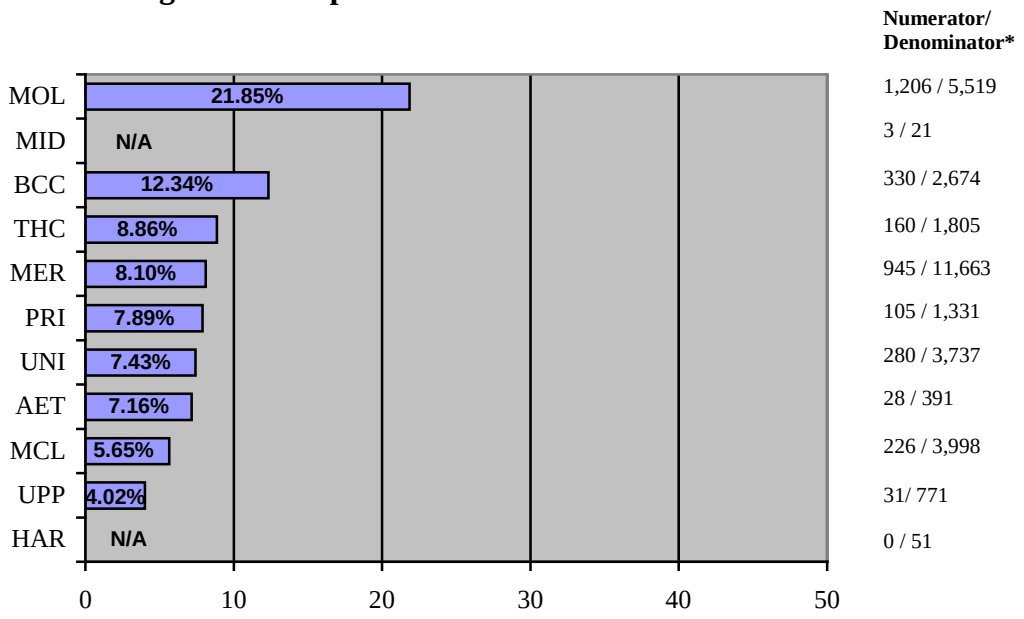
Measurement Frequency
Quarterly

Summary: ***Data for this measure will not be reported this year.***

Table 4: Program Total

Medicaid Program	Numerator	Denominator	Percentage
HMP-MC	3,357	33,335	10.07%

Figure 5: Completion of Annual HRA[4]



Completion of Annual HRA Percentages

*Numerator depicts the number of eligible beneficiaries who completed a second HRA within one year (defined as 11-15 months) of their first HRA. Denominator depicts the total number of eligible beneficiaries.

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

Outreach and Engagement to Facilitate Entry to Primary Care

Measure
The 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 50% (as shown on bar graph below)

Enrollment Dates
January 2017 – March 2017

Data Source
MDHHS Data Warehouse

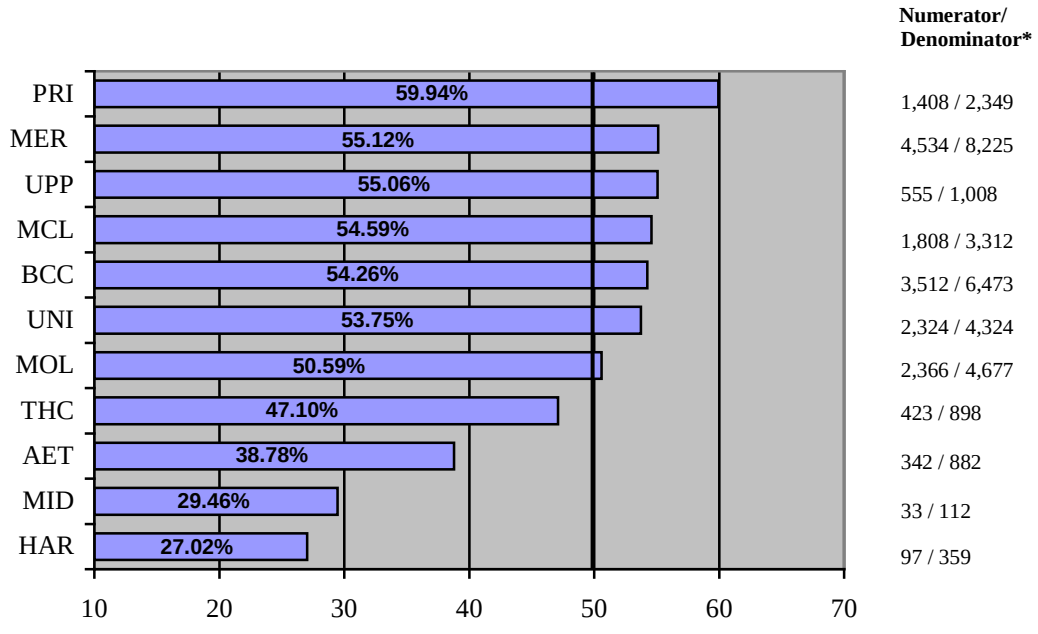
Measurement Frequency
Quarterly

Summary: Seven plans met or exceeded the standard, while four plans (AET, HAR, MID, and THC) did not. Results ranged from 27.02% to 59.94%.

Table 5: Program Total[5]

Medicaid Program	Numerator	Denominator	Percentage
HMP-MC	23,481	38,698	60.68%

Figure 6: Outreach & Engagement to Facilitate Entry to Primary Care



Outreach & Engagement to Facilitate Entry to Primary Care Percentages

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

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

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 2016 – June 2017

Data Source
MDHHS Data Warehouse

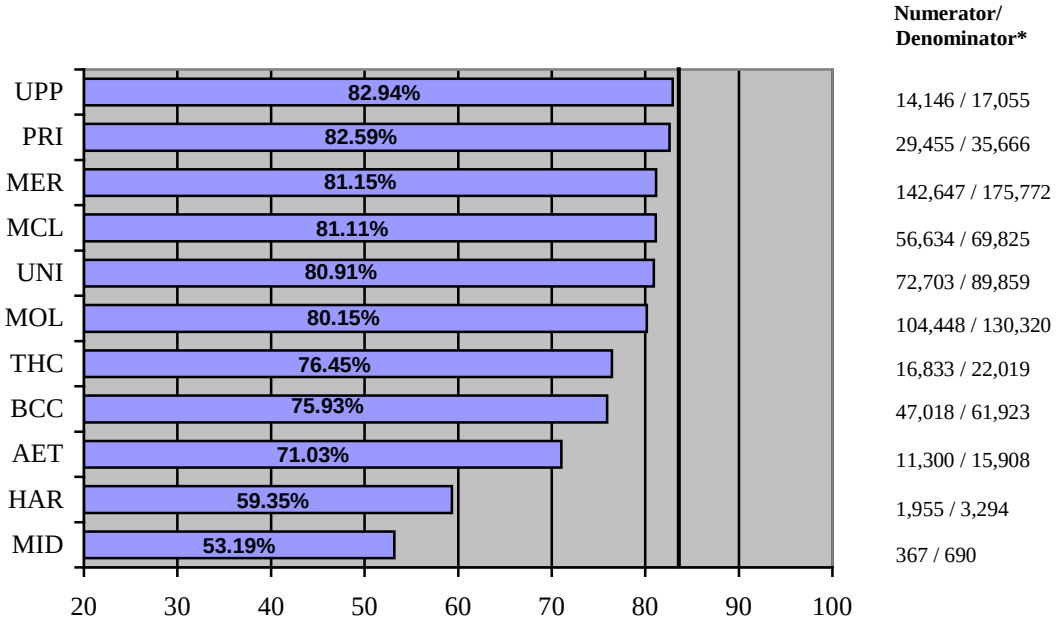
Measurement Frequency
Quarterly

Summary: None of the plans met or exceeded the standard. Results ranged from 53.19% to 82.94%.

Table 6: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
Michigan Medicaid All	616,044	778,150	79.17%
Fee For Service (FFS) only	9,864	16,413	60.10%
Managed Care only	511,345	637,825	80.17%
MA-MC	226,738	274,699	82.54%
HMP-MC	230,157	298,078	77.21%

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.

Transition into Consistently Fail to Pay (CFP) Status

Measure
The percentage of Healthy Michigan Plan beneficiaries who transitioned from non-CFP status into CFP status during the last quarter of the measurement period.

Standard
N/A – Informational Only

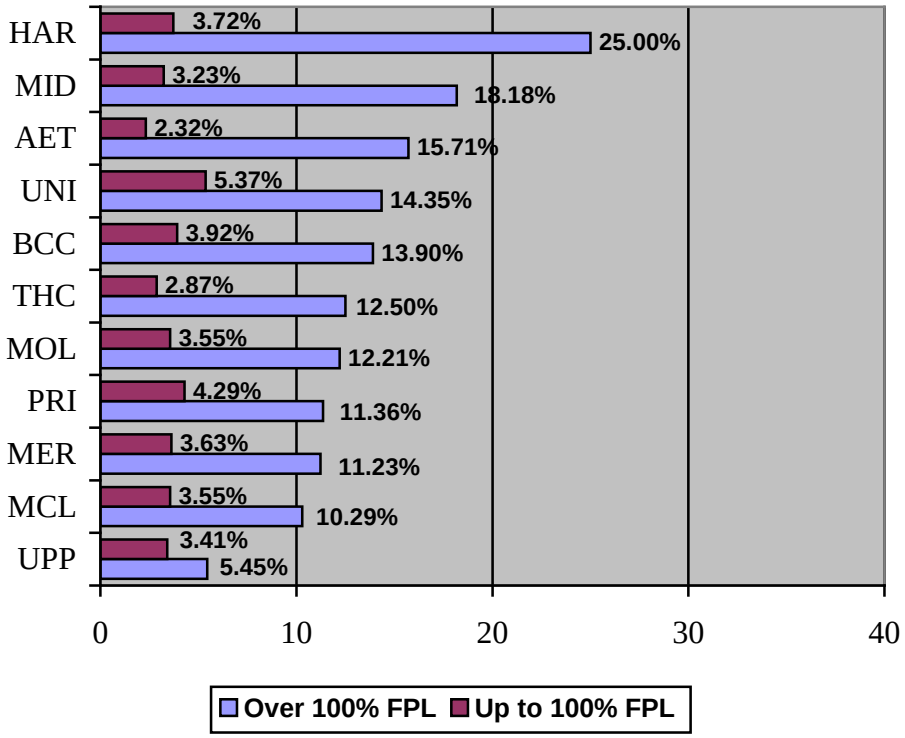
Measurement Period
November 2016 –December 2017

Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

Summary: The results shown are informational only. In Cohort 1, the results ranged from 5.45% to 25.00% for beneficiaries with income over 100% FPL. The results ranged from 2.32% to 5.37% for beneficiaries with income that never exceeded 100% FPL.
In Cohort 2, the results ranged from 0.00% to 25.00% for beneficiaries with income over 100% FPL. The results ranged from 1.36% to 4.98% for beneficiaries with income that never exceeded 100% FPL.
In Cohort 3, the results ranged from 0.00% to 24.24% for beneficiaries with income over 100% FPL. The results ranged from 1.18% to 3.23% for beneficiaries with income that never exceeded 100% FPL.

Figure 8: Transition into CFP Status - Cohort 1



Transition in to CFP Status Percentages
*In the graphs represented for this measure, FPL represents the Federal Poverty Level.

Figure 9: Transition into CFP Status - Cohort 2

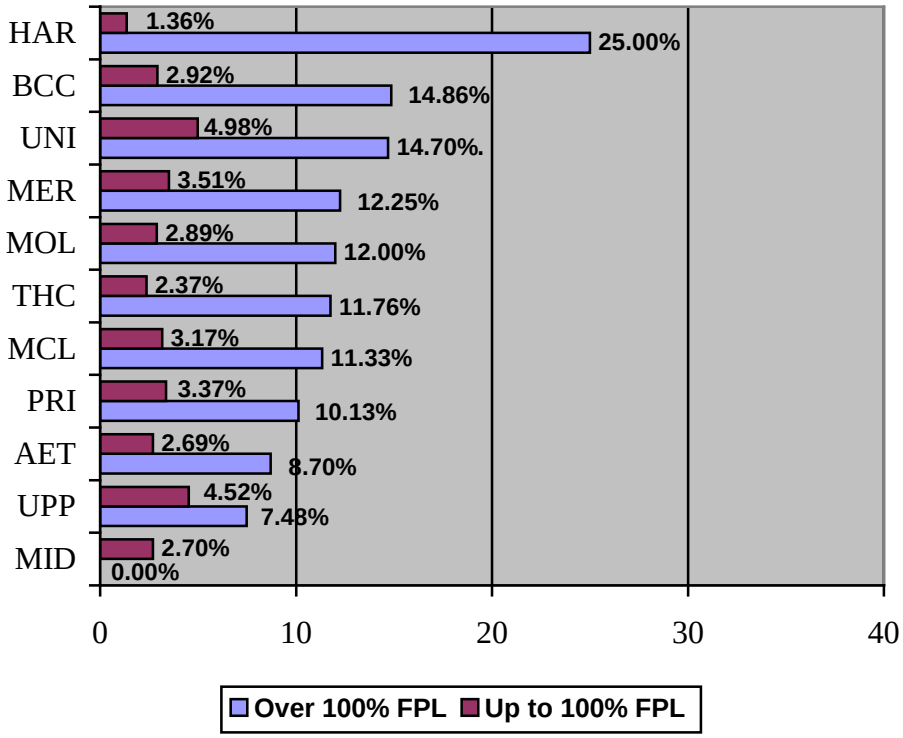
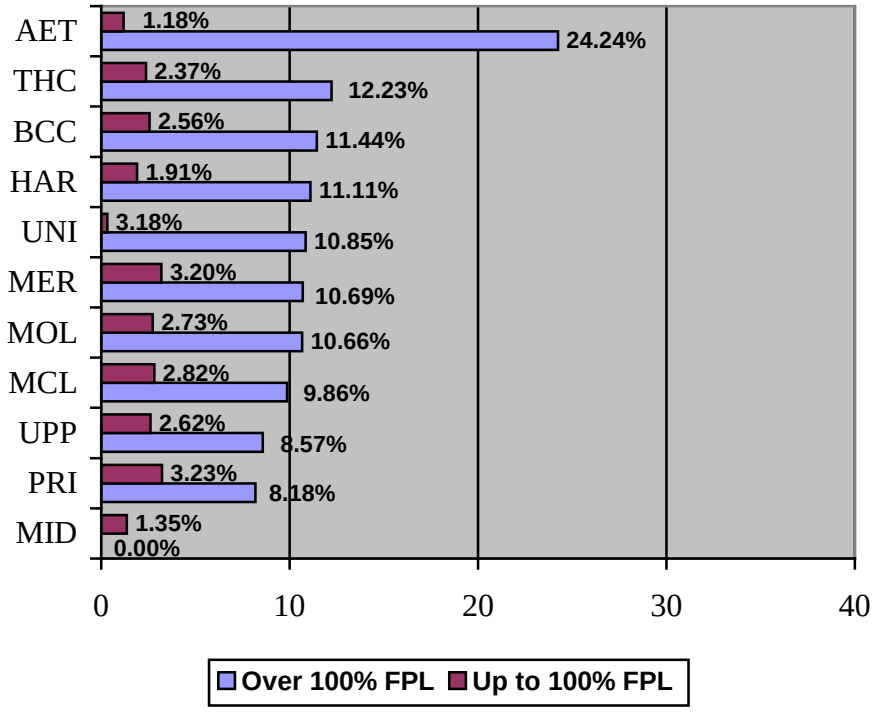


Figure 10: Transition into CFP Status - Cohort 3



Transition out of Consistently Fail to Pay (CFP) Status

Measure
The percentage of Healthy Michigan Plan beneficiaries who transitioned from CFP status to non-CFP status during the last quarter of the measurement period.

Standard
N/A – Informational Only

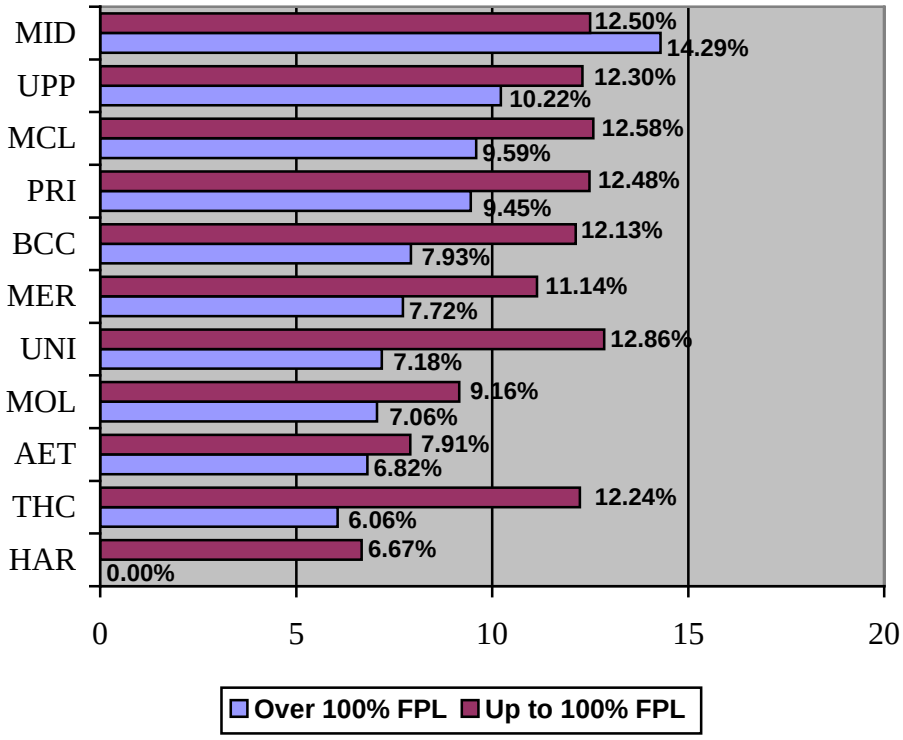
Measurement Period
November 2016 – December 2017

Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

Summary: The results shown are informational only. In Cohort 1, the results ranged from 0.00% to 14.29% for beneficiaries with income over 100% FPL. The results ranged from 6.67% to 12.86% for beneficiaries with income that never exceeded 100% FPL.
In Cohort 2, the results ranged from 0.00% to 8.03% for beneficiaries with income over 100% FPL. The results ranged from 2.22% to 13.70% for beneficiaries with income that never exceeded 100% FPL.
In Cohort 3, the results ranged from 0.00% to 10.37% for beneficiaries with income over 100% FPL. The results ranged from 0.00% to 10.49% for beneficiaries with income that never exceeded 100% FPL.

Figure 11: Transition out of CFP Status - Cohort 1



Transition out of CFP Status Percentages
*In the graphs represented for this measure, FPL represents the Federal Poverty Level.

Figure 12: Transition out of CFP Status - Cohort 2

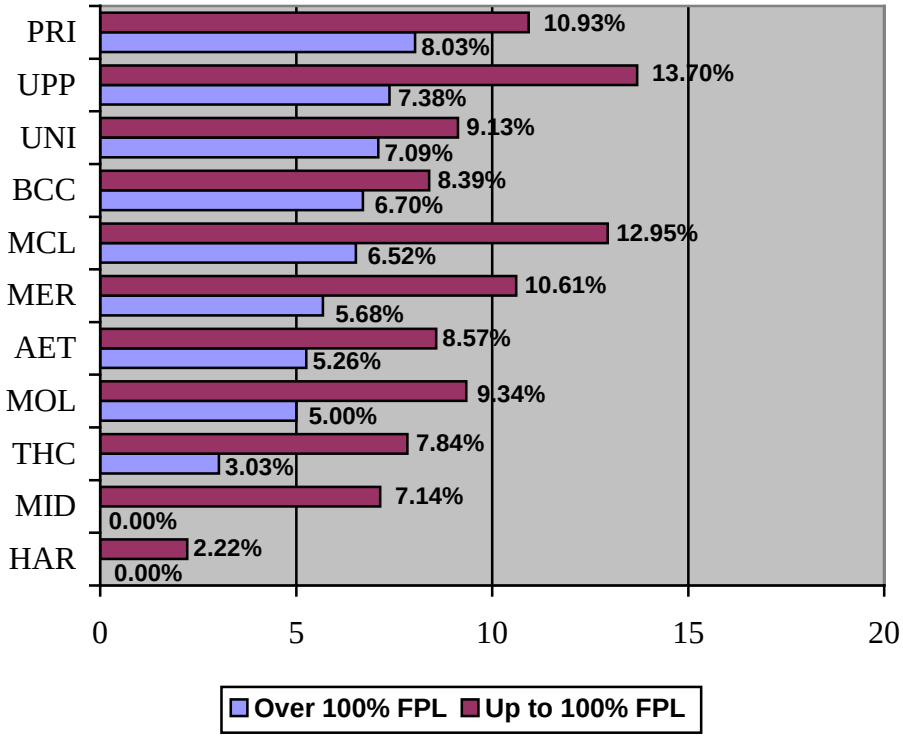
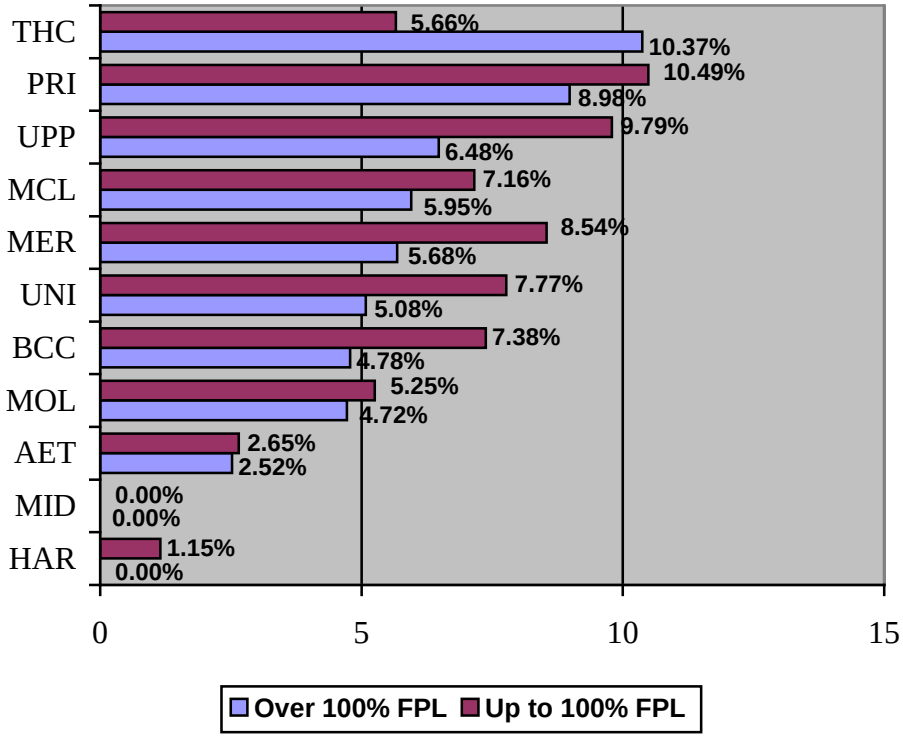


Figure 13: Transition out of CFP Status - Cohort 3



Appendix A: 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
HAR	Harbor Health Plan
MCL	McLaren Health Plan
MER	Meridian Health Plan of Michigan
MID	HAP Midwest Health Plan
MOL	Molina Healthcare of Michigan
PRI	Priority Health Choice
THC	Total Health Care
UNI	UnitedHealthcare Community Plan
UPP	Upper Peninsula Health Plan

Appendix B: One Year Plan-Specific Analysis

Aetna Better Health of Michigan – AET

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 17 – Jun 17**	**84%**	**84.64%**	**Yes**
Timely Completion of HRA	**Jan 17 – Mar 17**	**9%**	**7.45%**	**No**
Completion of Annual HRA	**Jun 16 – Sep 17**	**Informational Only**	**7.16%**	**N/A**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 17 – Mar 17**	**50%**	**38.78%**	**No**
Adults' Access to Ambulatory Health Services	**Jul 16 – Jun 17**	**83%**	**71.03%**	**No**

Transition into CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	22.22%	3.80%	N/A	Info Only	16.92%	2.82%	N/A	Info Only	27.63%	4.11%	N/A
Info Only	13.85%	3.91%	N/A	Info Only	4.69%	3.01%	N/A	Info Only	16.92%	2.20%	N/A
Info Only	**15.71%**	**2.32%**	**N/A**	**Info Only**	**8.70%**	**2.69%**	**N/A**	**Info Only**	**24.24%**	**1.18%**	**N/A**

Transition out of CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	0.00%	0.00%	N/A	Info Only	0.00%	1.89%	N/A	Info Only	0.00%	3.64%	N/A
Info Only	2.33%	5.30%	N/A	Info Only	2.56%	2.72%	N/A	Info Only	0.00%	3.57%	N/A
Info Only	**6.82%**	**7.91%**	**N/A**	**Info Only**	**5.26%**	**8.57%**	**N/A**	**Info Only**	**2.52%**	**2.65%**	**N/A**

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

Appendix B: One Year Plan-Specific Analysis

Blue Cross Complete of Michigan – BCC

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 17 – Jun 17**	**84%**	**84.78%**	**Yes**
Timely Completion of HRA	**Jan 17 – Mar 17**	**9%**	**10.80%**	**Yes**
Completion of Annual HRA	**Jun 16 – Sep 17**	**Informational Only**	**12.34%**	**N/A**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 17 – Mar 17**	**50%**	**54.26%**	**Yes**
Adults' Access to Ambulatory Health Services	**Jul 16 – Jun 17**	**83%**	**75.93%**	**No**

Transition into CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	16.32%	3.70%	N/A	Info Only	19.88%	4.14%	N/A	Info Only	18.76%	4.16%	N/A
Info Only	15.69%	4.39%	N/A	Info Only	14.63%	3.09%	N/A	Info Only	19.13%	2.95%	N/A
Info Only	**13.90**	**3.92%**	**N/A**	**Info Only**	**14.86%**	**2.92%**	**N/A**	**Info Only**	**11.44%**	**2.56%**	**N/A**

Transition out of CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	1.09%	2.63%	N/A	Info Only	1.15%	2.52%	N/A	Info Only	0.64%	2.80%	N/A
Info Only	1.08%	3.91%	N/A	Info Only	2.04%	3.16%	N/A	Info Only	5.71%	8.15%	N/A
Info Only	**7.93%**	**12.13%**	**N/A**	**Info Only**	**6.70%**	**8.39%**	**N/A**	**Info Only**	**4.78%**	**7.38%**	**N/A**

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

Appendix B: One Year Plan-Specific Analysis

Harbor Health Plan – HAR

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 17 – Jun 17**	**84%**	**85.45%**	**Yes**
Timely Completion of HRA	**Jan 17 – Mar 17**	**9%**	**N/A**	**N/A**

N/A in the "Plan Result" column indicates that the plan had a numerator less than 5 or a denominator less than 30.

Completion of Annual HRA	**Jun 16 – Sep 17**	**Informational Only**	**N/A**	**N/A**

N/A in the "Plan Result" column indicates that the plan had a numerator less than 5 or a denominator less than 30.

Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 17 – Mar 17**	**50%**	**27.02%**	**No**
Adults' Access to Ambulatory Health Services	**Jul 16 – Jun 17**	**83%**	**59.35%**	**No**

Transition into CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	12.50%	2.15%	N/A	Info Only	0.00%	2.17%	N/A	Info Only	28.00%	1.54%	N/A
Info Only	14.29%	2.24%	N/A	Info Only	12.50%	1.60%	N/A	Info Only	19.23%	1.46%	N/A
Info Only	**25.00%**	**3.72%**	**N/A**	**Info Only**	**25.00%**	**1.36%**	**N/A**	**Info Only**	**11.11%**	**1.91%**	**N/A**

Transition out of CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	0.00%	0.00%	N/A	Info Only	0.00%	3.45%	N/A	Info Only	0.00%	0.00%	N/A
Info Only	0.00%	0.00%	N/A	Info Only	0.00%	0.00%	N/A	Info Only	6.73%	9.57%	N/A
Info Only	**0.00%**	**6.67%**	**N/A**	**Info Only**	**0.00%**	**2.22%**	**N/A**	**Info Only**	**0.00%**	**1.15%**	**N/A**

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

Appendix B: One Year Plan-Specific Analysis

McLaren Health Plan – MCL

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 17 – Jun 17**	**84%**	**84.43%**	**Yes**
Timely Completion of HRA	**Jan 17 – Mar 17**	**9%**	**10.83%**	**Yes**
Completion of Annual HRA	**Jun 16 – Sep 17**	**Informational Only**	**5.65%**	**N/A**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 17 – Mar 17**	**50%**	**54.59%**	**Yes**
Adults' Access to Ambulatory Health Services	**Jul 16 – Jun 17**	**83%**	**81.11%**	**No**

Transition into CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	13.91%	6.42%	N/A	Info Only	15.63%	5.88%	N/A	Info Only	18.73%	5.08%	N/A
Info Only	13.89%	5.14%	N/A	Info Only	10.57%	3.63%	N/A	Info Only	11.53%	2.78%	N/A
Info Only	**10.29%**	**3.55%**	**N/A**	**Info Only**	**11.33%**	**3.17%**	**N/A**	**Info Only**	**9.86%**	**2.82%**	**N/A**

Transition out of CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	2.34%	3.25%	N/A	Info Only	2.18%	3.56%	N/A	Info Only	2.36%	3.05%	N/A
Info Only	3.32%	4.97%	N/A	Info Only	1.94%	5.77%	N/A	Info Only	5.13%	8.18%	N/A
Info Only	**9.59%**	**12.58%**	**N/A**	**Info Only**	**6.52%**	**12.95%**	**N/A**	**Info Only**	**5.95%**	**7.16%**	**N/A**

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

Appendix B: One Year Plan-Specific Analysis

Meridian Health Plan of Michigan – MER

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 17 – Jun 17**	**84%**	**84.55%**	**Yes**
Timely Completion of HRA	**Jan 17 – Mar 17**	**9%**	**12.42%**	**Yes**
Completion of Annual HRA	**Jun 16 – Sep 17**	**Informational Only**	**8.10%**	**N/A**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 17 – Mar 17**	**50%**	**55.12%**	**Yes**
Adults' Access to Ambulatory Health Services	**Jul 16 – Jun 17**	**83%**	**81.15%**	**No**

Transition into CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	15.87%	4.94%	N/A	Info Only	13.34%	5.18%	N/A	Info Only	19.84%	4.28%	N/A
Info Only	14.52%	4.61%	N/A	Info Only	14.19%	4.26%	N/A	Info Only	14.73%	3.35%	N/A
Info Only	**11.23%**	**3.63%**	**N/A**	**Info Only**	**12.25%**	**3.51%**	**N/A**	**Info Only**	**10.69%**	**3.20%**	**N/A**

Transition out of CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	0.94%	3.37%	N/A	Info Only	2.28%	3.03%	N/A	Info Only	1.80%	3.13%	N/A
Info Only	2.19%	4.75%	N/A	Info Only	2.11%	4.59%	N/A	Info Only	0.00%	0.00%	N/A
Info Only	**7.72%**	**11.14%**	**N/A**	**Info Only**	**5.68%**	**10.61%**	**N/A**	**Info Only**	**5.68%**	**8.54%**	**N/A**

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

Appendix B: One Year Plan-Specific Analysis

HAP Midwest Health Plan – MID

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 17 – Jun 17**	**84%**	**84.73%**	**Yes**
Timely Completion of HRA	**Jan 17 – Mar 17**	**9%**	**N/A**	**N/A**

N/A in the "Plan Result" column indicates that the plan had a numerator less than 5 or a denominator less than 30.

Completion of Annual HRA	**Jun 16 – Sep 17**	**Informational Only**	**N/A**	**N/A**

N/A in the "Plan Result" column indicates that the plan had a numerator less than 5 or a denominator less than 30.

Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 17 – Mar 17**	**50%**	**29.46%**	**No**
Adults' Access to Ambulatory Health Services	**Jul 16 – Jun 17**	**83%**	**53.19%**	**No**

Transition into CFP Status : **Nov 16 – Dec 17**

Cohort 1 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 2 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 3 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved
Info Only	25.00%	3.33%	N/A	Info Only	25.00%	0.00%	N/A	Info Only	0.00%	0.00%	N/A
Info Only	10.00%	4.17%	N/A	Info Only	N/A	2.90%	N/A	Info Only	16.67%	2.99%	N/A
Info Only	**18.18%**	**3.23%**	**N/A**	**Info Only**	**0.00**	**2.70%**	**N/A**	**Info Only**	**0.00%**	**1.35%**	**N/A**

Transition out of CFP Status : **Nov 16 – Dec 17**

Cohort 1 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 2 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved	Cohort 3 Standard	>100% FPL Result	≤100% FPL Result	Standard Achieved
Info Only	0.00%	0.00%	N/A	Info Only	0.00%	11.11%	N/A	Info Only	0.00%	0.00%	N/A
Info Only	0.00%	0.00%	N/A	Info Only	0.00%	11.11%	N/A	Info Only	5.36%	8.62%	N/A
Info Only	**14.29%**	**12.50%**	**N/A**	**Info Only**	**0.00%**	**7.14%**	**N/A**	**Info Only**	**0.00%**	**0.00%**	**N/A**

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

Appendix B: One Year Plan-Specific Analysis

Molina Healthcare of Michigan – MOL

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 17 – Jun 17**	**84%**	**85.83%**	**Yes**
Timely Completion of HRA	**Jan 17 – Mar 17**	**9%**	**8.04%**	**No**
Completion of Annual HRA	**Jun 16 – Sep 17**	**Informational Only**	**21.85%**	**N/A**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 17 – Mar 17**	**50%**	**50.59%**	**Yes**
Adults' Access to Ambulatory Health Services	**Jul 16 – Jun 17**	**83%**	**80.15%**	**No**

Transition into CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	16.04%	4.90%	N/A	Info Only	14.48%	4.99%	N/A	Info Only	20.16%	4.67%	N/A
Info Only	14.35%	4.91%	N/A	Info Only	13.00%	4.10%	N/A	Info Only	13.60%	3.00%	N/A
Info Only	**12.21%**	**3.55%**	**N/A**	**Info Only**	**12.00%**	**2.89%**	**N/A**	**Info Only**	**10.66%**	**2.73%**	**N/A**

Transition out of CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	1.20%	2.41%	N/A	Info Only	1.75%	2.66%	N/A	Info Only	1.30%	2.52%	N/A
Info Only	1.67%	2.82%	N/A	Info Only	2.35%	3.47%	N/A	Info Only	7.56%	11.04%	N/A
Info Only	**7.06%**	**9.16%**	**N/A**	**Info Only**	**5.00%**	**9.34%**	**N/A**	**Info Only**	**4.72%**	**5.25%**	**N/A**

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

Appendix B: One Year Plan-Specific Analysis

Priority Health Choice – PRI

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 17 – Jun 17**	**84%**	**84.09%**	**Yes**
Timely Completion of HRA	**Jan 17 – Mar 17**	**9%**	**11.97%**	**Yes**
Completion of Annual HRA	**Jun 16 – Sep 17**	**Informational Only**	**7.89%**	**N/A**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 17 – Mar 17**	**50%**	**59.94%**	**Yes**
Adults' Access to Ambulatory Health Services	**Jul 16 – Jun 17**	**83%**	**82.59%**	**No**

Transition into CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	11.93%	5.24%	N/A	Info Only	15.37%	4.87%	N/A	Info Only	14.40%	4.99%	N/A
Info Only	13.57%	6.90%	N/A	Info Only	13.01%	5.75%	N/A	Info Only	12.42%	4.90%	N/A
Info Only	**11.36%**	**4.29%**	**N/A**	**Info Only**	**10.13%**	**3.37%**	**N/A**	**Info Only**	**8.18%**	**3.23%**	**N/A**

Transition out of CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	2.16%	2.53%	N/A	Info Only	2.68%	4.14%	N/A	Info Only	1.37%	3.41%	N/A
Info Only	1.15%	5.61%	N/A	Info Only	1.59%	7.66%	N/A	Info Only	6.79%	5.61%	N/A
Info Only	**9.45%**	**12.48%**	**N/A**	**Info Only**	**8.03%**	**10.93%**	**N/A**	**Info Only**	**8.98%**	**10.49%**	**N/A**

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

Appendix B: One Year Plan-Specific Analysis

Total Health Care – THC

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 17 – Jun 17**	**84%**	**86.01%**	**Yes**
Timely Completion of HRA	**Jan 17 – Mar 17**	**9%**	**6.43%**	**No**
Completion of Annual HRA	**Jun 16 – Sep 17**	**Informational Only**	**8.86%**	**N/A**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 17 – Mar 17**	**50%**	**47.10%**	**No**
Adults' Access to Ambulatory Health Services	**Jul 16 – Jun 17**	**83%**	**76.45%**	**No**

Transition into CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	12.50%	3.80%	N/A	Info Only	19.70%	3.73%	N/A	Info Only	19.46%	3.02%	N/A
Info Only	16.92%	3.43%	N/A	Info Only	9.76%	3.55%	N/A	Info Only	15.11%	2.85%	N/A
Info Only	**12.50%**	**2.87%**	**N/A**	**Info Only**	**11.76%**	**2.37%**	**N/A**	**Info Only**	**12.23%**	**2.37%**	**N/A**

Transition out of CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	0.00%	2.60%	N/A	Info Only	1.71%	3.30%	N/A	Info Only	2.42%	2.71%	N/A
Info Only	2.10%	1.68%	N/A	Info Only	3.33%	3.13%	N/A	Info Only	7.79%	7.62%	N/A
Info Only	**6.06%**	**12.24%**	**N/A**	**Info Only**	**3.03%**	**7.84%**	**N/A**	**Info Only**	**10.37%**	**5.66%**	**N/A**

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

Appendix B: One Year Plan-Specific Analysis

UnitedHealthcare Community Plan – UNI

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 17 – Jun 17**	**84%**	**86.38%**	**Yes**
Timely Completion of HRA	**Jan 17 – Mar 17**	**9%**	**17.94%**	**Yes**
Completion of Annual HRA	**Jun 16 – Sep 17**	**Informational Only**	**7.43%**	**N/A**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 17 – Mar 17**	**50%**	**53.75%**	**Yes**
Adults' Access to Ambulatory Health Services	**Jul 16 – Jun 17**	**83%**	**80.94%**	**No**

Transition into CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	13.25%	4.07%	N/A	Info Only	13.74%	3.83%	N/A	Info Only	17.84%	4.15%	N/A
Info Only	13.59%	4.44%	N/A	Info Only	12.04%	3.88%	N/A	Info Only	13.46%	4.93%	N/A
Info Only	**14.35%**	**5.37%**	**N/A**	**Info Only**	**14.70%**	**4.98%**	**N/A**	**Info Only**	**10.85%**	**3.18%**	**N/A**

Transition out of CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	1.33%	3.05%	N/A	Info Only	1.83%	3.95%	N/A	Info Only	2.75%	3.61%	N/A
Info Only	3.14%	5.19%	N/A	Info Only	2.70%	5.62%	N/A	Info Only	7.66%	12.39%	N/A
Info Only	**7.18%**	**12.86%**	**N/A**	**Info Only**	**7.09%**	**9.13%**	**N/A**	**Info Only**	**5.08%**	**7.77%**	**N/A**

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

Appendix B: One Year Plan-Specific Analysis

Upper Peninsula Health Plan – UPP

HEALTHY MICHIGAN PLAN:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Adults' Generic Drug Utilization	**Apr 17 – Jun 17**	**84%**	**83.22%**	**No**
Timely Completion of HRA	**Jan 17 – Mar 17**	**9%**	**8.41%**	**No**
Completion of Annual HRA	**Jun 16 – Sep 17**	**Informational Only**	**4.02%**	**N/A**
Outreach/Engagement to Facilitate Entry to Primary Care	**Jan 17 – Mar 17**	**50%**	**55.06%**	**Yes**
Adults' Access to Ambulatory Health Services	**Jul 16 – Jun 17**	**83%**	**82.94%**	**No**

Transition into CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	10.00%	6.90%	N/A	Info Only	13.95%	6.75%	N/A	Info Only	9.55%	5.92%	N/A
Info Only	11.70%	5.00%	N/A	Info Only	10.21%	4.41%	N/A	Info Only	9.15%	3.95%	N/A
Info Only	**5.45%**	**3.41%**	**N/A**	**Info Only**	**7.48%**	**4.52%**	**N/A**	**Info Only**	**8.57%**	**2.62%**	**N/A**

Transition out of CFP Status : **Nov 16 – Dec 17**											
Cohort 1 Standard	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 2 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**	**Cohort 3 Standard**	**>100% FPL Result**	**≤100% FPL Result**	**Standard Achieved**
Info Only	1.09%	2.25%	N/A	Info Only	4.32%	2.83%	N/A	Info Only	1.79%	3.74%	N/A
Info Only	2.28%	4.69%	N/A	Info Only	3.14%	5.21%	N/A	Info Only	2.70%	7.03%	N/A
Info Only	**10.22%**	**12.30%**	**N/A**	**Info Only**	**7.38%**	**13.70%**	**N/A**	**Info Only**	**6.48%**	**9.79%**	**N/A**

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

Medical Services Administration
Bureau of Medicaid Care Management and Quality Assurance

PERFORMANCE MONITORING REPORT

HEALTHY MICHIGAN PLAN – DENTAL MEASURES

Composite – All Plans

January 2018

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

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Healthy Michigan Plan Dental Measures

Appendixes

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Executive Summary

This Dental 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 three (3) key performance measures aimed at improving the quality and efficiency of dental services provided to the Michigan residents enrolled in the Healthy Michigan Plan. The following HMP-Dental measures will be included in this report:

Healthy Michigan Plan		
Diagnostic Dental Services	*Preventive Dental Services*	*Restorative (Dental Filings) Dental Services*

Data for these measures will be 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. Measurement Periods may vary and are based on the specifications for that individual measure. Appendix A contains specific three letter codes identifying each of the MHPs. Appendix B contains the one-year plan specific analysis for each measure.

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 2018 unless otherwise noted.

Table 1: Fiscal Year 2018[1]

Quarterly Reported Measures	Reported in 1st Quarter	Reported in 2nd Quarter	Reported in 3rd Quarter	Reported in 4th Quarter
Diagnostic Dental Services	N/A			
Preventive Dental Services	N/A			
Restorative (Dental Fillings) Dental Services	N/A			

[1] N/A will be shown for measures where the standard is Informational Only.

Healthy Michigan Plan Enrollment

The Healthy Michigan Plan (HMP-MC) enrollment has remained steady over the past year. Due to changes with the way the reports are pulled, current enrollment data is unavailable at this time.

Figure 1: HMP-MC Enrollment, February 2017 – January 2018

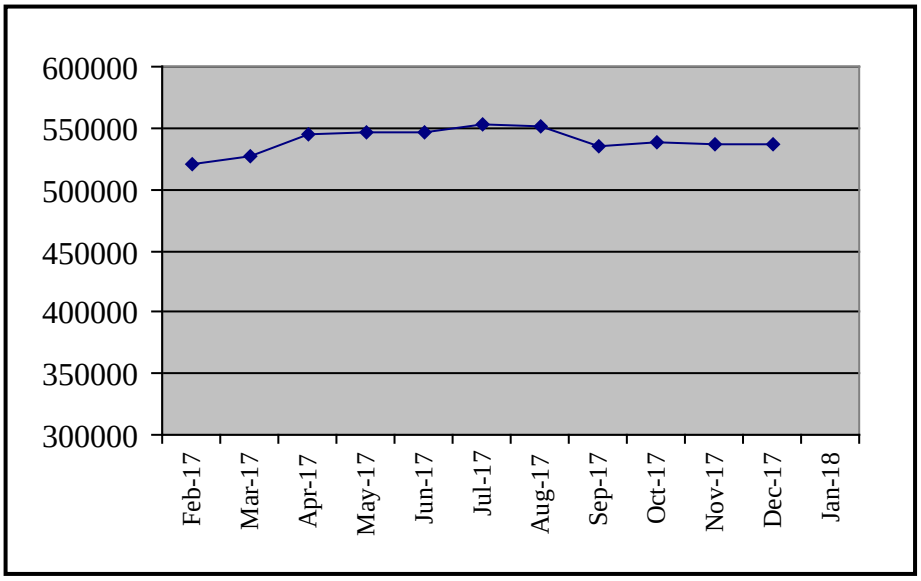
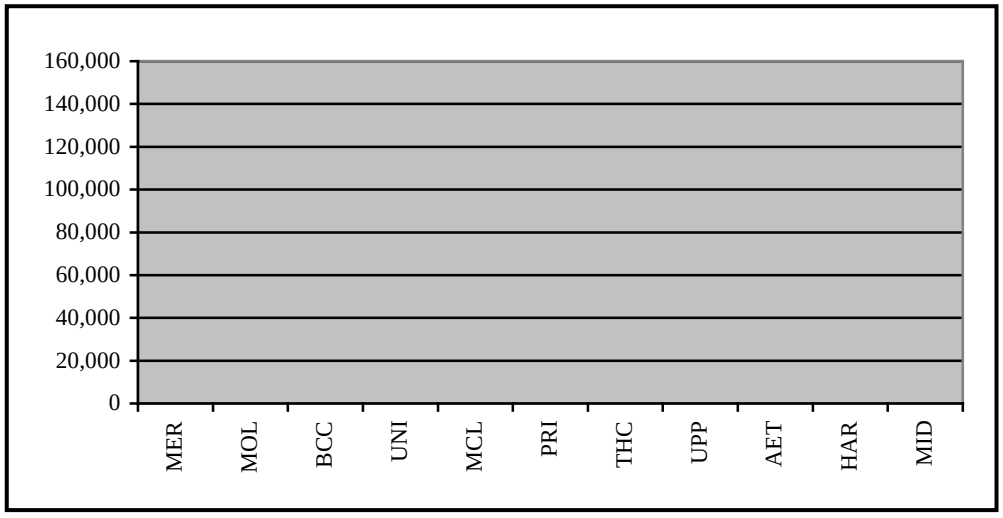


Figure 2: HMP-MC Enrollment by Medicaid Health Plan, January 2018



Medicaid Health Plan News

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

Diagnostic Dental Services

Measure
The percentage of Healthy Michigan Plan enrollees between the ages of 19 and 64 who received at least one diagnostic dental service within the measurement period.

Standard
N/A – Informational Only

Measurement Period
July 2016 –June 2017

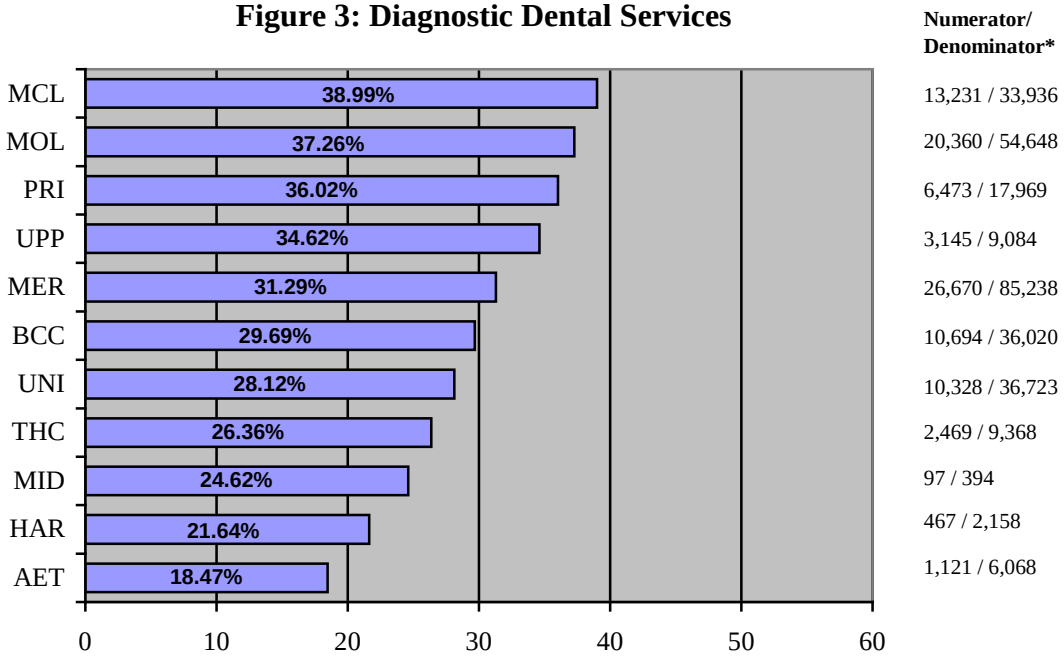
Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

Table 2: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
HMP Fee For Service (FFS) Only	934	6,732	13.87%
HMP Managed Care (MC) Only	97,849	298,078	32.83%

Figure 3: Diagnostic Dental Services



Diagnostic Dental Services Percentages

*Numerator depicts the number of eligible beneficiaries between the ages of 19 and 64 who had at least one diagnostic dental service. Denominator depicts the total number of eligible beneficiaries.

Preventive Dental Services

Measure
The percentage of Healthy Michigan Plan enrollees between the ages of 19 and 64 who received at least one preventive dental service within the measurement period.

Standard
N/A – Informational Only

Measurement Period
July 2016 –June 2017

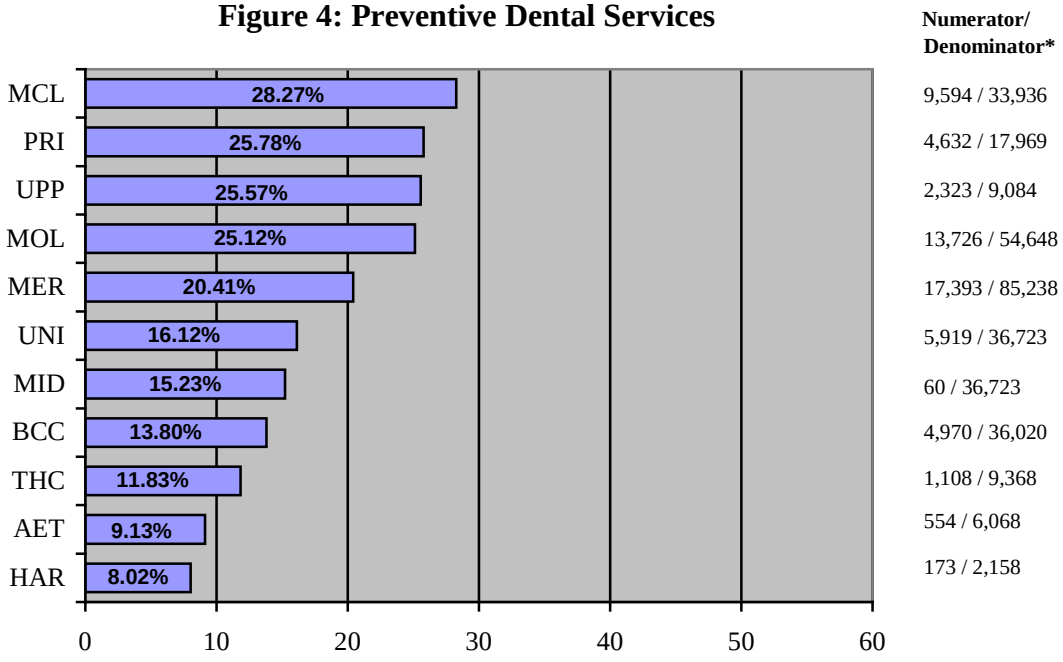
Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

Table 3: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
HMP Fee For Service (FFS) Only	496	6,732	7.37%
HMP Managed Care (MC) Only	62,110	298,078	20.84%

Figure 4: Preventive Dental Services



Preventive Dental Services Percentages

*Numerator depicts the number of eligible beneficiaries between the ages of 19 and 64 who had at least one preventive dental service. Denominator depicts the total number of eligible beneficiaries.

Restorative (Dental Fillings) Services

Measure
The percentage of Healthy Michigan Plan enrollees between the ages of 19 and 64 who received at least one preventive dental service within the measurement period.

Standard
N/A – Informational Only

Measurement Period
July 2016 –June 2017

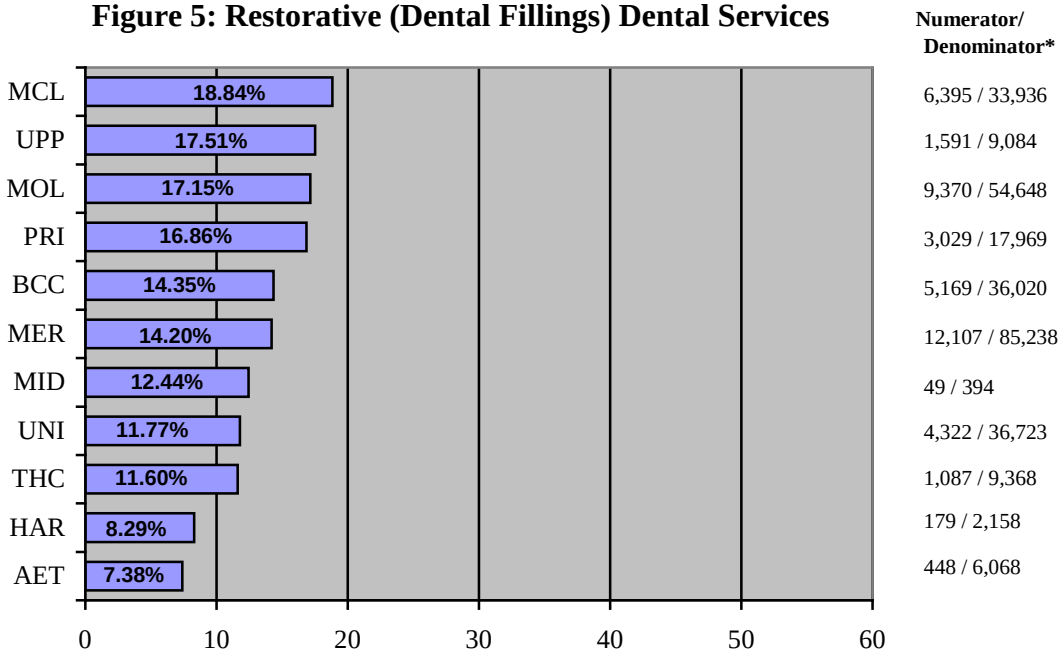
Data Source
MDHHS Data Warehouse

Measurement Frequency
Quarterly

Table 4: Comparison across Medicaid Programs

Medicaid Program	Numerator	Denominator	Percentage
HMP Fee For Service (FFS) Only	373	6,732	5.54%
HMP Managed Care (MC) Only	45,095	298,078	15.13%

Figure 5: Restorative (Dental Fillings) Dental Services



Restorative (Dental Fillings) Dental Services Percentages

*Numerator depicts the number of eligible beneficiaries between the ages of 19 and 64 who had at least one restorative dental service. Denominator depicts the total number of eligible beneficiaries.

Appendix A: 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
HAR	Harbor Health Plan
MCL	McLaren Health Plan
MER	Meridian Health Plan of Michigan
MID	HAP Midwest Health Plan
MOL	Molina Healthcare of Michigan
PRI	Priority Health Choice
THC	Total Health Care
UNI	UnitedHealthcare Community Plan
UPP	Upper Peninsula Health Plan

Appendix B: One Year Plan-Specific Analysis

Aetna Better Health of Michigan – AET

HEALTHY MICHIGAN PLAN – DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	Apr 16 – Mar 17	Informational Only	19.14%	N/A
	Jul 16 – June 17	**Informational Only**	**18.47%**	**N/A**
Preventive Dental Services	Apr 16 – Mar 17	Informational Only	19.45%	N/A
	Jul 16 – June 17	**Informational Only**	**9.13%**	**N/A**
Restorative (Dental Fillings) Dental Services	Apr 16 – Mar 17	Informational Only	7.61%	N/A
	Jul 16 – June 17	**Informational Only**	**7.38%**	**N/A**

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

Appendix B: One Year Plan-Specific Analysis

Blue Cross Complete – BCC

HEALTHY MICHIGAN PLAN – DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	Apr 16 – Mar 17	Informational Only	30.47%	N/A
	Jul 16 – June 17	**Informational Only**	**29.69%**	**N/A**
Preventive Dental Services	Apr 16 – Mar 17	Informational Only	30.97%	N/A
	Jul 16 – June 17	**Informational Only**	**13.80%**	**N/A**
Restorative (Dental Fillings) Dental Services	Apr 16 – Mar 17	Informational Only	14.76%	N/A
	Jul 16 – June 17	**Informational Only**	**14.35%**	**N/A**

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

Appendix B: One Year Plan-Specific Analysis

Harbor Health Plan – HAR

HEALTHY MICHIGAN PLAN – DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	Apr 16 – Mar 17	Informational Only	19.50%	N/A
	Jul 16 – June 17	**Informational Only**	**21.64%**	**N/A**
Preventive Dental Services	Apr 16 – Mar 17	Informational Only	19.96%	N/A
	Jul 16 – June 17	**Informational Only**	**8.02%**	**N/A**
Restorative (Dental Fillings) Dental Services	Apr 16 – Mar 17	Informational Only	7.03%	N/A
	Jul 16 – June 17	**Informational Only**	**8.29%**	**N/A**

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

Appendix B: One Year Plan-Specific Analysis

McLaren Health Plan – MCL

HEALTHY MICHIGAN PLAN – DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	Apr 16 – Mar 17	Informational Only	40.09%	N/A
	Jul 16 – June 17	**Informational Only**	**38.99%**	**N/A**
Preventive Dental Services	Apr 16 – Mar 17	Informational Only	40.82%	N/A
	Jul 16 – June 17	**Informational Only**	**28..27%**	**N/A**
Restorative (Dental Fillings) Dental Services	Apr 16 – Mar 17	Informational Only	19.46%	N/A
	Jul 16 – June 17	**Informational Only**	**18.84%**	**N/A**

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

Appendix B: One Year Plan-Specific Analysis

Meridian Health Plan of Michigan – MER

HEALTHY MICHIGAN PLAN – DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	Apr 16 – Mar 17	Informational Only	34.65%	N/A
	Jul 16 – June 17	**Informational Only**	**31.29%**	**N/A**
Preventive Dental Services	Apr 16 – Mar 17	Informational Only	35.71%	N/A
	Jul 16 – June 17	**Informational Only**	**20.41%**	**N/A**
Restorative (Dental Fillings) Dental Services	Apr 16 – Mar 17	Informational Only	15.99%	N/A
	Jul 16 – June 17	**Informational Only**	**14.20%**	**N/A**

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

Appendix B: One Year Plan-Specific Analysis

HAP Midwest Health Plan – MID

HEALTHY MICHIGAN PLAN – DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	Apr 16 – Mar 17	Informational Only	26.38%	N/A
	Jul 16 – June 17	**Informational Only**	**24.62%**	**N/A**
Preventive Dental Services	Apr 16 – Mar 17	Informational Only	26.38%	N/A
	Jul 16 – June 17	**Informational Only**	**15.23%**	**N/A**
Restorative (Dental Fillings) Dental Services	Apr 16 – Mar 17	Informational Only	12.88%	N/A
	Jul 16 – June 17	**Informational Only**	**12.44%**	**N/A**

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

Appendix B: One Year Plan-Specific Analysis

Molina Healthcare of Michigan – MOL

HEALTHY MICHIGAN PLAN – DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	Apr 16 – Mar 17	Informational Only	38.01%	N/A
	Jul 16 – June 17	**Informational Only**	**37.26%**	**N/A**
Preventive Dental Services	Apr 16 – Mar 17	Informational Only	38.59%	N/A
	Jul 16 – June 17	**Informational Only**	**25.12%**	**N/A**
Restorative (Dental Fillings) Dental Services	Apr 16 – Mar 17	Informational Only	17.57%	N/A
	Jul 16 – June 17	**Informational Only**	**17.15%**	**N/A**

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

Appendix B: One Year Plan-Specific Analysis

Priority Health Choice – PRI

HEALTHY MICHIGAN PLAN – DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	Apr 16 – Mar 17	Informational Only	36.31%	N/A
	Jul 16 – June 17	**Informational Only**	**36.02%**	**N/A**
Preventive Dental Services	Apr 16 – Mar 17	Informational Only	37.57%	N/A
	Jul 16 – June 17	**Informational Only**	**25.78%**	**N/A**
Restorative (Dental Fillings) Dental Services	Apr 16 – Mar 17	Informational Only	17.37%	N/A
	Jul 16 – June 17	**Informational Only**	**16.86%**	**N/A**

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

Appendix B: One Year Plan-Specific Analysis

Total Health Care – THC

HEALTHY MICHIGAN PLAN – DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	Apr 16 – Mar 17	Informational Only	24.91%	N/A
	Jul 16 – June 17	**Informational Only**	**26.36%**	**N/A**
Preventive Dental Services	Apr 16 – Mar 17	Informational Only	25.33%	N/A
	Jul 16 – June 17	**Informational Only**	**11.83%**	**N/A**
Restorative (Dental Fillings) Dental Services	Apr 16 – Mar 17	Informational Only	11.09%	N/A
	Jul 16 – June 17	**Informational Only**	**11.60%**	**N/A**

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

Appendix B: One Year Plan-Specific Analysis

UnitedHealthcare Community Plan – UNI

HEALTHY MICHIGAN PLAN – DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	Apr 16 – Mar 17	Informational Only	28.29%	N/A
	Jul 16 – June 17	**Informational Only**	**28.12%**	**N/A**
Preventive Dental Services	Apr 16 – Mar 17	Informational Only	28.54%	N/A
	Jul 16 – June 17	**Informational Only**	**16.12%**	**N/A**
Restorative (Dental Fillings) Dental Services	Apr 16 – Mar 17	Informational Only	12.13%	N/A
	Jul 16 – June 17	**Informational Only**	**11.77%**	**N/A**

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

Appendix B: One Year Plan-Specific Analysis

Upper Peninsula Health Plan – UPP

HEALTHY MICHIGAN PLAN – DENTAL MEASURES:

Performance Measure	Measurement Period	Standard	Plan Result	Standard Achieved
Diagnostic Dental Services	Apr 16 – Mar 17	Informational Only	34.08%	N/A
	Jul 16 – June 17	**Informational Only**	**34.62%**	**N/A**
Preventive Dental Services	Apr 16 – Mar 17	Informational Only	34.67%	N/A
	Jul 16 – June 17	**Informational Only**	**25.57%**	**N/A**
Restorative (Dental Fillings) Dental Services	Apr 16 – Mar 17	Informational Only	17.45%	N/A
	Jul 16 – June 17	**Informational Only**	**17.51%**	**N/A**

- 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

NOVEMBER 2017

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 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 2017 and the program totals from October 2014 to August 2017.

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
Jun-17	107,297	21,166	7,964	12,230	38.55%
Jul-17	127,307	26,431	9,903	14,875	40.22%
Aug-17	105,826	20,676	9,335	12,473	40.15%
Calendar YTD	**862,636**	**180,393**	**70,317**	**104,797**	**41.21%**
Program Total	**2,794,415**	**613,299**	**246,424**	**307,799**	**41.78%**

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 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 2017. Program totals are from October 2014 through August 2017. 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
Jun-17	$258,268.97	$104,532.28	40%	33,396	14,832
Jul-17	$318,978.94	$109,139.64	34%	41,306	16,226
Aug-17	$271,857.79	$91,456.24	34%	33,149	13,115
Calendar YTD	**$2,292,810.76**	**$933,122.68**	**41%**	**285,190**	**128,481**
Program Total	**$6,936,289.87**	**$2,947,038.39**	**42%**	**921,098**	**421,632**
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
Jun-17	$1,287,429.18	$396,714.68	31%	20,194	8,736
Jul-17	$1,581,050.65	$428,870.87	27%	24,778	9,876
Aug-17	$1,393,758.67	$358,203.23	26%	21,808	8,645
Calendar YTD	**$10,974,487.37**	**$3,464,261.01**	**32%**	**175,114**	**77,314**
Program Total	**$32,309,015.64**	**$11,102,056.22**	**34%**	**554,223**	**262,746**

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 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	$23,613.53	$16,116.23	68.25%
	Jan 2015 - Mar 2015	$193,287.16	$143,318.58	74.15%
	Apr 2015 - Jun 2015	$165,636.46	$117,653.53	71.03%
	Jul 2015 - Sep 2015	$163,258.58	$109,811.85	67.26%
	Oct 2015 - Dec 2015	$153,872.56	$101,146.07	65.73%
	Jan 2016 - Mar 2016	$140,343.98	$91,067.55	64.89%
	Apr 2016 - Jun 2016	$188,021.42	$103,731.84	55.17%
	Jul 2016 - Sep 2016	$139,146.16	$57,205.85	41.11%
	Oct 2016 - Dec 2016	$174,857.83	$78,887.19	45.12%
	Jan 2017 - Mar 2017	$172,737.94	$75,852.53	43.91%
	Apr 2017 - Jun 2017	$149,073.20	$59,172.75	39.69%
	Jul 2017 - Sep 2017	$128,909.34	$44,880.43	34.82%
May-14	Nov 2014 - Jan 2015	$35,660.43	$27,464.85	77.02%
	Feb 2015 - Apr 2015	$56,591.54	$42,304.83	74.75%
	May 2015 - Jul 2015	$45,888.47	$33,149.16	72.24%
	Aug 2015 - Oct 2015	$41,697.21	$29,209.07	70.05%
	Nov 2015 - Jan 2016	$39,537.66	$27,750.12	70.19%
	Feb 2016 - Apr 2016	$37,381.78	$25,589.57	68.45%
	May 2016 - Jul 2016	$44,979.42	$25,343.28	56.34%
	Aug 2016 - Oct 2016	$39,636.30	$20,591.50	51.95%
	Nov 2016 - Jan 2017	$45,315.47	$24,210.72	53.43%
	Feb 2017 - Apr 2017	$40,548.19	$20,813.91	51.33%
	May 2017 - Jul 2017	$35,656.43	$17,208.44	48.26%
	Aug 2017 - Oct 2017	$34,916.23	$14,764.56	42.29%

Chart 3 continued on page 5

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 2017

Chart 3 continued from page 4

Chart 3: Quarterly Collection				
Enrollment Month	**Quarterly Pay Cycles**	**Amount Owed**	**Amount Collected**	**Percentage Collected**
Jun-14	Dec 2014 - Feb 2015	$456,202.02	$353,281.18	77.44%
	Mar 2015 - May 2015	$348,483.50	$269,266.45	77.27%
	Jun 2015 - Aug 2015	$346,980.86	$262,985.06	75.79%
	Sep 2015 - Nov 2015	$328,352.05	$240,525.04	73.25%
	Dec 2015 - Feb 2016	$234,997.62	$167,417.30	71.24%
	Mar 2016 - May 2016	$265,222.88	$184,101.49	69.41%
	Jun 2016 - Aug 2016	$221,184.15	$121,490.20	54.93%
	Sep 2016 - Nov 2016	$307,991.20	$184,300.66	59.84%
	Dec 2016 - Feb 2017	$283,411.72	$161,066.51	56.83%
	Mar 2017 - May 2017	$249,568.45	$134,424.46	53.86%
	Jun 2017 - Aug 2017	$227,558.79	$115,983.70	50.97%
	Sep 2017 - Nov 2017	$220,758.55	$94,315.86	42.72%
Jul-14	Jan 2015 - Mar 2015	$340,294.17	$249,847.54	73.42%
	Apr 2015 - Jun 2015	$251,809.63	$183,700.58	72.95%
	Jul 2015 - Sep 2015	$242,498.54	$171,509.90	70.73%
	Oct 2015 - Dec 2015	$221,580.91	$154,007.04	69.50%
	Jan 2016 - Mar 2016	$195,448.70	$134,609.17	68.87%
	Apr 2016 - Jun 2016	$210,933.43	$124,550.26	59.05%
	Jul 2016 - Sep 2016	$164,196.02	$72,614.61	44.22%
	Oct 2016 - Dec 2016	$191,975.20	$90,576.73	47.18%
	Jan 2017 - Mar 2017	$183,826.59	$81,764.73	44.48%
	Apr 2017 - Jun 2017	$158,727.78	$67,631.75	42.61%
	Jul 2017 - Sep 2017	$139,889.76	$55,410.64	39.61%

Chart 3 continued on page 6

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 2017

Chart 3 continued from page 5

Chart 3: Quarterly Collection				
Enrollment Month	**Quarterly Pay Cycles**	**Amount Owed**	**Amount Collected**	**Percentage Collected**
Aug-14	Feb 2015 - Apr 2015	$169,747.38	$126,076.87	74.27%
	May 2015 - Jul 2015	$121,573.71	$86,022.76	70.76%
	Aug 2015 - Oct 2015	$111,077.22	$82,080.99	73.90%
	Nov 2015 - Jan 2016	$103,341.91	$74,791.10	72.37%
	Feb 2016 - Apr 2016	$96,489.74	$67,190.45	69.63%
	May 2016 - Jul 2016	$104,271.55	$54,877.93	52.63%
	Aug 2016 - Oct 2016	$85,945.70	$39,846.12	46.36%
	Nov 2016 - Jan 2017	$101,152.88	$49,207.25	48.65%
	Feb 2017 - Apr 2017	$95,530.52	$45,119.36	47.23%
	May 2017 - Jul 2017	$78,572.48	$34,013.54	43.29%
	Aug 2017 - Oct 2017	$71,578.90	$26,632.64	37.21%
Sep-14	Mar 2015 - May 2015	$212,404.10	$144,336.88	67.95%
	Jun 2015 - Aug 2015	$147,467.83	$99,817.30	67.69%
	Sep 2015 - Nov 2015	$150,091.13	$101,316.07	67.50%
	Dec 2015 - Feb 2016	$120,756.14	$80,530.70	66.69%
	Mar 2016 - May 2016	$135,765.20	$83,158.37	61.25%
	Jun 2016 - Aug 2016	$96,824.71	$38,260.36	39.52%
	Sep 2016 - Nov 2016	$112,707.90	$50,847.90	45.11%
	Dec 2016 - Feb 2017	$111,783.15	$50,976.99	45.60%
	Mar 2017 - May 2017	$104,443.76	$44,547.49	42.65%
	Jun 2017 - Aug 2017	$87,097.68	$34,793.28	39.95%
	Sep 2017 - Nov 2017	$79,005.29	$26,067.43	32.99%
Oct-14	Apr 2015 - Jun 2015	$173,728.65	$117,244.24	67.49%
	Jul 2015 - Sep 2015	$125,478.67	$87,365.07	69.63%
	Oct 2015 - Dec 2015	$124,560.14	$86,310.76	69.29%
	Jan 2016 - Mar 2016	$119,213.93	$81,479.29	68.35%
	Apr 2016 - Jun 2016	$135,637.74	$77,327.62	57.01%
	Jul 2016 - Sep 2016	$100,040.16	$39,810.05	39.79%
	Oct 2016 - Dec 2016	$115,878.11	$52,206.62	45.05%
	Jan 2017 - Mar 2017	$113,172.59	$50,172.63	44.33%
	Apr 2017 - Jun 2017	$96,369.96	$40,171.15	41.68%
	Jul 2017 - Sep 2017	$80,841.21	$30,172.75	37.32%

Chart 3 continued on page 7

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 2017

Chart 3 continued from page 6

Chart 3: Quarterly Collection				
Enrollment Month	**Quarterly Pay Cycles**	**Amount Owed**	**Amount Collected**	**Percentage Collected**
Nov-14	May 2015 - Jul 2015	$194,575.29	$130,166.73	66.90%
	Aug 2015 - Oct 2015	$125,952.62	$86,021.39	68.30%
	Nov 2015 - Jan 2016	$132,709.57	$93,610.78	70.54%
	Feb 2016 - Apr 2016	$133,521.08	$89,425.32	66.97%
	May 2016 - Jul 2016	$154,421.63	$73,249.98	47.44%
	Aug 2016 - Oct 2016	$117,462.76	$45,387.41	38.64%
	Nov 2016 - Jan 2017	$138,281.84	$58,892.27	42.59%
	Feb 2017 - Apr 2017	$133,395.32	$54,167.96	40.61%
	May 2017 - Jul 2017	$113,212.55	$42,646.10	37.67%
	Aug 2017 - Oct 2017	$89,830.25	$29,171.00	32.47%
Dec-14	Jun 2015 - Aug 2015	$105,081.89	$72,727.98	69.21%
	Sep 2015 - Nov 2015	$81,661.22	$58,464.48	71.59%
	Dec 2015 - Feb 2016	$67,280.11	$48,907.44	72.69%
	Mar 2016 - May 2016	$80,038.48	$53,269.46	66.55%
	Jun 2016 - Aug 2016	$67,885.21	$27,501.34	40.51%
	Sep 2016 - Nov 2016	$71,445.39	$30,367.95	42.51%
	Dec 2016 - Feb 2017	$69,797.06	$30,215.74	43.29%
	Mar 2017 - May 2017	$69,239.72	$29,303.48	42.32%
	Jun 2017 - Aug 2017	$58,065.34	$21,748.26	37.45%
	Sep 2017 - Nov 2017	$49,438.91	$15,234.29	30.81%
Jan-15	Jul 2015 - Sep 2015	$211,198.27	$152,677.13	72.29%
	Oct 2015 - Dec 2015	$170,179.60	$121,179.46	71.21%
	Jan 2016 - Mar 2016	$166,192.81	$119,828.31	72.10%
	Apr 2016 - Jun 2016	$191,245.22	$116,374.14	60.85%
	Jul 2016 - Sep 2016	$156,718.40	$67,110.22	42.82%
	Oct 2016 - Dec 2016	$162,995.80	$74,981.56	46.00%
	Jan 2017 - Mar 2017	$165,082.86	$75,742.92	45.88%
	Apr 2017 - Jun 2017	$144,125.64	$63,009.19	43.72%
	Jul 2017 - Sep 2017	$125,682.87	$50,087.17	39.85%

Chart 3 continued on page 8

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 2017

Chart 3 continued from page 7

Chart 3: Quarterly Collection				
Enrollment Month	**Quarterly Pay Cycles**	**Amount Owed**	**Amount Collected**	**Percentage Collected**
Feb-15	Aug 2015 - Oct 2015	$205,963.69	$146,031.98	70.90%
	Nov 2015 - Jan 2016	$132,664.64	$97,746.08	73.68%
	Feb 2016 - Apr 2016	$147,251.63	$109,074.59	74.07%
	May 2016 - Jul 2016	$190,889.95	$103,153.12	54.04%
	Aug 2016 - Oct 2016	$152,985.22	$69,679.61	45.55%
	Nov 2016 - Jan 2017	$153,495.49	$72,102.39	46.97%
	Feb 2017 - Apr 2017	$153,382.43	$72,916.91	47.54%
	May 2017 - Jul 2017	$136,602.96	$61,376.81	44.93%
	Aug 2017 - Oct 2017	$119,820.85	$47,509.47	39.65%
Mar-15	Sep 2015 - Nov 2015	$221,431.17	$148,163.63	66.91%
	Dec 2015 - Feb 2016	$100,513.55	$70,205.03	69.85%
	Mar 2016 - May 2016	$109,991.17	$77,294.49	70.27%
	Jun 2016 - Aug 2016	$125,591.94	$62,137.76	49.48%
	Sep 2016 - Nov 2016	$130,106.83	$63,131.17	48.52%
	Dec 2016 - Feb 2017	$115,208.38	$53,942.60	46.82%
	Mar 2017 - May 2017	$116,591.49	$54,233.25	46.52%
	Jun 2017 - Aug 2017	$107,818.74	$46,308.66	42.95%
	Sep 2017 - Nov 2017	$96,355.92	$33,489.80	34.76%
Apr-15	Oct 2015 - Dec 2015	$276,120.26	$182,036.57	65.93%
	Jan 2016 - Mar 2016	$137,495.37	$97,183.57	70.68%
	Apr 2016 - Jun 2016	$172,066.70	$111,441.18	64.77%
	Jul 2016 - Sep 2016	$149,639.23	$76,778.68	51.31%
	Oct 2016 - Dec 2016	$157,148.64	$77,276.36	49.17%
	Jan 2017 - Mar 2017	$144,968.46	$69,822.15	48.16%
	Apr 2017 - Jun 2017	$138,494.12	$66,393.27	47.94%
	Jul 2017 - Sep 2017	$125,397.09	$54,320.04	43.32%

Chart 3 continued on page 9

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 2017

Chart 3 continued from page 8

Chart 3: Quarterly Collection				
Enrollment Month	**Quarterly Pay Cycles**	**Amount Owed**	**Amount Collected**	**Percentage Collected**
May-15	Nov 2015 - Jan 2016	$189,970.60	$127,797.23	67.27%
	Feb 2016 - Apr 2016	$125,099.36	$91,936.17	73.49%
	May 2016 - Jul 2016	$167,116.54	$100,127.85	59.91%
	Aug 2016 - Oct 2016	$144,674.73	$76,979.45	53.21%
	Nov 2016 - Jan 2017	$141,674.96	$71,553.69	50.51%
	Feb 2017 - Apr 2017	$121,496.11	$61,614.22	50.71%
	May 2017 - Jul 2017	$119,165.63	$57,732.33	48.45%
	Aug 2017 - Oct 2017	$109,271.04	$46,625.81	42.67%
Jun-15	Dec 2015 - Feb 2016	$159,388.55	$98,738.70	61.95%
	Mar 2016 - May 2016	$106,252.43	$69,056.95	64.99%
	Jun 2016 - Aug 2016	$98,122.63	$48,370.06	49.30%
	Sep 2016 - Nov 2016	$110,782.26	$51,958.64	46.90%
	Dec 2016 - Feb 2017	$99,958.10	$44,130.74	44.15%
	Mar 2017 - May 2017	$89,832.68	$39,450.06	43.92%
	Jun 2017 - Aug 2017	$82,685.55	$35,734.06	43.22%
	Sep 2017 - Nov 2017	$79,350.51	$27,141.11	34.20%
Jul-15	Jan 2016 - Mar 2016	$150,804.48	$99,467.26	65.96%
	Apr 2016 - Jun 2016	$110,994.64	$65,916.19	59.39%
	Jul 2016 - Sep 2016	$94,070.02	$44,556.38	47.37%
	Oct 2016 - Dec 2016	$97,759.51	$44,667.89	45.69%
	Jan 2017 - Mar 2017	$91,501.28	$38,564.36	42.15%
	Apr 2017 - Jun 2017	$78,725.50	$30,746.55	39.06%
	Jul 2017 - Sep 2017	$72,309.46	$27,627.24	38.21%
Aug-15	Feb 2016 - Apr 2016	$157,846.92	$93,241.52	59.07%
	May 2016 - Jul 2016	$112,609.33	$54,392.34	48.30%
	Aug 2016 - Oct 2016	$95,018.71	$43,032.81	45.29%
	Nov 2016 - Jan 2017	$105,391.53	$44,984.32	42.68%
	Feb 2017 - Apr 2017	$94,430.60	$38,886.83	41.18%
	May 2017 - Jul 2017	$78,751.03	$30,535.10	38.77%
	Aug 2017 - Oct 2017	$73,062.01	$24,451.88	33.47%

Chart 3 continued on page 10

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 2017

Chart 3 continued from page 9

Chart 3: Quarterly Collection				
Sep-15	Mar 2016 - May 2016	$125,800.37	$72,754.12	57.83%
	Jun 2016 - Aug 2016	$80,401.46	$31,723.83	39.46%
	Sep 2016 - Nov 2016	$74,834.31	$34,343.59	45.89%
	Dec 2016 - Feb 2017	$78,651.26	$33,070.99	42.05%
	Mar 2017 - May 2017	$75,905.56	$30,554.90	40.25%
	Jun 2017 - Aug 2017	$62,774.20	$22,817.15	36.35%
	Sep 2017 - Nov 2017	$57,533.31	$16,103.62	27.99%
Oct-15	Apr 2016 - Jun 2016	$145,282.11	$54,438.66	37.47%
	Jul 2016 - Sep 2016	$88,699.48	$34,337.47	38.71%
	Oct 2016 - Dec 2016	$96,307.35	$40,861.22	42.43%
	Jan 2017 - Mar 2017	$94,566.14	$38,387.91	40.59%
	Apr 2017 - Jun 2017	$86,413.41	$31,913.26	36.93%
	Jul 2017 - Sep 2017	$69,582.39	$22,230.33	31.95%
Nov-15	May 2016 - Jul 2016	$172,166.18	$62,694.28	36.41%
	Aug 2016 - Oct 2016	$116,209.42	$43,193.10	37.17%
	Nov 2016 - Jan 2017	$129,461.74	$50,057.65	38.67%
	Feb 2017 - Apr 2017	$122,858.25	$44,526.95	36.24%
	May 2017 - Jul 2017	$109,687.31	$35,198.52	32.09%
	Aug 2017 - Oct 2017	$76,937.85	$22,797.71	29.63%
Dec-15	Jun 2016 - Aug 2016	$157,727.63	$60,382.05	38.28%
	Sep 2016 - Nov 2016	$126,736.98	$47,955.10	37.84%
	Dec 2016 - Feb 2017	$129,611.31	$50,452.92	38.93%
	Mar 2017 - May 2017	$134,824.88	$48,811.87	36.20%
	Jun 2017 - Aug 2017	$114,504.45	$36,873.71	32.20%
	Sep 2017 - Nov 2017	$83,452.34	$22,394.93	26.84%
Jan-16	Jul 2016 - Sep 2016	$204,202.52	$88,426.95	43.30%
	Oct 2016 - Dec 2016	$161,923.29	$68,589.62	42.36%
	Jan 2017 - Mar 2017	$155,741.25	$70,029.78	44.97%
	Apr 2017 - Jun 2017	$146,471.32	$60,099.74	41.03%
	Jul 2017 - Sep 2017	$122,696.36	$44,002.51	35.86%

Chart 3 continued on page 11

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 2017

Chart 3 continued from page 10

Chart 3: Quarterly Collection				
Feb-16	Aug 2016 - Oct 2016	$276,109.87	$134,919.21	48.86%
	Nov 2016 - Jan 2017	$216,695.31	$103,642.09	47.83%
	Feb 2017 - Apr 2017	$198,174.33	$97,975.57	49.44%
	May 2017 - Jul 2017	$186,058.33	$83,610.57	44.94%
	Aug 2017 - Oct 2017	$155,336.00	$61,381.56	39.52%
Mar-16	Sep 2016 - Nov 2016	$248,608.23	$107,025.20	43.05%
	Dec 2016 - Feb 2017	$178,084.09	$76,270.56	42.83%
	Mar 2017 - May 2017	$173,420.92	$73,152.45	42.18%
	Jun 2017 - Aug 2017	$162,533.06	$61,313.71	37.72%
	Sep 2017 - Nov 2017	$139,851.96	$41,701.55	29.82%
Apr-16	Oct 2016 - Dec 2016	$236,627.95	$93,777.18	39.63%
	Jan 2017 - Mar 2017	$184,389.33	$72,615.47	39.38%
	Apr 2017 - Jun 2017	$182,242.36	$68,076.76	37.36%
	Jul 2017 - Sep 2017	$160,203.70	$53,337.89	33.29%
May-16	Nov 2016 - Jan 2017	$240,988.61	$91,828.53	38.10%
	Feb 2017 - Apr 2017	$185,623.25	$67,400.61	36.31%
	May 2017 - Jul 2017	$175,469.44	$60,835.85	34.67%
	Aug 2017 - Oct 2017	$155,213.73	$43,618.66	28.10%
Jun-16	Dec 2016 - Feb 2017	$147,989.82	$60,977.47	41.20%
	Mar 2017 - May 2017	$124,157.55	$45,399.71	36.57%
	Jun 2017 - Aug 2017	$113,561.52	$39,945.45	35.18%
	Sep 2017 - Nov 2017	$106,707.08	$30,004.90	28.12%
Jul-16	Jan 2017 - Mar 2017	$173,131.24	$64,985.91	37.54%
	Apr 2017 - Jun 2017	$149,152.06	$50,608.49	33.93%
	Jul 2017 - Sep 2017	$133,065.27	$38,777.14	29.14%
Aug-16	Feb 2017 - Apr 2017	$188,534.01	$70,605.21	37.45%
	May 2017 - Jul 2017	$161,836.33	$54,373.03	33.60%
	Aug 2017 - Oct 2017	$146,801.65	$41,860.29	28.51%
Sep-16	Mar 2017 - May 2017	$164,892.76	$60,663.36	36.79%
	Jun 2017 - Aug 2017	$127,017.52	$39,791.25	31.33%
	Sep 2017 - Nov 2017	$108,965.69	$27,626.91	25.35%
Oct-16	Apr 2017 - Jun 2017	$210,487.44	$70,625.52	33.55%
	Jul 2017 - Sep 2017	$162,773.71	$44,231.61	27.17%

Chart 3 continued on page 12

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 2017

Chart 3 continued from page 11

Chart 3: Quarterly Collection				
Nov-16	May 2017 - Jul 2017	$180,930.02	$56,588.71	31.28%
	Aug 2017 - Oct 2017	$122,906.82	$30,890.27	25.13%
Dec-16	Jun 2017 - Aug 2017	$172,057.86	$47,490.27	27.60%
	Sep 2017 - Nov 2017	$112,893.03	$24,716.72	21.89%
Jan-17	Jul 2017 - Sep 2017	$235,961.85	$74,382.46	31.52%
Feb-17	Aug 2017 - Oct 2017	$209,238.39	$63,042.48	30.13%
Mar-17	Sep 2017 - Nov 2017	$215,089.71	$63,202.65	29.38%

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			
	Jun-17	**Jul-17**	**Aug-17**
Percent Paid Online	31.05%	31.28%	33.13%
Percent Paid by Mail	68.95%	68.72%	66.87%

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 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 2017 and the cumulative total for the program from October 2014 through August 2017.

Chart 5A: Adjustment Activities

	Jun-17		Jul-17		Aug-17	
	#	Total $	#	Total $	#	Total $
Beneficiary is under age 21	525	$32,579.00	649	$38,924.00	544	$32,384.00
Pregnancy	240	$5,572.29	264	$5,684.10	248	$5,955.64
Hospice	0	$0.00	0	$0.00	0	$0.00
Native American	20	$2,099.33	13	$1,717.00	12	$1,525.00
Five Percent Cost Share Limit Met	36,257	$374,305.20	42,136	$389,693.58	32,329	$294,558.89
FPL No longer >100% - Contribution	4	$59.00	4	$31.56	0	$0.00
TOTAL	**37,046**	**$414,614.82**	**43,066**	**$436,050.24**	**33,133**	**$334,423.53**
	June-17 to Aug-17		**Calendar YTD**		**Program YTD**	
	#	Total $	#	Total $	#	Total $
Beneficiary is under age 21	1,718	$103,887.00	5,203	$321,893.00	17,675	$996,738.29
Pregnancy	752	$17,212.03	1,922	-$46,164.47	8,572	$204,547.53
Hospice	0	$0.00	0	$0.00	0	$0.00
Native American	45	$5,341.33	145	$14,745.33	772	$50,803.67
Five Percent Cost Share Limit Met	110,722	$1,058,557.67	287,142	$2,889,590.87	931,264	$10,588,811.29
FPL No longer >100% - Contribution	8	$90.56	31	$355.32	285	$10,404.69
TOTAL	**113,245**	**$1,185,088.59**	**294,443**	**$3,180,420.05**	**958,568**	**$11,851,305.47**

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 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 2017 and the cumulative total for the program from October 2014 through August 2017.

Chart 5B: Healthy Behaviors

	Jun-17		Jul-17		Aug-17	
	#	Total $	#	Total $	#	Total $
Co-pay	832	$3,616.50	1,142	$5,123.96	958	$4,609.73
Contribution	1,298	$45,276.50	1,604	$54,608.00	1,483	$49,306.50
Gift Cards	2,529	n/a	3,348	n/a	2,849	n/a
TOTAL	**4,659**	**$48,893.00**	**6,094**	**$59,731.96**	**5,290**	**$53,916.23**
	June 17 to Aug-17		**Calendar YTD**		**Program YTD**	
	#	Total $	#	Total $	#	Total $
Co-pay	2,932	$13,350.19	7,424	$35,042.92	35,439	$203,497.69
Contribution	4,385	$149,191.00	11,757	$404,135.88	68,313	$2,240,015.77
Gift Cards	8,726	n/a	22,170	n/a	120,603	n/a
TOTAL	**16,043**	**$162,541.19**	**41,351**	**$439,178.80**	**224,355**	**$2,443,513.46**

HEALTHY MICHIGAN PLAN
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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
Jun-17	38,750	$338,400
Jul-17	46,513	$412,933
Aug-17	50,127	$404,161
Calendar YTD	**328,982**	**$2,851,767**
Program Total	**586,298**	**$5,080,949**

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

Chart 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
Jun-17	188,296	72,803
Jul-17	181,845	74,011
Aug-17	186,162	76,552

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	$1,050,872.77	$963,386.17	$952,032.00	$917,960.69	$12,563,562.01	**$16,447,813.64**
Number of Beneficiaries That Owe	78,415	74,348	73,141	70,302	193,756	**234,772**

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 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
Jul-17	68,201	$10,049,454.41	7,345	$805,457.87
Calendar YTD	**68,201**	**$10,049,454.41**	**7,345**	**$805,457.87**
Program Total	**115,554**	**$15,747,377.74**	**14,158**	**$1,289,049.36**

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
Nov-17	49,857	$7,178,042.86

HEALTHY MICHIGAN PLAN
MI HEALTH ACCOUNT: NOVEMBER 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

Tax Year	Collected by Taxes		Collected by Lottery		Total Garnishments Collected	
	#	Total	#	Total	#	Total
2016	2,151	$207,873.10	7	$485.67	**2,158**	**$208,358.77**
2017	19,400	$2,186,182.40	59	$6,733.49	**19,459**	**$2,192,915.89**
Calendar YTD	**19,400**	**$2,186,182.40**	**59**	**$6,733.49**	**19,459**	**$2,192,915.89**
Program Total	**21,551**	**$2,394,055.50**	**66**	**$7,219.16**	**21,617**	**$2,401,274.66**

Non-Emergency Transportation (NEMT) Survey
October 2017

Executive Summary

Michigan State University's Institute for Health Policy (IHP) surveyed Michigan Medicaid beneficiaries in collaboration with the Michigan State University Office of Survey Research (OSR) regarding experiences with non-emergency medical transportation (NEMT).

- OSR mailed over 4,000 surveys to randomly selected beneficiaries who had a history of using these services (Users) as well as those who did not (Non-Users).
- User response rate of 23% statewide
- Non-Users response rate just 11%.
- Calculated margins of error for each region closer to 10% with 95% confidence level.

Non-Users:

- A smaller proportion of Non-User respondents reported a need for NEMT compared to Users (17% vs. 82%, respectively).
- Less than 40% of Non-User respondents documented they were aware of NEMT
- Less than 10% of Non-User respondents had attempted to use NEMT in the prior 6 months.
- Predominant reasons supplied for not using NEMT:
    - Drivers not showing (before or after visits)
    - Scheduling difficulty (including the 3 day advance notice)
    - Not needing the service
    - Inability to choose NEMT provider, and
    - Feeling the vehicle was unsafe

Users:

- User respondents documented higher need and use of NEMT (82% and 95%, respectively).
    - Region 1 experienced the lowest use rate (52%) while Region 10 had the highest use rate (92%).
- Users (92%) use NEMT to get to doctor appointments
    - Other health care services (labs, pharmacy, urgent care) reported in less than 40%.
- Largest group of individuals (38%) used NEMT 2-5 times in the past 6 months
    - Substantial group (17%) report service use in excess of 20 times in the prior 6 months
- More than half of Users reported that NEMT "always" met their needs
    - 26% reported the service "usually" met their needs.
    - Region 2 had significantly higher rates compared to Regions 1, 7 or 10.
    - Region 10 had significantly lower proportion of "met" responses compared to Regions 4 and 8.
- NEMT received an average score of 8.0 (95% CI: 7.8, 8.3) using numeric scale where 0=worst service ever and 10=best service ever.
    - Region 10 was rated significantly lower than Regions 1, 2, and 4 with a mean rating of 6.8.
- Approximately half User respondents acknowledged experiencing a problem with NEMT with most frequent problems mentioned:
    - Rides not on time (49%)
    - Missed appointments (44%)
    - Drivers using cell phone while driving (29%)

    - Inability to choose ride service (24%)
- Nearly 90% reported that drivers "usually or always" showed up on the correct day.
- 87% stated that drivers "usually or always" arrived on time.
    - When there was a late pickup, 60% waited more than 15 minutes
- 65% claimed they "never" missed an appointment because of a late driver.
- 42% stated they "never" had to wait more than 30 minutes for pick-up after an appointment.
- 90% of respondents felt their driver drove safely "usually" or "always".
- Vehicle conditions had an average score of 7.8.
    - Cleanliness received the lowest score compared to the remaining measures of safety, working seat belts and running well.
- 20% indicated a need for a car seat.
    - 29% of these reported the driver provided a car seat.
    - 90% report car seat clean and in good working order.
- 75% reporting drivers "always" treated the client with respect.
    - 20% reported the driver "usually" treated them with respect.
- 84% claimed the driver never ignored requests.
- About half of respondents knowledgeable about how to file a complaint if they had one
    - 28% stated they had submitted a complaint.
    - No respondents reported confronting the drivers directly with complaints.
    - 42% complaints reported to Transportation Company.
        - 56% reported they had a response to their complaint.
        - Just over half of those with complaints reported being satisfied with the resolution.

In summary, these survey results suggest that 80% of Medicaid beneficiaries using the services feel these meet their needs "usually" or "always" despite 50% acknowledging problems using the service. There is some discrepancy in timeliness aspects of the service. Respondents report drivers not showing up on time leading to missed appointments. However, when asked specifically about frequency with which drivers show up on time, 87% say this occurs "usually" or "always". Thirty-five percent mention they had missed appointments due to a late driver at least some of the time. Post-visit pick-up appears to have the most issues with timeliness with almost 60% saying they had to wait more than 30 minutes at least some of the time. Driver interactions appear to be positive with less than 5% pointing to a lack of respect or a driver ignoring requests. It does appear that member education regarding how to file a complaint would be productive, as just half report being knowledgeable about the procedure.

Background

In response to a request from Michigan Medical Services Administration (MSA), MSU-IHP drafted two surveys on non-emergency medical transportation (NEMT) services intended for Medicaid beneficiaries. MSA identified NEMT services as a concern with anecdotal reports of beneficiary and provider complaints. MSA indicated an interest in obtaining beneficiary feedback from those who had used NEMT. MSA was also interested in surveying beneficiaries who had not used these services. Since obtaining access for NEMT service varies depending on whether a beneficiary is covered under Managed Care (MC) or Fee-For-Service (FFS), separate samples were identified for each category of coverage. MSA expressed further interest in being able to compare Prosperity Regions as the geographic and population density characteristics could influence delivery of these types of services. MSU-IHP executed the beneficiary surveys in collaboration with the MSU Office for Survey Research (OSR).

Beneficiary Identification and Selection

- IHP identified the population of MC and FFS Medicaid beneficiaries continuously enrolled for 6 months from July-December 2016 by Prosperity Region from the MDHHS Data Warehouse in April 2017. The unique count of MC was 1,959,797 and the unique count of FFS individuals was 246,700.
    - We merged several prosperity regions for efficiency and cost issues. Specifically, we combined Regions 2, 3, 5, and 6. We referred to this mega-region as Region 2 in figures below.
    - We used the 6-month enrollment period in order to ensure beneficiaries had a sufficient opportunity to attempt to use the NEMT services.
    - We identified NEMT Users by the presence of at least one claim/encounter with an allowable procedure code indicating NEMT service in the prior six months. MSA provided the list of transportation codes. (Attachment 1) Non-Users included those lacking any instance of the allowable procedure codes in the prior six months. The number of unique MC NEMT Users statewide was 308,845 and unique FFS Users in the three NEMT contracted counties of Macomb, Oakland, and Wayne was 6,662.
- Representative samples of “Users” and “Non-Users” were calculated by prosperity region for MC beneficiaries and beneficiaries were randomly selected for participation. The target completion was 1,338 for MC.
- MDHHS identifies FFS members that use NEMT services through encounter data submitted to the MDHHS data warehouse by the Region 10 contractor. Local Department of Human Service (DHS) offices deliver NEMT services for FFS members in all other counties. This reduced the identifiable eligible population for the survey to 78,390, of which 6,662 were identified as Users. Similar calculations identified representative samples of “Users” and “Non-Users” for FFS beneficiaries in this region only. The target completion was 191.
- For each region and coverage type, IHP selected 288 beneficiaries as the sample for this survey.

Beneficiary Communication and Survey Tool

- All selected participants received an introductory letter (Attachments 2 and 3).
    - IHP obtained mailing addresses from the MDHHS Data Warehouse.
    - OSR mailed an introductory letter in May 2017 to validate address information and to alert potential respondents to the upcoming survey.
    - IHP developed two versions of cover letters depending on the age of the beneficiary identified for participation. Beneficiaries 18 years of age or older received the letter to their attention while beneficiaries less than 18 years of age received letters addressed to the “parent or guardian”.

  - 294/4,600 (6.4%) letters were returned as undeliverable.
- All remaining participants who did not have the introductory letter returned by mid-June then received a survey packet including a cover letter (Attachments 4 and 5), the applicable survey instrument depending on their classification as a User or Non-User (Attachments 6 and 7) and a self-addressed stamped envelope.
  - Here also, we used two versions of cover letters depending on the age of the beneficiary identified for participation.
  - Respondent options to complete the survey included a phone-in option in lieu of the paper survey. OSR provided a toll-free number to make this call.
- OSR coded and mailed 4,383 survey packets in June 2017. IHP set up the coding scheme based on the member's Prosperity Region ID and a random number so that responses would be properly attributed to the correct region upon return.
- Non-responders received reminder postcards in July 2017.

Results and Statistical Analyses

- Based on the statewide responses, the MC descriptive statistics have a margin of error less than 5% with a 95% confidence level while the FFS margin of error was greater at 6% with a 95% confidence level.
- The survey asked participants to confirm if they had any Medicaid enrollment in the prior 6 months.
  - We excluded those that denied participation in the prior 6 months from analyses.
- Region specific margins of error vary as shown in Table 1

Table 1: Region and Statewide Margin of Error

	Users			Non-Users		
Region	**Target**	**Eligible Completed**	**Margin of Error (95% confidence level)**	**Target**	**Eligible Completed**	**Margin of Error (95% confidence level)**
1	94	86	10.6%	96	38	15.9%
2, 3, 5, 6	96	73	11.5%	96	26	19.2%
4	96	82	10.8%	96	30	17.9%
7	94	56	13.1%	96	32	17.3%
8	95	71	11.6%	96	25	19.6%
9	95	50	13.9%	96	38	15.9%
10	96	48	14.1%	96	18	23.1%
MC SubTotal	666	466	4.5%	672	207	6.8%
10 (FFS)	95	67	12.0%	96	31	17.6%
Total	**761**	**533**	**4.2%**	**768**	**238**	**6.4%**

The response rate varied by region. Among MC enrollees, the statewide response rate was 23.1% for Users but only 11% for Non-Users. We expected this pattern as those not using the service would be less likely to take time to give input. Region 1 showed the highest response rates for both surveys (29.9% for Users and 13.2% for Non-Users). On the other hand, Region 10 showed the lowest response rate for both surveys (16.7% for Users and 6.3% for Non-Users). (Figures 1 and 2). When we evaluated the FFS cohort, the response rate was 23.3% (67/288) for Users and 12.2% (31/288) for Non-Users

Figure 1. User Response rate and number of respondents by region for enrollees

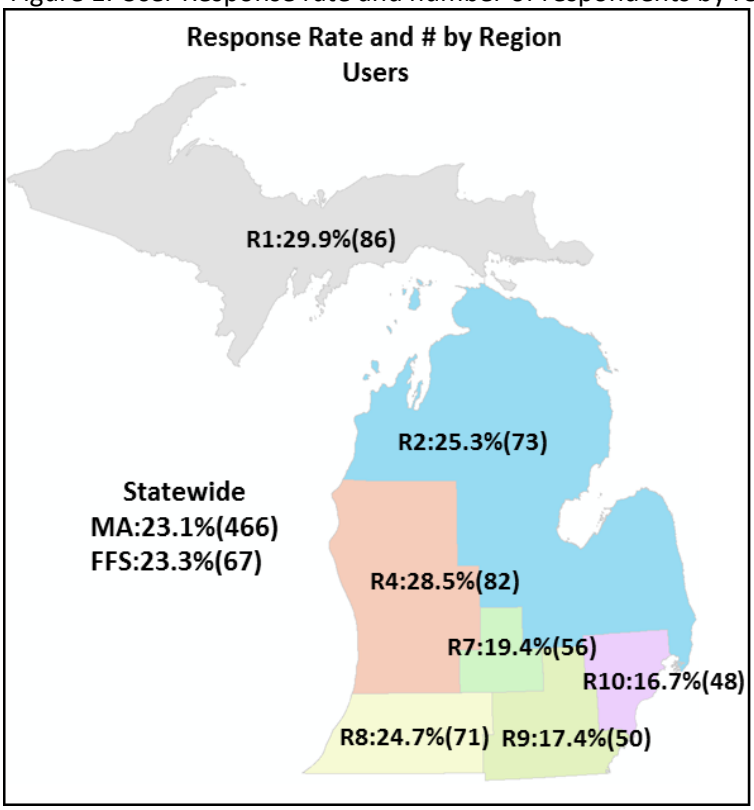
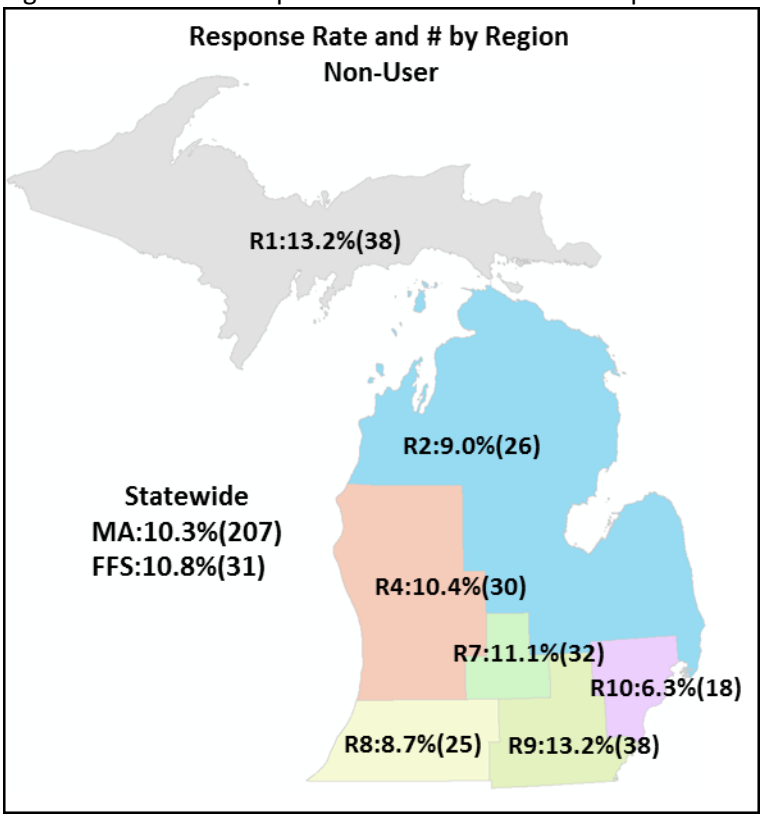


Figure 2: Non-User Response rate and number of respondents by region for enrollees



A total of 573 User responses were originally received. Among the Users, 40 (7%) of individuals denied meeting the requirement that they were enrolled at least 1 month during the past 6 months and further did not identify as being a current member. Thus, we excluded these from further analyses. Non-User responses originally numbered 252. Among the Non-Users, 14 (5.6%) denied being enrolled in the prior 6 months. These respondents further denied current enrollment so we dropped them leaving 238 Non-Users available for subsequent analysis.

Demographic information

More than 70% of the Users were female and more than 50% were between 45 and 64 years old (Figures 3 and 4). Non-Users had a similarly high proportion of female respondents but were considerably younger than the Users.

Figure 3: Statewide Gender Distributions

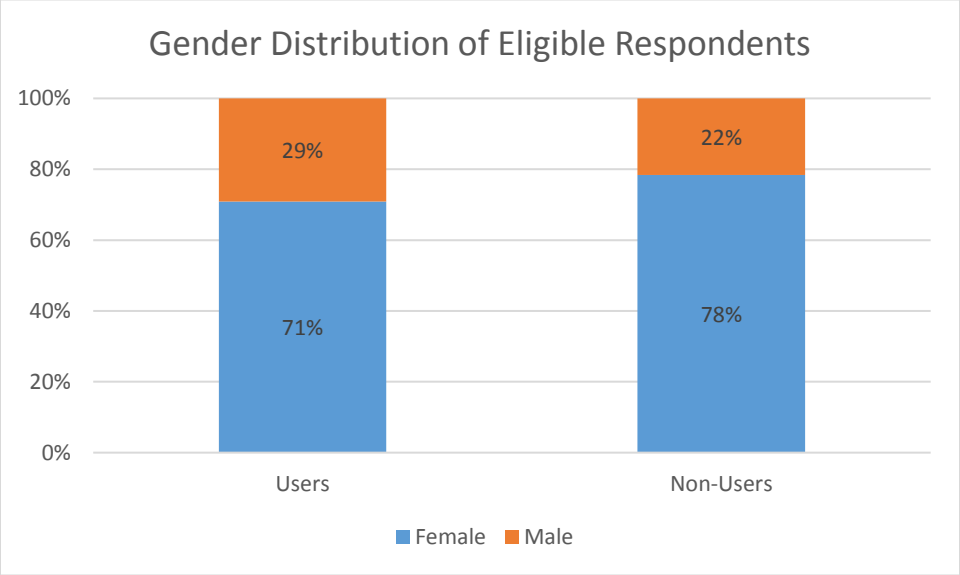
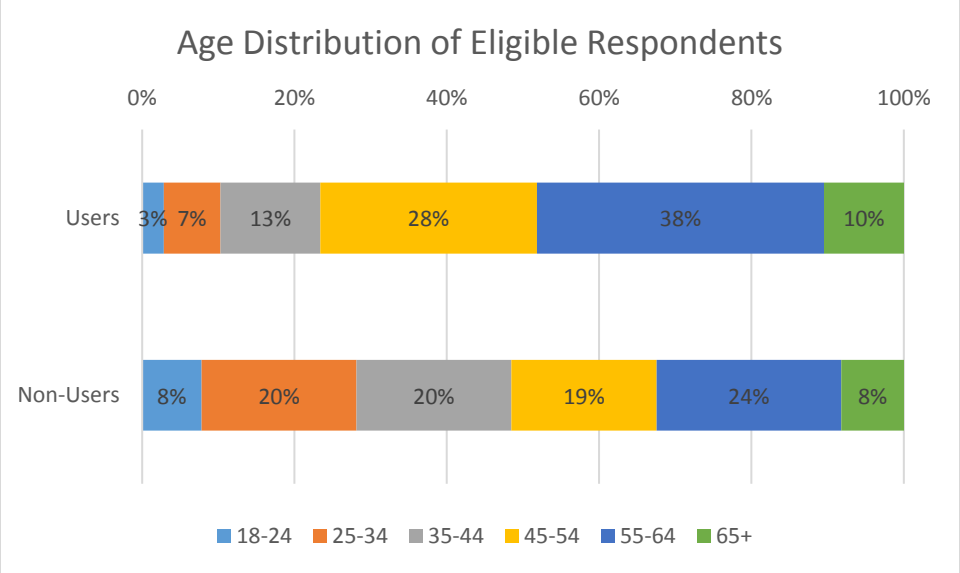
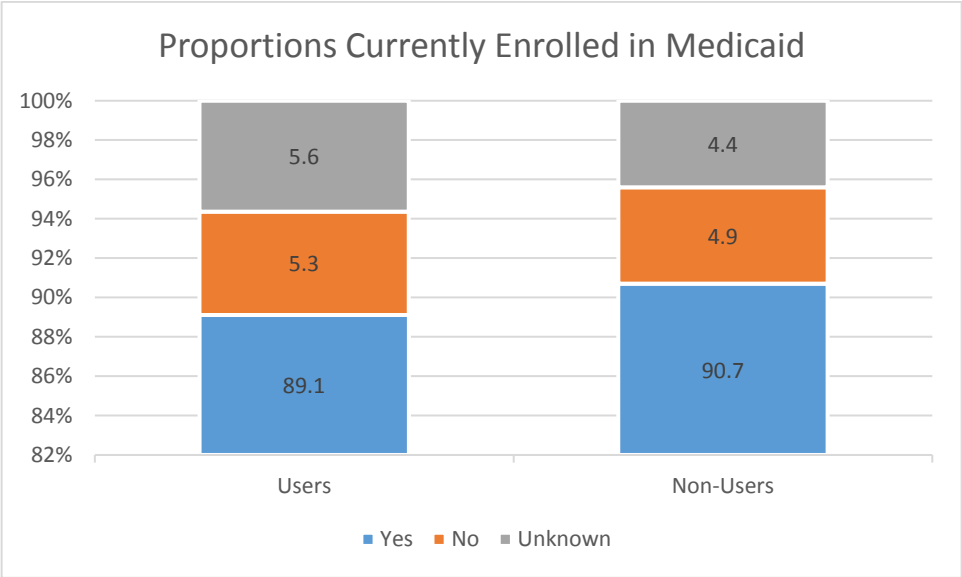


Figure 4: Statewide Age Distributions



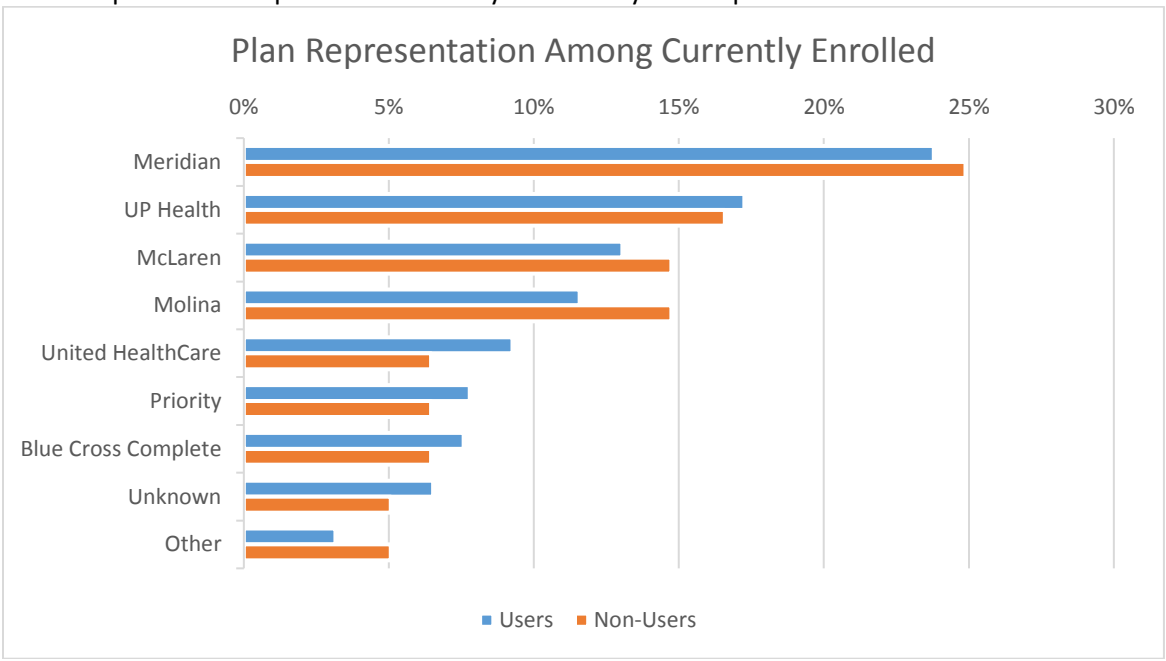
Among the 533 User individuals remaining, approximately 90% (n=475, 89.1%) were currently enrolled in Medicaid at the time they answered the survey (Figure 5). Approximately 90% of the Non-Users were enrolled at the time of the survey.

Figure 5. Proportion of beneficiaries currently enrolled



Among currently enrolled beneficiaries, the largest proportion reported being members of Meridian Health Plan followed by Upper Peninsula Health Plan for Users and Non-Users. About 7% of currently enrolled beneficiaries did not identify their health plan. Figure 6.

Figure 6. Proportion of respondents currently enrolled by health plan



As expected, the proportion citing a need for NEMT was higher among the Users compared to the Non-Users. Approximately 80% of the MC User respondents reported a need for NEMT service (n=421, 79%) while over 90% of FFS User respondents did so. Among the Users who cited a need, almost all of them did use the service, 95% for MC and 97% for FFS. (Figure 7) There was no significant difference between coverage types and need or use of NEMT. We further explored the association between region and need/use of NEMT. Region 10 experienced the greatest proportion of Users reporting need and use of NEMT while Region 1 respondents reported significantly lower rates. (Figure 8).

Figure 7. Users Reporting Need and Use of NEMT service

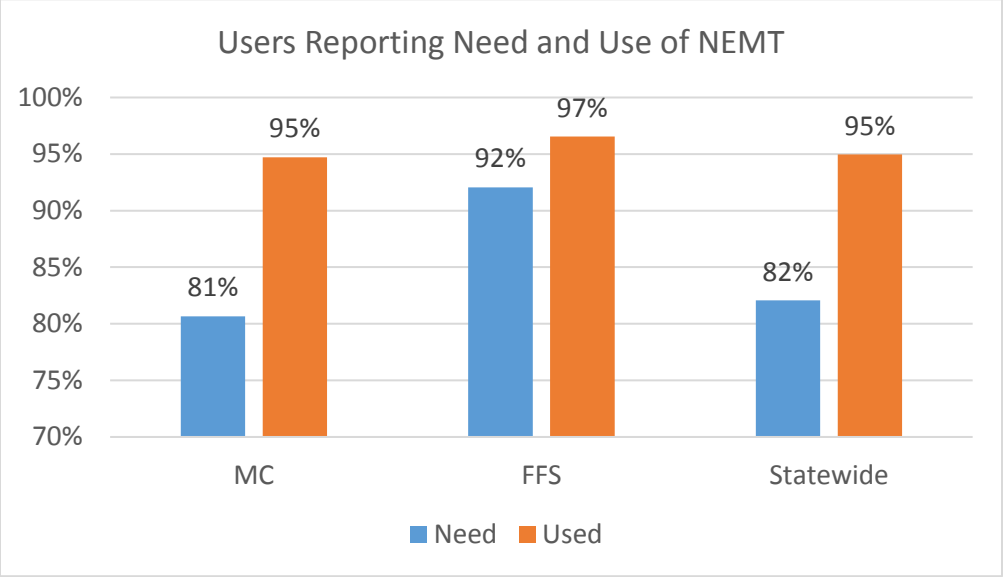
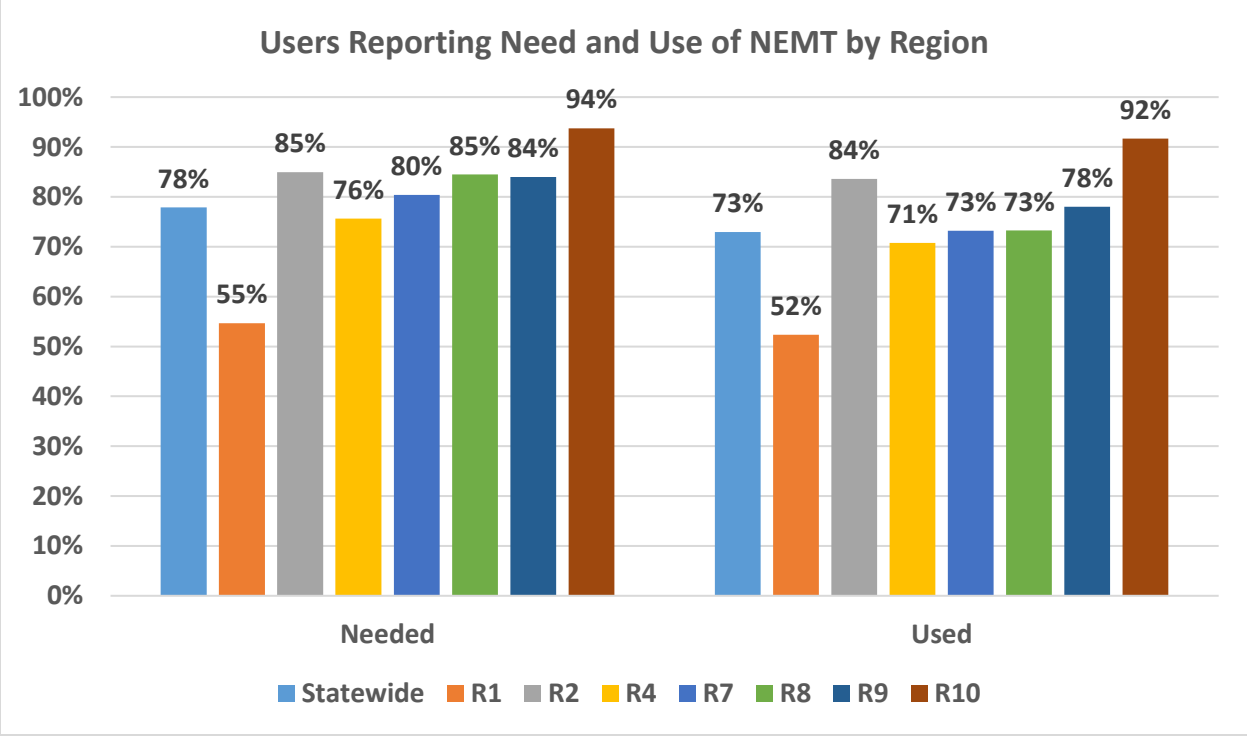
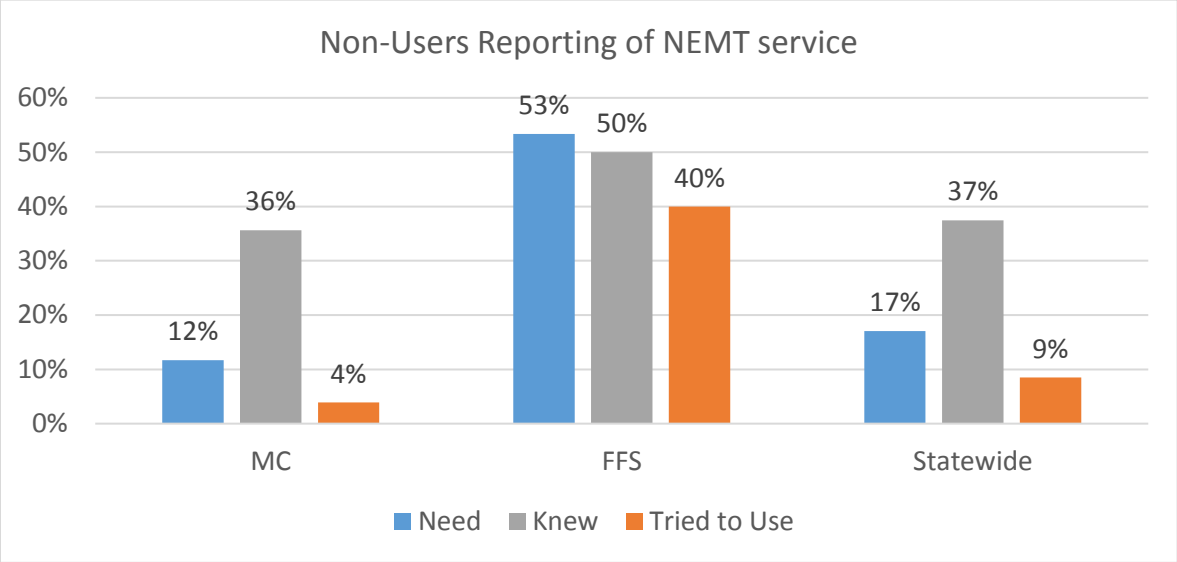


Figure 8. Users Reporting Need and Use of NEMT service by Region (MC only)



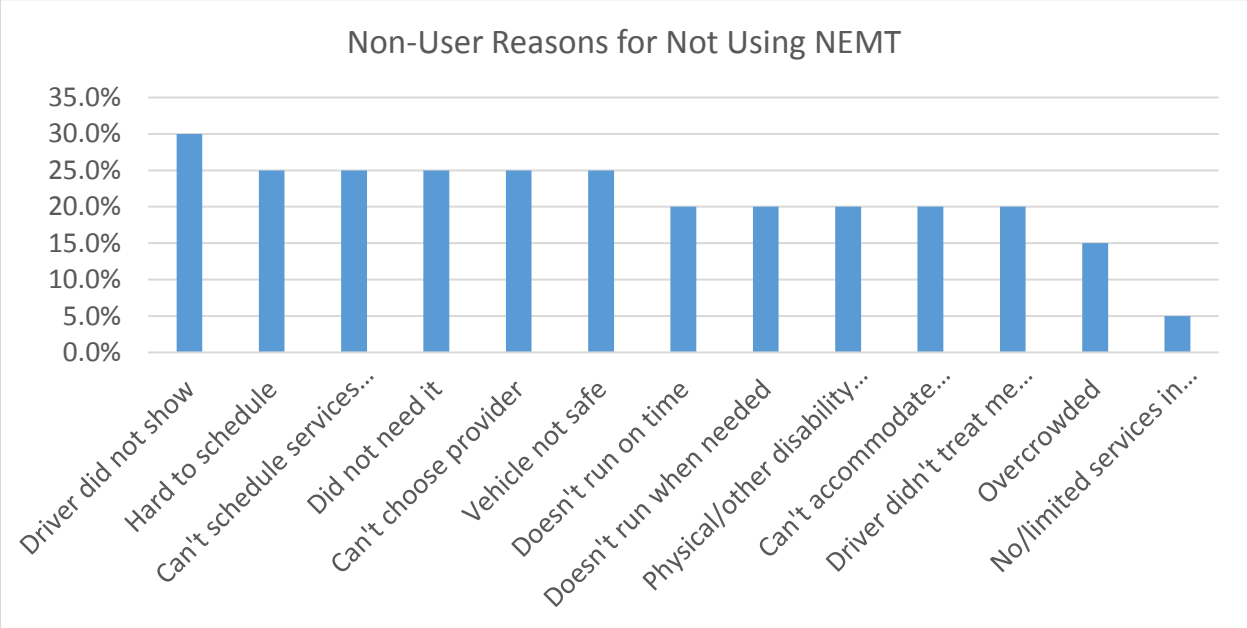
As expected, the Non-Users reported less need for NEMT services for both MC and FFS subgroups. Among the MC group, only 35% reported being aware of the service while more FFS (50%) beneficiaries were knowledgeable. Very few MC beneficiaries attempted to use the service while 40% of the FFS individuals tried to do so. (Figure 9)

Figure 9. Non-Users Reporting of NEMT Service



Relatively few (n=20) Non-Users tried to use NEMT. This affects the proportions displayed for the reasons they were unable to do so. (Figure 10) Just four individuals provided comments for why they did not use the service, which included “not interested”, driver looks like they came off the street, driver hit a vehicle and didn’t report it causing the beneficiary stress, and the ride being cancelled by the driver.

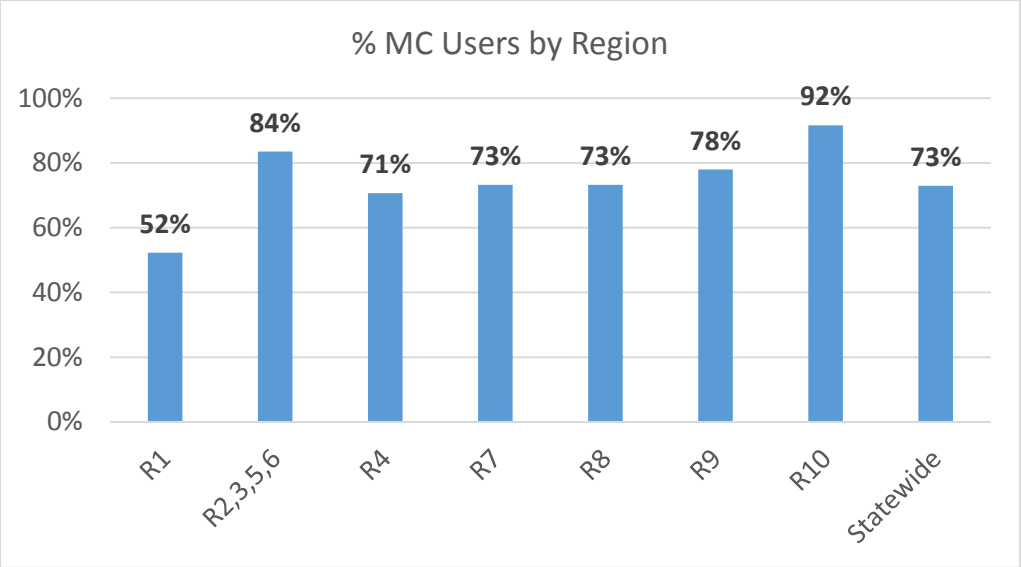
Figure 10: Non-User Reasons for Not Using NEMT



Transportation Users

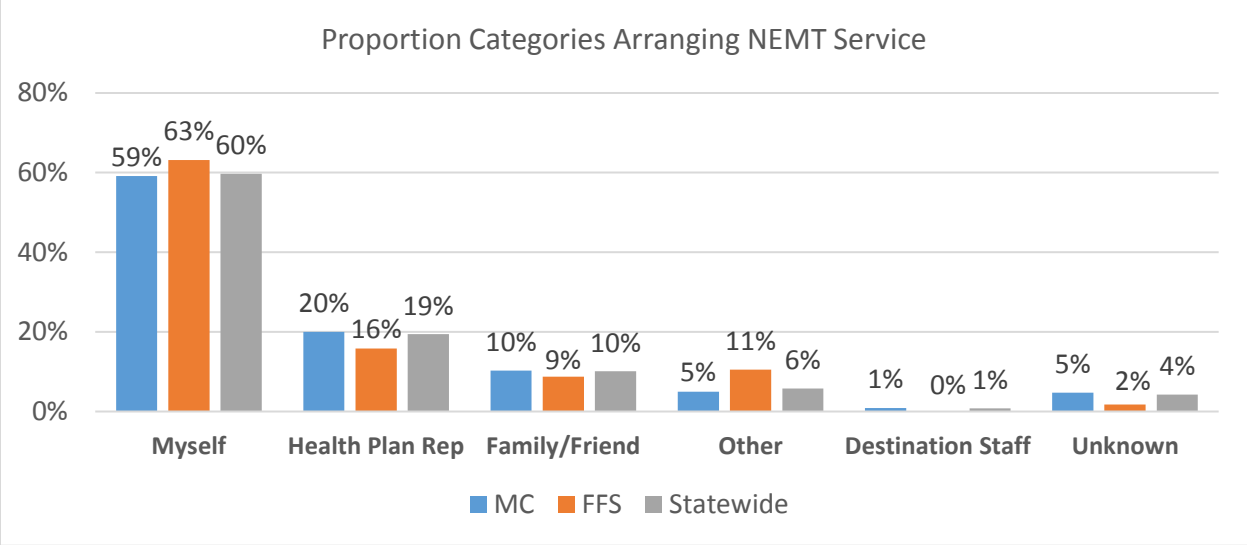
The overall proportion of MC beneficiaries who used NEMT service varied by region (Figure 11). Region 1 showed significantly lower use compared to the statewide estimate.

Figure 11. Proportion of MC Users by region



About 60% of beneficiaries who used a NEMT service in the past 6 months arranged the service themselves. Health plans arranged nearly 20% (n=78, 19.4%) of NEMT services. Both FFS and MC showed similar observations with significant difference. Respondents did not identify the "other" parties assisting with travel arrangements.

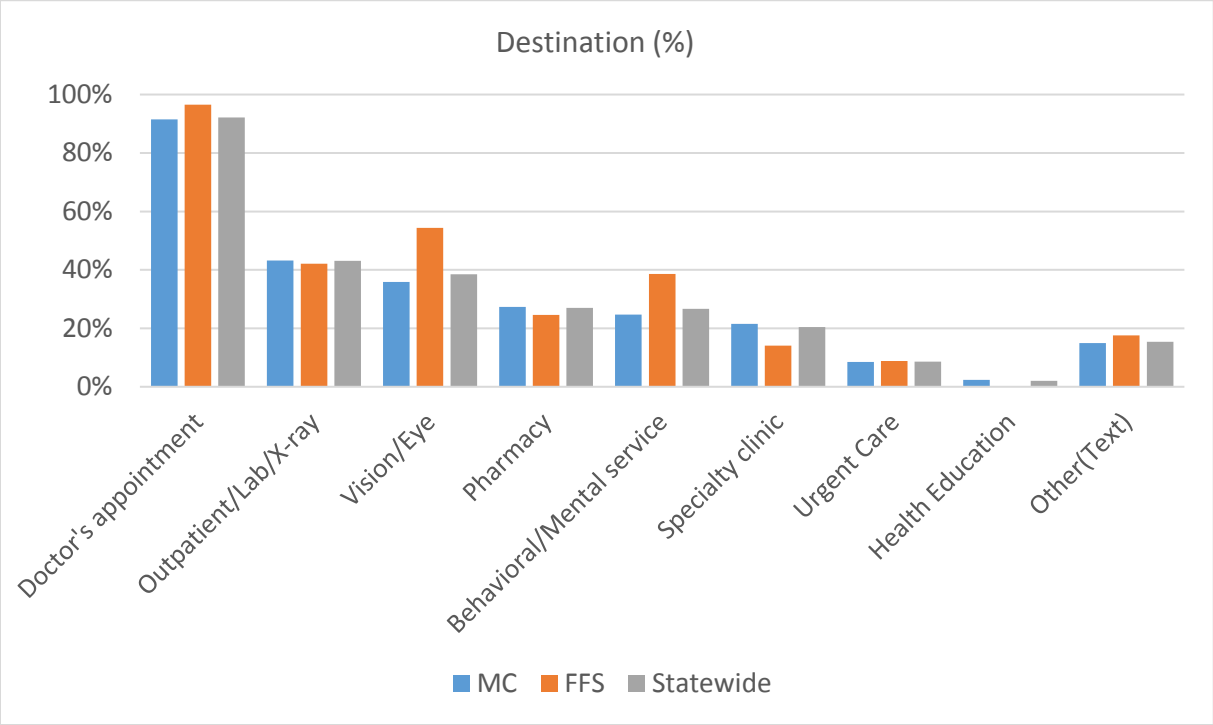
Figure 12. Proportion of beneficiaries by the type of NEMT service arrangement



More than 80% of NEMT service is for transportation for a doctor's appointment for both MC and FFS cohorts. Forty percent of respondents use NEMT to get to outpatient services such as lab or radiology. Over 50% of FFS respondents use NEMT for vision services. (Figure 13). Upon review of destinations identified in the "Other" category, we could reassign them to one of the existing options with 2/3 of

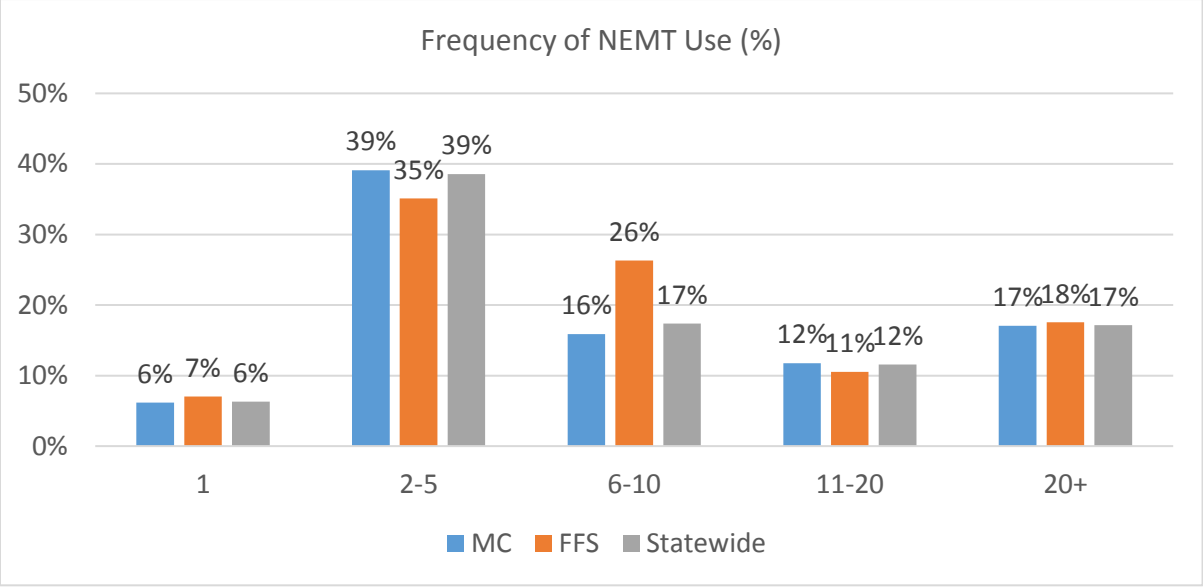
responses reflecting a provider/professional office visit (e.g., podiatrist, chiropractor, dental). A few responses specifically mentioned provider visits in distant locations.

Figure 13. Destination Reported by Participants



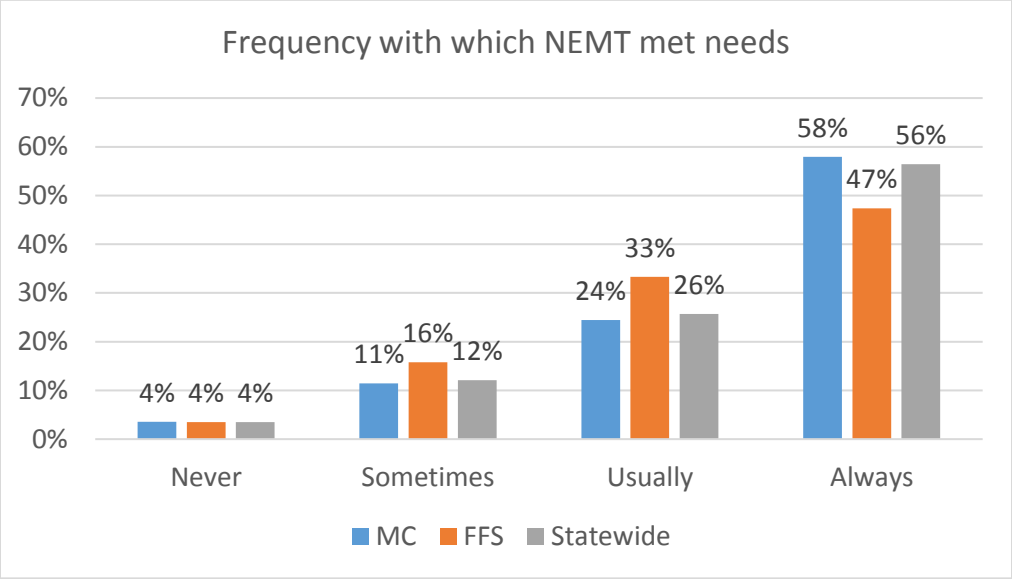
More than 17% of beneficiaries used NEMT more than 20 times in the past 6 months. The greatest proportion (n=153, 39%) used the service 2-5 times. There was no significant difference between frequency of use by type of Medicaid coverage. (Figure 14).

Figure 14. Proportion of beneficiaries by the frequency of use of NEMT services in past 6 months



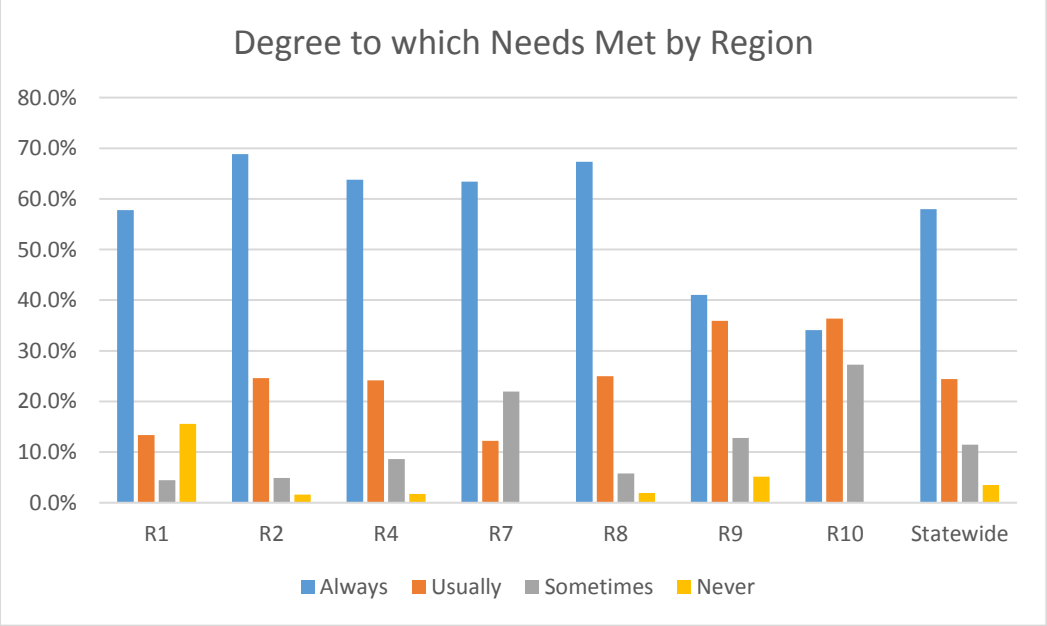
More than half of respondents (n=224, 57%) report that the NEMT services "always" met their needs while an additional 26% (n=102) documented that the service "usually" met their needs. Although we documented variation between FFS and MC respondents, these were not statistically significant. Approximately 15% report that the services only sometimes or never meet their needs.

Figure 15: Proportion of Respondents Reporting Degree to which NEMT met needs



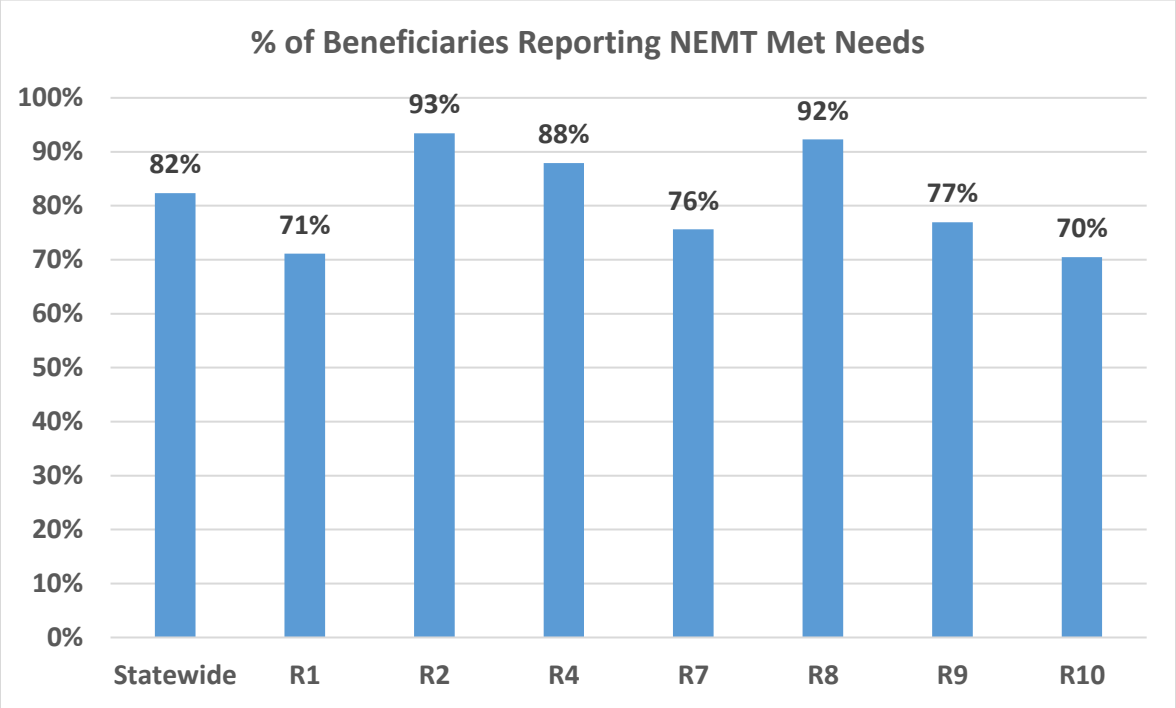
Regions 1 and 9 have a greater proportion of respondents reporting a "never" compared to the statewide average when we evaluate the degree to which needs are met by region. (Figure 16). Among Region 10, there is no difference if we look at MC vs. FFS.

Figure 16. Degree to which Needs Met by Region



Due to sample size constraints, we collapsed the "never" and "sometimes" categories as a proxy for "not met" while we combined "usually" and "always" as a proxy for "met". When we carried out the regional comparison of degree to which NEMT services met needs, Region 2 had significantly higher rates compared to Regions 1, 7 or 10. In addition, Region 10 had significantly lower proportion of "met" responses compared to Regions 4 and 8. (Figure 17)

Figure 17: Proportion of Respondents Reporting NEMT Meets Needs



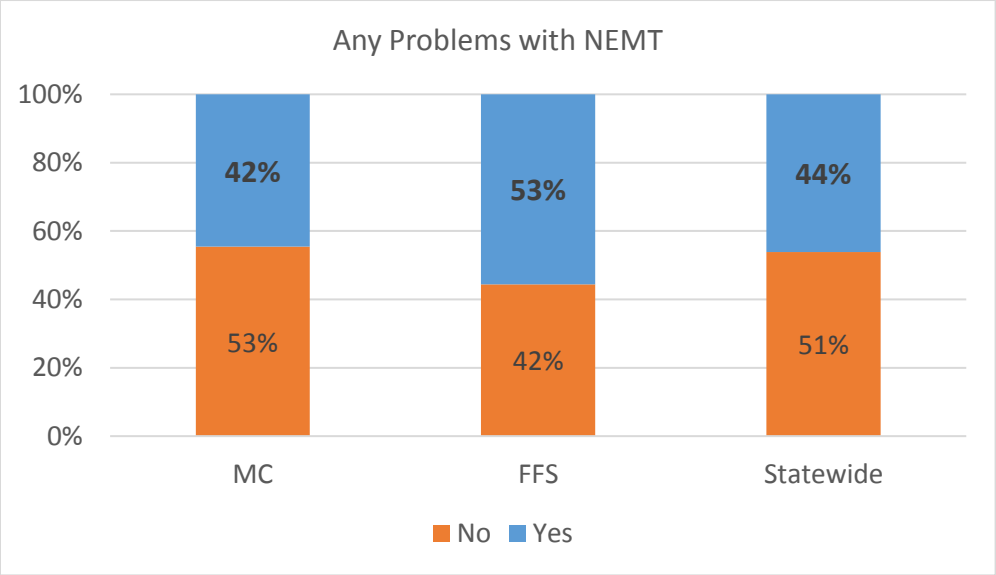
The MC beneficiaries gave significantly higher numeric ratings than the FFS beneficiaries did. Using a scale of 0-10 where 0 was the "worst service possible" and 10 was "the best service possible", the average MC score for NEMT was 8.0 while the FFS score was 6.8. (Table 2). Region 10 was rated significantly lower than Regions 1, 2, and 4 when comparing between regions.

Table 2. Mean Satisfaction Rating for NEMT service

TYPE	Mean	Lower 95%	Upper 95%
FFS	6.8	6.0	7.6
MC	8.0	7.8	8.3
REGION			
R1	8.5	7.8	9.1
R2	9.0	8.7	9.3
R4	8.4	7.8	8.9
R7	8.1	7.3	9.0
R8	7.8	7.0	8.6
R9	7.3	6.3	8.3
R10*	6.7	5.8	7.5
Statewide	8.0	7.8	8.3

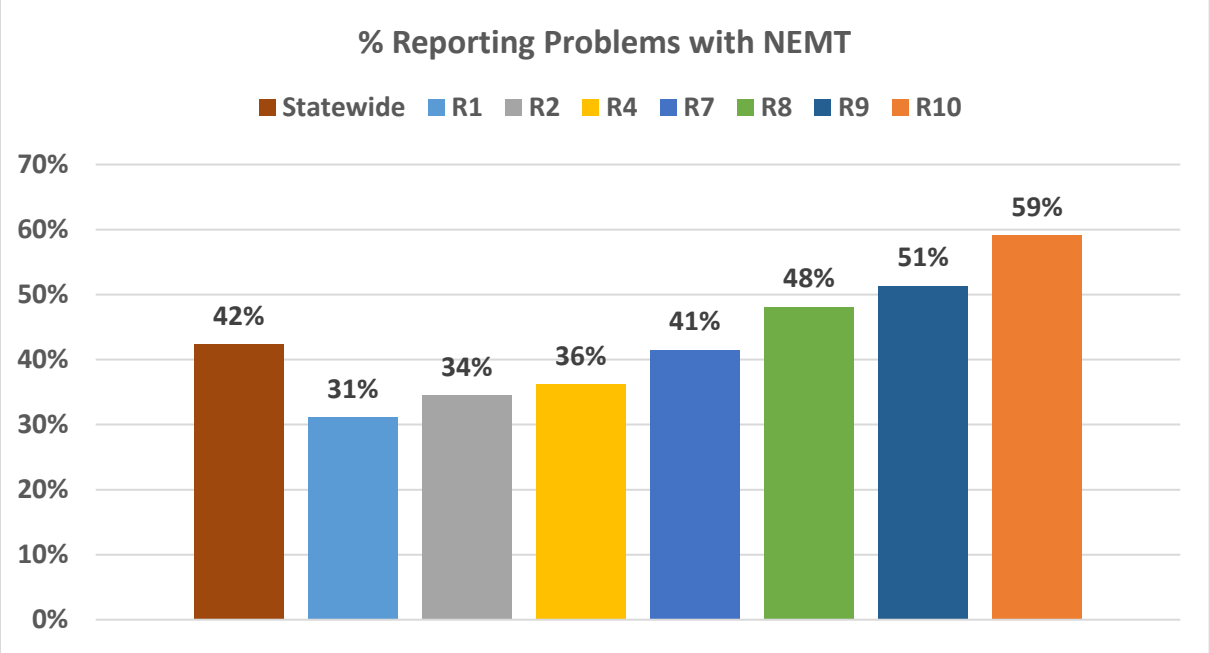
A larger proportion of FFS beneficiaries reported problems (52%) compared to the MC subgroup however, this difference was not statistically significant. (Figure 18).

Figure 18. Proportion of beneficiaries experienced any problems with NEMT



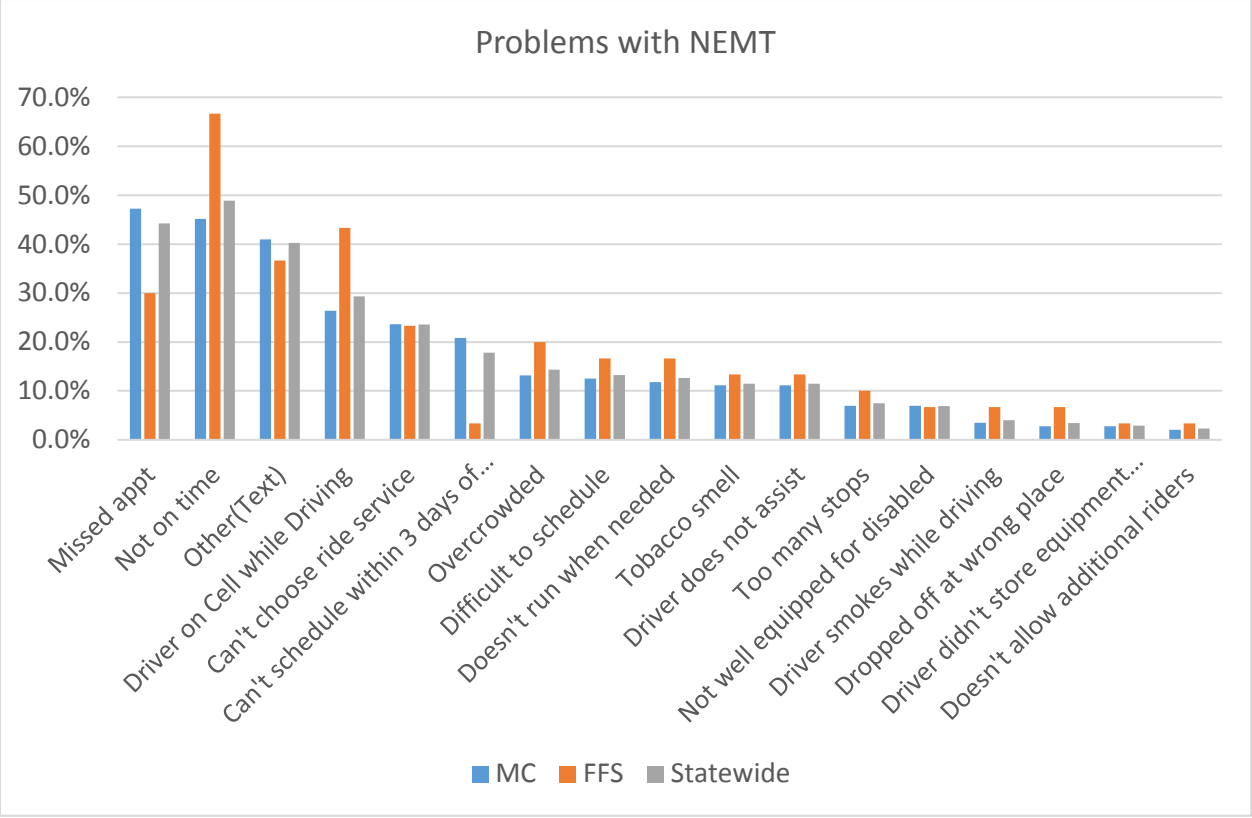
When comparing the regions for reports of problems, Region 10 showed significantly higher proportion of respondents citing problems compared to Regions 1, 2, and 4. The proportion reporting problems in Region 9 was significantly higher than Region 1. (Figure 19)

Figure 19. Proportion of beneficiaries experienced any problems with NEMT by Region



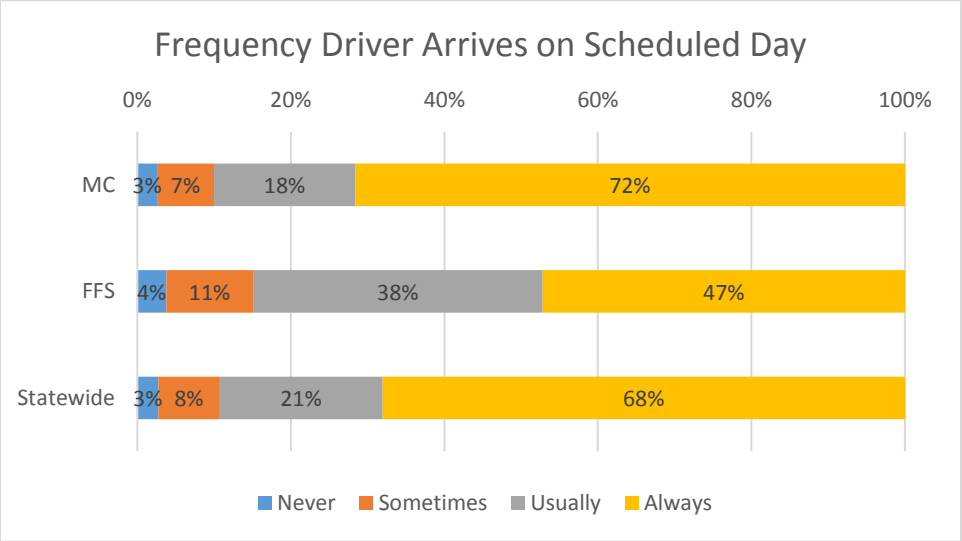
Among those who reported experiencing problems with NEMT service, the top five problems reported were: missed my appointment, not on time, use of cellphone while driving, scheduling, and overcrowding (Figure 20). The average wait time reported by respondents who gave a wait time was 90 minutes (± 61 minutes, range 2-360 minutes). The "Other" comments primarily targeted driver no-shows (with no notice) and driver interactions (rude, harassing, nosy, unsafe driving, etc.). Beneficiaries also mentioned that drivers would arrive hours early and then not return at the scheduled time. Additionally, several respondents mentioned paperwork issues such as processing reimbursements for drivers.

Figure 20. Problems with NEMT Service



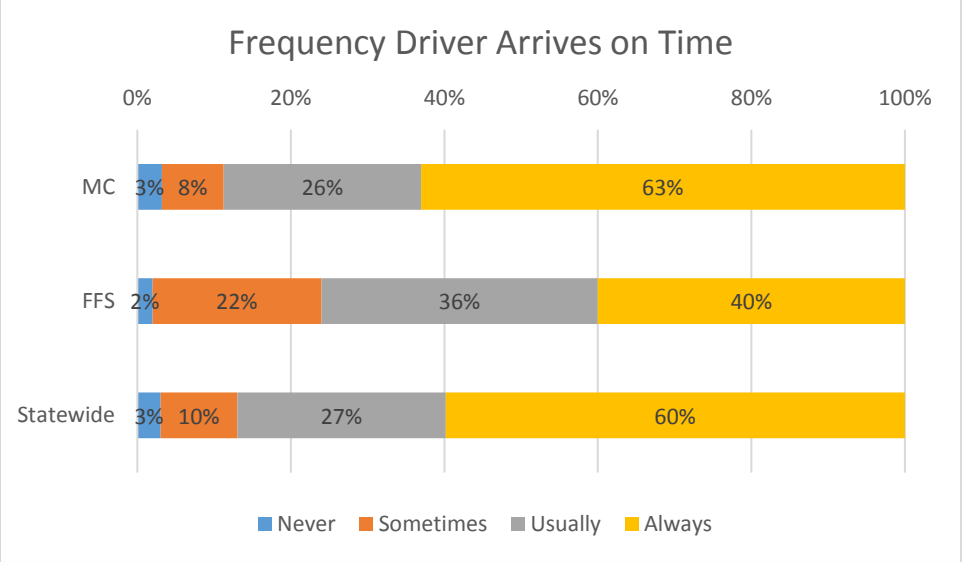
The survey instrument posed specific scenarios to respondents asking about their experience with each. Approximately 90% reported drivers “usually” or “always” arrived on the scheduled day. (Figure 21).

Figure 21: Frequency with which Drivers Arrive on Scheduled Day



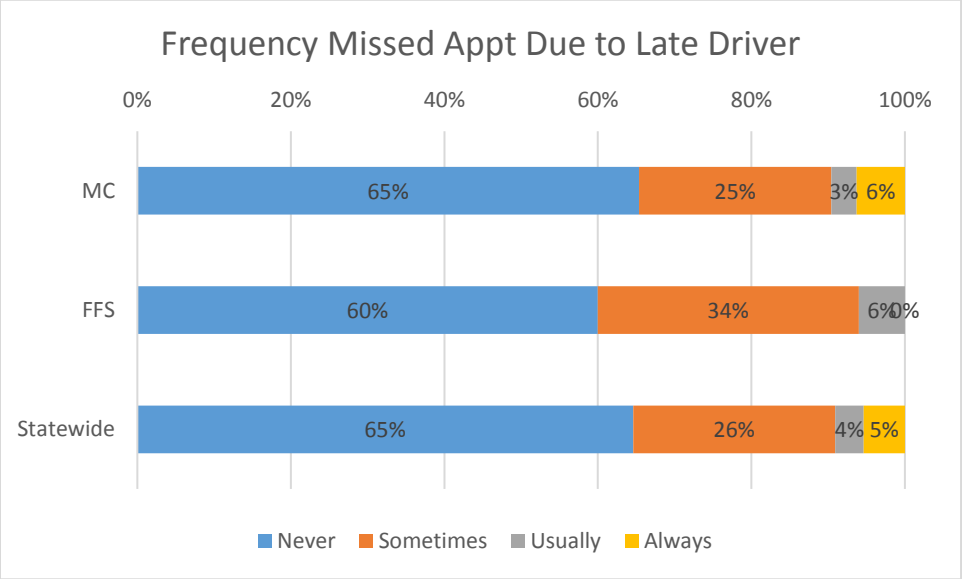
Only a slightly lesser proportion of respondents, 87% reported that drivers “usually” or “always” arrived on time. FFS respondents documented over 20% only arrived on time “sometimes”. (Figure 22).

Figure 22: Frequency with which Drivers Arrive on Time



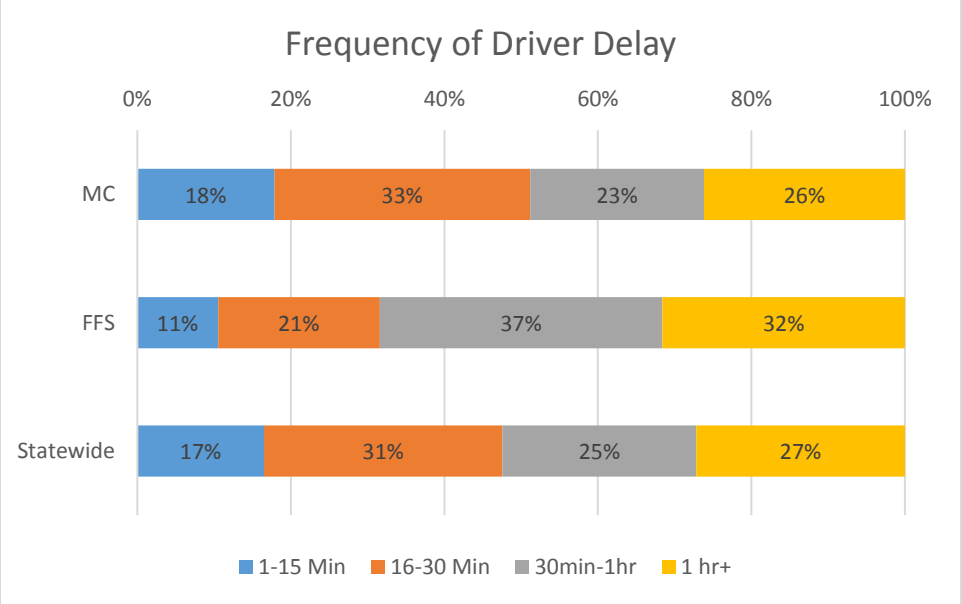
The next scenario asked respondents to rate how often they missed an appointment because their driver was late. We see here the inverse of the prior question so where 60% stated their driver “always” arrived on time, 65% reported they “never” missed an appointment. The “usually” category from the prior question also relates with the 26% reporting they “sometimes” missed an appointment.

Figure 23:Frequency Respondent Missed an Appointment Because Driver was Late



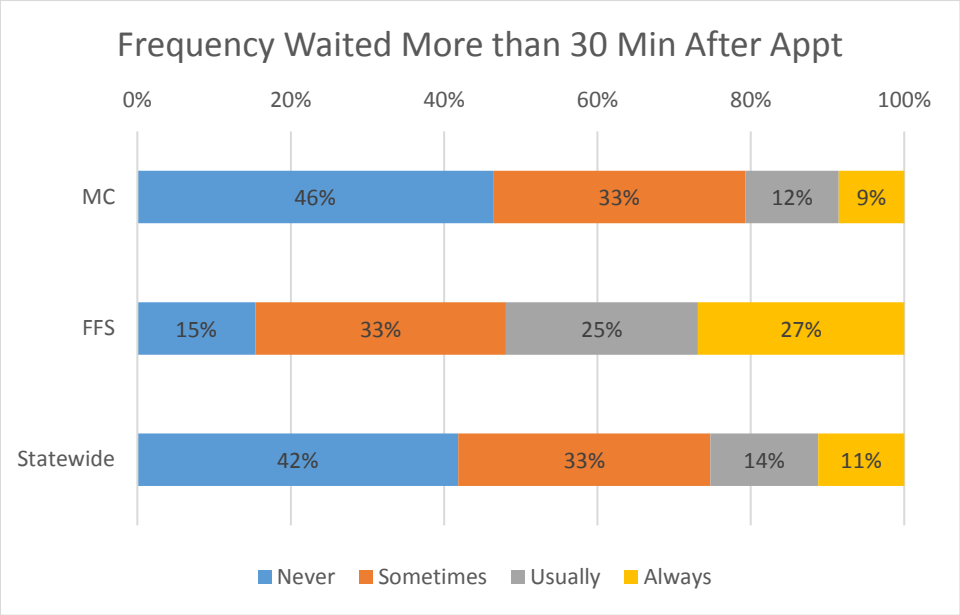
For those that reported a driver delay, almost half (48%) documented the delay was less than 30 minutes. (Figure 24).

Figure 24: Frequency of Delays Due to Waiting for Driver



A greater proportion of MC respondents reported having wait times exceeding 30 minutes after their appointment. (Figure 25). Region 1 had greater proportions of “never” or “always” responses compared to the statewide averages.

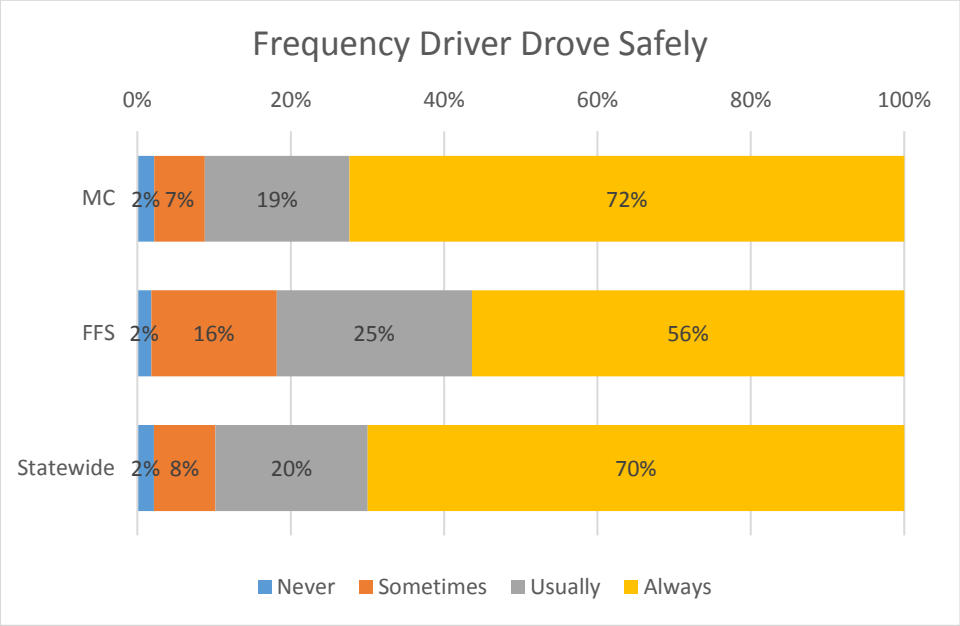
Figure 25. Frequency of Wait Time > 30 Minutes After Appointment



About the Driver and Vehicle

About 90% of the beneficiaries answered that the driver always or usually drove safely (Figure 26). Again, we documented no difference between FFS and MC beneficiaries.

Figure 26. Frequency Driver Drove Safely



MC beneficiaries rated the condition of the vehicles somewhat higher in all categories compared to the FFS cohort although these differences were not significant. (Table 3). Both groups indicate that automobiles are close to very good condition with most scores greater than 8 (7.8 – 9.4). Cleanliness showed the lowest ranking compared to the other measures.

Table 3. Vehicle Rating (0: worst condition, 10:great condition)

Medicaid Type	Variable	Mean	Lower 95% CI	Upper 95% CI
FFS	Safe	8.0	7.4	8.7
	Clean	7.8	7.1	8.5
	Working Seat belts	8.6	8	9.3
	Running Well	8.4	7.8	9
Managed Care	Safe	8.9	8.7	9.1
	Clean	8.8	8.6	9.0
	Working Seat belts	9.4	9.2	9.6
	Running Well	9.1	8.9	9.3

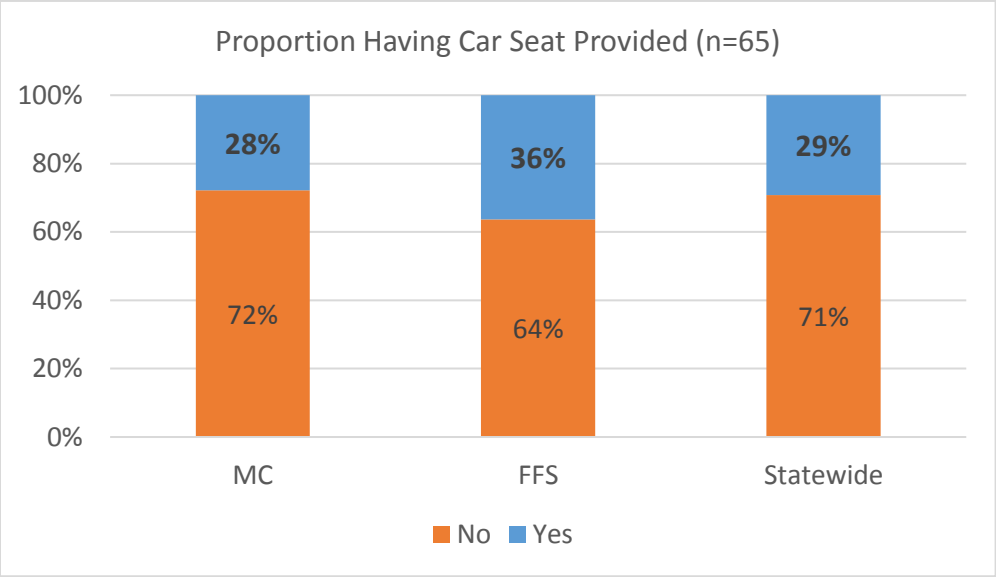
We documented no difference between the vehicle condition scores assigned for working seat belts by region. However, Region 10 had significantly lower ratings than Regions 1, 2, and 4 for safety, cleanliness, and running well. Region 10 also had significantly lower safety ratings compared to Region 7. (Table 4).

Table 4: Vehicle Rating by Region

Region	Safe			Clean			Running Well		
	Mean	Lower 95%	Upper 95%	Mean	Lower 95%	Upper 95%	Mean	Lower 95%	Upper 95%
R1	9.7	9.5	9.9	9.7	9.5	9.9	9.8	9.7	10.0
R2	9.2	8.8	9.6	9.1	8.7	9.6	9.3	8.9	9.7
R4	9.2	8.8	9.6	9.2	8.8	9.6	9.5	9.2	9.9
R7	9.2	8.7	9.7	8.8	8.1	9.6	9.2	8.6	9.7
R8	8.7	8.1	9.3	8.6	8.0	9.3	9.1	8.5	9.6
R9	8.2	7.4	9.0	8.6	7.9	9.3	8.5	7.7	9.3
R10	7.8	7.0	8.6	7.5	6.7	8.3	8.0	7.2	8.7

Approximately 1/3 of respondents indicated drivers provided car seats when needed (n=64). However, among those that did, 90% (n=17) reported them to be clean and in good working condition.

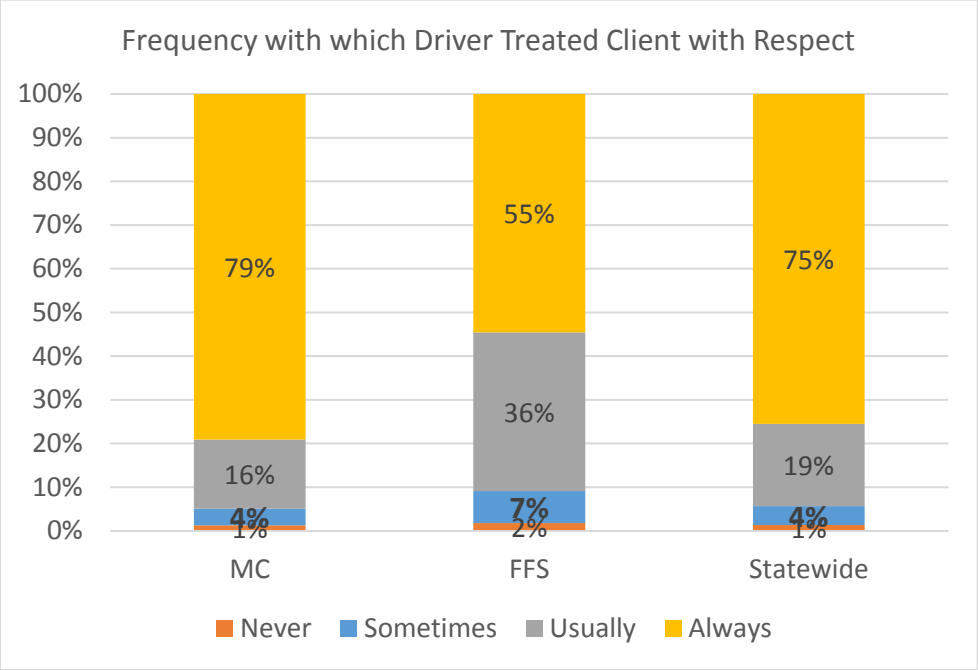
Figure 27. Proportion of Drives Providing Car Seat when Needed



How you were treated

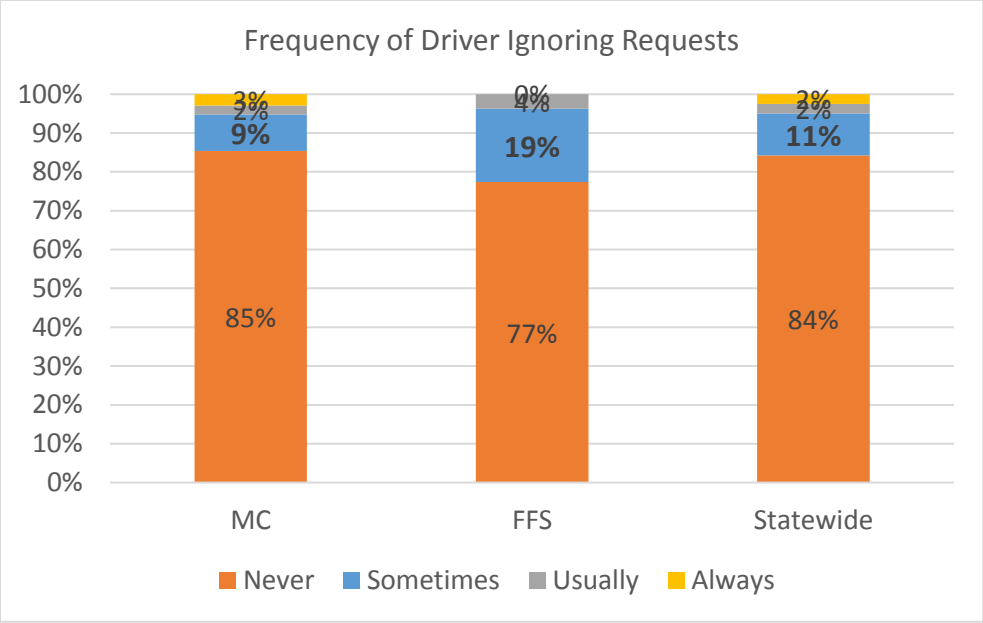
MC beneficiaries reported that the driver always (79%) or usually (16%) treated them with respect compared to responses for FFS beneficiaries (55%, 36%) respectively. However, more than 5% indicated that the driver never or only sometimes treated them with courtesy or respect.

Figure 28. How often did the driver treat you with courtesy and respect during a ride



About 5% reported that the driver always or usually ignored requests. About 80% answered that the driver never ignored their request.

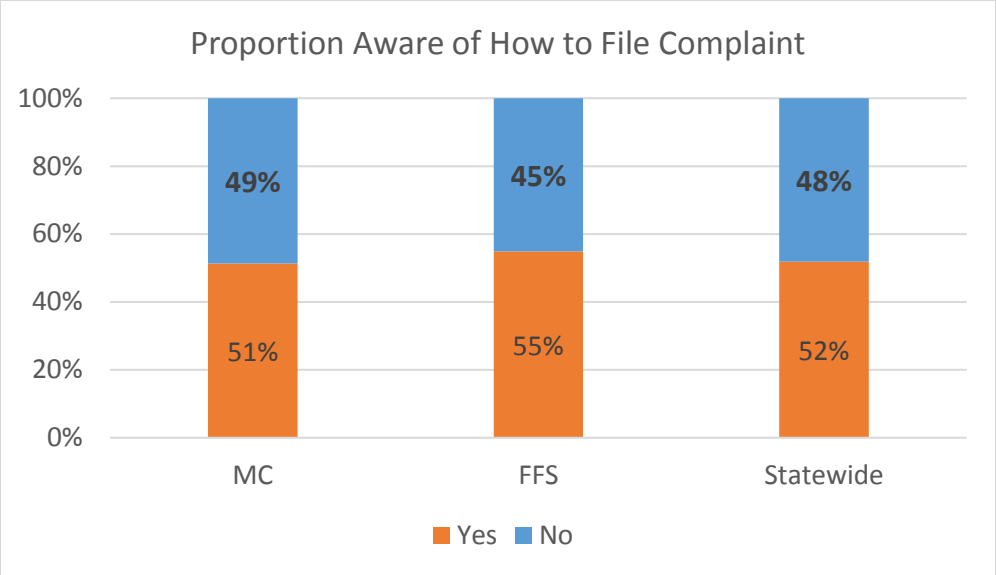
Figure 29. Frequency of Driver Ignoring Requests



File a Complaint

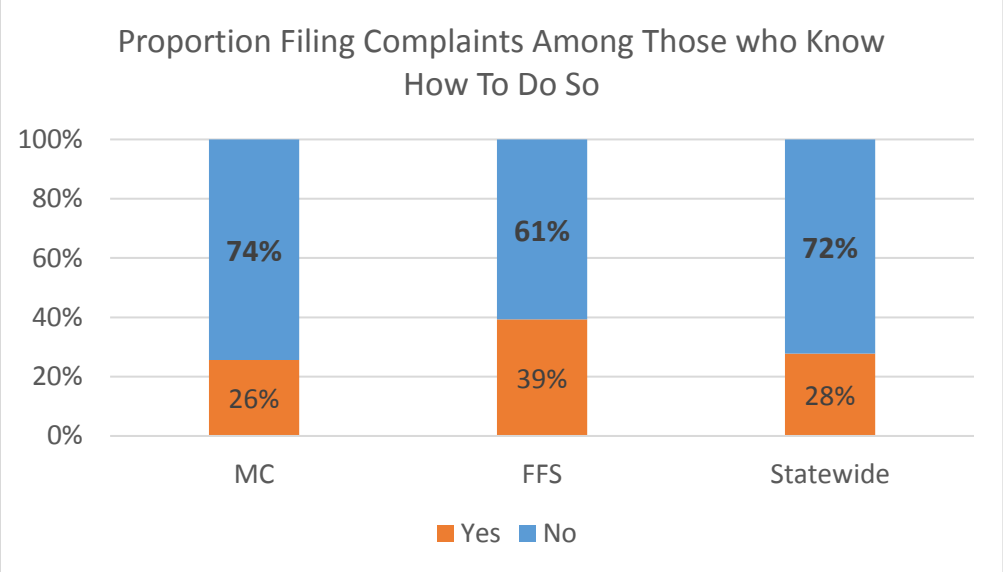
Only half of those that responded to the survey reported they knew how to file a complaint. (Figure 29).

Figure 29. Proportion Aware of How to File Complaint



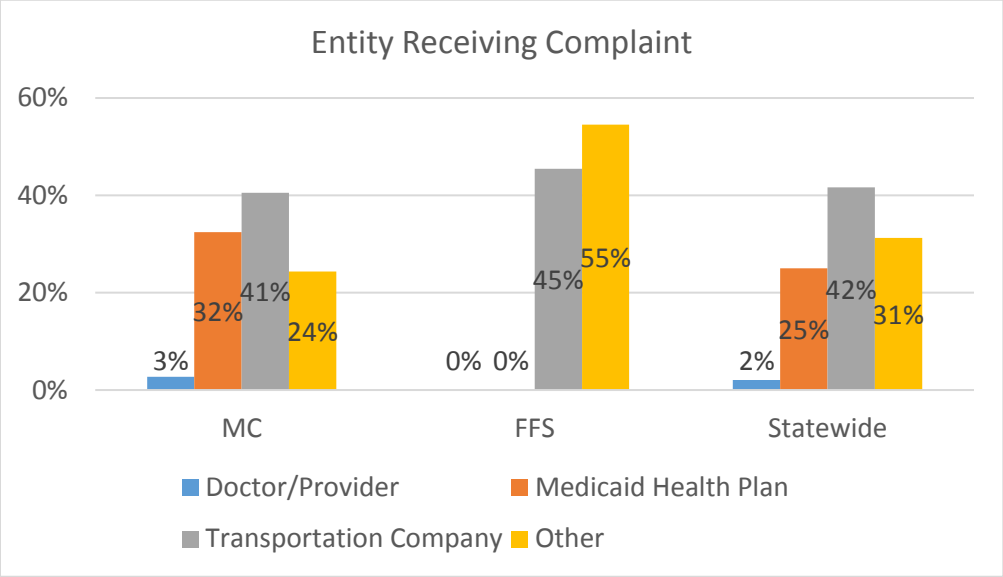
About 40% of the Users in FFS filed a complaint and about 26% of the Users in MC filed a complaint.

Figure 30. Proportion Reporting They Filed Complaint



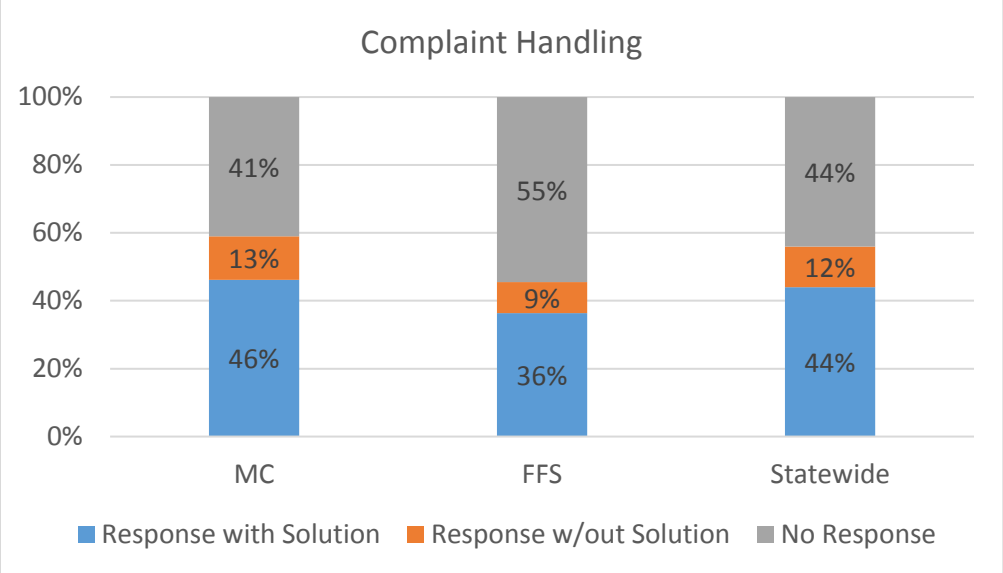
More than 40% of the FFS Users who filed complaints reported the issues to the transportation service company followed by their Medicaid Health Plan. Of note, just two individuals reported complaints to the drivers directly in addition to contacting transportation companies. Most of the "Other" responses targeted the transportation company (Logisticare) followed by the health plan.

Figure 31.Entity Contacted with Complaint Among Those who Filed



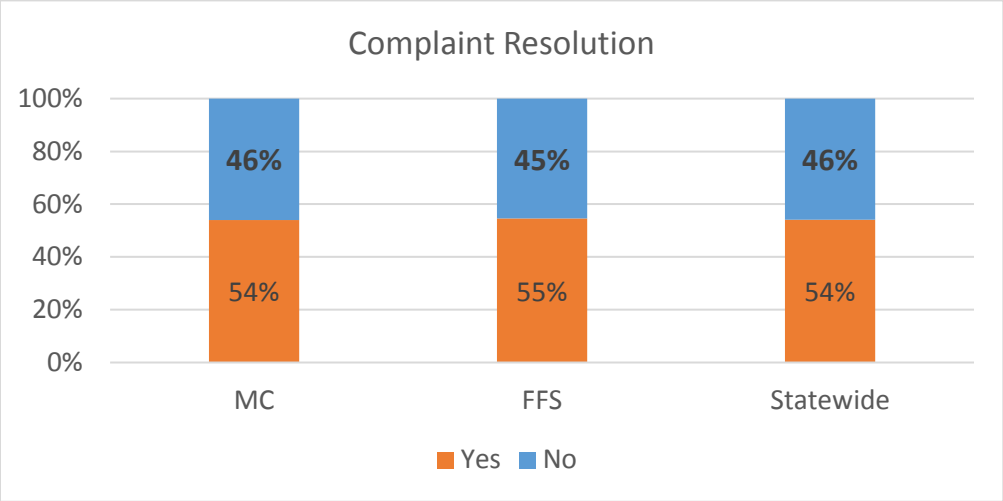
More than 40% of Users that filed a complaint reported they did not receive a reply to their complaints (Figure 32).

Figure 32. Proportion Experiencing Categories of Complaint Handling



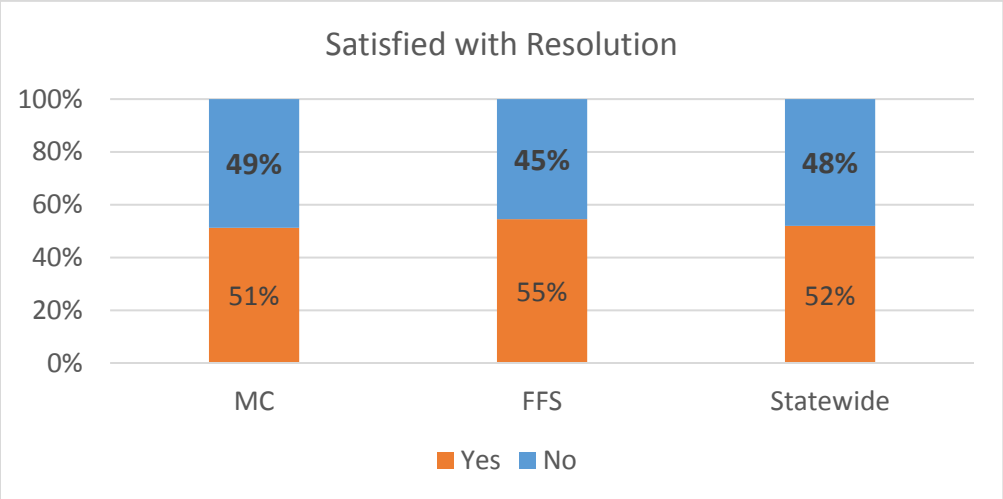
About 54% of the Users that filed complaints reported the complaints were resolved (Figure 33).

Figure 33. Complaint Resolution



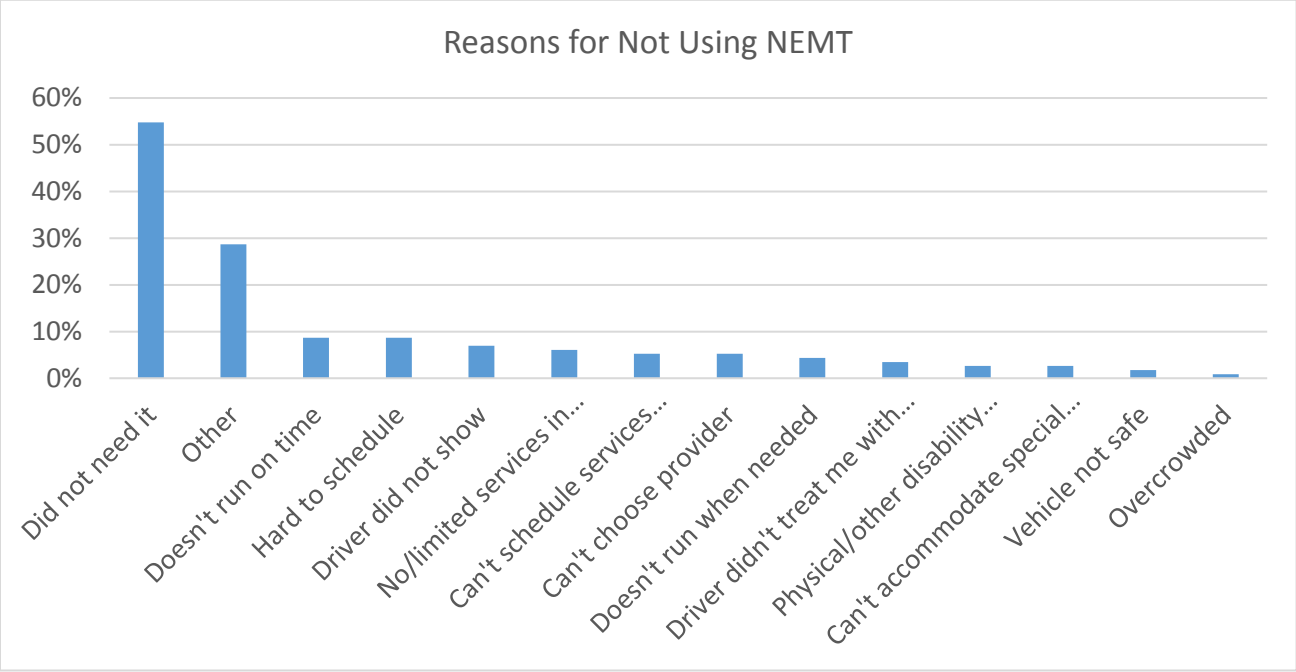
Approximately the same proportion reported satisfaction with the resolution of their complaint. Reasons for dissatisfaction are primarily that nothing changes in response to complaints. Several individuals indicated they felt their comments/situations were not believed or taken seriously by those that received the complaint, “They are rude/argue with you and often take the side of the providers”, “I was told no driver working with the company drove the way described”.

Figure 34. Resolution Satisfaction



More than 50% respondents who did not use NEMT reported they did not need these services. Less than 10% of the respondents did not use NEMT due to the difficulty in scheduling, no service, and/or the service did not run on time. We were able to reassign some of the 37 “Other” responses into existing options. Most, 18 (49%) had other options and did not need the transportation with most of these indicating they have their own car. Six others reported they prefer to drive themselves with specifically mentioning reimbursements. A few individuals mentioned not being eligible for the service after becoming eligible for Medicare.

Figure 35. The reasons you did not use NEMT.



General Comments:

- 288 individuals provided general comments as part of the survey process
    - 39% of these were entirely positive expressing gratitude for the service and fondness for the drivers.
    - 15% provided only negative feedback.
    - 8% indicated they arranged their own transportation and expressed satisfaction with reimbursement system that support these arrangements.
    - 40% included both positive and negative experiences with some offering suggestions for what would improve their experiences.

Chief among suggested improvements:

- Improving timeliness
- Preventing no-shows or cancellations
- Providing a mechanism for beneficiaries to select the transportation company that provides service.
- Respondents suggest calls from the driver about one hour ahead of pick-up would be helpful (confirming the ride and estimated arrival so they could be prepared, be watching for them, and alleviate concern about a no-show.)
- Having a mechanism to arrange for transportation with just 24 hours-notice would be helpful
- Transportation regulations such as only being able to schedule a ride within a current month, only allowing one ride per day, or only allowing pharmacy transportation on a day with a provider visit as barriers.
- Same day surgical procedures identified as problematic with facilities not wanting to perform these when transportation was not present before and during the procedure.
- Other comments reflected the categories of driver and scheduler rudeness, overcrowding and concern over how driver was operating vehicle (speeding, lane changes, etc.).

- Several beneficiaries reported dismay over losing eligibility for these services after enrolling in Medicare.

Comments of concern:

- Several reported harassment and assault from NEMT providers.
    - One reports they contacted law enforcement.
    - Another reported they were “kicked out” of the vehicle after a seizure and left at the side of the road until an ambulance arrived.
- Respondents mentioned that when they contact the transportation company with complaints, they felt they were not believed or taken seriously, “they always take the drivers side”.
- After submitting complaint(s), some report being subsequently informed their “account was closed” or that the service was no longer available to the destination they identified.
- Beneficiaries reported being dropped by doctors because of problems getting to their scheduled appointments and some having to pay “late cancellation fees” or additional penalties when the transportation service was not timely.